DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation
7 CCR 1101-3
WORKERS' COMPENSATION RULES OF PROCEDURE

Rule 16 UTILIZATION STANDARDS

16-1 STATEMENT OF PURPOSE

In an effort to comply with its legislative charge to assure appropriate and timely medical care at a reasonable cost, the Director (Director) of the Division of Workers' Compensation (Division) has promulgated these utilization standards, effective January 1, ~~2017~~2018. 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. With respect to any matter arising under the Colorado Workers' Compensation Act and/or the Workers' Compensation Rules of Procedure and to the extent not otherwise precluded by the laws of this state, all providers and payers shall use and comply with the provisions of the "Medical Treatment Guidelines," Rule 17, and the "Medical Fee Schedule," Rule 18, as incorporated and defined in the Workers' Compensation Rules of Procedure, 7 CCR 1101-3.

16-2 STANDARD TERMINOLOGY FOR RULES 16 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.

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(E) Certificate of Mailing – a signed and dated statement containing the names and mailing addresses of all persons receiving copies of attached or referenced document(s), certifying the documents were placed in the U.S. Mail, postage pre-paid, to those persons.

(F) Children's Hospital – identified and Medicare-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) – Medicare-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 –licensed and Medicare-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, "Medical Treatment Guidelines."

(O) Over-the-Counter Drugs – Drugs that are safe and effective for use by the general public without a prescription.

(P) Payer – an insurer, employer, or their designated agent(s) who is responsible for payment of medical expenses.

(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 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 – Medicare-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) "Supply et al." – any single supply, durable medical equipment (DME), orthotic, prosthesis, biologic item, or single drug dose, for which the billed amount exceeds $500.00 and all implants.

(X) 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. .

(Y) 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 treatment plan, including medications and/or specialized therapy.

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

16-3 REQUIRED USE OF THE MEDICAL TREATMENT GUIDELINES AND PAYMENT FOR SERVICE

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. 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 contest appropriate processes to deny are required. Refer to applicable sections of 16-10, 16-11 and/or 16-12.

16-4 REQUIRED USE OF THE MEDICAL FEE SCHEDULE

(A) When services provided to an injured worker fall within the purview of the Medical Fee Schedule, all payers shall use the fee schedule to determine maximum allowable fees~~.~~, except as permitted by Rule 16-5(B)(3).

(B) Providers must accurately report their services using codes and modifiers listed in the National Relative Value File, as published by Medicare in ~~January 2016~~the February 2017 Resource Based Relative Value Scale (RBRVS). Providers also must use codes, modifiers, instructions, and parenthetical notes listed in the American Medical Association's Current Procedural Terminology (CPT®) ~~2016~~2017 edition. Finally, providers must use codes, modifiers, and billing instructions listed in Rule 18, Medical Fee Schedule. The Medical Fee Schedule sets the maximum allowable payment but the fee schedule does not limit the billing charges.

(C) The provider may be subject to penalties under the Workers' Compensation Act 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.

16-5 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 state boards:

~~1)~~ (i) Colorado Medical Board;

(ii) ~~2)~~ Colorado Board of Chiropractic Examiners;

(iii) ~~3)~~ Colorado Podiatry Board; or

(iv) ~~4)~~ Colorado Dental Board.

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), C.R.S.

(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:

~~1)~~(i) Acupuncturist (LAc) – licensed by the Office of Acupuncture Licensure, Colorado Department of Regulatory Agencies;

~~2)~~(ii) Advanced Practice Nurse (APN) – licensed by the Colorado Board of Nursing; Advanced Practice Nurse Registry;

~~3)~~(iii) Anesthesiologist Assistant (AA) – licensed by the Colorado Medical Board, Colorado Department of Regulatory Agencies;

~~4)~~(iv) Athletic Trainers (ATC) –registered by the Office of Athletic Trainer Registration, Colorado Department of Regulatory Agencies;

~~5)~~(v) Audiologist (AU.D. CCC-A) – licensed by the Office of Audiology and Hearing Aid Provider Licensure, Colorado Department of Regulatory Agencies;

~~6)~~(vi) Certified Registered Nurse Anesthetist (CRNA) – licensed by the Colorado Board of Nursing;

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~~7)~~(vii) Clinical Social Worker (LCSW) – licensed by the Board of Social Work Examiners, Colorado Department of Regulatory Agencies;

~~8)~~(viii) Durable Medical Equipment, Prosthetic, Orthotics and Supplies (DMEPOS) Supplier – licensed by the Colorado Secretary of State;

~~9)~~(ix) Marriage and Family Therapist (LMFT) – licensed by the Board of Marriage and Family Therapist Examiners, Colorado Department of Regulatory Agencies;

~~10)~~(x) Massage Therapist (MT) –licensed as a massage therapist by the Office of Massage Therapy Licensure, Colorado Department of Regulatory Agencies;

~~11)~~(xi) Nurse Practitioner (NP) – licensed as an APN and authorized by the Colorado Board of Nursing;

~~12)~~(xii) Occupational Therapist (OTR) – licensed by the Office of Occupational Therapy, Colorado Department of Regulatory Agencies,;

~~13)~~(xiii) Optometrist (OD) – licensed by the Board of Optometry, Colorado Department of Regulatory Agencies;

~~14)~~(xiv) Orthopedic Technologist (OTC) – certified by the National Board for Certification of Orthopedic Technologists;

~~15)~~(xv) Pharmacist – licensed by the Board of Pharmacy, Colorado Department of Regulatory Agencies;

~~16)~~(xvi) Physical Therapist (PT) – licensed by the Physical Therapy Board, Colorado Department of Regulatory Agencies;

~~17)~~(xvii) Physical Therapist Assistant (PTA) – licensed by the Physical Therapy Board, Colorado Department of Regulatory Agencies;

~~18)~~(xviii) Physician Assistant (PA) – licensed by the Colorado Medical Board;

~~19)~~(xix) Practical Nurse (LPN) – licensed by the Colorado Board of Nursing;

~~20)~~(xx) Professional Counselor (LPC) – licensed by the Board of Professional Counselor Examiners, Colorado Department of Regulatory Agencies;

~~21)~~(xxi) Psychologist (PsyD, PhD, EdD) – licensed by the Board of Psychologist Examiners, Colorado Department of Regulatory Agencies;

~~22)~~(xxii) Registered Nurse (RN) – licensed by the Colorado Board of Nursing;

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~~23)~~(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;

~~24)~~(xxiv) Speech Language Pathologist (CCC-SLP) – certified by the Office of Speech-Language Pathology Certification, Colorado Department of Regulatory Agencies; and

~~25)~~(xxv) Surgical Technologist (CST) – registered by the Office of Surgical Assistant and Surgical Technologist Registration, Colorado Department of Regulatory Agencies.

(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 16-5(A)(1)(a) or (b) must comply with section 16-10, Prior Authorization when providing all services.

(4) Referrals:

(a) A payer or employer shall not redirect or alter the scope of an authorized treating provider'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 an authorized treating physician. An authorized treating physician making the referral to any listed or unlisted non-physician provider 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) Rule 18, Medical Fee Schedule applies to authorized services provided in relation to a specific workers' compensation claim.

(6) 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 provider 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.

(d) 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), C.R.S. 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.

(e) 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) Injured Worker Relocated

(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) ~~1)~~ Through referral by the injured worker's authorized treating physician; or

(ii) ~~2)~~ In accordance with § 8-43-404 (5)(a), C.R.S.

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(2) Injured Worker Referred

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 16-10, Prior Authorization. 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.

(3) The Colorado fee schedule should govern reimbursement for out-of-state providers~~.~~, but the payer and provider may negotiate reimbursement in excess of

this fee schedule when necessary to obtain reasonable and necessary care for an injured worker.

16-6 HANDLING, PROCESSING AND PAYMENT OF MEDICAL BILLS

(A) 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 employer or insurer from their legal responsibilities for compliance with these Rules.

(B) Payment for billed services identified in the Medical Fee Schedule shall not exceed those scheduled rates and fees, or the provider's actual billed charges, whichever is less. except as permitted by Rule 16-5(B)(3).

(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 as set forth in section 16-10, Prior Authorization, 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 the prior authorization request exception(s) include ambulance bills or supply bills that are covered under Rule18-6(H) with an identified payment mechanism.

Similar established code values from the Medical Fee Schedule, recommended by the requesting physician, shall govern the maximum fee value payment.

(D) Any payer contesting a provider's treatment shall follow the procedures as outlined under section 16-11, Contest of a Request for Prior Authorization, or section 16-12, Payment of Medical Benefits.

~~(E) International Classification of Diseases (ICD) codes shall not be used to establish the work relatedness of an injury or treatment.~~

16-7 REQUIRED BILLING FORMS AND ACCOMPANYING DOCUMENTATION

(A) Providers may use electronic reproductions of any required form(s) referenced in this section; however, any such reproduction shall be an exact duplication of such form(s) in content and appearance. With the agreement of the payer, identifying information may be placed in the margin of the form.

(B) Required Billing Forms

All health care providers shall use only the following billing forms or electronically produced formats when billing for services:

(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.

(a) 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 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 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 UB-04.

(3) American Dental Association's Dental Claim Form, Version 2012 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.

NCPDP Workers' Compensation/Property and Casualty (P&C) universal claim form, version 1.1, for prescription drug billed on paper shall be used by dispensing pharmacies and pharmacy benefit managers (PBM). Physicians may use the CMS-1500 billing form as described in section 16-7(B)(1).

Physicians shall list the "repackaged" and the "original" NDC numbers in field 24 of the CMS-1500. List the "repackaged" NDC number first and the "original" NDC number second, with the prefix 'ORIG' appended.

(C) International Classification of Diseases (ICD) Codes

All provider bills~~, including outpatient hospital bills,~~ shall list the ~~appropriate diagnosis codes using the~~ current ICD-10~~-~~ Clinical Modification (CM) diagnosis code(s~~).~~) and preferably include the Chapter 20 External Causes of Morbidity code(s). If ICD-10-CM requires a seventh character ~~is required by ICD-10-CM, it~~, the provider must ~~be applied~~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 code(s) shall not be used as a sole factor to establish work-relatedness of an injury or treatment.

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(D) Required Billing Codes

All billed services shall be itemized on the appropriate billing form as set forth in sections 16-7(A) and (B), and shall include applicable billing codes and modifiers from the Medical Fee Schedule. 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 should be that of the rendering provider and should include the correct place of service codes at the line level.

(E) Inaccurate Billing Forms or Codes

Payment for any services not billed on the forms identified in this Rule, and/or not itemized as instructed in sections 16-7(B) and (C), may be contested until the provider complies. However, when payment is contested, the payer shall comply with the applicable provisions set forth in section 16-12, Payment of Medical Benefits.

(F) Accompanying Documentation

(1) Authorized treating physicians sign (or countersign) 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:

(a) The report type as "initial" when the injured worker has ~~their~~his or her initial visit with the authorized treating physician managing the total workers' compensation claim of the patient. Generally, this will be the designated or selected authorized treating physician. When applicable, the emergency room or urgent care authorized treating physician for this workers' compensation injury may also create a WC 164 initial report. Unless requested or prior authorized by the payer in a specific workers' compensation claim, no other authorized physician should complete and bill for the initial WC 164 form. This form shall include completion of items 1-7 and 10. Note that certain information in item 2 (such as Insurer Claim #) may be omitted if not known by the provider.

(b) The report type as "closing" when the authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient determines the injured worker has reached maximum medical improvement (MMI) for all injuries or diseases covered under this workers' compensation claim, with or without a permanent impairment. The form requires the completion of items 1-5, 6.B, C, 7, 8 and 10. If the injured worker has sustained a permanent impairment, then item 9 must also be completed and the following additional information shall be attached to the bill at the time MMI is determined:

(i) ~~1)~~ All necessary permanent impairment rating reports when the authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient is Level II Accredited; or

(ii) ~~2)~~ Referral to a Level II Accredited physician requested to perform the permanent impairment rating when a rating is necessary and the authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient is not determining the permanent impairment rating.

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(c) At no charge, the physician shall supply the injured worker with one legible copy of all completed "Physician's Report of Workers' Compensation Injury" (WC 164) forms at the time the form is completed.

(d) The provider shall submit to the payer the completed WC 164 form as specified in section 16-7(F), no later than 14 days from the date of service.

(2) Providers, other than hospitals, shall provide the payer with all supporting documentation at the time of submission of the bill unless other agreements have been made between the payer and provider. This shall include copies of the examination, surgical, and/or treatment records.

(3) Hospital documentation shall be available to the payer upon request. Payers shall specify what portion of a hospital record is being requested. (For example, only the emergency room (ER) chart notes, in-patient physician orders and chart notes, x-rays, pathology reports, etc.)

(4) In accordance with section 16-12, the payer may contest payment for billed services until the provider completes and submits the relevant required accompanying documentation as specified by section16-7(F).

(G) 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. 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.

(H) 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 properly documented. 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 July 2016 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)).

16-8 REQUIRED MEDICAL RECORD DOCUMENTATION

(A) A treating provider shall maintain medical records for each injured worker when the provider intends to bill for the provided services.

(B) All medical records shall contain legible documentation substantiating the services billed. The documentation shall itemize each contact with the injured worker and shall detail at least the following information per contact or, at a minimum for cases where contact occurs more than once a week, be summarized 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 the prior authorization for payment, services authorized, dollar amount, length of time, etc.).

16-9 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 16-9 (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).

(1) The completed form shall include:

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

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

(c) 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 contest of the proposed treatment. Initially, payer may limit its approval to the number of treatments or treatment duration listed in the "time to produce effect" section(s) of the relevant Medical Treatment Guideline(s), without a medical review. If subsequent medical records document functional progress, payer shall pay for the additional number of treatments/treatment duration listed in the relevant Guideline(s). 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 16-11(B).

~~(D)~~(E) Payers may 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:

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

(3) Provider submitting Notification is not an Authorized Treating Provider (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 (see section 16-9(E~~)~~)).

~~(E)~~(F) If the payer contests Notification under sections (16-9(D)(2), (5) or (6) above, the payer shall notify the provider, allow the submission of relevant supporting medical documentation as defined in section 16-10 (F), and review the submission as a prior authorization request, allowing an additional seven (7) business days for review.

~~(F)~~(G) Contests for denied Notification by a provider shall be made in accordance with the prior authorization dispute process outlined in 16-11(C).

~~(G)~~(H) Any provider or payer who incorrectly applies the Medical Treatment Guidelines in the Notification/prior authorization process may be subject to penalties under the Workers' Compensation Act.

16-10 PRIOR AUTHORIZATION

(A) Granting of prior authorization is a guarantee of payment when in accordance with Rule 18, RBRVS and CPT® for those services/procedures requested by the provider per section16-10 (F).

(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 16-6(C).

(C) Prior authorization for a prescribed service or procedure may be granted immediately and without medical review. However, the payer shall respond to all providers requesting prior authorization within seven (7) business days from receipt of the provider's completed request, as defined in section16-10(F). The duty to respond to a provider's written request applies without regard for who transmitted the request.

(D) The payer, ~~upon receipt of the "Employer's First Report of Injury" or a "Worker's Claim for Compensation," shall give written notice to the injured worker stating that the requirements for obtaining prior authorization for payment are available from the payer.~~

~~(E) The payer,~~ unless ~~they have~~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.

(~~F~~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.

(1) When the indications of the Medical Treatment Guidelines are met, no prior authorization is required. When prior authorization for payment is indicated, the following documentation is required:

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

(b) Identification of the appropriate Medical Treatment Guideline application to the requested service, if applicable; and

(c) Final diagnosis.

(2) When the service/procedure does not fall within the Medical Treatment Guidelines and/or past treatment failed functional goals; or if the requested procedure is not identified in the Medical Fee Schedule or does not have an established value under the Medical Fee Schedule, such as any unlisted procedure/service with a BR value or an RNE value listed in the RBRVS, authorization requests may be made using the "Authorized Treating Provider's Request for Prior Authorization" (Form WC 188).

(~~G~~F) To contest a request for prior authorization, the payer is required to comply with the provisions outlined in section 16-11.

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

(~~I~~H) If, after the service was provided, the payer agrees the service provided was reasonable and necessary, lack of prior authorization for payment does not warrant denial of payment. However, the provider is still required to provide, with the bill, the documentation required by section 16-10(F) for any unlisted valued service or procedure for payment.

(~~J~~I) All medical records should be signed by the rendering provider. Electronic signatures are accepted.

16-11 CONTEST OF A REQUEST FOR PRIOR AUTHORIZATION

(A) If the payer contests a request for prior authorization for non-medical reasons as defined under section 16-12(B)(1), the payer shall notify the provider and parties, in writing, of the basis for the contest within seven (7) business days from receipt of the provider's

completed request as defined in section 16-10(F). A certificate of mailing of the written contest must be sent to the provider and parties.

If an ATP requests prior authorization and indicates in writing, including ~~their~~ reasoning and relevant documentation, that ~~they believe~~he or she believes the requested treatment is related to the admitted workers' compensation claim, the insurer cannot deny ~~based~~ solely ~~on~~for relatedness without a medical ~~review~~opinion as required by section 16-11(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) If the payer is 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 16-10(F) reviewed by a physician or other health care professional, as defined in section 16-5(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 physicians or chiropractors performing this review shall be Level I or Level II accredited.

(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 contest or approval still needs to be completed within the specified seven (7) business days under section 16-11(B).

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

(a) An explanation of the specific medical reasons for the 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 exhibits to Rule 17, when applicable;

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

(d) A certificate of mailing to the provider and parties.

(C) Prior Authorization Disputes

(1) The requesting party or provider shall have seven (7) business days from the date of the certificate of mailing on the written contest to provide a written response to the payer, including a certificate of mailing. 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 certificate of mailing of the response to issue a final decision, including a certificate of mailing 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 authorized treating provider, shall be deemed good cause for an expedited hearing.

(E) Failure of the payer to timely comply in full with ~~the requirements of~~ section 16-11(A) or (B~~),~~) shall be deemed authorization for payment of the requested treatment unless~~:~~

~~(1)~~ ~~A hearing is requested~~ the payer has scheduled an independent medical examination (IME) and notified the requesting provider of the IME within the time prescribed for responding ~~as~~ set forth in section 16-11(~~A)~~B). The IME must occur within 30 days, or ~~(B) and the requesting provider is notified accordingly. A~~upon first available appointment, of the prior authorization request ~~for hearing~~, not to exceed 60 days absent an order extending the deadline. The IME physician must issue his or her report within 20 days of the IME and the insurer shall ~~not relieve the payer from conducting a medical review of the requested treatment, as set forth in section 16-11(B); or~~

~~(2)~~ ~~The~~ respond to the prior authorization request within five business days of the receipt of the IME report. If the injured worker does not attend or reschedules the IME, the payer ~~has scheduled an independent medical examination (IME) within the time prescribed for responding as set forth in section 16-11(B).~~may deny the prior authorization request pending completion of the IME. The IME shall comply with Rules 8-8 to 8-13 as applicable.

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(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.

16-12 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. In those instances where 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 then the payer's written notice shall include:

(a) Name of the injured worker or patient;

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

(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 relevant issue is being brought to hearing.

(2) The payer shall send the billing party written notice that complies with sections 16-12(A)(1) and (B) or (C) if contesting payment for non-medical or medical reasons within 30 days of receipt of the bill. Any notice that fails to include the required information set forth in sections 16-12(A)(1) and (B) or (C) if contesting payment for non-medical or medical reasons is defective and does not satisfy the payer's 30-day notice requirements set forth in this section.

(3) Unless the payer provides timely and proper reasons as set forth by the provisions outlined in sections 16-12(B) - (D), all bills submitted by a provider are due and payable in accordance with the Medical Fee Schedule within 30 days after receipt of the bill 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, 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 may report the incident to the Division's Carrier Practices Unit who may use it during an audit.

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

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

(2) If an ATP bills for medical services and indicates in writing, including ~~their~~ reasoning and relevant documentation that ~~they believe~~he or she believes the medical services are related to the admitted WC claim, the payer cannot deny ~~based~~ solely ~~on~~for relatedness without a medical review as required by section 16-12(C). A medical review that only addresses the relatedness of the requested treatment to the admitted claim may precede the prior authorization request.

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(3) In all cases where a billed service is contested for non-medical reasons, the payer shall send the billing party written notice of the contest within 30 days of receipt of the bill. The written notice shall include all of the notice requirements set forth in section 16-12(A)(1) and shall also include:

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

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

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

(d) Clear and persuasive reasons for 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 for contesting payment.

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) Prior to modifying or down-coding a billed code, the payer must contact the billing provider and determine if the ~~modified~~ code is accurate or, in the case of down-coding, 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 ~~their~~the explanation of benefits (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 is in disagreement, then the payer shall proceed according to section 16-12(B) or 16-12(C), as appropriate.

(5) Lack of prior authorization for payment does not warrant denial of liability for 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 ~~their~~the written notice of contest (see section 16-12(A)(1)) 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 as required by section 16-10(F~~); or~~).

~~(c) The billed charges.~~

If the payer disagrees with the provider's recommended code value, the 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 ~~what their~~how the payer calculated/derived its maximum fee recommendation ~~is, based on the payment options.~~

. If the payer is contesting the medical necessity of any non-valued procedure after a prior authorization was requested, the payer shall follow section 16-12(C).

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

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

(1) Have the bill and all supporting medical documentation under section 16-7(F) reviewed by a physician or other health care professional as defined in section 16-5(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 physicians or chiropractors performing this review shall be Level I or Level II accredited. 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 contested for medical reasons, the payer shall send the provider and the parties written notice of the contest within 30 days of receipt of the bill. The written notice shall include all of the notice requirements set forth in section 16-12(A)(1) and shall also include:

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

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

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

(d) An explanation of the 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 exhibits to Rule 17, when applicable; and

(f) Identification of the information deemed most likely to influence the reconsideration of the 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 contesting the medical necessity of any non-valued procedure provided without prior authorization, the payer shall follow the procedures given in sections 16-12(C)(1)and (2).

(D) Process for Ongoing Contest of Billed Services

(1) The billing party shall have 60 days to respond to the payer's written notice under section 16-12(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) contested;

(d) Clear and persuasive supporting documentation or clear and persuasive reasons for the 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 16-12(D)(1), the payer shall:

(a) When contesting for medical reasons, have the bill and all supporting medical documentation and reasoning under section16-7(F) and, if applicable, section 16-12(D)(1) reviewed by a physician or other health care professional as defined in section 16-5(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. After reviewing the provider's 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 contesting for non-medical reasons, have the bill and all supporting medical documentation and reasoning under section 16-7(F) and, if applicable, section 16-12(D)(1) reviewed by a person who has knowledge of the bill. After reviewing the provider's documentation and response, the reviewing person may call the billing 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 16-12(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 16-12(D)(2), if there is still a dispute regarding the billed services, the payer shall send the billing party written notice of contest within 30 days of receipt of the response. The written notice shall include all of the notice requirements set forth in section 16-12(A)(1) and shall also include:

(a) Date(s) of service(s) being contested, if date(s) was(were) submitted by the provider;

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

(c) Reference to the bill and each item of the bill being 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 contest is over a medical reason; and

(e) The explanation shall include the citing of appropriate statutes, rules and/or documents supporting the payer's reasons for 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, and within 12 months of the date the original bill should have been processed in compliance with section 16-12, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts.

(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 explanation of benefits 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, C.R.S.

(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 or other health care professional as defined in section 16-5(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 payer shall send the billing party written notice that shall include all of the notice requirements set forth in section 16-12(A)(1) and shall also 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 of the notice requirements set forth in section 16-12(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 as covered 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 16-12.

16-13 DISPUTE RESOLUTION PROCESS

When seeking dispute resolution from the Division's Medical Policy Unit (MPU), the requesting party must complete the Division's "Medical ~~Billing~~ 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, allowing the other party ten (10) business days to respond.

The MPU 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), C.R.S., upon all sums not paid timely and in accordance with the Division Rules.

Upon review of all submitted documentation, disputes resulting from violation of Rules 11, 16, 17 and ~~/or~~ 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, C.R.S. Daily fines up to $~~1000~~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 MPU 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.

16-14 ONSITE REVIEW OF HOSPITAL OR OTHER MEDICAL CHARGES

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

(B) 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:

(1) Name of the injured worker;

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

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

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

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

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

(2) 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;

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

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

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

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

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

(2) Negotiate the starting date for the review;

(3) 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;

(4) 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 listing of discrepancies at an exit conference upon the completion of the review; and

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

Style Definition ...

DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation
7 CCR 1101-3
WORKERS' COMPENSATION RULES OF PROCEDURE

Rule 18 MEDICAL FEE SCHEDULE

Table of Contents

18-1 STATEMENT OF PURPOSE

Pursuant to § 8-42-101(3)(a)(I), C.R.S., and § 8-47-107, C.R.S., the Director promulgates this Medical Fee Schedule to review and establish maximum allowable fees for health care services falling within the purview of the Act. The Director adopts and hereby incorporates by reference, as modified and published by Medicare in ~~January 2016~~February 2017, National Physician Fee Schedule Relative Value file (RBRVS-Resource Based Relative Value Scale); the Current Procedural Terminology CPT® ~~2016~~2017, Professional Edition, published by the American Medical Association (AMA); and Medicare Severity Diagnosis Related Groups (MS-DRGs) Definitions Manual, Version 34 using MS-DRGs effective after October 1, ~~2016~~2017. The incorporation is limited to the specific editions named and does not include later revisions or additions. For information about inspecting or obtaining copies of the incorporated materials, contact the Medical Policy Unit Supervisor, 633 17th Street, Suite 400, Denver, Colorado 80202-3626. These materials may be examined at any state publications depository library. All guidelines and instructions are adopted as set forth in the RBRVS, CPT® and MS-DRGs, and all CPT® modifiers, unless otherwise specified in this Rule.

This Rule applies to all services rendered on or after January 1, ~~2017~~2018. All other bills shall be reimbursed in accordance with the fee schedule in effect at the time service was rendered.

18-2 STANDARD TERMINOLOGY FOR THIS RULE

(A) CPT® - Current Procedural Terminology CPT® ~~2016~~2017, copyrighted and distributed by the AMA and incorporated by reference in 18-1.

(B) DoWC Zxxxx – Colorado Division of Workers' Compensation created codes.

(C) MS-DRGs – version 34.0 incorporated by reference in 18-1.

(D) Medicare's ~~January 2016~~February 2017 National Physician Fee Schedule Relative Value file (RBRVS)

(E) For other terms, see Rule 16, Utilization Standards.

18-3 HOW TO OBTAIN COPIES

All users are responsible for the timely purchase and use of Rule 18 and its supporting documentation as referenced herein. The Division shall make available for public review and inspection the copies of all materials incorporated by reference in Rule 18. Copies of the RBRVS may be obtained from Medicare's website, ~~www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/PhysicianFeeSched/Index.html.~~www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/PhysicianFeeSched/Index.html. The Current Procedural Terminology, ~~2016~~2017 Edition, may be purchased from the AMA. The MS-DRGs Definitions Manual may be purchased from 3M Health Information Systems. The Colorado Workers' Compensation Rules of Procedures with Treatment Guidelines, 7 CCR 1101-3, may be purchased from LexisNexis Matthew Bender & Co., Inc., Albany, NY. Interpretive Bulletins and unofficial copies of all rules, including Rule 18, are available on the Colorado Department of Labor and Employment web site. An official copy of the rules is available on the Secretary of State's webpage.

18-4 CONVERSION FACTORS (CF)

The following CFs shall be used to determine the maximum allowed fees. The maximum fee is determined by multiplying the following section CFs by the established facility or non-facility total relative value unit(s) (RVUs) found in the corresponding RBRVS sections:

RBRVS SECTION	CF
Anesthesia	$~~55.61~~50.00/RVU
Surgery	$~~68.01~~71.17/RVU
Radiology	$71.~~99~~17/RVU
Pathology	$68.~~31~~40/RVU
Medicine	$~~67.00~~68.34/RVU
Physical Medicine and Rehabilitation (Includes Medical Nutrition Therapy and Acupuncture)	$~~41.14~~42.38/RVU
Evaluation & Management (E&M)	$~~50.20~~53.53/RVU

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.

~~Table #1~~	
~~Place of Service Code~~	~~Place of Service Code Description~~
~~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~~

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18-5 INSTRUCTIONS AND/OR MODIFICATIONS INCORPORATED BY REFERENCE IN RULE 18-1

(A) MAXIMUM ALLOWANCE

Maximum allowance for all providers under Rule 16-5 is 100% of the RBRVS value or as specified in this Rule. The maximum fee schedule value for professional services ~~provided by a~~of Physician Assistants (PAs) and Nurse Practitioners (NPs) shall be 85% of the Medical Fee Schedule. However, PAs and NPs may be allowed 100% of the Medical Fee Schedule value if the requirements of Rule 16-5(A)(6) have been met and one of the following conditions applies:

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

(a) a county outside a Metropolitan Statistical Area (MSA) or

(b) a Health Professional Shortage Area, either located 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.

(2) The ~~"incident to" criteria found in 42 CFR §§ 410.26(a) and (b), 410.27, and 410.32(b)(3) have been met.~~PA or NP has received Level I accreditation.

(B) RBRVS, CPT AND Z CODES

(1) Unless modified herein, the RBRVS is adopted for RVUs. Division-created codes (Zxxxx) and values supersede the CPT® or RBRVS codes. Those 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

pursuant to Rule 16. The CPT® ~~2016~~2017 is adopted for codes, descriptions, parenthetical notes and coding guidelines, unless modified in this Rule.

(2) When billing for services reported with time-based codes, practitioners are required to document in the medical record the duration of the encounter. The time considered is time spent face-to-face with the patient, performing the billed service (e.g., 60 minutes of psychotherapy) and/or the time spent performing non-face-to-face services/procedures (e.g., prolonged record review).

(3) Any billed CPT® code identified as a "separate procedure" in CPT® shall have an appropriate modifier appended to the code for the payer to allow separate payment (i.e., modifier 59 or one of the below applicable X modifiers).

One of the following descriptive modifiers may be used in place of modifier 59:

(a) XE - Separate Encounter: a service that is distinct because it occurred during a separate encounter.

(b) XS – Separate Structure: a service that is distinct because it was performed on a separate organ/structure.

(c) XP – Separate Practitioner: a service that is distinct because it was performed by a different practitioner.

(d) XU – Unusual Non-Overlapping Service: the use of a service that is distinct because it does not overlap usual components of the main service.

(4) No code listed in CPT® identified as an "add-on" code is payable unless an appropriate primary code is billed with the "add-on" code in the same episode of care.

(5) The National Physician Fee Schedule Relative Value file, as modified, are the only fields recognized in the Colorado Workers' Compensation Medical Fee Schedule:

(a) HCPCS (Healthcare Common Procedure Coding System) –including any non-listed CPT® codes;

(b) Level I (CPT®) and Level II (HCPCS) Modifiers (listed and unlisted);

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

(d) Total Non-Facility RVU;

(e) Total Facility RVU;

(f) PC/TC (Professional Component/Technical Component) Indicators:

(i) "0" – Physician Services Only – PC/TC distinction does not apply to these service codes;

(ii) "1" – Diagnostic Radiology Tests/Services - diagnostic test codes for radiology service may be billed with or without modifiers 26 or TC;

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(iii) "2" – Professional Component Only Codes – stand-alone professional service codes only (no modifier is appropriate because the code description dictates the service is professional only, e.g., CPT® 93010 Electrocardiogram represents "interpretation and report only");

(iv) "3" - Technical Component Only Codes - stand-alone technical service codes only (no modifier is appropriate because the code description dictates the service is technical only, e.g., CPT® 93005 Electrocardiogram represents "tracing only");

(v) "4" – Global Test Only Codes - modifiers 26 and TC cannot be used with these codes because the values equal to the sum of the total RVUs (work, practice expense and malpractice);

(vi) "5" - Incident To Codes - do not apply to workers' compensation;

(vii) "6" - Laboratory Physician Interpretation Codes – clinical laboratory codes for which separate payments for interpretations by laboratory physicians may be made (these codes represent the professional component of a clinical laboratory service and cannot be billed with a modifier TC);

(viii) "7" - Physical Therapy Services – these codes are not recognized by DoWC;

(ix) "8" - Physician Interpretation Codes –clinical laboratory codes for which separate payments may be made only when a physician interprets an abnormal smear for a hospital in-patient. This indicator applies to CPT® codes 88411, 85060, and HCPCS code P3001-26. No TC component is recognized;

(x) "9" - Not Applicable – PC/TC component does not apply to this indicator;

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(g) Global Days;

(h) Conversion factors as specified in Rule 18-4.

(6) CPT® Category III codes listed in the RBRVS may be used for billing with agreement of the payer as to reimbursement. Payment shall be in compliance with Rule 16-6(C).

(C) ANESTHESIA

(1) All anesthesia base values shall be established by the use of the codes as set forth in Medicare's ~~2016~~2017 Anesthesia Base Values. 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 anesthesia is administered by a CRNA or AA:

(a) CRNAs not under the medical direction of an anesthesiologist, reimbursement shall be 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 the anesthesia includes performing the following activities:

(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 the course of 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.

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(2) The following modifiers are to be used when billing for anesthesia services:

(a) AA – anesthesia services performed personally and billed by the anesthesiologist. Maximum allowance is 100% of maximum anesthesia calculated fees.

(b) AD – greater than four (4) concurrent (occurring at the same time) anesthesia service cases being supervised by an anesthesiologist. Maximum allowance for supervising multiple cases is calculated using three (3) base anesthesia units to each case, regardless of the number of base anesthesia units assigned to each specific anesthesia episode of care.

(c) QK – anesthesiologist providing direction to qualified individuals of two (2) to four (4) concurrent anesthesia cases. Maximum allowance is 50% of maximum anesthesia calculated fees for the billing anesthesiologist providing direction.

(d) QX – CRNA or AA service; with medical direction by a physician. Maximum allowance is 50% of the maximum anesthesia calculated fees for the CRNA or AA administering the anesthesia.

(e) QZ – CRNA service; without medical direction by a physician. Maximum allowance is 90% of maximum anesthesia calculated fees for the CRNA.

(f) QY – Medical direction of one CRNA or AA by an anesthesiologist. Maximum allowance is 50% of maximum anesthesia calculated fees for the anesthesiologist providing direction.

(g) QS – Monitored anesthesia care service (MAC).

(h) G8 – Monitored anesthesia care (MAC) for deep complex complicated, or markedly invasive surgical procedure.

(i) G9 – Monitored anesthesia care (MAC) of a patient who has a history of severe cardiopulmonary disease.

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

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

(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

(5) Qualifying circumstance codes are reimbursed using the anesthesia conversion factor:

(a)	Anesthesia complicated by extreme age; under 1 year old or > 70 years old	1 RVU
(b)	Anesthesia complicated by utilization of total body hypothermia	5 RVUs
(c)	Anesthesia complicated by utilization of controlled hypotension	5 RVUs
(d)	Anesthesia complicated by emergency conditions (specify)	2 RVUs

(6) 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.

(7) Anesthesia time begins when the anesthesiologist prepares the patient for the induction of anesthesia and ends when the anesthesiologist is no longer in personal attendance and the patient is placed under postoperative supervision. 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.

(8) Calculation of Maximum Fees for Anesthesia

Base Anesthesia value from the Medicare's ~~2016~~2017 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
Total Maximum Anesthesia Fees

(9) Non-time based Anesthesia Procedures

Modifier -47 shall be used by surgeons performing non-time based anesthesia.

(D) SURGERY

(1) The use of assistant surgeons shall be limited according to the American College Of Surgeons' Physicians as Assistants at Surgery: 2016 Update (April 2016), available from the American College of Surgeons, Chicago, IL, or from their web page. The incorporation is limited to the edition named and does not include later revisions or additions. Copies of the material incorporated by reference may be inspected at any State publications depository library. For information about inspecting or obtaining copies of the incorporated material, contact the Medical Policy Unit Supervisor, 633 17th Street, Suite 400, Denver, Colorado, 80202-3626.

Where the publication restricts use of such assistants to "almost never" or a procedure is not referenced in the publication, prior authorization for payment (see Rule 16-10) is required.

(2) Incidental procedures are commonly performed as an integral part of a total service and do not warrant a separate benefit.

(3) No payment shall be made for more than one (1) assistant surgeon or minimum assistant surgeon without prior authorization for payment (see Rule 16-10).

(4) The payer may use available billing information such as provider credential(s) and clinical record(s) to determine if an appropriate modifier should be used on the bill. To modify a billed code refer to Rule 16-12(B)(4).

(5) When an operation requires two primary surgeons performing two distinct portions of the operation, modifier -62 is used with the procedure in question and reimbursement is increased to 125% of the value, apportioned in relation to the responsibilities and work of each surgeon or 50% of the total increased maximum fee to each surgeon.

Surgical team reimbursement requires prior authorization and the use of modifier - 66 on the surgical codes.

Assistant Surgeon, indicated by modifier -80 has a maximum allowance of 20 % of the surgeon’s fees.

Assistant Surgeon (when qualified resident surgeon is not available), indicated by modifier -82, is also reimbursed at 20% of the surgeon’s fees.

Minimum Assistant Surgeon's maximum fees are 10% of the surgeon's fees. Modifiers should be appended as follows:

(a) –AS for services performed by NPs or PAs (the 85% adjustment in section 18-5(A) does not apply);

(b) –81 for services performed by clinical nurse specialists, surgical technicians, or any other non-physician providers~~;~~.

(6) Global Period

(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) Intraoperative services that are normally a usual and necessary part of a surgical procedure;

(iv) Immediate postoperative 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 postoperative follow-up care during the global period of the surgery that is related to recovery from the surgery as identified in RBRVS as global:

- 000 –are endoscopies or some minor surgical procedures, typically a 0 day postoperative period. Visits on the same day of procedures are generally included in the allowance for the procedure, unless a separately identifiable service is performed and billed with the appropriate modifier.
- 010 - are other minor procedures, 10 day postoperative period.
- 090 - are major surgeries, 90 day postoperative period.
- XXX – does not apply
- ZZZ – are covered under another procedure's global days
- MMM – global service day's concept does not apply. (See Medicare's Global Maternity Care reporting rule.)
- Global period, defined RBRVS, begins the day after surgery and continues for the defined period.

(viii) Supplies – Except for those identified as exclusions;

(ix) Miscellaneous Services – Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts and splints; insertion, irrigation and removal of urinary catheters, routine peripheral IV lines, ~~nasogastric~~nasogastric and rectal tubes; changes and removal of tracheostomy tubes;

(x) Applicable Surgical Modifiers:

- 22 – Increased procedural service. The payer and provider shall negotiate the value based on the fee schedule and the amount of additional work.

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- 24 - Unrelated E&M service by the same physician during a postoperative period.
- 25 - Significant and separately identifiable E&M service on the same day of the procedure within the global period of minor surgical procedures (0 or 10 days).
- 54 - Surgical Care only. Fee is 60% of the billed surgery code Maximum Fee Schedule value.
- 55 - Postoperative management only. Fee is 30% of the billed surgery code Maximum Fee Schedule value.
- 56 - Preoperative management only. Fee is 10% of the billed surgery code Maximum Fee Schedule value.
- 57 - Decision for surgery.
- 58 - Staged or related procedure or service by the same physician during the postoperative period.
- 76 - Repeat procedure or service by the same physician.
- 78 - Unplanned Return to the Operating/Procedure Room by the same physician following initial procedure for a related procedure during the postoperative period.
- 79 - Un-related procedure or service by the same physician during the postoperative period.

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(b) The following services performed during a global period would warrant separate billing if documentation demonstrates significant identifiable services were involved, such as:

(i) E&M services unrelated to the primary surgical procedure.
(ii) Services necessary to stabilize the patient for the primary surgical procedure.
(iii) Services not considered part of the surgical procedure, including an E&M visit by an authorized treating physician for disability management. The E&M service shall have an appropriate modifier appended to the E&M level of the service code when the surgeon is performing services during the global period. If at all possible, an appropriate identifying diagnosis code shall identify the E&M service as unrelated to the surgical global period. In addition, the reasonableness and necessity for an E&M service that is separate and identifiable from the surgical global period shall be clearly documented in the medical record.
(iv) Disability management of an injured worker for the same diagnosis requires the managing physician to clearly identify in the medical record the specific disability management detail that was performed during that visit. The definitions of what is considered disability counseling can be located under 18-5(I)(1) and in Exhibit #7 of this Rule.
(v) Unusual circumstances, complications, exacerbations, or recurrences.
(vi) Unrelated diseases or injuries.
(vii) If a patient is seen for the first time or an established patient is seen for a new problem and the "decision for surgery" is made the day of the procedure or the day before the procedure is performed, then the

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surgeon can bill both the procedure code and an E&M code, using a -57 modifier or -25 modifier on the E&M code.

(c) Separately identifiable services shall use an appropriate CPT®/ modifier in conjunction with the billed service.

(7) Multiple Procedures (modifier -51) and Bilateral Procedures (modifier -50)

Multiple procedure guidelines (modifier -51) do not apply to codes specifically identified in CPT® as add-on procedures "+" or to those specifically identified as exempt from modifier -51.

Bilateral procedures not identified by CPT® as bilateral shall be billed on one line with one (1) unit and modifier -50 shall be appended to the CPT® code. The maximum fee is calculated at 150% of the Maximum Fee Schedule value.

When multiple procedures are performed by the same surgeon during the same surgical setting, modifier -51 shall be appended to the lower valued procedure(s). When multiple surgical procedures are performed in a single surgical setting, the highest valued or primary procedure is allowed 100% of the maximum fee and all other valued procedures, appended with a modifier -51, are allowed at 50% of the maximum fee.

(8) If a surgical arthroscopic procedure is converted to the same surgical 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 or modifier -50.

(9) Use code G0289 to report any combination of surgical knee arthroscopies for removal of loose body, foreign body, and/or debridement/shaving of articular cartilage.

G0289 shall not be paid when reported in conjunction with other knee arthroscopy codes in the same compartment of the same knee.

G0289 shall be paid when reported in conjunction with other knee arthroscopy codes in a different compartment of the knee.

(10) Venipuncture maximum fee allowance is covered under Exhibit #8 of this Rule.

(11) Platelet Rich Plasma (PRP) Injections

The Medical Treatment Guidelines ~~promulgated by the Director of the Division of Workers' Compensation~~ (Rule 17) govern ~~when~~ PRP injections ~~are appropriate~~. 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 ~~all-inclusive~~ allowance of $~~735~~744.00, for ~~PRP injections~~ professional fees.

The provider performing PRP injections in a facility setting shall bill CPT® 0232T, maximum total allowance of $269.50, for professional fees.

The above allowances include and apply to ~~any~~all body ~~part. This includes~~parts, imaging guidance, harvesting ~~and~~, preparation ~~(if performed),~~ the injection itself, ~~as well as~~and kits and supplies.

(E) RADIOLOGY

(1) General Policies

(a) The professional component (PC) represents the supervision and interpretation of a procedure provided by the physician or other healthcare professional. It is identified by appending modifier 26 to the procedure code.

(b) The technical component (TC) represents the cost of equipment, supplies and personnel to perform the procedure. It is identified by appending modifier TC to the procedure code.

(c) A global service includes both professional and technical components. The global service is identified by reporting the eligible code without modifier 26 or TC.

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~~Advanced Diagnostic Imaging (ADI) procedures (magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine scan). Providers separately reporting Z9999 certify accreditation status. The payer may also request proof of accreditation.

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

(c) The cost of dyes and contrast shall be reimbursed in accordance with 18-6(H~~)~~.).

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

(e) The payer may use available billing information such as provider credential(s) and clinical record(s) to determine if an appropriate CPT®/RBRVS modifier should have been used on the bill. To modify a billed code, refer to Rule 16-12(B)(4).

(f) In billing radiology services, the applicable radiology procedure code shall be billed using the appropriate modifier to bill either the professional component (26) or the technical component (TC). -If a physician bills the total or professional component, a separate written interpretive report is required.

(g) Providers using film instead of digital X-rays shall append "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 evaluation and management 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:

(i) American Academy of Thermology~~;~~ or
(ii) American Chiropractic College of Infrared Imaging.

(b) Indications for diagnostic thermographic evaluation must be one (1) of the following:

(i) Complex Regional Pain Syndrome/Reflex Sympathetic Dystrophy (CRPS/RSD);
(ii) Sympathetically Maintained Pain (SMP);or
(iii) Autonomic neuropathy~~;~~.

(c) General Protocols for Stress Testing

Cold Water Autonomic Functional Stress Testing – Baseline infrared images are obtained in a 68º F +/- 1 degree steady state environment following equilibration for 15 minutes. After the quantitative and qualitative baseline images are captured, cold water autonomic functional stress testing is performed by submersing the asymptomatic extremity in 68º F +/- 1 degree cold water bath for 5 minutes while imaging and evaluating the autonomic response.

Whole Body Autonomic Stress Testing – Refer to the thermogram discussion section found in the Complex Regional Pain Syndrome Medical Treatment Guidelines.

(d) Thermography Billing Codes:

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DoWC Z0200 Upper body w/ Autonomic Stress Testing
$~~865.37~~980.00

DoWC Z0201 Lower body w/Autonomic Stress Testing
$~~865.37~~980.00

(e) Prior authorization for payment (see Rule 16-10) is required for thermography services only if the requested study does not meet the indicators for thermography as outlined in this radiology section. The billing shall include a report supplying the thermographic evaluation and reflecting compliance with 18-5(E)(2).

(4) Urea breath test C-14 (Isotopic); acquisition for analysis and the analysis maximum fees are listed under Exhibit #8 of this Rule.

(F) PATHOLOGY

(1) General Policies

(a) The professional component (PC) represents the supervision and interpretation of a procedure provided by the physician or other healthcare professional. It is identified by appending modifier 26 to the procedure code.

(b) The technical component (TC) represents the cost of equipment, supplies and personnel to perform the procedure. It is identified by appending modifier TC to the procedure code.

(c) A global service includes both professional and technical components. The global service is identified by reporting the eligible code without modifier 26 or TC.

A standalone 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 dollar value listed under Exhibit #8 of this Rule or billed charges, whichever is less. No separate technical or professional component maximum dollar split is separately payable by the payer. However the technical and professional component billing parties may agree upon a dollar value split of the total maximum fees listed in Exhibit #8 of this Rule.

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 the RBRVS values and the pathology conversion factors. Maximum Fee Schedule value is determined by the Pathology Conversion Factor when the Pathology CPT® code description includes "interpretation" and "report" or the following Pathology CPT® code description is from:

(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 ordering physician requested additional medical interpretation and judgment and requested a separate written report. Upon such a request, the pathologist may bill using the proper CPT® code and values from the RBRVS, not DoWC Z0755.

(4) Clinical Drug Screening/Testing Codes and Values

(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 ~~medication(s);~~medications; or
(iii) The patient is taking any illicit or non-prescribed drugs.

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(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.

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(iv) Medicare codes used in the ~~2016~~2017 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 to this rule.

(c) Presumptive Tests

Presumptive drug class assays identify possible use or non-use of drug(s) or drug class(es), but may not identify the specific drug or metabolite. All drug class immunoassays or enzymatic methods are considered to be presumptive. Providers may ONLY bill for one (1) of the three presumptive codes per date of service, regardless of the number of drug classes tested~~:~~. Presumptive drug class screening shall be billed using one of three codes – 80305, 80306, or 80307.

~~(i) Drug test(s), presumptive, any number of drug classes; any number of devices or procedures (e.g. immunoassay) capable of being read by a direct optical observation only (e.g. dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service (G0477).~~

~~(ii) Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g, immunoassay) read by instrument-assisted direct optical observation (e.g. dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service (G0478).~~

~~(iii) Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers (e.g, immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service (G0479).~~

~~Presumptive drug class screening shall be billed using one of three codes - G0477, G0478 or G0479.~~

(d) Definitive Tests – Gas Chromatography/Mass Spectrometry (GC/MS) or Liquid Chromatography/Mass Spectrometry (LC/MS) – no immunoassays or enzymatic methods.

(i) 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. Definitive quantitative tests must be ordered by a physician. 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, noroxycodone and oxycodone

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- 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 is receiving chronic opioid management, additional drug screens with documented justification may be conducted. Examples of documented justification include the following:
    - Concern regarding the functional status of the patient
    - Abnormal results on previous testing
    - Change in management of dosage or pain
    - Chronic daily opioid dosage above 150 mg of morphine or equivalent
- ~~The following four definitive drug testing codes replace the G6030 - G6058 HCPCS codes.~~ Providers may ONLY bill for one ~~(1)~~ of the ~~four~~five definitive codes per day:

  - G0480- Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to ~~GC/MS~~gc/ms (any type, single or tandem) and ~~LC/MS~~lc/ms (any type, single or tandem and excluding immunoassays (~~eg, IA, EIA, ELISA, EMIT, FPIA~~e.g., Ia, eia, elisa, emit, fpia) and enzymatic methods ~~(eg,~~[e.g., alcohol dehydrogenase~~));~~]), (2) Stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day~~,~~; 1-7 drug class(es), including metabolite(s) if performed.
  - G0481- Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to ~~GC/MS~~gc/ms (any type, single or tandem) and ~~LC/MS~~lc/ms (any type, single or tandem and excluding immunoassays (e.g~~, IA, EIA, ELISA, EMIT, FPIA~~., Ia, eia, elisa, emit, fpia) and enzymatic methods ~~(~~[e.g~~.~~., alcohol dehydrogenase~~));~~]), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day~~,~~; 8-14 drug class(es), including metabolite(s) if performed.
  - G0482- Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish

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between structural isomers (but not necessarily stereoisomers), including, but not limited to ~~GC/MS~~gc/ms (any type, single or tandem) and ~~LC/MS~~lc/ms (any type, single or tandem and excluding immunoassays (e.g~~, IA, EIA, ELISA, EMIT, FPIA~~., Ia, eia, elisa, emit, fpia) and enzymatic methods (e.g~~,~~., alcohol dehydrogenase~~));~~)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day~~,~~; 15-21 drug class(es), including metabolite(s) if performed~~.~~).

- G0483- Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to ~~GC/MS~~gc/ms (any type, single or tandem) and ~~LC/MS~~lc/ms (any type, single or tandem and excluding immunoassays (~~eg, IA, EIA, ELISA, EMIT, FPIA~~e.g., Ia, eia, elisa, emit, fpia) and enzymatic methods (~~eg, alcohol~~e.g., Alcohol dehydrogenase~~));~~)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., To control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., To control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day~~,~~; 22 or more drug class(es), including metabolite(s) if performed.

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- ~~(ii)~~ G0659 - Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to gc/ms (any type, single or tandem) and lc/ms (any type, single or tandem), excluding immunoassays (e.g., Ia, eia, elisa, emit, fpia) and enzymatic methods (e.g., alcohol dehydrogenase), performed without method or drug-specific calibration, without matrix-matched quality control material, or without use of stable isotope or other universally recognized internal standard(s) for each drug, drug metabolite or drug class per specimen; qualitative or quantitative, all sources, includes specimen validity testing, per day, any number of drug classes.

(iii) The table below should be used to determine the appropriate drug class(es) when billing G0480-G0483. The AMA CPT Manual may be consulted for examples of individual drugs within each class. Each class of drug can only be billed once per day.

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~~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~~			

Anabolic steroids	Buprenorphine	hetamines	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			

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(G) MEDICINE

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(1) Medicine home therapy services in the RBRVS are not adopted. For appropriate codes see section 18-6(M) Home Care Services.

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

(3) 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 BCIA, practice within the scope of their

training, and receive a 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. For purposes of this rule, "licensed" means holding a license issued by the Colorado Medical Board, the Colorado Board of Chiropractic Examiners, the Colorado Podiatry Board, the Colorado Dental Board, or a board of the Colorado Department of Regulatory Agencies (DORA).

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 EMG, HRV, EEG, or temperature training), placement of instruments, and patient response, if sufficient time has passed.

Maximum Fee Schedule values for biofeedback services shall be as follows:

CPT® Code 90901, Biofeedback training by any modality:

Non-facility RVU is 2.14, Facility RVU is 1.14

CPT® Code 90911, Biofeedback peri/uro/rectal:

Non-facility RVU is 4.76, Facility RVU is 2.48

(4) Appendix J of the ~~2016~~2017 CPT® identifies mixed, motor, and sensory nerve conduction studies and ~~their appropriate~~applicable billing~~.~~ requirements. EMG and 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 the 2017 CPT® for billing modifier 25 have been met.

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

(a) Prior authorization for payment (see Rule 16-10) shall be obtained before billing for more than four body regions in one (1) visit. Manipulative therapy is limited to the maximum allowed in Rule 17, Medical Treatment Guidelines. The provider's medical records shall reflect medical necessity and prior authorization for payment (see Rule 16-10) if treatment exceeds these limitations.

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

(c) Facility RVU is 0.79 and non-facility RVU is 1.00 for CPT® code 98940.

(6) Psychiatric/Psychological Services:

(a) A licensed psychologist (PsyD, PhD, EdD) is reimbursed a maximum of 100% of the medical fee listed in the RBRVS. Other non-physician

providers performing psychological/psychiatric services shall be paid at 85% of the fee allowed for physicians.

(b) Prior authorization for payment (see Rule 16-10) is required any time the limitations discussed in this rule are exceeded on a single day.

The relative value weights for psychiatric diagnostic evaluations, with or without medical services, including time for internal records review, are as follows:

(i) Without Evaluation & Management Service:
Non-facility is 9.91 RVUs
Facility is 9.6 RVUs
(ii) With Evaluation and Management Service
Non-facility is 11.12 RVUs
Facility is 10.8 RVUs

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Psychiatric diagnostic evaluation code(s) are limited to one per provider, per admitted claim, unless prior authorization is received from the payer.

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

Brief psychological screens (including, but not limited to, the 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, CPT® codes 96101-96127.

The RVUs for the following psychological and neuropsychological tests and for health and behavior assessments/interventions shall be modified to:

CPT® code	Non-facility Relative Value Units	Facility Relative Value Units
96101	3.00	2.91
96102	1.79	0.65
96103	1.36	1.33
96116	3.40	3.16
96118	4.11	3.31
96119	2.51	0.74
96120	2.30	1.24
96150	0.80	0.79
96151	0.78	0.77
96152	0.74	0.73
96153	0.18	0.17
96154	0.74	0.73
96155	0.73	0.73

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

(d) The limit for psychotherapy services is 60 min. per visit.

Prior authorization for payment (see Rule 16-10) 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 for payment (see Rule 16-10) except where specifically addressed in Rule 17, Medical Treatment Guidelines.

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

(1) Both services must be separately identifiable;

(2) The level of E&M is based on history, exam and medical decision making;

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

(4) 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) Upon request of a party to a workers' compensation claim and pursuant to HIPAA Privacy regulations, a psychiatrist, psychologist or other qualified health care professional may generate a separate report and bill for that service using CPT® code 90889. A party to a claim may bill for any separate documentation under CPT® code 90889. The relative value for this code is 1.4 RVUs for both facility and non-facility billings.

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

Reimbursement to qualified non-physician providers for coordination of care with 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 employment facility(ies) and/or to the injured worker or their family.

(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;

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(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) Maximum fee when all of the services outlined in 18-5(G)(9)(a) are completed and documented.

QSART Billing Code
DoWC Z0401 QSART $1,~~007~~066.00

Z0401 may only be billed once per workers' compensation claim, regardless of the number of limbs tested.

(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 setup 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/registered with:

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

(ii) Professional/Supervisory /Interpretive

A ~~specifically neurophysiology trained~~ 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 (1) 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

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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

~~The technical component (equipment, technical certified staff) is only payable to the person who owns the equipment.~~

CPT® 95940 and 95941 do not have separate professional and technical components. However, certain tests performed in conjunction with CPT® 95940 and 95941 throughout the surgical procedure do have separate professional and technical components, which may be separately payable if documented and otherwise allowed under Rule 18.

The monitoring physician is the only billing party allowed to report ~~the intraoperative neuro-monitoring codes (~~CPT® 95940 or 95941~~).~~.

(10) Speech Therapy/Evaluation and Treatment

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.

Reimbursement shall be according to the unit values as listed in the RBRVS, multiplied by their section's respective CF.

(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), or at cost to the billing provider if no dollar value is listed in ASP.

(12) 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 appropriate CPT®/RBRVS code units multiplied by the Medicine conversion factor is the

Maximum Fee Schedule value for the infusion service. 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 is covered under section 18-6(M)(1).

~~(13~~ (13) Moderate (conscious) sedation

Providers billing for moderate sedation services shall comply with all applicable 2017 CPT® billing instructions. The maximum fee schedule value is determined using the Medicine Conversion Factor.

(14) Special Services, Procedures and Reports in the Medicine Section of CPT®

(a) Handling and conveyance of specimens in connection with a transfer from an office to a laboratory is a flat rate of $25.00 (CPT® codes 99000 and/or 99001). Any other handling and conveyance in connection with implementation of an order involving devices (such as orthotics) is a flat rate of $13.00 (CPT® code 99002).

(b) Postoperative follow-up visit, CPT® code 99024, is included in the global package and is not separately payable.

(c) Educational supplies are considered "at cost" to the provider and may be billed based upon an agreement between the payer and provider (CPT® codes 99070, 99071 or 99078).

(d) 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 (CPT® codes 99090 and 99091).

(e) The charges for services performed after regular business hours, during holidays, or during scheduled disruptions of regular office services are not separately payable unless the provider shows the reasonableness and necessity of these services and obtains prior authorization (CPT® codes 99026, 99027, 99050, 99051, 99053, 99056, 99058, and 99060).

(f) Unusual travel expenses require prior authorization by the payer. The payer and billing provider shall agree upon maximum fees (CPT® code 99082).

(g) Medical testimony is covered under Rule 18-6(D) and special reports are covered under Rule 18-6(G)(3)&(4) (CPT® codes 99075 and 99080).

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

Restorative services are an integral part of the healing process for a variety of injured workers.

(1) Billing and documentation requirements:

Physical therapy or any care provided under a physical therapist's plan of care shall be billed with a "GP" modifier appended to all billed 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 billed codes.

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

Functional objectives shall be included in the PM&R plan of care for all injured workers, in compliance with Rule 16-8. Any request for additional treatment must be supported by evidence of positive objective functional gains or PM&R treatment plan changes. The ordering PM&R ATP must also agree with the PM&R continuation or changes to the treatment plan.

(2) Prior authorization for payment (see Rule 16-10) is required for medical nutrition therapy.

(3) For recommendations on the use of the physical medicine and rehabilitation procedures, modalities, and testing, see Rule 17, Medical Treatment Guidelines.

(4) Special Note to All Physical Medicine and Rehabilitation Providers:

The authorized treating provider shall obtain prior authorization for payment (see Rule 16-10) from the payer for any physical medicine or rehabilitation treatment not listed in or exceeding the frequency or duration recommendations in Rule 17, Medical Treatment Guidelines.

The injured worker shall be re-evaluated by the prescribing physician within 30 calendar days from the initiation of the prescribed treatment and at least once every month while that treatment continues to establish achievement of functional goals. Prior authorization for payment (see Rule 16-10) shall be required for treatment of a condition not covered under Rule 17, Medical Treatment Guidelines and exceeding 60 calendar days from the initiation of treatment.

(5) Interdisciplinary Rehabilitation Programs – Requires Prior Authorization for Payment (see Rule 16-10).

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 Rule 17, Medical Treatment Guidelines, interdisciplinary rehabilitation programs may include, but are not limited to: chronic pain, spinal cord, or brain injury programs.

Billing Restrictions: All billing providers shall detail to the payer 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 mutually 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 billing 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.

(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 for payment (see Rule 16-10) if the procedures are not recommended or the frequency and duration exceeds the recommendations of the Rule 17, 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.

Unlisted procedure CPT~~®~~® code 97139 value is equal to the value for therapeutic exercises.

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Dry Needling of Trigger Points, Single or multiple needles,

DoWC Z0501 - initial 15 minutes of dry needling	1.3 non-facility RVUs .77 facility RVUs
DoWC Z0502 - each add'l 15 minutes of dry needling	.77 non-facility RVUs .72 facility RVUs

(7) Modalities

RBRVS Timed and Non-timed Modalities

Billing Restrictions: 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 using CPT® ~~code~~ 64550. Rental or purchase of a TENS unit requires prior authorization for payment (see Rule 16-10). For Maximum Fee Schedule value, see 18-6(H).

The maximum value for any unlisted modality, CPT® code 97039, is equal to the value of ultrasound CPT® code 97035.

(8) Evaluation Services for Therapists: Physical Therapy (PT), Occupational Therapy (OT) and Athletic Trainers (ATC).

(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 2017 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 reexamination, reevaluation, or ~~reassessment (CPT® codes 97002, 97004, or 97006) are~~re-assessment is different from a progress note. Therapists should not bill these codes for a progress note. Therapists may bill CPT® codes ~~97002, 9700497164, 97168~~, or ~~9700697172~~ for a reevaluation only in the following cases:

(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 (POC) for that time interval.
(ii) New clinical findings come to light.
(iii) The patient fails to respond to the treatment outlined in the current POC.

(b) PT and OT and Athletic Trainer Evaluation and Re-Evaluation RVU changes are as follows:

~~CPT® code 9700197161 –~~ PT ~~and 97003 OT Initial Evaluation =~~initial evaluation, low complexity, 1.66 RVUs

~~(i)~~ 97162 – PT initial evaluation, moderate complexity, 2.48 RVUs~~, facility and non-facility;~~

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~~CPT® code 97005 Athletic Trainer Initial Evaluation is 85% of the PT/~~97163 – PT initial evaluation, high complexity, 3.71 RVUs

97164 – PT re-evaluation, 1.60 RVUs

97165 – OT initial evaluation, low complexity, 1.66 RVUs

~~(ii)~~ 97166 – OT initial evaluation~~ service value;~~, moderate complexity, 2.48 RVUs

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~~CPT® code 97002 PT and 9700497167 –~~ OT ~~Re-Evaluation = 1.68~~initial evaluation, high complexity, 3.71 RVUs~~,~~

97168 – OT re-evaluation, 1.60 RVUs

97169 – ATC initial evaluation, low complexity, 1.41 RVUs

97170 – ATC initial evaluation, moderate complexity, 2.10 RVUs

97171 – ATC initial evaluation, high complexity, 3.10 RVUs

97172 – ATC re-evaluation, 1.36 RVUs

~~(iii)~~ The above RVUs are for both facility and non-facility~~,~~ providers.

~~(iv) CPT® code 97006 Athletic Trainer re-evaluation is 85% of the PT/OT reevaluation value.~~

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(c) 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, reevaluation or reassessment. The WC196 form must be completed and include which of the approved functional tools, from the Division's Quality Performance and Outcomes Payments (QPOP) list, 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.

Billing code DoWC Z0817 - $15.00

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

(e) A patient may be seen by more than one (1) health care professional on the same day. An evaluation service with appropriate documentation may be charged by each professional per patient, per day.

(f) 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 RBRVS Medicine Section. Coordination of care reimbursement is limited to telephone calls made to outside professionals and/or to the injured worker or their family.

(g) All interdisciplinary team conferences shall be billed in compliance with section18-5(H)(5).

(9) Special Tests

(a) The following ~~respective tests~~ 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)

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The facility and non-facility RVUs for DoWC Z0503 and DoWC Z0504 shall be 0.93.

(b) Billing Restrictions:

(i) Job Site Evaluations require prior authorization for payment (see Rule 16-10) if exceeding two (2) hours. Computer-Enhanced Evaluations and Work Tolerance Screenings require prior authorization for payment for more than four (4) hours per test or more than three (3) tests per claim. Functional Capacity Evaluations require prior authorization for payment for more than four (4) hours per test or two (2) tests per claim.

(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 physical medicine professional before it is payable as a special test.

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(c) Provider Restrictions: 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.

(10) Supplies

Physical medicine supplies are reimbursed in accordance with section18-6(H).

(11) Unattended Treatment

When a patient uses a facility or its equipment for unattended procedures, in an individual or a group setting, bill:

DoWC Z0505	fixed fee per day	0.232 RVU

(12) Non-Medical Facility

Fees, such as gyms, pools, etc., and training or supervision by non-medical providers require prior authorization for payment (see Rule 16-10) and a written negotiated fee.

(13) Unlisted Service Physical Medicine

All unlisted services or procedures require a report.

(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. Refer to Rule 17, Medical Treatment Guidelines.

Restriction: Maximum daily time is two (2) hours per day without additional prior authorization for payment (see Rule 16-10).

(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. Refer to Rule 17, Medical Treatment Guidelines.

Restriction: Maximum daily time is six (6) hours per day without additional prior authorization for payment (see Rule 16-10).

(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. Refer to Rule 17, Medical Treatment Guidelines.

(d) For Work Conditioning, Work Hardening, or Work Simulation, the following apply:

(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 for payment is required (see Rule 16-10).
(iii) Provider Restrictions: All procedures must be performed by or under the onsite supervision of a physician, psychologist, PT, OT, speech language pathologist or audiologist.

(e) Work Hardening/Conditioning/Simulation Billing codes and RVUs:

(i) CPT® code 97545 Initial 2 hours, 3.4 RVUs
(ii) CPT® code 97546 Each additional hour, 1.7 RVUs

(15) Wound Care

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

(I) EVALUATION AND MANAGEMENT (E&M)

(1) Evaluation and management codes may be billed by medical providers as defined in Rule 16-5(A)(1)(a~~) as well as~~), nurse practitioners (NP~~)~~), and physician

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assistants (PA). ~~Medical~~To justify the billed level of E&M service, medical record documentation shall ~~encompass~~utilize the 2017 CPT® E&M Services Guidelines and either the "E&M Documentation Guidelines" criteria ~~as~~ adopted in Exhibit #7 of this Rule, or Medicare's 1997 Evaluation and Management Documentation Guidelines~~, to justify the billed level of E&M service.~~ .

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.

(2) New or Established Patients

An E&M visit shall be billed as a "new" patient service for each "new injury" even though the provider has seen the patient within the last three (3) years. Any subsequent E&M visits are to be billed as an "established patient" and reflect the level of service indicated by the documentation when addressing all of the current injuries.

Transfer of care from one physician to another with the same tax ID and the same specialty shall be billed as an "established patient" regardless of the 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 for payment is obtained (see Rule 16-10). The E&M Guideline criteria as specified in the RBRVS E&M Section shall be used in all office visits to determine the appropriate level.

(4) Treating Physician Telephone or On-line Services (CPT® 99441-99444):

Telephone or on-line services may be billed if~~:~~

~~(a) The service is performed more than one (1) day prior to a related E&M office visit, or~~

~~(b) The service is performed more than seven (7) days following a related E&M office visit, and~~

~~(c) The~~ the medical records/documentation specifies all the following:

~~(i~~
(a) The amount of time and date;
(~~ii~~b) The patient, family member, or healthcare provider talked to; and
(~~iii~~c) The specifics of the discussion and/or decision made during the communication.

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The 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 of the criteria are met under CPT®. A medical team conference shall consist of medical professionals caring for the injured worker. The billing statement shall be prepared in accordance with Rule 16, Utilization Standards.

(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 18-6(G).

In order to bill for any of the inpatient or outpatient consultation codes (CPT® 99241-99255) the following criteria must be documented in the billing providers report:

(a) Identification of the requesting physician for the opinion.

(b) Documentation in the report supports the need for a consultant's opinion.

(c) Identification the report was submitted to the requesting provider (either carbon copied or written directly to the requesting provider).

Outpatient Consultation RVUs:

CPT® 99241 non-facility = 2.57; facility = 2.15

CPT® 99242 non-facility = 3.77; facility = 3.18

CPT® 99243 non-facility = 4.71; facility = 3.96

CPT® 99244 non-facility = 6.39; facility = 5.57

CPT® 99245 non-facility = 8.15; facility = 7.23

Inpatient Consultation facility RVUs:

CPT® 99251 = 2.79

CPT® 99252 = 3.83

CPT® 99253 = 4.95

CPT® 99254 = 6.39

CPT® 99255 = 8.47

Subsequent Hospital RVU changes are as follows:

CPT® 99231 = 2.21 RVUs

CPT® 99232 = 3.15 RVUs

CPT® 99233 = 4.22 RVUs

(7) ~~When~~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 CPT® 99354-99357.
(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~~, either face-to-face or non-face-to-face, the provider shall provide a report that documents time distinguishable from the E&M visit~~.
(iv) The provider billing CPT® 99358 and 99359 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 CPT® 99354-99359 for the time spent supervising clinical staff.
(ii) Clinical staff services cannot be provided in an urgent care or emergency room setting.

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(J) TELEHEALTH

(1) "Telehealth" ~~is~~and "telemedicine" are defined in ~~Rule~~Rules 16-2(X~~).~~) and (Y). The healthcare services listed in Appendix P of CPT® and Division Z-codes (when appropriate) may be provided via telehealth or telemedicine. 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 ~~State~~ Board of Psychologist Examiners.

~~(2) Telehealth facilities can bill for the originating fee as follows:~~

~~Q3014 $35.00 /per 15 minutes~~

~~A private residence at which an injured worker is located when he or she is receiving healthcare services through telehealth may not bill for the originating fee.~~

~~(3~~(2) HIPAA privacy and electronic security standards are required for ~~both~~ the originating site(s) and the rendering ~~providers.~~ provider(s).

~~(a) Protecting patient health information, and patient / client decision making and consent are vital.~~

~~(b) Policies and procedures need to be in place to protect the electronic security of data, and the physical security of telehealth equipment so that patient health information is protected.~~

~~(c) Compliance with accreditation requirements, regulations, and relevant legislation is necessary.~~

~~(d) Health professionals providing telehealth services shall be fully licensed, registered, and credentialed by the appropriate governing agency.~~

~~(4) All telehealth procedures are required to be at an originating site that is deemed appropriate with the appropriate HIPAA privacy and electronic security standards in place.~~ (3) The originating site is responsible for establishing and verifying injured worker and provider identity. Authorized originating sites include:

(a) The office of a physician or practitioner

(b) A hospital (inpatient or outpatient)

(c) A critical access hospital (CAH)

(d) A rural health clinic (RHC)

(e) A federally qualified health center (FQHC)

(f) A hospital based or critical access hospital based renal dialysis center (including satellites)

(g) A skilled nursing facility (SNF)

(h) A community mental health center (CMHC)

~~(5~~(4) 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) Physicians / psychologists need to meet standard of care.

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

~~(6~~(5) Payment for telehealth and telemedicine services:

(a) Telehealth 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 telehealth services. The rendering provider shall bill CPT® place of service (POS) code 02, with a GT modifier. This POS code does not apply to the originating site billing a facility fee.

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

(c) For all telehealth services, the provider shall bill the appropriate CPT® code with the GT modifier. Reimbursement is the RBRVS unit value for the CPT® code times the appropriate CF + $5.00 when modifier GT is appended to the appropriate CPT® code(s).

GT – Attached to the distance (rendering) provider billed CPT® or HCPCS indicates the service was performed via telehealth. Using the modifier certifies that the patient was present at an eligible originating site when the telehealth service was furnished.

(d) ~~from~~Telehealth:

(i) Approved telehealth facilities can bill for the originating fee as follows:
Q3014 $35.00 /per 15 minutes
A private residence at which an injured worker is located when he or she is receiving healthcare services through telehealth may not bill for the originating fee.

(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 ~~practitioners~~provider interpreting the results shall bill the professional component (modifier 26).

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

(e) Telemedicine:

(i) The medical providers shall bill codes G0425-G0427 for telehealth consultations, emergency department or initial inpatient. The

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maximum fee values are determined by multiplying the RBRVS RVUs and the E&M conversion factor listed in Rule 18-4.

~~(b~~(ii) 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 conversion factor listed in Rule 18-4.

~~(c) For all telehealth services, the provider shall bill the appropriate RBRVS CPT® code with the GT modifier. Reimbursement is the RVU value for the CPT® code times the appropriate CF + $5.00 when modifier GT is appended to the appropriate CPT® code(s).~~

~~GT Attached to the distance (rendering) provider billed CPT® or HCPCS indicates the service was performed via telehealth. Using the modifier certifies that the patient was present at an eligible originating site when the telehealth service was furnished.~~

18-6 DIVISION ESTABLISHED CODES AND VALUES

(A) FACE-TO-FACE OR TELEPHONIC MEETINGS

(1) Face-to-face or telephonic meeting by a treating physician with the employer, claim representatives, or any attorney, and with or without the injured worker. Claim representatives may include physicians or qualified medical personnel performing payer-initiated medical treatment reviews, but this code does not apply to requests initiated by a provider for prior authorization for payment (see Rule 16-10).

Before the meeting is separately payable, the following requirements must be met:

(a) Each meeting shall be at a minimum 15 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); and
(v) Billing code DoWC Z0701.
$~~75~~85.00 per 15 minutes for time 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.

(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 Z0601: $~~65~~74.00 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 in order 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 as defined in Rule 16-10(F).

Billing Code DoWC Z0602: $74.00 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~~ The payer shall pay one-half of the usual fee for the scheduled services, or $~~150~~180.00, whichever is less~~.~~:

Cancellation Fee Billing Code: DoWC Z0720 or the code corresponding to the service that has been cancelled and append modifier 51.

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. The provider shall bill the code corresponding to the service that has been cancelled and append modifier 51.

(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 request whether 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 section 18-6(B).

(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.

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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)

DoWC Z0725 - $0.85 per paper page for the next 11-40 paper page(s)

DoWC Z0726 - $0.57 per paper page for remaining paper page(s)

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 frames and/or fees, the following deposition and testimony rules and fees shall be used.

If, in an individual case, a party can show 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 section 18-6(D) for that case.

(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 ~~Provider: DoWC Z0730 $325.00 per hour~~Physician as defined by Rule 16-5(A)(1)(a) or Psychologist (PsyD, PhD, or EdD):

DoWC Z0730 $367.00 per hour, 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 $~~325~~367.00 per hour 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 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 shall refund to the deposing party any portion of an advance payment in excess of time actually spent preparing and/or testifying. Bill using code DoWC Z0731.

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 using code DoWC Z0732.

If the provider is notified less than five (5) business days in advance of a cancellation, 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 using code DoWC Z0733.

Deposition:

Treating or Non-treating ~~provider:~~ Physician as defined by Rule 16-5(A)(1)(a) or Psychologist (PsyD, PhD, or EdD):

DoWC Z0734 $~~325~~367.00 per ~~hr.~~

~~Billed~~hour, billed in half-hour increments.

Other providers shall be paid 85% of this fee.

(4) Testimony:

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 notified of the cancellation of the testimony 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 and shall refund any portion of an advance payment in excess of time actually spent preparing and/or testifying. Bill using code DoWC Z0735.

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 using code DoWC Z0736.

If the provider is notified of a cancellation less than five (5) business days prior to the date of the testimony 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 using code DoWC Z0737.

Testimony:

Treating or Non-treating ~~provider:~~ Physician as defined by Rule 16-5(A)(1)(a) or Psychologist (PsyD, PhD, or EdD):

DoWC Z0738 $~~450~~508.00 per hour, billed in half-hour increments.

Other providers shall be paid 85% of this fee.

(E) INJURED WORKER TRAVEL EXPENSES

The payer shall pay an injured worker for reasonable and necessary expenses for travel to and from medical appointments and reasonable mileage to obtain prescribed medications. The rate for mileage shall be 53 cents per mile. The injured worker shall submit a request to the payer showing the date(s) of travel and mileage, with an explanation for any other reasonable and necessary travel expenses incurred or anticipated.

Mileage Expense Billing Code: DoWC Z0723

Other Travel Expenses Billing Code: DoWC Z0724

(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 authorized treating provider is required to submit in writing all permanent restrictions and future maintenance care related to the injury or occupational disease.

(2) Provider Restrictions

The permanent impairment rating shall be determined by the Level II Accredited Authorized Treating Physician (see Rule 5-5(D)).

(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, as defined in the RBRVS. 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 Division form, titled 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 record reviewed and the dates represented by the record(s) 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) Use the appropriate DoWC code:

(i) Fee for the Level II Accredited Authorized Treating Physician Providing Primary Care:
Bill DoWC Z0759 $~~355~~575.00.

(ii) Fee for the Referral, Level II Accredited Authorized Physician~~.~~ (the claimant is not a previously established patient to that physician):
Bill DoWC Z0760 $~~575~~775.00.

(iii) A return visit for a range of motion (ROM) validation shall be reimbursed using the appropriate separate procedure CPT® code in the medicine section of the RBRVS.

(iv) Fee for a 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.

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(G) REPORT PREPARATION

(1) Routine Reports

Providers shall submit routine reports free of charge as directed in Rule 16-7(E) and by statute. Requests for additional copies of routine reports and for reports not in Rule 16-7(E) 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 (WC164)

(a) Initial Report

The authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient completes the initial WC164 and submits it to the payer and to the injured worker after the first visit with the injured worker. When applicable, the emergency department or urgent care authorized treating physician for this workers' compensation injury may also create a WC164 initial report. Unless requested or prior authorized by the payer in a specific workers' compensation claim, no other authorized physician should complete and bill for the initial WC164 form. This form shall include completion of items 1-7 and 10. Note that certain information in Item 2 (such as Insurer Claim #) may be omitted if not known by the provider.

(b) Closing Report

The WC164 closing report is required from the authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient when the injured worker is at maximum medical improvement for all injuries or diseases covered under this workers' compensation claim, with or without a permanent impairment. The form requires the completion of items 1-5, 6 b-c, 7, 8 and 10. If the injured worker has sustained a permanent impairment, then item 9 must be completed and the following additional information shall be attached to the bill at the time MMI is determined:

(i) All necessary permanent impairment rating reports, medical reports and narrative relied upon ~~bythe~~by the authorized treating physician(ATP), when the ATP (generally the designated or selected physician) managing the total 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 (generally the designated or selected physician) managing the total workers' compensation claim of the patient is not determining the permanent impairment rating.

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(c) Payer Requested WC164 Report

If the payer requests a provider complete the WC164 report, the payer shall pay the provider for the completion and submission of the completed WC164 report.

(d) Provider Initiated WC164 Report

If a provider wants to use the WC164 report as a progress report or for any purpose other than those designated in section18-6(G)(2)(a), (b) or (c), and seeks reimbursement for completion of the form, the provider shall get prior approval from the payer.

(e) Billing Codes and Maximum Allowance for completion and submission of WC164 report

Maximum allowance for the completion and submission of the WC164 report is:

DoWC Z0750	$~~47~~49.00	Initial Report
DoWC Z0751	$~~47~~49.00	Progress Report (Payer Requested or Provider Initiated)
DoWC Z0752	$~~47~~49.00	Closing Report
DoWC Z0753	$~~47~~49.00	Initial and Closing Reports are completed on the same form for the same date of service

(3) Request for physicians to complete additional forms sent to them by a payer or employer shall be paid by the requesting party. A form requiring 15 minutes or less of a physician's time shall be billed pursuant to (a) and (b) below. Forms requiring more than 15 minutes shall be paid as a special report.

(a) Billing Code Z0754

(b) Maximum fee is $~~47~~49.00 per form completion

(4) Special Reports

Description: The term special reports includes reports not otherwise addressed under Rule 16, Utilization Standards, Rule 17, Medical Treatment Guidelines and Rule 18, including any form, questionnaire or letter with variable content. This includes, but is not limited to, independent medical evaluations (Z0756, Z0770 and Z0768) or reviews when the physician is requested to review files and examine the patient to provide an opinion for the requesting party, performed outside C.R.S. §8-42-107.2 (the Division IME process) and treating or non-treating medical reviewers or evaluators producing written reports pertaining to injured workers not otherwise addressed. Special reports also include payment for meeting, reviewing another's written record, and amending or signing that record (see section 18-5(I)(8)). Reimbursement for preparation of special reports or records shall require prior agreement with the requesting party.

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 any patient exam associated with a special report.

Cancellation:

Written Reports Only: 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. Bill the cancellation using DoWC code Z0761.

IME/report with patient exam: In cases of special reports requiring a scheduled patient exam, if the provider is notified of a cancellation at least seven (7) business days prior to the scheduled patient exam, the provider shall be paid for the time s/he has reasonably spent in preparation and shall refund to the party requesting the special report any portion of an advance payment in excess of time actually spent preparing. Bill the cancellation using DoWC code Z0762.

In cases of special reports requiring a scheduled patient exam, if the provider is notified of a cancellation at least five (5) business days but less than seven (7) business days prior to the scheduled patient exam, the provider shall be paid for the time s/he has reasonably spent in preparation and one-half the time scheduled for the patient exam. Any portion of a deposit in excess of this amount shall be refunded. Bill the cancellation using DoWC code Z0763.

In cases of special reports requiring a scheduled patient exam, if the provider is notified of a cancellation less than five (5) business days prior to the scheduled patient exam, the provider shall be paid for the time s/he has reasonably spent in preparation and has scheduled for the patient exam. Bill the cancellation using DoWC code Z0764.

Billing Codes:

Written Report Only	DoWC Code:	Z0755
Lengthy Form Completion	DoWC Code:	Z0757
18-5(I)(8) meeting and report with Non-treating Physician	DoWC Code:	Z0758

Special Report Maximum Fees: $367.00 per hour billed in 15- minute increments.

RIME: Respondent requested Independent Medical Examination (RIME)/Report with patient exam DoWC Code: Z0756

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CRS 8-43-404 requires RIMEs to be recorded in audio in their entirety and retained by the examining physician until requested by any party.

IME Audio Recording exam	DoWC Code:	Z0766 $~~30~~34.00 per
IME Audio copying fee copy	DoWC Code:	Z0767 $~~20~~23.00 per

CIME: Claimant requested Independent Medical Examination (CIME)/Report with patient exam DoWC Code: Z0770

DIME: Division Independent Medical Examination (DIME)/Report with patient exam ~~DoWC Code: Z0768~~

~~IME Fees are established in~~See Rule 11~~.~~ for billing codes and fees

~~Lengthy Form Completion DoWC Code: Z0757~~

~~18-5(l)(8) meeting and report with Non-treating Physician DoWC Code: Z0758~~

~~Special Report Maximum Fees: $325.00 per hour billed in 15- minute increments.~~

All RIME, CIME and DIME reports are due no later than 20 calendar days after the examination.

(H) SUPPLIES, DURABLE MEDICAL EQUIPMENT, ORTHOTICS AND PROSTHESES

(1) 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.

(2) Unless other limitations exist in this Rule, medical professionals shall bill supplies, including "Supply et al.," orthotics, prostheses, durable medical equipment (DME) or drugs, including injectables, using Medicare's HCPCS Level II codes, when one exists, as established in the January ~~2016~~2017 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) schedule for rural (R) or non-rural (NR). Rural is identified in Medicare's DME Rural Zip and Formats file on their website or the January ~~2016~~2017 Medicare's Part B Drug Average Sale Price (ASP). Otherwise, the billing provider shall identify their cost by submitting a copy of their invoice with their bill. The DMEPOS schedule can be found at ~~http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html~~http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html.The Medicare Part B Drug Average Sale Price (ASP) fees can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html?redirect=/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp

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® code 97760.

(3) Payers shall pay medical professionals using Medicare's January ~~2016~~2017 DMEPOS Colorado HCPCS Level II maximum fee values or Medicare's Part B Drug ASP values listed for the codes billed. If no code exists,

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the payer shall pay 120% of the cost for the item as indicated on the provider's invoice. Payers shall not recognize the KE modifier.

(4) Unless other limitations exist in this Rule, DMEPOS suppliers shall be reimbursed using Medicare's HCPCS Level II codes, when one exists, as established in the ~~January~~July 2016 DMEPOS schedule. Otherwise, the supplier shall be reimbursed at 100% of Colorado Medicaid's January ~~2016~~2017 fee schedule. The Colorado Medicaid Fee Schedule can be found at: ~~https://www.colorado.gov/hcpf/provider-rates-fee-schedule.~~https://www.colorado.gov/hcpf/provider-rates-fee-schedule. If no Medicare or Medicaid fee schedule value exists, payers shall reimburse Suppliers the published Manufactures Suggested Retail Price (MSRP), the item will be reimbursed at MSRP less 20%. If there is no established fee schedule value or MSRP, reimbursement shall be based on 120% of the cost of the item as indicated on the supplier's invoice. Shipping and handling charges are not separately payable.

(5) Durable Medical Equipment (DME) is equipment that can withstand repeated use and allows injured workers accessibility in the home, work, and community. DME can be categorized as:

(a) Inexpensive or Routinely Purchased: These items cost less than $50.00. The maximum fee for these items is identified in section (9) of this rule.

(b) Capped Rental/Purchased Equipment:

(i) Rented DME items must be purchased or discontinued after 15 months of continuous use.

(ii) 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). The payer shall not pay for rental fees once the ~~purchase~~total fee scheduled price of the rented item has been reached. 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.

(iii) Items that cost $100.00 or less (according to provider's invoice) shall be purchased and reimbursed pursuant to section 18-6(H) of this rule.

(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.

(c) All electrical stimulators are bundled kits that include the portable unit(s), 2 to 4 leads and pads, initial battery(s), electrical adapters, and carrying case. The kits that cost more than $100.00 shall be rented for the first month of use before a potential purchase ~~price.~~. The monthly rental rate shall not exceed 10% of the total fee scheduled price. Provider shall request prior authorization and document the effectiveness of the kit for the injured worker prior to purchasing an item that costs more than $100.00. Effectiveness should include functional improvement and decreased pain. The billing provider shall append modifiers "NU" for new

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or "UE" for used purchased items or modifier "RR" for rented items. Billing codes for the items are as follows:

~~(6~~

(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) Osteogenesis electrical stimulation: E0748 or E0749 for non-invasive spinal application, or E0760 for ultrasound low intensity;

(iv) All replacement supplies may be billed no more than once a month using A4595 for electrical stimulator supplies, 2 leads, or A4557 for replacement leads. Code A4557 should not be billed with the first month's rent.

(v) Conductive Garments: E0731;

(d) Continuous Passive Motion Devices (CPMs):

E0935 – continuous passive motion exercise device for use on the knee only; or E0936 – continuous passive motion exercise device for use on body parts other than knee. These devices are bundled into the facility fees and not separately payable.

(e) Intermittent Pneumatic Devices (including, but not limited to, Game Ready and cold compression) are bundled into the facility fees and not separately payable. The use of these devices after discharge requires prior authorization. The billing codes are as follows:

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.

(6) Auto-shipping of monthly DMEPOS supplies is not allowed.

(7) Reimbursement of supplies to facilities shall be in compliance with sections 18-6 (I) – (O).

(~~7~~8) 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.

(~~8~~9) Take home exercise supplies with a total cost of $50 or less may be billed 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.

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(~~9~~10) 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.

(c) CRT shall be reimbursed as set out in section 18-6(H)(4).

(I) INPATIENT HOSPITAL FACILITY FEES

(1) Provider Restrictions

All non-emergency, inpatient admissions require prior authorization for payment (see Rule 16-10).

(2) Bills 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 of this Rule 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 of this Rule 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 section18-6(I)(3)(d) 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.

(3) 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

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(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 of this Rule)
(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).

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(c) Medicare Long Term Care Hospitals (MLTCH)

MLTCHs are reimbursed at $3,200 per day, not to exceed 75% of 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 and no interim bills are payable.

(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 of this Rule and locate the hospital's base rate in Exhibit #2 of this Rule.

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 section18-6(J)(6)(b)5).
(iii) For organ acquisition allowance, (revenue codes 810-819) see section 18-6(I)(3)(h).

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(e) Outliers are admissions with extraordinary cost warranting additional reimbursement beyond the maximum allowance under section 18-6(I)(3)(c). 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.

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(ii) Each hospital's cost-to-charge ratio is given in Exhibit #2 of this Rule.
(iii) The "Difference" = "Hospital's Cost" – "Maximum Fee Allowance" excluding any trauma center activation or organ acquisition allowance (see (c) above).
(iv) If the "Difference" is greater than $~~23,570~~26,713.00, 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 section 18-6 (I)(3),
(ii) Trauma Center activation fees (see section 18-6(J)(6)(b)5)) and organ acquisition allowance (see section 18-6(I)(3)(h)) are paid in addition to inpatient fees (see sections 18-6(I)(3)(c-d)).

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(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 of this Rule) divided by the MS-DRG geometric mean length of stay (Exhibit #1 of this Rule). 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) To comply with Rule 16-6(B), 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
(iv) under section 18-6(I)(3)(h).

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

(J) OUTPATIENT HOSPITAL FACILITY FEES

(1) Provider Restrictions

(a) All non-emergency outpatient surgeries require prior authorization for payment (see Rule 16-10).

(b) A separate facility fee is only payable if the location of where the services are provided is licensed as a hospital, or ASC for surgical episodes, by the Colorado Department of Public Health and Environment (CDPHE) or applicable out of state governing agency and 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 of this Rule 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 (J)(2)(b) above):

(i) Children's hospitals
(ii) Veterans' Administration hospitals
(iii) State psychiatric hospitals

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

(c) Exhibit #4 to this Rule:

Hospital reimbursement is based upon Medicare's ~~2016~~2017 Outpatient Prospective Payment System (OPPS) as modified in Exhibit #4 of this Rule. Exhibit #4 lists Medicare's Outpatient Hospital Ambulatory Prospective Payment (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 sections18-6(J)(3)(a) and (b).

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(iv) Column 4 is used to determine maximum fees for all Ambulatory Surgery Centers (ASC) when outpatient surgery is performed in an ASC.

To identify which APC grouper is aligned with an Exhibit #4 APC code # and dollar value, use Medicare's ~~2016~~2017 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 5123.

(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 fees 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.

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(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; and

(l) post-operative pain blocks.

(m) implanted items.

Packaged Services	
Revenue Code	Description

Packaged Services	
Revenue 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
0390	Administration, Processing and Storage for Blood and Blood Components; General Classification
0392	Administration, Processing and Storage for Blood and Blood Components; Processing and Storage
0399	Administration, Processing and Storage for Blood and 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%

Packaged Services	
Revenue Code	Description
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:

(a) "A" means use another fee schedule instead of Exhibit #4, i.e., 18-4 Conversion Factors and RBRVS RVUs,18-6(R) Ambulance Fee Schedule, or Exhibit #8.

(b) "B" means it 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, such as home health.

(c) "C" means recognized by Medicare as inpatient only procedures; however, the Division does recognize these procedures can be done outpatient if prior authorization is obtained per Rule 16-10.

(d) "D" means discontinued code and not paid under OPPS by Medicare. Therefore, this code is not separately payable in OPPS by DoWC.

(e) "~~E~~E1" or "E2" means 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) "F" means corneal tissue acquisition and certain CRNA services and Hepatitis A vaccines are allowed at a reasonable cost to the facility. The facility must provide a separate invoice identifying their cost.

(g) "G" means "Pass-Through Drugs and Biologicals" that are separately payable under Exhibit #4 as an APC value.

(h) "H" means a "Pass-Through Device" that is separately payable based upon cost to the facility.

(i) "J1" or "J2" means 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 to implement "comprehensive APCs."

(j) "K" means a separately payable "Pass-Through Drug or Biological or Device," for therapeutic radiopharmaceuticals, brachytherapy sources, blood and blood products as listed under Exhibit #4's APC value.

(k) "L" represents Influenza Vaccine and therefore, is generally not considered workers' compensation related.

(l) Any "Packaged Codes" with Q1, Q2, Q3, Q4 or STVX combinations are not recognized unless the payer and provider make a prior agreement.

(m) "M" means not separately payable.

(n) "N" means the service is bundled and is not separately payable.

(o) "P" means partial hospitalization and is paid based upon observation fees as outlined in section 18-6(J).

(p) "R" means separate payment for blood and blood products under Exhibit #4 APC value.

(q) "S" and "T" mean there are 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.

(r) "U" means brachytherapy source and is separately payable under Exhibit #4 APC value.

(s) "V" represents a clinic or Emergency Department visit and is separately payable for hospitals as specified in section18-6(J).

(t) "Y" represents non-implantable Durable Medical Equipment and is paid according to Medicare's Durable Medical Equipment Regional Carrier (DMERC) fee schedule for Colorado.

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

(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.

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(b) Hospitals billing type "A" or "B" Emergency Department (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 with level of care CPT® codes 99281-99285; or
(ii) A free-standing 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

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billed using revenue code 456 with level of care HCPCS codes G0380-G0384, even though the facility may not be open 24/7;

(c) Emergency Department (ED) level of care criteria includes:

(i) The ED "Level of Care" is identified based upon one (1) of five (5) levels of care for either a type "A" (CPT® 99281-99285, 99291 or 99292) or type "B" (G0380-G0384) 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).

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(d) APC 5045, Trauma Response with Critical Care, is not recognized for separate payment. Trauma Center fees are not paid for alerts. Trauma activation fees are as follows:

- Revenue Code 681 $3,000.00
- Revenue Code 682 $2,500.00
- Revenue Code 683 $1,000.00
- Revenue Code 684 $0

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- These fees are in addition to ED and inpatient fees.
- Activation fees mean a trauma team has been activated, not just alerted.
- The level of trauma activation shall be determined by CDPHE's assigned hospital trauma level designation.

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(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 18-6(I)(3).

(f) Multiple APCs identified by multiple CPT® codes are to be 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.

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(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) In compliance with Rule 16-6(B), the sum of section 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 the calculated maximum fee schedule allowance of section 18-6(J)(3)(c) is not appropriate.

(g) Any diagnostic testing clinical labs or therapies with a status indicator (SI) of "A" may be reimbursed using Exhibit #8 of this Rule 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. Modifier L1 should be appended to the billed laboratory services. The maximum fees are based upon Exhibit #8.

(h) Observation room Maximum Fee Schedule value is limited to six (6) hours without prior authorization for payment (see Rule 16-10). 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 Codes:

G0378 Observation/Convalescence rate: $45.00 per hour, round to the nearest hour.

(i) Professional fees are reimbursed according to the fee schedule times the appropriate conversion factor regardless of the facility type. Additional reimbursement is payable for the following services not included in the values found in Exhibit #4 of this Rule:

(i) ambulance services (Revenue Code 540), see section18-6(R)

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(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 conversion factor. Modifiers are required to indicate the type of care plan or therapist being billed. See Rule 18-5(H) Physical Medicine & Rehabilitation 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(N).

(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 under Rule 18, Exhibit #5 and/or as certified by the Colorado Department of Public Health and Environment;
- Critical Access Hospitals as identified under Rule 18, Exhibit #3 and/or as certified by the 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 to this Rule 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 of this Rule 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 sections 18-6(I), (J), (K) or (L).
- Maximum fees for hospital urgent care facilities or services are covered under section 18-6(L). These are identified by either place of service code 20, as billed on a CMS-1500 or by revenue code(s) 456, 516 or 526 on a UB-04.

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

(l) IV Infusions Performed in Outpatient Hospital Facilities

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IV infusion therapy performed in an outpatient hospital facility is reimbursed per section18-6(J).

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

(K) AMBULATORY SURGERY CENTERS

(1) Provider Restrictions

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

(b) All outpatient surgical procedures performed in an ASC shall be reasonable and necessary and warrant the performance of the procedure at an ASC level.

(2) Billing Codes and Maximum Fees

ASCs are reimbursed in accordance with section18-6(J) for any surgical episodes of care. Column 4 from Exhibit #4 of this Rule lists the dollar value used to determine the maximum fees.

(L) URGENT CARE FACILITIES (hospital - revenue codes 516, 526 or non-hospital)

(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) 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.

(b) Urgent Care Facility fee is HCPCS code S9088, $75.00.

(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 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 conversion factor.

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(iv) Hospital and non-hospital based urgent care facilities may bill for the facility fee, HCPCS code S9088, 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 Rule 18-4 conversion factor.

(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 Rule 18-4 conversion factor.

(d) The Observation Room allowance shall not exceed $45.00 per hour and is limited to a maximum of three (3) hours without prior authorization for payment (see Rule 16-10).

G0378 Observation rate: $45.00 per hour

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

(f) 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 Rule 18-6(N).

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(M) HOME CARE SERVICES

Prior authorization for payment (see Rule 16-10) 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.

(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 workers 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:

S9364	<1 Liter	$160.00/ day
S9365	1 liter	$174.00/ day
S9366	1.1 - 2.0 liter	$200.00/ day

S9367	2.1 - 3.0 liter	$227.00/ day
S9368	> 3.0 liter	$254.00/ day

The per day rates include 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(N).

(b) Antibiotic Therapy per day rate by professional + drug cost at Medicare's Average Sale Price (ASP). If ASP is not available, bill using the drug cost at Average Wholesale Price (AWP).

S9494	hourly	$158.00/ day
S9497	once every 3 hours	$152.00/ day
S9500	every 24 hours	$97.00/ day
S9501	once every 12 hours	$110.00/ day
S9502	once every 8 hours	$122.00/ day
S9503	once every 6 hours	$134.00/ day
S9504	once every 4 hours	$146.00/ day

(c) Chemotherapy per day rate + drug cost at Medicare's Average Sale Price (ASP). If ASP is not available, bill using the drug cost at Average Wholesale Price (AWP).

S9329	Administrative Services	$ 0.00/ day
S9330	Continuous (24 hrs. or more) chemotherapy	$91.00/ day
S9331	Intermittent (less than 24 hrs.)	$103.00/ day

(d) Enteral nutrition (enteral formula and nursing services separately billable):

S9341	Via Gravity	$44.09/ day
S9342	Via Pump	$24.23/ day
S9343	Via Bolus	$24.23/ day

(e) Pain Management per day or refill + drug cost at Medicare's Average Sale Price (ASP). If ASP is not available, bill using the drug cost at Average Wholesale Price (AWP).

S9326	Continuous (24 hrs. or more)	$ 79.00/ day
S9327	Intermittent (less than 24 hrs.)	$103.00/ day

S9328 Implanted pump $116.00/ refill
(No separate daily rate is applicable when the patient has an implanted pain pump.)

(f) Fluid Replacement per day rate + drug cost at Medicare's Average Sale Price (ASP). If ASP is not available, bill using the drug cost at Average Wholesale Price (AWP).

S9373 < 1 liter per day	$61.00/ day
S9374 1 liter per day	$85.00/ day
S9375 >1 but <2 liters per day	$85.00/ day
S9376 >2 liters but <3 liters	$85.00/ day
S9377 >3 liters per day	$85.00/ day

(g) Multiple Therapies:

Highest cost per day or refill only + drug cost at Medicare's Average Sale Price (ASP). If ASP is not available, bill using the drug cost at Average Wholesale Price (AWP).

Medication/Drug Restrictions - the payment for drugs may be based upon Medicare's Average Sale Price (ASP). If ASP is not available, bill using the drug cost at Average Wholesale Price (AWP).

AWP (see section 18-6(N)) of the drug is determined through the use of industry publications such as the monthly Price Alert, First Databank, Inc.

(2) Nursing Services

(a) Skilled Nursing (LPN & RN)

S9123 RN	$111.00/hr.
S9124 LPN	$ 89.00/hr.

There is a limit of two (2) hours without prior authorization for payment (see Rule 16-10).

(b) Certified Nurse Assistant (CNA):

S9122 CNA $ 45.00/hr.

The amount of time spent with the injured worker must be specified in the medical records and on the bill.

(3) Physical Medicine

Physical medicine procedures are payable at the same rate as provided in section ~~185~~18-5(H), Physical Medicine and Rehabilitation.

(4) Mileage

Travel allowances should be agreed upon with the payer and the mileage rate should not exceed $0.53 per mile, portal to portal.

DoWC code: 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 for payment (see Rule 16-10) and shall not exceed $~~30~~34.00 per hour.

DoWC code: Z0773

(6) Drugs/Supplies/DME/Orthotics/Prosthetics Used For At-Home Care

As defined in Rule 18-6(H), any drugs/supplies/DME/Orthotics/Prosthetics considered integral to any 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 Rule 18-6(H). All IV infusion supplies are included in the per diem or refill rates listed in this rule.

(N) DRUGS AND MEDICATIONS

(1) 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).

(2) 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, 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 it is found in this Rule.

(3) Reimbursement for 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, C.R.S. (2015), to 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 the provider's actual cost incurred or Medicare's Part B Drug Average Sale Price (ASP).

~~-~~(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 HCPC 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.

(4) 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 Fee $ ~~75~~80.00 per 30 day supply

Any anti-inflammatory medication or any local anesthetic single agent.

Category II Z0791 Fee $~~150~~160.00 per 30 day supply

Any anti-inflammatory agent or agents in combination with any local anesthetic agent or agents.

Category III Z0792 Fee $~~250~~265.00 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 Fee $~~350~~370.00 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, the 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.

(5) Over-the-Counter Medications

(a) Over-the-counter medications, drugs that are safe and effective for use by the general public without a prescription, 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.

(6) Injured Worker Reimbursement

In the event the injured worker has directly paid for authorized prescriptions, 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 16-12(G).

(7) Dietary Supplements, Vitamins and Herbal Medicines

Reimbursement for outpatient dietary supplements, vitamins and herbal medicines dispensed in conjunction with acupuncture and complementary alternative medicine are authorized only by prior agreement of the payer, except if specifically provided for in Rule 17, Medical Treatment Guidelines.

(8) Prescription Writing

(a) Physicians shall indicate on the prescription form that the medication is related to a workers' compensation claim.

(b) 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 requirements outlined in Rule 16-5(B)(2), providers using pharmacies and prescribing a brand name compounded topical drug with a DAW indication shall provide a written medical justification explaining the reasonableness and necessity of the brand name over the generic equivalent. This rule applies to all pharmacies, whether located in-state or out-of-state.

(c) The provider shall prescribe no more than a 60-day supply per prescription.

(9) Required Billing Forms

(a) All parties shall use one (1) of the following forms:

(i) CMS-1500 – the dispensing provider shall bill by using the metric quantity and NDC number of the drug being dispensed; or, if one does not exist, the RBRVS supply code; or

(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 (PBMs). Physicians may use the CMS-1500 billing form as described in Rule 16-7(B)(1).

~~Physicians shall list the "repackaged" and the "original" NDC numbers in field 24 of the CMS-1500. List the "repackaged" NDC number first and the "original" NDC number second, with the prefix 'ORIG' appended.~~

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(b) Items prescribed for the work-related injury that do not have an NDC code shall be billed as a supply, using the RBRVS supply code (see section18-6(H)).

(c) The payer may return any prescription billing form if the information is incomplete.

(d) A signature shall be kept on file indicating that the injured worker or his/her authorized representative has received the prescription.

(10) A line-by-line itemization of each drug billed and the payment for that drug shall be made on the payment voucher by the payer.

(O) COMPLEMENTARY ALTERNATIVE MEDICINE (CAM)

CAM is a term used to describe 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 CAM 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. CAM requires prior authorization for payment (see Rule 16-10). Refer to Rule 17, Medical Treatment Guidelines for the specific types of CAM modalities.

(P) ACUPUNCTURE

Acupuncture is an accepted procedure for the relief of 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 return of functional recovery. Acupuncture may be performed with or without the use of electrical current on the needles at the acupuncture site.

(1) Provider Restrictions

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

(2) Billing Restrictions

(a) For treatment frequencies exceeding the maximum allowed in Rule 17, Medical Treatment Guidelines, the provider must obtain prior authorization for payment (see Rule 16-10).

(b) Unless the provider's medical records reflect medical necessity and the provider obtains prior authorization for payment (see Rule 16-10), the maximum amount of time allowed for acupuncture and procedures is one (1) hour of procedures, per day, per discipline.

(3) Billing Codes:

(a) Reimburse acupuncture, including or not including electrical stimulation, as listed in the RBRVS.

(b) Non-Physician evaluation services

(i) New or established patient services are reimbursable only 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 16-12)

(ii) LAc new patient visit: DOWC Z0800
Maximum value $99.80

(iii) LAc established patient visit: DOWC Z0801
Maximum value $67.60

(c) Herbs require prior authorization for payment (see Rule 16-10) and fee agreements as per section18-6(N)(7).

(d) See the appropriate Physical Medicine and Rehabilitation section of the RBRVS for other billing codes and limitations (see also section18-5(H)).

(e) Acupuncture supplies are reimbursed in accordance with section 18-6(H).

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(Q) USE OF AN INTERPRETER

Rates and terms shall be negotiated. Prior authorization for payment (see Rule 16-10) is required except for emergency treatment. Use DoWC Z0722 to bill.

(R) AMBULANCE FEE SCHEDULE

(1) Billing Requirements:

Payment under the fee schedule for ambulance services is comprised of a base rate payment plus 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 considered inclusive with the base rate and mileage rate.

(2) General Claims Submission:

(a) All hospitals billing for ground or air ambulance services shall bill on the UB-04 and all other ambulance providers shall bill on the CMS-1500.

(b) Use the appropriate HCPCS code plus the HCPCS origin/destination modifier.

(c) The transporting supplier's name, complete address and provider number should be listed in Item 33 (CMS-1500).

(d) The zip code for the origin (point of pickup) must be in Item 23 (CMS-1500). If billing on the UB-04 use FL 39-41 with an "AO" and the point of pick up zip 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 and Air Ambulance Vehicle and Crew Requirements

As required by the Colorado Department of Public Health and Environment.

(4) HCPCS Procedure Codes and Maximum Allowances for Ambulance Services:

(a) Ground (both water and land) Ambulance Base Rates and Mileage

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.

~~Ground Ambulance~~	HCPCS ~~Code Description~~	~~Urban~~ ~~Medicare~~Base Rate *250%	~~Rural (R = Zip Code) First 17 miles or > if not a Super Rural Medicare Rate~~URBAN BASE RATE / URBAN MILEAGE *250%	~~Super Rural (B =Zip code) Medicare Rate~~RURAL BASE RATE / RURAL MILEAGE *250%	RURAL BA RATE / LOWEST QUARTILE *250%	

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~~Ground Ambulance~~	HCPCS ~~Code Description~~	~~Urban Medicare~~Base Rate *250%		~~Rural (R = Zip Code) First 17 miles or > if not a Super Rural Medicare Rate~~URBAN BASE RATE / URBAN MILEAGE *250%	~~Super Rural (B =Zip code) Medicare Rate~~RURAL BASE RATE / RURAL MILEAGE *250%	RURAL BA RATE LOWEST QUARTILE *250%	
A0425		~~Ground mileage, per statute mile $ 17.88~~		$~~–~~18.~~11~~23	$~~–~~18.~~28~~40	~~$ 18.28~~n/a	$27.60
A0426		~~Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1- Non-Emergency) $~~ 555.73	~~$ 680.67~~	$~~-~~687.~~34~~35	$ ~~842.68~~694.10	$850.98	
A0427		~~Ambulance service, advanced life support, emergency transport, level 1 (ALS1-Emergency) $~~ 555.73	~~$1,077.72~~	$1,088.~~29~~30	$1,~~334.24~~098.98	$1,347.35	n/a
A0428		~~Ambulance service, basic life support, non-emergency transport (BLS) $~~ 555.73	~~$ 567.22~~	$572.~~28~~80	$ ~~702.23~~578.40	$709.13	n/a
A0429		~~Ambulance service, basic life support, emergency transport (BLS-Emergency) $~~ 555.73	~~$ 907.55~~	$~~–~~916.~~45~~48	$925.45	$1,~~123.571~~160	
A0432		~~Paramedic intercept (PI), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers. $~~ 555.73		~~$992.64~~1,002.38	~~$1002.37~~1,012.20	~~$1002.37~~n/a	n/a
A0433		~~Advanced life support, level 2 (ALS2) $~~ 555.73	~~$1,559.86~~	$1,575.~~15~~18	$1,~~931.14~~590.63	$1,950.10	
A0434		~~Specialty care transport (SCT) $~~ 555.73	~~$1,843.47~~	$1,861.~~54~~58	$1,879.83	$2,~~282.253~~68	
A0435		$ 21.40		$21.40	$32.10	n/a	$32.10
A0436		$ 57.10		$57.10	$85.65	n/a	$85.65

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The “urban” base rate(s) and mileage rate(s) as indicated in section 18-6(R) shall be applied 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 08/27/2014.

(5) Modifiers

Modifiers identify place of origin and destination of the ambulance trip. The modifier is to be placed next to the HCPCS code billed. The following is a list of current ambulance 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 SNF (other than 1819 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 (e.g., airport, ferry, or helicopter pad) between modes of ambulance transport
J	Non-hospital-based dialysis facility - Non-Hospital administered/Non-Hospital located - Hospital administered/Non-Hospital located
N	Skilled Nursing Facility (SNF) (1819 Facility)
P	Physician's Office (includes HMO 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 HMO 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. Payment is allowed for all medically necessary mileage. If mileage is billed, the miles must be in whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number. Use code "1" as the mileage for trips of less than a mile.

18-7 DENTAL FEE SCHEDULE

The dental fee schedule is adopted using the American Dental Association's Current Dental Terminology, ~~2016~~2017 (CDT-~~2016~~2017). However, surgical treatment for dental trauma and subsequent, related procedures may be billed using medical codes from the RBRVS. If billed using medical codes as listed in the RBRVS, reimbursement shall be in accordance with the Surgery/ Anesthesia section of the RBRVS and its corresponding conversion factor. All dental billing and reimbursement shall be in accordance with the Division's Rule 16, Utilization Standards, and Rule 17, Medical Treatment Guidelines. See Exhibit #6 of this Rule for the listing and Maximum Fee Schedule value for CDT-~~2016~~2017 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.

18-8 QUALITY INITIATIVES

(A) ~~***CHRONIC***~~ OPIOID MANAGEMENT

(1) ~~(1)~~ 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.

(2) Acute opioid prescriptions should be limited to seven (7) days and 50 morphine milliequivalents per day. Providers considering repeat opioid refills at any time during treatment are encouraged to perform the actions in this section and bill accordingly.

(3) When the authorized treating physician (ATP) prescribes ~~long term~~ opioid treatment, s/he shall ~~use~~comply with the Division of Workers' Compensation

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Chronic Pain Disorder Medical Treatment Guidelines and review the Colorado Medical Board Policy #40-26, "Policy for Prescribing and Dispensing Opioids."

(4) 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 18-5(F)(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) When drug screen tests are ordered, the authorized treating physician shall utilize the Colorado Prescription Drug Monitoring Program (PDMP).~~

~~(c)~~(b) While the injured worker is receiving ~~chronic~~ opioid management, additional drug screens with documented justification may be conducted. Examples of documented justification include ~~the following~~:

(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 ~~100~~50 mg of morphine or equivalent.

(5) The ATP should utilize the Colorado Prescription Drug Monitoring Program (PDMP) when prescribing opioids and must utilize the PDMP when prescribing opioid refills.

(6) The patient should initially and periodically be evaluated for risk of misuse or addiction.

~~(d)~~(7) The opioids classified as Schedule II or Schedule III controlled substances that are prescribed for treatment lasting longer than 30 days shall be provided through a pharmacy.

~~(e)~~(8) The ~~authorized treating physician~~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, C.R.S. (2015). For reimbursement~~if the patient is deemed at risk for an opiate antagonist~~, please~~ (see ~~Rule~~section 18-6(N)(3)(c)~~.~~)).

~~(f)~~(9) The prescribing ~~authorized treating physician~~ATP shall review and integrate the drug screening results~~,~~ required for subacute and chronic opioid management as appropriate; the PDMP~~, and~~ 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 ~~on~~in determining the prescribed levels of medications. A written report will document the treating physician's assessment of the patient's past and

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current functional status of work, leisure ~~activities~~, and activities of daily living ~~competencies~~.

(~~2~~10) Codes and maximum fees ~~for~~are payable to the ~~authorized treating physician~~ATP for a written report with all the following review services completed and documented:

(a) Ordering and reviewing drug tests for subacute or chronic opioid management;

(b) Ordering and reviewing PDMP results;

(c) Reviewing the medical records;

(d) Reviewing the injured workers' current functional status;

(e) Evaluating the risk of misuse and abuse periodically; and

~~(e)~~(f) Determining what actions, if any, need to be taken.

~~(f) Appropriate chronic pain diagnostic code (ICD-10)~~

~~Bill using code~~ Opioid Management:

Acute Phase	DoWC ~~Z0765 $75~~Code: Z0771 ~~$84~~.00 per 15 minutes – maximum of 30 minutes per report

~~NOTE: This code is not to be used for acute or sub-acute pain management.~~

Subacute/Chronic Phase	DoWC Code: Z0765 $84.00 per 15 minutes – maximum of 30 minutes per report

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(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 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 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, Gaeslen, 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 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 elements are documented, the billing codes and maximum fees are as follows:

DOWC Z0811 $~~60~~62.00 per episode for the initial functional assessment of pre-injection care, billed along with the appropriate E&M code, related to spinal or SI joint injections.

DOWC Z0812 $~~31.44~~33.00 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 $~~31.44~~33.00 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 ~~validated~~ Division-approved psychological screen and a Division-approved functional tool. The psychological screen and the ~~validated~~ functional ~~data provided~~tool are approved by the ~~injured worker or another health care provider~~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.

If these elements have been met, the billing code and maximum fee are as follows:

DOWC Z0815 $ 80.00 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 $ 40.00 for subsequent visits during which the injured worker provides follow-up functional data which 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.

(2) QPOP for post-MMI patients requires prior authorization based on clearly documented functional goals.

(D) PILOT PROGRAMS

(1) 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 C.R.S. 8-43-602 and shall include:

(a) Beginning and end date for the pilot program.

(b) Population to be managed (e.g. size, specific diagnosis codes).

(c) Provider group(s) participating in the program.

(d) Proposed codes and fees.

(e) 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.

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
1	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W MCC	25.2117	28.5	36.1
2	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W/O MCC	15.2867	16.9	20.3
3	PRE	SURG	ECMO OR TRACH W MV >96 HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	17.7325	24.3	30.8
4	PRE	SURG	TRACH W MV >96 HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	11.2228	19.6	23.8
5	PRE	SURG	LIVER TRANSPLANT W MCC OR INTESTINAL TRANSPLANT	10.3701	15.3	20.5
6	PRE	SURG	LIVER TRANSPLANT W/O MCC	4.4655	7.8	8.5
7	PRE	SURG	LUNG TRANSPLANT	9.8276	16.1	18.8
8	PRE	SURG	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	5.0846	9.2	10.7
10	PRE	SURG	PANCREAS TRANSPLANT	4.3783	8.1	9.0
11	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W MCC	4.9109	10.9	13.6
12	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W CC	3.5109	8.4	9.7
13	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W/O CC/MCC	2.4030	6.0	6.8
14	PRE	SURG	ALLOGENEIC BONE MARROW TRANSPLANT	11.5318	23.8	27.3
16	PRE	SURG	AUTOLOGOUS BONE MARROW TRANSPLANT W CC/MCC	6.2657	17.2	18.5
17	PRE	SURG	AUTOLOGOUS BONE MARROW TRANSPLANT W/O CC/MCC	4.1772	8.5	11.6
20	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W MCC	10.0449	13.5	16.7
21	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W CC	7.5504	11.8	13.3
22	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W/O CC/MCC	5.8233	7.0	8.6
23	01	SURG	CRANIOTOMY W MAJOR DEVICE IMPLANT OR ACUTE CNS PDX W MCC OR CHEMOTHERAPY IMPLANT OR EPILEPSY W NEUROSTIMULATOR	5.5252	7.6	10.7

Exhibit #1 – Proposed						
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MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
24	01	SURG	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W/O MCC	3.8539	4.2	5.5
25	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W MCC	4.3085	7.0	9.1
26	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W CC	3.0000	4.2	5.6
27	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W/O CC/MCC	2.3655	2.2	2.9
28	01	SURG	SPINAL PROCEDURES W MCC	5.5357	9.1	11.7
29	01	SURG	SPINAL PROCEDURES W CC OR SPINAL NEUROSTIMULATORS	3.2706	4.2	5.8
30	01	SURG	SPINAL PROCEDURES W/O CC/MCC	2.1233	2.2	2.8
31	01	SURG	VENTRICULAR SHUNT PROCEDURES W MCC	4.1179	7.0	10.1
32	01	SURG	VENTRICULAR SHUNT PROCEDURES W CC	2.1277	3.2	4.6
33	01	SURG	VENTRICULAR SHUNT PROCEDURES W/O CC/MCC	1.6956	1.9	2.4
34	01	SURG	CAROTID ARTERY STENT PROCEDURE W MCC	4.0289	5.1	7.6
35	01	SURG	CAROTID ARTERY STENT PROCEDURE W CC	2.2355	2.1	3.1
36	01	SURG	CAROTID ARTERY STENT PROCEDURE W/O CC/MCC	1.7633	1.3	1.5
37	01	SURG	EXTRACRANIAL PROCEDURES W MCC	3.1639	5.1	7.4
38	01	SURG	EXTRACRANIAL PROCEDURES W CC	1.5647	2.2	3.1
39	01	SURG	EXTRACRANIAL PROCEDURES W/O CC/MCC	1.1117	1.3	1.5
40	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W MCC	3.6812	7.4	10.2
41	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W CC OR PERIPH NEUROSTIM	2.3414	4.3	5.4
42	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W/O CC/MCC	1.9535	2.6	3.2
52	01	MED	SPINAL DISORDERS & INJURIES W CC/MCC	1.5386	4.1	5.5
53	01	MED	SPINAL DISORDERS & INJURIES W/O CC/MCC	0.9514	2.7	3.3
54	01	MED	NERVOUS SYSTEM NEOPLASMS W MCC	1.3288	3.9	5.3
55	01	MED	NERVOUS SYSTEM NEOPLASMS W/O MCC	1.0026	2.9	4.0
56	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS W MCC	1.9249	5.4	7.7
57	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS W/O MCC	1.1329	3.8	5.4

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MS-DRG Table						
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MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
58	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W MCC	1.6924	5.1	6.7
59	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W CC	1.0719	3.7	4.6
60	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W/O CC/MCC	0.8434	3.1	3.6
61	01	MED	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA W THROMBOLYTIC AGENT W MCC	2.8410	5.0	6.5
62	01	MED	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA W THROMBOLYTIC AGENT W CC	1.9528	3.5	4.1
63	01	MED	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA W THROMBOLYTIC AGENT W/O CC/MCC	1.6402	2.6	2.9
64	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	1.7938	4.5	6.1
65	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	1.0330	3.1	3.8
66	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W/O CC/MCC	0.7448	2.2	2.6
67	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W MCC	1.4214	3.5	4.8
68	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W/O MCC	0.8938	2.2	2.8
69	01	MED	TRANSIENT ISCHEMIA W/O THROMBOLYTIC	0.7500	2.1	2.5
70	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W MCC	1.6531	4.6	6.4
71	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	0.9871	3.4	4.4
72	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC/MCC	0.7572	2.4	3.0
73	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W MCC	1.4138	3.9	5.3
74	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O MCC	0.9543	2.9	3.7
75	01	MED	VIRAL MENINGITIS W CC/MCC	1.6583	5.1	6.4
76	01	MED	VIRAL MENINGITIS W/O CC/MCC	0.9584	3.1	3.7

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
77	01	MED	HYPERTENSIVE ENCEPHALOPATHY W MCC	1.5683	4.3	5.5
78	01	MED	HYPERTENSIVE ENCEPHALOPATHY W CC	0.9940	3.2	3.9
79	01	MED	HYPERTENSIVE ENCEPHALOPATHY W/O CC/MCC	0.7663	2.3	2.7
80	01	MED	NONTRAUMATIC STUPOR & COMA W MCC	1.7311	4.5	6.5
81	01	MED	NONTRAUMATIC STUPOR & COMA W/O MCC	0.7512	2.5	3.3
82	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W MCC	2.1988	3.8	6.4
83	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W CC	1.2621	3.3	4.2
84	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W/O CC/MCC	0.8991	2.2	2.7
85	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W MCC	2.0884	4.8	6.6
86	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W CC	1.1938	3.2	4.1
87	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W/O CC/MCC	0.8323	2.2	2.7
88	01	MED	CONCUSSION W MCC	1.4218	3.6	4.6
89	01	MED	CONCUSSION W CC	1.0048	2.7	3.3
90	01	MED	CONCUSSION W/O CC/MCC	0.7805	2.0	2.3
91	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W MCC	1.5437	4.1	5.6
92	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.9368	3.1	3.9
93	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC/MCC	0.7263	2.2	2.7
94	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W MCC	3.4364	7.8	10.2
95	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W CC	2.3653	5.8	7.0
96	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W/O CC/MCC	2.2456	4.7	5.6
97	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W MCC	3.4224	8.5	11.4
98	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W CC	1.8771	5.5	7.3
99	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W/O CC/MCC	1.2062	3.6	4.6
100	01	MED	SEIZURES W MCC	1.6628	4.2	5.7

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
101	01	MED	SEIZURES W/O MCC	0.8310	2.6	3.3
102	01	MED	HEADACHES W MCC	1.0636	3.0	4.1
103	01	MED	HEADACHES W/O MCC	0.7475	2.3	2.9
113	02	SURG	ORBITAL PROCEDURES W CC/MCC	2.1895	4.2	5.9
114	02	SURG	ORBITAL PROCEDURES W/O CC/MCC	1.2730	2.3	3.0
115	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT	1.4918	3.9	4.9
116	02	SURG	INTRAOCULAR PROCEDURES W CC/MCC	1.4965	3.3	4.7
117	02	SURG	INTRAOCULAR PROCEDURES W/O CC/MCC	0.9835	2.1	2.8
121	02	MED	ACUTE MAJOR EYE INFECTIONS W CC/MCC	0.9943	3.8	4.8
122	02	MED	ACUTE MAJOR EYE INFECTIONS W/O CC/MCC	0.7624	3.2	4.1
123	02	MED	NEUROLOGICAL EYE DISORDERS	0.7464	2.1	2.6
124	02	MED	OTHER DISORDERS OF THE EYE W MCC	1.2611	3.6	4.9
125	02	MED	OTHER DISORDERS OF THE EYE W/O MCC	0.7714	2.6	3.3
129	03	SURG	MAJOR HEAD & NECK PROCEDURES W CC/MCC OR MAJOR DEVICE	2.2841	3.7	5.2
130	03	SURG	MAJOR HEAD & NECK PROCEDURES W/O CC/MCC	1.4257	2.3	2.9
131	03	SURG	CRANIAL/FACIAL PROCEDURES W CC/MCC	2.5424	4.4	6.1
132	03	SURG	CRANIAL/FACIAL PROCEDURES W/O CC/MCC	1.5333	2.2	2.8
133	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W CC/MCC	1.9803	3.8	5.4
134	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W/O CC/MCC	1.1548	2.0	2.5
135	03	SURG	SINUS & MASTOID PROCEDURES W CC/MCC	2.2733	4.4	6.3
136	03	SURG	SINUS & MASTOID PROCEDURES W/O CC/MCC	1.3199	2.0	2.7
137	03	SURG	MOUTH PROCEDURES W CC/MCC	1.3491	3.5	4.6
138	03	SURG	MOUTH PROCEDURES W/O CC/MCC	0.8512	1.9	2.4
139	03	SURG	SALIVARY GLAND PROCEDURES	1.1117	1.9	2.7
146	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W MCC	1.9321	5.4	7.8
147	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W CC	1.2413	3.6	5.0
148	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W/O CC/MCC	0.8064	2.1	2.9
149	03	MED	DYSEQUILIBRIUM	0.7007	2.1	2.5
150	03	MED	EPISTAXIS W MCC	1.3374	3.5	4.8
151	03	MED	EPISTAXIS W/O MCC	0.7339	2.3	2.8
152	03	MED	OTITIS MEDIA & URI W MCC	1.0519	3.2	4.1

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
153	03	MED	OTITIS MEDIA & URI W/O MCC	0.7136	2.4	2.9
154	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W MCC	1.4583	4.1	5.5
155	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W CC	0.8990	3.0	3.8
156	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W/O CC/MCC	0.6645	2.2	2.7
157	03	MED	DENTAL & ORAL DISEASES W MCC	1.5609	4.4	5.8
158	03	MED	DENTAL & ORAL DISEASES W CC	0.8864	3.0	3.7
159	03	MED	DENTAL & ORAL DISEASES W/O CC/MCC	0.6709	2.2	2.6
163	04	SURG	MAJOR CHEST PROCEDURES W MCC	5.1039	10.2	12.7
164	04	SURG	MAJOR CHEST PROCEDURES W CC	2.6096	5.1	6.1
165	04	SURG	MAJOR CHEST PROCEDURES W/O CC/MCC	1.8581	3.1	3.7
166	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	3.5128	8.2	10.5
167	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	1.8016	4.4	5.7
168	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC/MCC	1.2768	2.4	3.1
175	04	MED	PULMONARY EMBOLISM W MCC	1.6094	4.6	5.7
176	04	MED	PULMONARY EMBOLISM W/O MCC	0.9555	3.0	3.7
177	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	1.8643	5.7	7.1
178	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W CC	1.3004	4.5	5.4
179	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W/O CC/MCC	0.9302	3.4	4.1
180	04	MED	RESPIRATORY NEOPLASMS W MCC	1.7074	5.0	6.5
181	04	MED	RESPIRATORY NEOPLASMS W CC	1.1585	3.5	4.6
182	04	MED	RESPIRATORY NEOPLASMS W/O CC/MCC	0.8413	2.4	3.1
183	04	MED	MAJOR CHEST TRAUMA W MCC	1.4845	4.5	5.6
184	04	MED	MAJOR CHEST TRAUMA W CC	1.0135	3.3	3.9
185	04	MED	MAJOR CHEST TRAUMA W/O CC/MCC	0.7579	2.5	2.9
186	04	MED	PLEURAL EFFUSION W MCC	1.5313	4.5	5.8
187	04	MED	PLEURAL EFFUSION W CC	1.0572	3.3	4.2
188	04	MED	PLEURAL EFFUSION W/O CC/MCC	0.7996	2.5	3.2
189	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.2265	3.7	4.8
190	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1.1573	3.8	4.7

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
191	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	0.9185	3.1	3.8
192	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	0.7253	2.6	3.0
193	04	MED	SIMPLE PNEUMONIA & PLEURISY W MCC	1.3795	4.5	5.5
194	04	MED	SIMPLE PNEUMONIA & PLEURISY W CC	0.9344	3.4	4.1
195	04	MED	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	0.7089	2.7	3.2
196	04	MED	INTERSTITIAL LUNG DISEASE W MCC	1.6058	5.0	6.3
197	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.0471	3.4	4.2
198	04	MED	INTERSTITIAL LUNG DISEASE W/O CC/MCC	0.7833	2.6	3.1
199	04	MED	PNEUMOTHORAX W MCC	1.8155	5.4	7.0
200	04	MED	PNEUMOTHORAX W CC	1.0613	3.4	4.3
201	04	MED	PNEUMOTHORAX W/O CC/MCC	0.7606	2.5	3.1
202	04	MED	BRONCHITIS & ASTHMA W CC/MCC	0.9280	3.1	3.8
203	04	MED	BRONCHITIS & ASTHMA W/O CC/MCC	0.7039	2.4	2.9
204	04	MED	RESPIRATORY SIGNS & SYMPTOMS	0.7692	2.2	2.8
205	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W MCC	1.5085	4.0	5.4
206	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O MCC	0.8511	2.5	3.1
207	04	MED	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT >96 HOURS	5.5696	12.2	14.1
208	04	MED	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <=96 HOURS	2.3991	5.0	6.8
215	05	SURG	OTHER HEART ASSIST SYSTEM IMPLANT	10.4983	7.3	11.7
216	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W MCC	9.5284	11.1	14.3
217	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W CC	6.2989	7.4	8.9
218	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W/O CC/MCC	5.7015	4.7	5.9
219	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W MCC	7.6245	9.2	11.2
220	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W CC	5.1476	6.2	6.8
221	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W/O CC/MCC	4.5800	4.5	5.0

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
222	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W MCC	8.4910	10.1	12.1
223	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W/O MCC	6.4303	5.6	6.8
224	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W MCC	7.3191	7.4	9.1
225	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W/O MCC	5.6638	4.1	4.8
226	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W MCC	6.8160	6.5	8.5
227	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W/O MCC	5.4019	3.3	4.4
228	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W MCC	6.8436	7.0	10.0
229	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W/O MCC	4.7204	3.7	4.9
231	05	SURG	CORONARY BYPASS W PTCA W MCC	8.1445	10.2	12.0
232	05	SURG	CORONARY BYPASS W PTCA W/O MCC	5.8621	7.6	8.4
233	05	SURG	CORONARY BYPASS W CARDIAC CATH W MCC	7.3640	11.5	12.9
234	05	SURG	CORONARY BYPASS W CARDIAC CATH W/O MCC	5.0756	8.1	8.7
235	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W MCC	5.7970	8.8	10.1
236	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W/O MCC	3.8931	6.0	6.5
239	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W MCC	4.6375	10.2	13.0
240	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W CC	2.6675	6.9	8.4
241	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W/O CC/MCC	1.4778	4.3	5.1
242	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W MCC	3.7192	5.5	7.0
243	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W CC	2.6090	3.4	4.2
244	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W/O CC/MCC	2.1384	2.4	2.8
245	05	SURG	AICD GENERATOR PROCEDURES	5.4414	4.5	6.4
246	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W DRUG-ELUTING STENT W MCC OR 4+ ARTERIES OR STENTS	3.2238	4.2	5.5

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
247	05	SURG	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	2.1227	2.2	2.6
248	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W NON-DRUG-ELUTING STENT W MCC OR 4+ ARTERIES OR STENTS	3.0604	4.7	6.3
249	05	SURG	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MCC	1.9638	2.5	3.0
250	05	SURG	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W MCC	2.5208	4.0	5.3
251	05	SURG	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W/O MCC	1.6707	2.3	2.7
252	05	SURG	OTHER VASCULAR PROCEDURES W MCC	3.2670	5.3	7.6
253	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.6030	4.1	5.5
254	05	SURG	OTHER VASCULAR PROCEDURES W/O CC/MCC	1.8423	2.3	2.8
255	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W MCC	2.5101	6.6	8.3
256	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W CC	1.7431	5.3	6.3
257	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W/O CC/MCC	1.1254	3.4	4.1
258	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT W MCC	3.1313	4.9	6.5
259	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT W/O MCC	2.0909	2.8	3.5
260	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W MCC	3.6283	7.0	9.4
261	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W CC	1.9520	3.3	4.2
262	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W/O CC/MCC	1.6461	2.4	2.8
263	05	SURG	VEIN LIGATION & STRIPPING	2.3563	4.4	6.2
264	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	3.2339	6.7	9.3
265	05	SURG	AICD LEAD PROCEDURES	3.3528	3.7	5.0
266	05	SURG	ENDOVASCULAR CARDIAC VALVE REPLACEMENT W MCC	7.7457	5.0	7.2
267	05	SURG	ENDOVASCULAR CARDIAC VALVE REPLACEMENT W/O MCC	6.1025	2.9	3.5

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
268	05	SURG	AORTIC AND HEART ASSIST PROCEDURES EXCEPT PULSATION BALLOON W MCC	6.5274	6.6	9.6
269	05	SURG	AORTIC AND HEART ASSIST PROCEDURES EXCEPT PULSATION BALLOON W/O MCC	4.1569	1.8	2.5
270	05	SURG	OTHER MAJOR CARDIOVASCULAR PROCEDURES W MCC	4.9547	6.5	9.4
271	05	SURG	OTHER MAJOR CARDIOVASCULAR PROCEDURES W CC	3.3885	4.4	5.8
272	05	SURG	OTHER MAJOR CARDIOVASCULAR PROCEDURES W/O CC/MCC	2.4581	2.2	2.8
273	05	SURG	PERCUTANEOUS INTRACARDIAC PROCEDURES W MCC	3.5838	5.7	7.7
274	05	SURG	PERCUTANEOUS INTRACARDIAC PROCEDURES W/O MCC	2.7696	2.3	3.0
280	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC	1.6683	4.3	5.5
281	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W CC	0.9898	2.7	3.4
282	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W/O CC/MCC	0.7600	1.9	2.3
283	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W MCC	1.7719	3.0	4.8
284	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W CC	0.7919	1.7	2.4
285	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W/O CC/MCC	0.5558	1.3	1.4
286	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W MCC	2.2405	5.3	7.1
287	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O MCC	1.1775	2.5	3.3
288	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W MCC	2.7255	7.3	9.6
289	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W CC	1.7053	5.4	6.8
290	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W/O CC/MCC	1.0907	3.9	4.6
291	05	MED	HEART FAILURE & SHOCK W MCC	1.4825	4.5	5.7
292	05	MED	HEART FAILURE & SHOCK W CC	0.9610	3.5	4.2
293	05	MED	HEART FAILURE & SHOCK W/O CC/MCC	0.6732	2.5	3.0
294	05	MED	DEEP VEIN THROMBOPHLEBITIS W CC/MCC	1.0948	3.6	4.6

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
295	05	MED	DEEP VEIN THROMBOPHLEBITIS W/O CC/MCC	0.8015	2.9	3.5
296	05	MED	CARDIAC ARREST, UNEXPLAINED W MCC	1.4952	2.0	3.1
297	05	MED	CARDIAC ARREST, UNEXPLAINED W CC	0.6576	1.3	1.6
298	05	MED	CARDIAC ARREST, UNEXPLAINED W/O CC/MCC	0.4844	1.1	1.2
299	05	MED	PERIPHERAL VASCULAR DISORDERS W MCC	1.4860	4.1	5.4
300	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	1.0585	3.4	4.2
301	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC/MCC	0.7519	2.4	3.0
302	05	MED	ATHEROSCLEROSIS W MCC	1.0792	2.8	3.9
303	05	MED	ATHEROSCLEROSIS W/O MCC	0.6629	1.9	2.3
304	05	MED	HYPERTENSION W MCC	1.0522	3.1	4.1
305	05	MED	HYPERTENSION W/O MCC	0.6914	2.1	2.6
306	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS W MCC	1.3704	3.8	5.1
307	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS W/O MCC	0.8275	2.5	3.1
308	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W MCC	1.1968	3.6	4.6
309	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.7751	2.5	3.1
310	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC/MCC	0.5631	1.9	2.3
311	05	MED	ANGINA PECTORIS	0.6808	1.9	2.4
312	05	MED	SYNCOPE & COLLAPSE	0.7950	2.4	3.0
313	05	MED	CHEST PAIN	0.6993	1.8	2.2
314	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W MCC	1.9690	4.8	6.5
315	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.9706	2.9	3.7
316	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC/MCC	0.7400	2.0	2.5
326	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W MCC	4.5588	8.8	12.0
327	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W CC	2.1177	4.6	6.0
328	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W/O CC/MCC	1.5028	2.4	3.0
329	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W MCC	4.9255	10.8	13.5

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
330	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	2.4685	6.3	7.5
331	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1.6745	3.8	4.3
332	06	SURG	RECTAL RESECTION W MCC	3.6476	7.7	9.6
333	06	SURG	RECTAL RESECTION W CC	1.9645	4.4	5.5
334	06	SURG	RECTAL RESECTION W/O CC/MCC	1.2915	2.5	3.1
335	06	SURG	PERITONEAL ADHESIOLYSIS W MCC	4.1069	10.3	12.5
336	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.3396	6.5	7.9
337	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC/MCC	1.6132	4.0	5.0
338	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W MCC	2.7662	6.5	8.2
339	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	1.7038	4.3	5.3
340	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC/MCC	1.1980	2.5	3.0
341	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W MCC	2.5000	4.6	6.5
342	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.4868	2.8	3.7
343	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC/MCC	1.0514	1.7	2.0
344	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W MCC	2.7467	7.2	9.6
345	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.5537	4.5	5.6
346	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1.0984	3.2	3.7
347	06	SURG	ANAL & STOMAL PROCEDURES W MCC	2.6309	6.3	8.4
348	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.4093	3.7	4.8
349	06	SURG	ANAL & STOMAL PROCEDURES W/O CC/MCC	1.0083	2.5	3.0
350	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W MCC	2.4607	5.2	7.1
351	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W CC	1.4796	3.4	4.3
352	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W/O CC/MCC	1.0312	2.1	2.5

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
353	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W MCC	3.0125	6.2	8.1
354	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W CC	1.7186	3.9	4.8
355	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W/O CC/MCC	1.3153	2.6	3.1
356	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W MCC	3.8751	7.8	10.5
357	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.1295	4.8	6.2
358	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	1.4039	2.9	3.7
368	06	MED	MAJOR ESOPHAGEAL DISORDERS W MCC	1.8657	4.6	6.1
369	06	MED	MAJOR ESOPHAGEAL DISORDERS W CC	1.0906	3.3	3.9
370	06	MED	MAJOR ESOPHAGEAL DISORDERS W/O CC/MCC	0.7481	2.4	2.9
371	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W MCC	1.7350	5.5	7.1
372	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC	1.0600	4.1	5.0
373	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W/O CC/MCC	0.7611	3.2	3.8
374	06	MED	DIGESTIVE MALIGNANCY W MCC	2.0302	5.7	7.7
375	06	MED	DIGESTIVE MALIGNANCY W CC	1.2356	3.9	5.0
376	06	MED	DIGESTIVE MALIGNANCY W/O CC/MCC	0.9399	2.6	3.2
377	06	MED	G.I. HEMORRHAGE W MCC	1.7359	4.5	5.8
378	06	MED	G.I. HEMORRHAGE W CC	0.9744	3.1	3.6
379	06	MED	G.I. HEMORRHAGE W/O CC/MCC	0.6432	2.2	2.5
380	06	MED	COMPLICATED PEPTIC ULCER W MCC	1.9186	5.2	6.7
381	06	MED	COMPLICATED PEPTIC ULCER W CC	1.0813	3.4	4.1
382	06	MED	COMPLICATED PEPTIC ULCER W/O CC/MCC	0.8018	2.5	3.0
383	06	MED	UNCOMPLICATED PEPTIC ULCER W MCC	1.3666	3.9	5.1
384	06	MED	UNCOMPLICATED PEPTIC ULCER W/O MCC	0.8742	2.7	3.3
385	06	MED	INFLAMMATORY BOWEL DISEASE W MCC	1.6662	5.4	7.2
386	06	MED	INFLAMMATORY BOWEL DISEASE W CC	0.9665	3.6	4.4
387	06	MED	INFLAMMATORY BOWEL DISEASE W/O CC/MCC	0.7368	2.8	3.4
388	06	MED	G.I. OBSTRUCTION W MCC	1.5344	4.9	6.5
389	06	MED	G.I. OBSTRUCTION W CC	0.8529	3.4	4.1

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
390	06	MED	G.I. OBSTRUCTION W/O CC/MCC	0.5949	2.6	3.0
391	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W MCC	1.2402	3.8	5.1
392	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	0.7576	2.7	3.3
393	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W MCC	1.6582	4.6	6.3
394	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W CC	0.9457	3.2	4.1
395	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W/O CC/MCC	0.6722	2.4	2.9
405	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W MCC	5.2915	9.9	13.1
406	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	2.7915	5.7	7.1
407	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC/MCC	2.0128	4.1	4.8
408	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W MCC	3.9489	9.2	11.8
409	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	2.3237	6.0	7.2
410	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC/MCC	1.7216	4.2	4.8
411	07	SURG	CHOLECYSTECTOMY W C.D.E. W MCC	3.3045	7.8	9.5
412	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	2.3762	5.5	6.6
413	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC/MCC	1.6823	3.6	4.4
414	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W MCC	3.5467	8.1	9.9
415	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	2.0132	5.3	6.2
416	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC/MCC	1.4004	3.4	3.9
417	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W MCC	2.3894	5.4	6.7
418	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.6627	3.8	4.5
419	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC/MCC	1.3004	2.5	3.0
420	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W MCC	4.1005	8.1	11.6
421	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W CC	1.8803	4.3	5.6

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
422	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W/O CC/MCC	1.5541	3.1	3.8
423	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W MCC	3.6347	8.1	11.2
424	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W CC	2.2078	5.8	7.5
425	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W/O CC/MCC	1.6155	3.6	4.3
432	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W MCC	1.8127	4.8	6.5
433	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W CC	1.0222	3.4	4.3
434	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W/O CC/MCC	0.6240	2.3	2.7
435	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W MCC	1.6814	4.9	6.4
436	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W CC	1.1327	3.6	4.7
437	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W/O CC/MCC	0.9071	2.6	3.3
438	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W MCC	1.6705	4.8	6.6
439	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W CC	0.8730	3.3	4.1
440	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W/O CC/MCC	0.6365	2.5	3.0
441	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W MCC	1.8237	4.8	6.6
442	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	0.9392	3.3	4.1
443	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC/MCC	0.6772	2.5	3.0
444	07	MED	DISORDERS OF THE BILIARY TRACT W MCC	1.6063	4.4	5.8
445	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.0561	3.2	3.9
446	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC/MCC	0.7882	2.3	2.8
453	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W MCC	9.7066	7.6	9.8
454	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W CC	6.4297	4.1	4.8

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
455	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W/O CC/MCC	5.0622	2.7	3.1
456	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W MCC	9.1643	9.6	11.7
457	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W CC	6.7933	5.4	6.4
458	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W/O CC/MCC	5.3542	3.2	3.7
459	08	SURG	SPINAL FUSION EXCEPT CERVICAL W MCC	6.0301	5.8	7.4
460	08	SURG	SPINAL FUSION EXCEPT CERVICAL W/O MCC	4.0032	2.9	3.4
461	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W MCC	4.9088	6.1	7.8
462	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W/O MCC	3.2606	3.0	3.2
463	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W MCC	5.0018	9.8	13.0
464	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W CC	2.8295	5.5	6.9
465	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W/O CC/MCC	1.8727	3.0	3.7
466	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W MCC	5.0324	6.7	8.3
467	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W CC	3.4652	3.5	4.2
468	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W/O CC/MCC	2.8066	2.4	2.7
469	08	SURG	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W MCC OR TOTAL ANKLE REPLACEMENT	3.1954	5.1	6.3
470	08	SURG	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	2.0473	2.4	2.7
471	08	SURG	CERVICAL SPINAL FUSION W MCC	4.9042	6.3	8.6
472	08	SURG	CERVICAL SPINAL FUSION W CC	2.8444	2.2	3.1
473	08	SURG	CERVICAL SPINAL FUSION W/O CC/MCC	2.2840	1.4	1.7
474	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W MCC	3.8607	9.0	11.5
475	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W CC	2.1480	5.8	7.2

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
476	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W/O CC/MCC	1.1647	3.1	3.9
477	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	3.2310	8.2	10.6
478	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	2.2343	5.4	6.6
479	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	1.7653	3.4	4.2
480	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC	3.0129	6.5	7.6
481	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC	2.0417	4.5	4.9
482	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC	1.6622	3.6	3.8
483	08	SURG	MAJOR JOINT/LIMB REATTACHMENT PROCEDURE OF UPPER EXTREMITIES	2.4185	1.7	2.0
485	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W MCC	3.2509	8.2	9.9
486	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.2116	5.3	6.2
487	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC/MCC	1.6517	3.9	4.3
488	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION W CC/MCC	1.9888	3.8	5.0
489	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION W/O CC/MCC	1.2814	2.2	2.6
492	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W MCC	3.2856	6.2	7.6
493	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W CC	2.1901	4.0	4.8
494	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W/O CC/MCC	1.7462	2.7	3.2
495	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W MCC	3.0039	6.5	8.7
496	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W CC	1.9650	3.5	4.5
497	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W/O CC/MCC	1.3839	1.8	2.2

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
498	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W CC/MCC	2.4277	5.3	7.1
499	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W/O CC/MCC	1.2468	2.3	2.8
500	08	SURG	SOFT TISSUE PROCEDURES W MCC	2.9764	7.1	9.4
501	08	SURG	SOFT TISSUE PROCEDURES W CC	1.6945	4.2	5.3
502	08	SURG	SOFT TISSUE PROCEDURES W/O CC/MCC	1.2649	2.5	3.0
503	08	SURG	FOOT PROCEDURES W MCC	2.4932	6.7	8.4
504	08	SURG	FOOT PROCEDURES W CC	1.7185	4.9	5.9
505	08	SURG	FOOT PROCEDURES W/O CC/MCC	1.5119	3.0	3.6
506	08	SURG	MAJOR THUMB OR JOINT PROCEDURES	1.3760	3.7	4.6
507	08	SURG	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W CC/MCC	1.9034	4.4	5.7
508	08	SURG	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W/O CC/MCC	1.5257	2.1	2.5
509	08	SURG	ARTHROSCOPY	1.8325	3.9	4.9
510	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W MCC	2.4801	4.8	6.0
511	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W CC	1.7728	3.4	3.9
512	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W/O CC/MCC	1.4832	2.3	2.6
513	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W CC/MCC	1.6035	4.2	5.5
514	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W/O CC/MCC	1.0239	2.4	2.9
515	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W MCC	2.8625	6.2	7.9
516	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.8777	3.8	4.8
517	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC/MCC	1.3716	2.2	2.7
518	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W MCC OR DISC DEVICE/NEUROSTIM	2.8795	3.2	5.1
519	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W CC	1.7929	3.2	4.1
520	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC	1.2871	1.9	2.4
533	08	MED	FRACTURES OF FEMUR W MCC	1.4448	4.3	5.7

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
534	08	MED	FRACTURES OF FEMUR W/O MCC	0.7627	2.9	3.5
535	08	MED	FRACTURES OF HIP & PELVIS W MCC	1.2697	3.9	5.0
536	08	MED	FRACTURES OF HIP & PELVIS W/O MCC	0.7517	3.0	3.4
537	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W CC/MCC	0.9713	3.3	4.1
538	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W/O CC/MCC	0.6701	2.5	2.9
539	08	MED	OSTEOMYELITIS W MCC	1.8946	5.9	7.8
540	08	MED	OSTEOMYELITIS W CC	1.2976	4.5	5.7
541	08	MED	OSTEOMYELITIS W/O CC/MCC	0.9440	3.4	4.3
542	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W MCC	1.8089	5.3	7.0
543	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W CC	1.0770	3.7	4.6
544	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W/O CC/MCC	0.7728	3.0	3.4
545	08	MED	CONNECTIVE TISSUE DISORDERS W MCC	2.4075	5.9	8.2
546	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.1297	3.6	4.6
547	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC/MCC	0.8113	2.6	3.2
548	08	MED	SEPTIC ARTHRITIS W MCC	2.0331	6.0	7.9
549	08	MED	SEPTIC ARTHRITIS W CC	1.2021	4.1	5.1
550	08	MED	SEPTIC ARTHRITIS W/O CC/MCC	0.8945	3.0	3.6
551	08	MED	MEDICAL BACK PROBLEMS W MCC	1.5657	4.5	5.8
552	08	MED	MEDICAL BACK PROBLEMS W/O MCC	0.8912	3.0	3.7
553	08	MED	BONE DISEASES & ARTHROPATHIES W MCC	1.2521	4.0	5.2
554	08	MED	BONE DISEASES & ARTHROPATHIES W/O MCC	0.7483	2.8	3.4
555	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W MCC	1.3023	3.9	5.1
556	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC	0.7863	2.7	3.4
557	08	MED	TENDONITIS, MYOSITIS & BURSITIS W MCC	1.4516	4.6	5.8
558	08	MED	TENDONITIS, MYOSITIS & BURSITIS W/O MCC	0.8566	3.2	3.8
559	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	1.6993	4.7	6.3
560	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	1.0790	3.8	4.8

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
561	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	0.7617	2.6	3.4
562	08	MED	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W MCC	1.3888	4.1	5.2
563	08	MED	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W/O MCC	0.8209	3.0	3.4
564	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W MCC	1.4708	4.7	5.9
565	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W CC	0.9539	3.5	4.2
566	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W/O CC/MCC	0.7751	2.6	3.1
570	09	SURG	SKIN DEBRIDEMENT W MCC	2.5922	7.0	9.1
571	09	SURG	SKIN DEBRIDEMENT W CC	1.6247	5.0	6.1
572	09	SURG	SKIN DEBRIDEMENT W/O CC/MCC	1.1689	3.5	4.3
573	09	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W MCC	4.0912	8.8	12.8
574	09	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W CC	2.9289	7.3	9.3
575	09	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	1.7389	4.5	5.6
576	09	SURG	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W MCC	4.5447	9.0	13.0
577	09	SURG	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W CC	2.4236	4.7	6.8
578	09	SURG	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	1.4714	2.7	3.6
579	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W MCC	2.7808	6.9	9.2
580	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.6549	3.9	5.1
581	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC/MCC	1.3030	2.2	2.8
582	09	SURG	MASTECTOMY FOR MALIGNANCY W CC/MCC	1.4695	2.3	3.1
583	09	SURG	MASTECTOMY FOR MALIGNANCY W/O CC/MCC	1.3454	1.7	2.0
584	09	SURG	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W CC/MCC	1.8434	3.7	4.9
585	09	SURG	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W/O CC/MCC	1.5842	2.2	2.7

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
592	09	MED	SKIN ULCERS W MCC	1.4815	5.0	6.6
593	09	MED	SKIN ULCERS W CC	1.0469	4.1	4.9
594	09	MED	SKIN ULCERS W/O CC/MCC	0.7568	3.0	3.7
595	09	MED	MAJOR SKIN DISORDERS W MCC	2.1080	5.5	7.5
596	09	MED	MAJOR SKIN DISORDERS W/O MCC	0.9785	3.5	4.4
597	09	MED	MALIGNANT BREAST DISORDERS W MCC	1.8241	5.3	7.1
598	09	MED	MALIGNANT BREAST DISORDERS W CC	1.0872	3.5	4.5
599	09	MED	MALIGNANT BREAST DISORDERS W/O CC/MCC	0.8761	2.5	3.1
600	09	MED	NON-MALIGNANT BREAST DISORDERS W CC/MCC	0.9557	3.7	4.5
601	09	MED	NON-MALIGNANT BREAST DISORDERS W/O CC/MCC	0.6270	2.6	3.1
602	09	MED	CELLULITIS W MCC	1.4571	4.8	5.9
603	09	MED	CELLULITIS W/O MCC	0.8559	3.4	4.0
604	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W MCC	1.4190	3.9	5.1
605	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W/O MCC	0.8531	2.7	3.3
606	09	MED	MINOR SKIN DISORDERS W MCC	1.3769	4.2	5.7
607	09	MED	MINOR SKIN DISORDERS W/O MCC	0.7901	2.9	3.7
614	10	SURG	ADRENAL & PITUITARY PROCEDURES W CC/MCC	2.3493	3.7	5.0
615	10	SURG	ADRENAL & PITUITARY PROCEDURES W/O CC/MCC	1.4724	2.0	2.4
616	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W MCC	4.0339	10.3	12.6
617	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W CC	2.0926	6.1	7.3
618	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W/O CC/MCC	1.1695	4.1	4.8
619	10	SURG	O.R. PROCEDURES FOR OBESITY W MCC	3.1291	3.6	5.7
620	10	SURG	O.R. PROCEDURES FOR OBESITY W CC	1.8443	2.2	2.6
621	10	SURG	O.R. PROCEDURES FOR OBESITY W/O CC/MCC	1.5876	1.6	1.8
622	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W MCC	3.6089	8.4	11.1
623	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W CC	1.8906	5.5	6.6

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
624	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W/O CC/MCC	1.1632	3.3	4.1
625	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W MCC	2.6784	4.8	7.2
626	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W CC	1.4948	2.3	3.1
627	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W/O CC/MCC	1.0537	1.5	1.8
628	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W MCC	3.4610	6.8	9.8
629	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.3137	6.1	7.2
630	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC/MCC	1.6099	2.8	3.6
637	10	MED	DIABETES W MCC	1.3458	3.9	5.1
638	10	MED	DIABETES W CC	0.8534	2.9	3.6
639	10	MED	DIABETES W/O CC/MCC	0.6250	2.2	2.6
640	10	MED	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W MCC	1.1757	3.3	4.5
641	10	MED	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W/O MCC	0.7456	2.6	3.3
642	10	MED	INBORN AND OTHER DISORDERS OF METABOLISM	1.2612	3.2	4.3
643	10	MED	ENDOCRINE DISORDERS W MCC	1.5996	5.1	6.5
644	10	MED	ENDOCRINE DISORDERS W CC	1.0040	3.6	4.4
645	10	MED	ENDOCRINE DISORDERS W/O CC/MCC	0.7387	2.7	3.3
652	11	SURG	KIDNEY TRANSPLANT	3.3376	5.5	6.4
653	11	SURG	MAJOR BLADDER PROCEDURES W MCC	5.7625	11.3	14.4
654	11	SURG	MAJOR BLADDER PROCEDURES W CC	2.9055	6.6	7.6
655	11	SURG	MAJOR BLADDER PROCEDURES W/O CC/MCC	2.1068	4.1	4.8
656	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W MCC	3.2492	6.0	7.8
657	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W CC	1.9728	3.8	4.5
658	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W/O CC/MCC	1.5580	2.4	2.7

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
659	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W MCC	3.4209	6.7	9.4
660	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W CC	1.8006	3.4	4.5
661	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W/O CC/MCC	1.4519	2.1	2.5
662	11	SURG	MINOR BLADDER PROCEDURES W MCC	3.0450	7.7	10.4
663	11	SURG	MINOR BLADDER PROCEDURES W CC	1.7790	3.9	5.3
664	11	SURG	MINOR BLADDER PROCEDURES W/O CC/MCC	1.2917	1.9	2.4
665	11	SURG	PROSTATECTOMY W MCC	3.1176	8.2	10.6
666	11	SURG	PROSTATECTOMY W CC	1.7342	4.4	5.8
667	11	SURG	PROSTATECTOMY W/O CC/MCC	0.9792	2.2	2.7
668	11	SURG	TRANSURETHRAL PROCEDURES W MCC	2.6316	6.6	8.7
669	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.3804	3.1	4.2
670	11	SURG	TRANSURETHRAL PROCEDURES W/O CC/MCC	0.9801	2.2	2.7
671	11	SURG	URETHRAL PROCEDURES W CC/MCC	1.5289	3.7	5.0
672	11	SURG	URETHRAL PROCEDURES W/O CC/MCC	1.0134	1.9	2.3
673	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W MCC	3.5441	7.7	10.7
674	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W CC	2.3314	5.3	7.0
675	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W/O CC/MCC	1.6581	2.6	3.3
682	11	MED	RENAL FAILURE W MCC	1.4921	4.3	5.8
683	11	MED	RENAL FAILURE W CC	0.9297	3.3	4.1
684	11	MED	RENAL FAILURE W/O CC/MCC	0.6267	2.3	2.8
685	11	MED	ADMIT FOR RENAL DIALYSIS	1.0531	2.7	3.4
686	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W MCC	1.7557	5.2	6.8
687	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.1052	3.5	4.5
688	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC/MCC	0.8523	2.0	2.4
689	11	MED	KIDNEY & URINARY TRACT INFECTIONS W MCC	1.0828	3.9	4.8
690	11	MED	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	0.7940	3.0	3.6
691	11	MED	URINARY STONES W ESW LITHOTRIPSY W CC/MCC	1.5943	2.6	3.4
692	11	MED	URINARY STONES W ESW LITHOTRIPSY W/O CC/MCC	1.1667	1.9	2.3

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
693	11	MED	URINARY STONES W/O ESW LITHOTRIPSY W MCC	1.4505	4.1	5.4
694	11	MED	URINARY STONES W/O ESW LITHOTRIPSY W/O MCC	0.8153	2.1	2.7
695	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W MCC	1.2113	3.9	5.0
696	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W/O MCC	0.7031	2.5	3.1
697	11	MED	URETHRAL STRICTURE	1.0321	2.9	3.8
698	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W MCC	1.6009	5.0	6.3
699	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W CC	1.0331	3.4	4.3
700	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W/O CC/MCC	0.7799	2.4	3.0
707	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC/MCC	1.7951	2.4	3.3
708	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC/MCC	1.3773	1.3	1.5
709	12	SURG	PENIS PROCEDURES W CC/MCC	2.2401	4.2	6.4
710	12	SURG	PENIS PROCEDURES W/O CC/MCC	1.4980	1.8	2.3
711	12	SURG	TESTES PROCEDURES W CC/MCC	2.0228	5.5	7.3
712	12	SURG	TESTES PROCEDURES W/O CC/MCC	0.9232	2.3	2.9
713	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC/MCC	1.4197	2.9	4.2
714	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC/MCC	0.8763	1.7	2.0
715	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W CC/MCC	2.1340	4.8	7.0
716	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W/O CC/MCC	1.4084	1.5	1.7
717	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W CC/MCC	1.9289	4.0	5.4
718	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W/O CC/MCC	1.2447	2.4	2.8
722	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W MCC	1.7556	5.2	7.0
723	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W CC	1.1231	3.6	4.6

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
724	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.7504	1.8	2.3
725	12	MED	BENIGN PROSTATIC HYPERTROPHY W MCC	1.2712	4.2	5.6
726	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O MCC	0.7378	2.6	3.2
727	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W MCC	1.4597	4.7	6.0
728	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W/O MCC	0.8109	3.1	3.7
729	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W CC/MCC	1.0535	3.3	4.3
730	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W/O CC/MCC	0.6343	1.9	2.4
734	13	SURG	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W CC/MCC	2.1648	3.8	5.3
735	13	SURG	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W/O CC/MCC	1.2971	1.8	2.2
736	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W MCC	3.9264	9.2	11.4
737	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W CC	1.9504	4.8	5.6
738	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W/O CC/MCC	1.3806	2.8	3.2
739	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W MCC	3.5399	6.7	9.4
740	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.7129	3.1	4.0
741	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC/MCC	1.2585	1.8	2.1
742	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC/MCC	1.6331	3.1	4.0
743	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	1.0680	1.8	2.0
744	13	SURG	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W CC/MCC	1.6950	4.3	5.7
745	13	SURG	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W/O CC/MCC	1.0578	2.2	2.6
746	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES W CC/MCC	1.6250	3.5	5.1

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
747	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES W/O CC/MCC	0.9144	1.6	2.0
748	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	1.3396	1.7	2.2
749	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W CC/MCC	2.5800	5.8	7.7
750	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	1.2694	2.4	3.0
754	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W MCC	1.7864	5.2	7.0
755	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.1069	3.5	4.6
756	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.6353	2.0	2.5
757	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W MCC	1.4708	5.1	6.5
758	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W CC	1.0093	3.9	4.8
759	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.7152	2.9	3.4
760	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W CC/MCC	0.8696	2.7	3.4
761	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W/O CC/MCC	0.6368	1.7	2.1
765	14	SURG	CESAREAN SECTION W CC/MCC	1.1541	3.7	4.7
766	14	SURG	CESAREAN SECTION W/O CC/MCC	0.8177	2.8	3.1
767	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.9126	2.4	2.9
768	14	SURG	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	1.0173	3.1	3.4
769	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	1.7736	3.3	5.3
770	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.7741	1.8	2.2
774	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.8016	2.6	3.4
775	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.6156	2.1	2.3

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MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
776	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.8129	2.5	3.4
777	14	MED	ECTOPIC PREGNANCY	0.8720	1.6	1.9
778	14	MED	THREATENED ABORTION	0.5961	2.1	3.1
779	14	MED	ABORTION W/O D&C	0.6768	1.7	2.4
780	14	MED	FALSE LABOR	0.4401	1.6	2.0
781	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.8556	2.7	4.1
782	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.6033	1.9	2.6
789	15	MED	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.6400	1.8	1.8
790	15	MED	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	5.4079	17.9	17.9
791	15	MED	PREMATURITY W MAJOR PROBLEMS	3.6934	13.3	13.3
792	15	MED	PREMATURITY W/O MAJOR PROBLEMS	2.2285	8.6	8.6
793	15	MED	FULL TERM NEONATE W MAJOR PROBLEMS	3.7940	4.7	4.7
794	15	MED	NEONATE W OTHER SIGNIFICANT PROBLEMS	1.3428	3.4	3.4
795	15	MED	NORMAL NEWBORN	0.1818	3.1	3.1
799	16	SURG	SPLENECTOMY W MCC	4.6581	8.0	10.4
800	16	SURG	SPLENECTOMY W CC	2.6807	5.1	6.5
801	16	SURG	SPLENECTOMY W/O CC/MCC	1.7047	2.6	3.2
802	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W MCC	3.3337	7.5	10.8
803	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W CC	1.8040	4.3	5.6
804	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W/O CC/MCC	1.1968	2.3	2.9
808	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W MCC	2.1388	5.6	7.5
809	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W CC	1.1972	3.6	4.5
810	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W/O CC/MCC	0.9385	2.8	3.4
811	16	MED	RED BLOOD CELL DISORDERS W MCC	1.3467	3.7	4.9
812	16	MED	RED BLOOD CELL DISORDERS W/O MCC	0.8817	2.8	3.5
813	16	MED	COAGULATION DISORDERS	1.7498	3.6	4.9

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MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
814	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W MCC	1.7687	4.8	6.6
815	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	1.0006	3.2	4.0
816	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC/MCC	0.7007	2.4	2.9
820	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W MCC	5.3536	11.2	15.2
821	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC	2.3315	4.4	6.1
822	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/O CC/MCC	1.2196	2.0	2.5
823	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER PROC W MCC	4.3480	10.6	13.7
824	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER PROC W CC	2.1737	5.3	7.1
825	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER PROC W/O CC/MCC	1.2700	2.5	3.4
826	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W MCC	5.2297	10.7	14.2
827	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC	2.3548	5.0	6.4
828	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC/MCC	1.6141	3.2	3.9
829	17	SURG	MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS W OTHER PROCEDURE W CC/MCC	3.1042	6.2	9.4
830	17	SURG	MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS W OTHER PROCEDURE W/O CC/MCC	1.2757	2.4	3.0
834	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W MCC	5.5307	10.1	16.8
835	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W CC	2.0965	4.4	7.0
836	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W/O CC/MCC	1.3865	3.0	4.9
837	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX OR W HIGH DOSE CHEMO AGENT W MCC	5.6932	14.0	19.4

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
838	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX W CC OR HIGH DOSE CHEMO AGENT	2.3687	6.1	8.2
839	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX W/O CC/MCC	1.3374	4.7	5.3
840	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W MCC	3.6284	8.0	11.1
841	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.7795	4.5	6.1
842	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC/MCC	1.4044	3.2	4.4
843	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W MCC	1.8021	5.3	7.2
844	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.2092	3.9	5.0
845	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC/MCC	0.8984	2.8	3.5
846	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W MCC	2.5766	6.1	8.3
847	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W CC	1.2848	3.6	4.1
848	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W/O CC/MCC	0.9369	2.8	3.3
849	17	MED	RADIOTHERAPY	1.7994	4.8	6.3
853	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	5.1567	10.3	13.3
854	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W CC	2.4260	6.4	7.7
855	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W/O CC/MCC	1.4549	3.4	4.1
856	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W MCC	4.5393	9.4	12.5
857	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W CC	2.0380	5.4	6.8
858	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W/O CC/MCC	1.3531	3.7	4.5
862	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W MCC	1.8700	5.2	6.8
863	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W/O MCC	1.0384	3.7	4.5
864	18	MED	FEVER	0.8705	2.8	3.5

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
865	18	MED	VIRAL ILLNESS W MCC	1.5090	4.1	5.6
866	18	MED	VIRAL ILLNESS W/O MCC	0.7987	2.7	3.4
867	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W MCC	2.1586	5.7	7.7
868	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W CC	1.0660	3.8	4.7
869	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W/O CC/MCC	0.7874	2.9	3.5
870	18	MED	SEPTICEMIA OR SEVERE SEPSIS W MV >96 HOURS	6.1735	12.6	14.6
871	18	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W MCC	1.8410	4.9	6.4
872	18	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W/O MCC	1.0591	3.7	4.5
876	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	3.5205	7.6	14.3
880	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	0.8085	2.7	3.7
881	19	MED	DEPRESSIVE NEUROSES	0.7420	3.8	5.2
882	19	MED	NEUROSES EXCEPT DEPRESSIVE	0.7762	3.2	4.5
883	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	1.1800	4.8	7.8
884	19	MED	ORGANIC DISTURBANCES & INTELLECTUAL DISABILITY	1.2302	4.2	6.4
885	19	MED	PSYCHOSES	1.1660	5.8	8.2
886	19	MED	BEHAVIORAL & DEVELOPMENTAL DISORDERS	1.0647	3.7	6.9
887	19	MED	OTHER MENTAL DISORDER DIAGNOSES	1.0732	3.1	4.6
894	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.5242	2.1	2.9
895	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY	1.3253	9.1	11.9
896	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W MCC	1.6504	4.8	6.7
897	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O MCC	0.7889	3.4	4.3
901	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W MCC	4.1574	9.0	13.1
902	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W CC	1.9938	5.1	6.8

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
903	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W/O CC/MCC	1.2455	3.1	3.9
904	21	SURG	SKIN GRAFTS FOR INJURIES W CC/MCC	3.2158	6.7	9.6
905	21	SURG	SKIN GRAFTS FOR INJURIES W/O CC/MCC	1.4535	3.5	4.4
906	21	SURG	HAND PROCEDURES FOR INJURIES	1.7377	2.9	4.4
907	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W MCC	4.1965	7.3	10.3
908	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.0626	4.0	5.3
909	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC/MCC	1.4323	2.5	3.2
913	21	MED	TRAUMATIC INJURY W MCC	1.4001	3.6	4.9
914	21	MED	TRAUMATIC INJURY W/O MCC	0.8301	2.5	3.2
915	21	MED	ALLERGIC REACTIONS W MCC	1.6317	3.7	5.0
916	21	MED	ALLERGIC REACTIONS W/O MCC	0.6030	1.8	2.1
917	21	MED	POISONING & TOXIC EFFECTS OF DRUGS W MCC	1.4129	3.5	4.8
918	21	MED	POISONING & TOXIC EFFECTS OF DRUGS W/O MCC	0.7522	2.3	3.0
919	21	MED	COMPLICATIONS OF TREATMENT W MCC	1.7831	4.4	6.1
920	21	MED	COMPLICATIONS OF TREATMENT W CC	1.0106	3.0	3.9
921	21	MED	COMPLICATIONS OF TREATMENT W/O CC/MCC	0.7230	2.3	2.8
922	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W MCC	1.5041	4.0	5.5
923	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O MCC	0.8186	2.6	3.6
927	22	SURG	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV >96 HRS W SKIN GRAFT	17.0027	23.9	30.2
928	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC/MCC	5.7285	10.7	14.5
929	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W/O CC/MCC	2.6456	5.6	7.5
933	22	MED	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV >96 HRS W/O SKIN GRAFT	3.2811	2.8	5.9
934	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ	1.7345	4.3	6.2
935	22	MED	NON-EXTENSIVE BURNS	1.6890	3.5	5.0
939	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W MCC	3.4944	6.5	9.6
940	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W CC	2.3390	4.0	5.3

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
941	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W/O CC/MCC	1.8555	2.5	3.2
945	23	MED	REHABILITATION W CC/MCC	1.2405	8.3	10.9
946	23	MED	REHABILITATION W/O CC/MCC	1.1266	6.4	7.3
947	23	MED	SIGNS & SYMPTOMS W MCC	1.1745	3.5	4.8
948	23	MED	SIGNS & SYMPTOMS W/O MCC	0.7711	2.7	3.3
949	23	MED	AFTERCARE W CC/MCC	1.1809	4.4	6.0
950	23	MED	AFTERCARE W/O CC/MCC	0.8042	3.4	4.7
951	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	0.7870	2.4	3.2
955	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	6.0288	7.4	10.9
956	24	SURG	LIMB REATTACHMENT, HIP & FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	3.8425	6.2	7.7
957	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W MCC	7.3069	9.6	13.7
958	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W CC	4.2762	7.1	8.7
959	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	2.7784	4.0	4.9
963	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W MCC	2.7694	5.5	8.1
964	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W CC	1.4301	4.0	4.8
965	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	0.9933	2.9	3.3
969	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE W MCC	5.4154	11.1	15.1
970	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE W/O MCC	2.5664	4.4	7.1
974	25	MED	HIV W MAJOR RELATED CONDITION W MCC	2.8070	6.6	9.2
975	25	MED	HIV W MAJOR RELATED CONDITION W CC	1.3529	4.4	5.8
976	25	MED	HIV W MAJOR RELATED CONDITION W/O CC/MCC	0.9976	3.2	4.3
977	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.3051	3.7	5.2
981		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	4.3369	8.5	11.5
982		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	2.5036	5.0	6.7
983		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.6378	2.5	3.5
987		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	3.3133	8.1	10.7

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
988		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W CC	1.7448	4.4	6.0
989		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.1192	2.2	2.9
998		**	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS			
999		**	UNGROUPABLE			

Exhibit #2 – Proposed			
Hospital Base Rates and Cost to Charge Ratios (CCR)			
Effective for Hospital Inpatient Discharge Date of Service on or after 1/1/2018			
Provider Number	**Name**	**Base Rate**	**Total CCR**
60001	NORTH COLORADO MEDICAL CENTER	$6,784.96	0.254
60003	LONGMONT UNITED HOSPITAL	$6,241.13	0.309
60004	PLATTE VALLEY MEDICAL CENTER	$6,386.71	0.34
60006	MONTROSE MEMORIAL HOSPITAL	$6,133.97	0.411
60008	SAN LUIS VALLEY HEALTH	$6,242.35	0.373
60009	LUTHERAN MEDICAL CENTER	$6,372.63	0.235
60010	POUDRE VALLEY HOSPITAL	$6,539.44	0.304
60011	DENVER HEALTH MEDICAL CENTER	$8,473.42	0.289
60012	CENTURA HEALTH-ST MARY CORWIN MEDICAL CENTER	$6,675.37	0.249
60013	MERCY REGIONAL MEDICAL CENTER	$7,906.12	0.34
60014	PRESBYTERIAN ST LUKES MEDICAL CENTER	$7,007.25	0.184
60015	CENTURA HEALTH-ST ANTHONY HOSPITAL	$6,331.38	0.201
60016	CENTURA HEALTH-ST THOMAS MORE HOSPITAL	$6,915.90	0.4
60020	PARKVIEW MEDICAL CENTER INC	$6,607.56	0.181
60022	UNIVERSITY COLO HEALTH MEMORIAL HOSPITAL CENTRAL	$6,417.21	0.256
60023	ST MARYS MEDICAL CENTER	$6,886.88	0.303
60024	UNIVERSITY OF COLORADO HOSPITAL AUTHORITY	$8,097.34	0.18
60027	FOOTHILLS HOSPITAL	$6,180.76	0.23
60028	SAINT JOSEPH HOSPITAL	$6,996.82	0.214
60030	MCKEE MEDICAL CENTER	$6,418.54	0.37
60031	CENTURA HEALTH-PENROSE ST FRANCIS HEALTH SERVICES	$6,282.89	0.221
60032	ROSE MEDICAL CENTER	$6,660.80	0.16
60034	SWEDISH MEDICAL CENTER	$6,419.01	0.139
60036	ARKANSAS VALLEY REGIONAL MEDICAL CENTER	$6,222.39	0.527
60043	KEEFE MEMORIAL HOSPITAL	$15,890.85	0.483
60044	COLORADO PLAINS MEDICAL CENTER	$6,519.64	0.276
60049	YAMPA VALLEY MEDICAL CENTER	$9,549.81	0.549
60054	COMMUNITY HOSPITAL	$5,990.97	0.393
60064	CENTURA HEALTH-PORTER ADVENTIST HOSPITAL	$6,246.32	0.21
60065	NORTH SUBURBAN MEDICAL CENTER	$6,590.82	0.143
60071	DELTA COUNTY MEMORIAL HOSPITAL	$6,131.00	0.431
60075	VALLEY VIEW HOSPITAL ASSOCIATION	$8,009.31	0.506

Exhibit #2 – Proposed			
Hospital Base Rates and Cost to Charge Ratios (CCR)			
Effective for Hospital Inpatient Discharge Date of Service on or after 1/1/2018			
Provider Number	**Name**	**Base Rate**	**Total CCR**
60076	STERLING REGIONAL MEDCENTER	$7,753.03	0.524
60096	VAIL VALLEY MEDICAL CENTER	$11,966.12	0.485
60100	MEDICAL CENTER OF AURORA, THE	$6,383.70	0.161
60103	CENTURA HEALTH-AVISTA ADVENTIST HOSPITAL	$6,399.01	0.281
60104	ST ANTHONY NORTH HEALTH CAMPUS	$7,138.78	0.267
60107	NATIONAL JEWISH HEALTH	$6,477.32	0.229
60112	SKY RIDGE MEDICAL CENTER	$6,096.15	0.138
60113	CENTURA HEALTH-LITTLETON ADVENTIST HOSPITAL	$6,093.76	0.186
60114	PARKER ADVENTIST HOSPITAL	$6,212.10	0.209
60116	GOOD SAMARITAN MEDICAL CENTER	$6,031.09	0.21
60117	ANIMAS SURGICAL HOSPITAL, LLC	$5,909.40	0.395
60118	ST ANTHONY SUMMIT MEDICAL CENTER	$6,280.79	0.356
60119	MEDICAL CENTER OF THE ROCKIES	$6,173.86	0.299
60124	ORTHOCOLORADO HOSPITAL AT ST ANTHONY MED CAMPUS	$6,038.42	0.216
60125	CASTLE ROCK ADVENTIST HOSPITAL	$6,095.85	0.297
60126	BANNER FORT COLLINS MEDICAL CENTER	$6,056.28	0.251

Exhibit #3 – Proposed	
Critical Access Hospitals	
Effective for Dates of Service on and After 1/1/2018	
Hospital Name	**Location in Colorado**
Arkansas Valley Regional Medical Center	La Junta
Aspen Valley Hospital	Aspen
Colorado Canyon 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
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
Weisbrod Memorial County Hospital	Eads
Wray Community District Hospital	Wray
Yuma District Hospital	Yuma

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
701	Sr89 strontium	$2,295.20	$1,950.92	
726	Dexrazoxane HCl injection	$371.39	$315.68	
731	Sargramostim injection	$66.76	$56.75	
736	Amphotericin b liposome inj	$35.15	$29.88	
738	Rasburicase	$466.47	$396.50	
747	Chlorothiazide sodium inj	$140.22	$119.19	
751	Mechlorethamine hcl inj	$478.60	$406.81	
752	Dactinomycin injection	$2,297.48	$1,952.86	
759	Naltrexone, depot form	$5.85	$4.97	
800	Leuprolide acetate	$1,844.19	$1,567.56	
802	Etoposide oral	$133.65	$113.60	
807	Aldesleukin injection	$5,521.75	$4,693.49	
809	Bcg live intravesical vac	$231.08	$196.42	
810	Goserelin acetate implant	$629.86	$535.38	
812	Carmustine injection	$6,924.53	$5,885.85	
820	Daunorubicin injection	$70.63	$60.04	
821	Daunorubicin citrate inj	$438.84	$373.01	
823	Docetaxel injection	$3.40	$2.89	
825	Nelarabine injection	$273.65	$232.60	
827	Floxuridine injection	$109.06	$92.70	
831	Ifosfamide injection	$50.53	$42.95	
832	Idarubicin hcl injection	$74.77	$63.55	
836	Interferon alfa-2b inj	$51.34	$43.64	
838	Interferon gamma 1-b inj	$11,354.63	$9,651.44	
840	Inj melphalan hydrochl	$3,247.43	$2,760.32	
843	Pegaspargase injection	$25,041.96	$21,285.67	
844	Pentostatin injection	$3,389.62	$2,881.18	
849	Rituximab injection	$1,472.96	$1,252.02	
850	Streptozocin injection	$576.38	$489.92	
851	Thiotepa injection	$1,569.85	$1,334.37	
856	Porfimer sodium injection	$38,195.23	$32,465.95	
858	Inj cladribine	$36.05	$30.64	
864	Mitoxantrone hydrochl	$59.13	$50.26	
868	Oral aprepitant	$21.20	$18.02	
873	Hyalgan/supartz inj per dose	$156.89	$133.36	
874	Synvisc or synvisc-one	$22.57	$19.18	
875	Euflexxa inj per dose	$276.91	$235.37	
877	Orthovisc inj per dose	$276.39	$234.93	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
887	Azathioprine parenteral	$450.81	$383.19	
890	Lymphocyte immune globulin	$2,661.84	$2,262.56	
901	Alpha 1 proteinase inhibitor	$8.68	$7.38	
902	Injection,onabotulinumtoxinA	$10.69	$9.09	
903	Cytomegalovirus imm IV /vial	$2,029.93	$1,725.44	
910	Interferon beta-1b / .25 MG	$677.34	$575.74	
913	Ganciclovir long act implant	$21.08	$17.92	
925	Factor viii	$1.82	$1.55	
927	Factor viii recombinant	$2.16	$1.84	
928	Factor ix complex	$2.41	$2.05	
929	Anti-inhibitor	$3.47	$2.95	
931	Factor IX non-recombinant	$2.09	$1.78	
932	Factor ix recombinant nos	$2.72	$2.31	
943	Octagam injection	$64.96	$55.22	
944	Gammagard liquid injection	$72.77	$61.85	
946	Hepagam b im injection	$105.57	$89.73	
947	Flebogamma injection	$54.32	$46.17	
948	Gamunex-C/Gammaked	$61.07	$51.91	
961	Albumin (human),5%, 50ml	$21.24	$18.05	
963	Albumin (human), 5%, 250 ml	$98.50	$83.73	
964	Albumin (human), 25%, 20 ml	$40.48	$34.41	
965	Albumin (human), 25%, 50ml	$96.19	$81.76	
1015	Injection glatiramer acetate	$356.22	$302.79	
1052	Injection, voriconazole	$6.55	$5.57	
1064	I131 iodide cap, rx	$73.26	$62.27	
1083	Adalimumab injection	$2,118.47	$1,800.70	
1086	Temozolomide	$3.35	$2.85	
1138	Hepagam b intravenous, inj	$105.57	$89.73	
1139	Protein c concentrate	$27.36	$23.26	
1142	Supprelin LA implant	$49,926.47	$42,437.50	
1150	I131 iodide sol, rx	$22.61	$19.22	
1166	Cytarabine liposome inj	$1,069.18	$908.80	
1168	Inj, temsirolimus	$121.14	$102.97	
1178	Busulfan injection	$65.70	$55.85	
1203	Verteporfin injection	$19.37	$16.46	
1207	Octreotide injection, depot	$315.99	$268.59	
1213	Antihemophilic viii/vwf comp	$1.78	$1.51	
1214	Inj IVIG privigen 500 mg	$69.97	$59.47	
1232	Mitomycin injection	$208.22	$176.99	
1235	Valrubicin injection	$2,084.60	$1,771.91	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
1236	Levoleucovorin injection	$1.28	$1.09	
1237	Inj iron dextran	$22.43	$19.07	
1238	Topotecan oral	$186.82	$158.80	
1253	Triamcinolone A inj PRS-free	$6.73	$5.72	
1263	Antithrombin iii injection	$5.80	$4.93	
1268	Xyntha inj	$2.20	$1.87	
1274	Edetate calcium disodium inj	$10,069.96	$8,559.47	
1280	Corticotropin injection	$6,366.76	$5,411.75	
1281	Bevacizumab injection	$3.31	$2.81	
1289	AbobotulinumtoxinA	$14.35	$12.20	
1291	Rilonacept injection	$43.36	$36.86	
1295	Sm 153 lexidronam	$21,700.64	$18,445.54	
1296	Degarelix injection	$6.53	$5.55	
1297	Ferumoxytol, non-esrd	$1.60	$1.36	
1311	Canakinumab injection	$166.52	$141.54	
1312	Hizentra injection	$17.69	$15.04	
1327	Imiglucerase injection	$75.24	$63.95	
1331	Olanzapine long-acting inj	$5.26	$4.47	
1332	Antithrombin recombinant	$186.03	$158.13	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
1338	Methyl aminolevulinate, top	$150.64	$128.04	
1340	Collagenase, clost hist inj	$73.24	$62.25	
1341	Amobarbital 125 MG inj	$349.67	$297.22	
1352	Wilate injection	$1.82	$1.55	
1353	Belimumab injection	$76.64	$65.14	
1354	Hydroxyprogesterone caproate	$4.93	$4.19	
1361	Enfuvirtide injection	$33.53	$28.50	
1408	Cyclophosphamide 100 MG inj	$76.16	$64.74	
1413	Lumizyme injection	$287.53	$244.40	
1415	Glassia injection	$7.85	$6.67	
1416	Factor xiii anti-hem factor	$14.74	$12.53	
1417	Gel-one	$978.50	$831.73	
1420	Aflibercept injection	$1,764.25	$1,499.61	
1421	Imported lipodox inj	$915.17	$777.89	
1424	Nabilone oral	$68.76	$58.45	
1426	Eribulin mesylate injection	$194.96	$165.72	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
1431	Centruroides immune f(ab)	$7,644.04	$6,497.43	
1433	Calcitonin salmon injection	$4,082.20	$3,469.87	
1440	Inj desmopressin acetate	$23.67	$20.12	
1442	Non-HEU TC-99M add-on/dose	$18.00	$15.30	
1443	Icatibant injection	$586.10	$498.19	
1446	Visualization adjunct	$5.35	$4.55	
1457	Totazoline hcl injection	$2,880.72	$2,448.61	
1458	Phentolaine mesylate inj	$602.86	$512.43	
1460	Interferon alfa-2a inj	$58.01	$49.31	
1464	Factor VIII (porcine)	$0.36	$0.31	
1466	Inj, vincristine sul lip 1mg	$4,680.65	$3,978.55	
1467	Factor ix recombinan rixubis	$2.25	$1.91	
1468	Inj Aripiprazole Ext Rel 1mg	$8.24	$7.00	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
1469	Inj filgrastim excl biosimil	$1.82	$1.55	
1471	Injection, Pertuzumab, 1 mg	$19.58	$16.64	
1472	Inj beta interferon im 1 mcg	$83.18	$70.70	
1474	Certolizumab pegol inj 1mg	$13.21	$11.23	
1475	Golimumab for iv use 1mg	$44.98	$38.23	
1476	Obinutuzumab inj	$103.25	$87.76	
1478	Human fibrinogen conc inj	$2.07	$1.76	
1480	Elosulfase alfa, injection	$403.87	$343.29	
1482	Darbepoetin alfa, esrd use	$6.93	$5.89	
1484	Pentazocine injection	$246.08	$209.17	
1485	Ferumoxytol, esrd use	$1.60	$1.36	
1486	Factor ix fc fusion recomb	$5.27	$4.48	
1488	Injection, ramucirumab	$101.29	$86.10	
1489	Injection, vedolizumab	$32.63	$27.74	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
1490	Inj pembrolizumab	$85.14	$72.37	
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-$30)	$45.90	$39.02	
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	

Exhibit #4 – Proposed

Hospital Outpatient APC Codes and Values

Effective for Dates of Service on and After 1/1/2018

APC	Group Title	Hospitals	ASC	Notes
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	

Exhibit #4 – Proposed

Hospital Outpatient APC Codes and Values

Effective for Dates of Service on and After 1/1/2018

APC	Group Title	Hospitals	ASC	Notes
1571	New Technology - Level 34 ($8001-$8500)	$14,850.90	$12,623.27	
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	
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	
1605	Abciximab injection	$2,073.94	$1,762.85	
1607	Eptifibatide injection	$42.50	$36.13	
1608	Etanercept injection	$787.64	$669.49	
1609	Rho(D) immune globulin h, sd	$40.86	$34.73	
1612	Daclizumab, parenteral	$18.00	$15.30	
1613	Trastuzumab injection	$170.08	$144.57	
1630	Hep b ig, im	$201.53	$171.30	
1631	Baclofen intrathecal trial	$138.31	$117.56	
1633	Alefacept	$74.95	$63.71	
1643	Y90 ibritumomab, rx	$84,801.42	$72,081.21	
1656	Factor viii fc fusion recomb	$3.56	$3.03	
1657	Puraply or puraply am	$187.42	$159.31	
1658	Injection, belinostat, 10mg	$61.90	$52.62	
1660	Injection, oritavancin	$44.21	$37.58	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
1661	Gen, neuro, HF, rechg bat	$0.00	$0.00	
1662	Inj tedizolid phosphate	$2.29	$1.95	
1663	Inj, phenylephrine ketorolac	$878.15	$746.43	
1664	Florbetapir f18	$4,960.80	$4,216.68	
1666	Tetracyclin injection	$13.12	$11.15	
1669	Erythro lactobionate /500 mg	$106.99	$90.94	
1670	Tetanus immune globulin inj	$657.27	$558.68	
1675	P32 Na phosphate	$101.95	$86.66	
1676	P32 chromic phosphate	$128.05	$108.84	
1683	Basiliximab	$6,043.21	$5,136.73	
1684	Corticorelin ovine triflutal	$14.62	$12.43	
1685	Darbepoetin alfa, non-esrd	$6.93	$5.89	
1686	Epoetin alfa, non-esrd	$24.52	$20.84	
1687	Digoxin immune fab (ovine)	$5,881.57	$4,999.33	
1688	Ethanolamine oleate	$760.27	$646.23	
1689	Fomepizole	$14.00	$11.90	
1690	Hemin	$41.15	$34.98	
1693	Lepirudin	$22.88	$19.45	
1694	Ziconotide injection	$13.19	$11.21	
1695	Nesiritide injection	$131.72	$111.96	
1696	Palifermin injection	$31.82	$27.05	
1697	Pegaptanib sodium injection	$1,898.46	$1,613.69	
1700	Inj secretin synthetic human	$62.60	$53.21	
1701	Treprostinil injection	$110.23	$93.70	
1704	Humate-P, inj	$1.96	$1.67	
1705	Factor viia	$3.47	$2.95	
1709	Azacitidine injection	$3.80	$3.23	
1710	Clofarabine injection	$274.27	$233.13	
1711	Vantas implant	$5,631.86	$4,787.08	
1712	Paclitaxel protein bound	$18.81	$15.99	
1738	Oxaliplatin	$0.49	$0.42	
1739	Pegademase bovine, 25 iu	$621.41	$528.20	
1741	Urofollitropin, 75 iu	$238.79	$202.97	
1743	Nandrolone decanoate 50 mg	$240.05	$204.04	
1745	Radium ra223 dichloride ther	$231.75	$196.99	
1746	Factor xiii recomb a-subunit	$26.53	$22.55	
1747	Monovisc inj per dose	$1,611.27	$1,369.58	
1748	Inj tbo filgrastim 1 microg	$1.21	$1.03	
1761	rolapitant, oral, 1mg	$3.87	$3.29	
1809	Injection, alemtuzumab	$3,155.44	$2,682.12	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
1822	Inj filgrastim gcsf biosimil	$1.37	$1.16	
1823	Injection, dalbavancin	$26.51	$22.53	
1824	Ceftaroline fosamil inj	$4.45	$3.78	
1825	Ceftazidime and avibactam	$138.83	$118.01	
1826	Hyqvia 100mg immuneglobulin	$23.33	$19.83	
1827	Factor viii recomb obizur	$7.13	$6.06	
1828	Carbidopa levodopa ent 100ml	$4.03	$3.43	
1829	Penicillin g benzathine inj	$19.35	$16.45	
1832	Dimethyl sulfoxide 50% 50 ml	$960.70	$816.60	
1836	Penicillin g procaine inj	$48.19	$40.96	
1838	Urokinase 250,000 iu inj	$473.02	$402.07	
1839	Oral busulfan	$42.61	$36.22	
1842	Leuprolide acetate implant	$303.26	$257.77	
1844	Factor viii pegylated recomb	$3.08	$2.62	
1845	Tacrol envarsus ex rel oral	$2.21	$1.88	
1846	Factor viii nuwiq recomb 1iu	$2.93	$2.49	
1847	Inj., infliximab biosimilar	$180.56	$153.48	
1848	Artiss fibrin sealant	$201.02	$170.87	
1849	Foscarnet sodium injection	$135.31	$115.01	
1850	Gamma globulin 1 cc inj	$64.33	$54.68	
1851	Gamma globulin > 10 cc inj	$643.28	$546.79	
1852	Interferon beta-1a inj	$867.98	$737.78	
1853	Minocycline hydrochloride	$2.72	$2.31	
1854	Pentobarbital sodium inj	$85.21	$72.43	
1855	Pralidoxime chloride inj	$156.67	$133.17	
1856	Factor viii recomb novoeight	$2.32	$1.97	
1857	Inj, factor x, (human), 1iu	$11.74	$9.98	
1858	Leuprolide acetate injeciton	$46.73	$39.72	
1859	Argatroban nonesrd use 1mg	$2.92	$2.48	
1860	Monoclonal antibodies	$416.20	$353.77	
1861	Inj., bendeka 1 mg	$42.23	$35.90	
1862	Gel-syn injection 0.1 mg	$3.92	$3.33	
1863	Inj diclofenac sodium 0.5mg	$0.29	$0.25	
1901	New Technology - Level 49 ($100,001-$120,000)	$198,000.90	$168,300.77	
1902	New Technology - Level 49 ($100,001-$120,000)	$198,000.90	$168,300.77	
1903	New Technology - Level 50 ($120,001-$140,000)	$234,000.90	$198,900.77	
1904	New Technology - Level 50 ($120,001-$140,000)	$234,000.90	$198,900.77	
1905	New Technology - Level 51 ($140,001-$160,000)	$270,000.90	$229,500.77	
1906	New Technology - Level 51 ($140,001-$160,000)	$270,000.90	$229,500.77	
2613	Lung bx plug w/del sys	$0.00	$0.00	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
2616	Brachytx, non-str,Yttrium-90	$29,713.91	$25,256.82	
2623	Cath, translumin, drug-coat	$0.00	$0.00	
2632	Iodine I-125 sodium iodide	$53.87	$45.79	
2634	Brachytx, non-str, HA, I-125	$216.94	$184.40	
2635	Brachytx, non-str, HA, P-103	$46.26	$39.32	
2636	Brachy linear, non-str,P-103	$33.57	$28.53	
2638	Brachytx, stranded, I-125	$68.35	$58.10	
2639	Brachytx, non-stranded,I-125	$64.26	$54.62	
2640	Brachytx, stranded, P-103	$131.80	$112.03	
2641	Brachytx, non-stranded,P-103	$117.81	$100.14	
2642	Brachytx, stranded, C-131	$157.70	$134.05	
2643	Brachytx, non-stranded,C-131	$106.54	$90.56	
2645	Brachytx, non-str, Gold-198	$243.54	$207.01	
2646	Brachytx, non-str, HDR Ir-192	$506.84	$430.81	
2647	Brachytx, NS, Non-HDRIr-192	$60.89	$51.76	
2648	Brachytx planar, p-103	$8.44	$7.17	
2698	Brachytx, stranded, NOS	$68.35	$58.10	
2699	Brachytx, non-stranded, NOS	$33.57	$28.53	
2731	Immune globulin, powder	$58.75	$49.94	
2770	Quinupristin/dalfopristin	$786.19	$668.26	
3041	Bivalirudin	$2.66	$2.26	
4001	Echo guidance radiotherapy	$39.40	$33.49	
4002	Stereoscopic x-ray guidance	$100.78	$85.66	
4003	Radiation treatment delivery, MeV <= 5; simple	$347.54	$295.41	
4004	Radiation treatment delivery, 6-10 MeV; simple	$263.57	$224.03	
4005	Radiation treatment delivery, 11-19 MeV; simple	$262.93	$223.49	
4006	Radiation treatment delivery, MeV>=20; simple	$262.93	$223.49	
4007	Radiation treatment delivery, MeV<=5; intermediate	$543.28	$461.79	
4008	Radiation treatment delivery, 6-10 MeV; intermediate	$363.04	$308.58	
4009	Radiation treatment delivery, 11-19 MeV; intermediate	$361.76	$307.50	
4010	Radiation treatment delivery, MeV >=20; intermediate	$360.47	$306.40	
4011	Radiation treatment delivery, MeV<=5; complex	$526.48	$447.51	
4012	Radiation treatment delivery, 6-10 MeV; complex	$480.62	$408.53	
4013	Radiation treatment delivery, 11-19 MeV; complex	$481.27	$409.08	
4014	Radiation treatment delivery, MeV >=20; complex	$481.91	$409.62	
5012	Clinic Visits and Related Services	$191.90	$163.12	
5021	Level 1 Type A ED Visits	$110.47	N/A	
5022	Level 2 Type A ED Visits	$200.65	N/A	
5023	Level 3 Type A ED Visits	$362.25	N/A	
5024	Level 4 Type A ED Visits	$598.34	N/A	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
5025	Level 5 Type A ED Visits	$879.73	N/A	
5031	Level 1 Type B ED Visits	$153.23	N/A	
5032	Level 2 Type B ED Visits	$136.03	N/A	
5033	Level 3 Type B ED Visits	$225.00	N/A	
5034	Level 4 Type B ED Visits	$321.39	N/A	
5035	Level 5 Type B ED Visits	$662.20	N/A	
5041	Critical Care	$1,236.91	N/A	
5045	Trauma Response with Critical Care	$0.00	N/A	See Rule 18-6(J) for Trauma Activation Fees
5051	Level 1 Skin Procedures	$275.62	$234.28	
5052	Level 2 Skin Procedures	$526.72	$447.71	
5053	Level 3 Skin Procedures	$815.58	$693.24	
5054	Level 4 Skin Procedures	$2,569.99	$2,184.49	
5055	Level 5 Skin Procedures	$4,508.44	$3,832.17	
5061	Hyperbaric Oxygen	$198.43	$168.67	
5071	Level 1 Excision/ Biopsy/ Incision and Drainage	$970.40	$824.84	
5072	Level 2 Excision/ Biopsy/ Incision and Drainage	$2,225.92	$1,892.03	
5073	Level 3 Excision/ Biopsy/ Incision and Drainage	$3,868.04	$3,287.83	
5091	Level 1 Breast/Lymphatic Surgery and Related Procedures	$4,499.06	$3,824.20	
5092	Level 2 Breast/Lymphatic Surgery and Related Procedures	$7,955.03	$6,761.78	
5093	Level 3 Breast/Lymphatic Surgery and Related Procedures	$11,675.43	$9,924.12	
5094	Level 4 Breast/Lymphatic Surgery and Related Procedures	$18,066.69	$15,356.69	
5101	Level 1 Strapping and Cast Application	$225.27	$191.48	
5102	Level 2 Strapping and Cast Application	$397.35	$337.75	
5111	Level 1 Musculoskeletal Procedures	$359.69	$305.74	
5112	Level 2 Musculoskeletal Procedures	$2,191.36	$1,862.66	
5113	Level 3 Musculoskeletal Procedures	$4,389.01	$3,730.66	
5114	Level 4 Musculoskeletal Procedures	$9,398.83	$7,989.01	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
5115	Level 5 Musculoskeletal Procedures	$17,210.21	$14,628.68	
5116	Level 6 Musculoskeletal Procedures	$26,467.43	$22,497.32	
5151	Level 1 Airway Endoscopy	$263.16	$223.69	
5152	Level 2 Airway Endoscopy	$651.46	$553.74	
5153	Level 3 Airway Endoscopy	$2,285.62	$1,942.78	
5154	Level 4 Airway Endoscopy	$4,376.21	$3,719.78	
5155	Level 5 Airway Endoscopy	$7,853.31	$6,675.31	
5161	Level 1 ENT Procedures	$318.76	$270.95	
5162	Level 2 ENT Procedures	$796.72	$677.21	
5163	Level 3 ENT Procedures	$1,869.39	$1,588.98	
5164	Level 4 ENT Procedures	$3,912.64	$3,325.74	
5165	Level 5 ENT Procedures	$7,435.69	$6,320.34	
5166	Cochlear Implant Procedure	$57,306.58	$48,710.59	
5181	Level 1 Vascular Procedures	$1,231.43	$1,046.72	
5182	Level 2 Vascular Procedures	$4,249.08	$3,611.72	
5183	Level 3 Vascular Procedures	$7,063.70	$6,004.15	
5191	Level 1 Endovascular Procedures	$5,100.39	$4,335.33	
5192	Level 2 Endovascular Procedures	$8,685.36	$7,382.56	
5193	Level 3 Endovascular Procedures	$17,554.37	$14,921.21	
5194	Level 4 Endovascular Procedures	$26,607.85	$22,616.67	
5200	Implantation Wireless PA Pressure Monitor	$53,131.63	$45,161.89	
5211	Level 1 Electrophysiologic Procedures	$1,560.33	$1,326.28	
5212	Level 2 Electrophysiologic Procedures	$9,011.52	$7,659.79	
5213	Level 3 Electrophysiologic Procedures	$30,213.41	$25,681.40	
5221	Level1 Pacemaker and Similar Procedures	$4,607.26	$3,916.17	
5222	Level 2 Pacemaker and Similar Procedures	$12,557.83	$10,674.16	
5223	Level 3 Pacemaker and Similar Procedures	$16,944.57	$14,402.88	
5224	Level 4 Pacemaker and Similar Procedures	$30,180.35	$25,653.30	
5231	Level 1 ICD and Similar Procedures	$39,599.96	$33,659.97	
5232	Level 2 ICD and Similar Procedures	$54,948.98	$46,706.63	
5241	Level 1 Blood Product Exchange and Related Services	$638.17	$542.44	
5242	Level 2 Blood Product Exchange and Related Services	$1,977.62	$1,680.98	
5243	Level 3 Blood Product Exchange and Related Services	$5,738.09	$4,877.38	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
5244	Level 4 Blood Product Exchange and Related Services	$49,976.05	$42,479.64	
5301	Level 1 Upper GI Procedures	$1,259.62	$1,070.68	
5302	Level 2 Upper GI Procedures	$2,402.69	$2,042.29	
5303	Level 3 Upper GI Procedures	$4,519.26	$3,841.37	
5311	Level 1 Lower GI Procedures	$1,201.81	$1,021.54	
5312	Level 2 Lower GI Procedures	$1,579.68	$1,342.73	
5313	Level 3 Lower GI Procedures	$3,901.52	$3,316.29	
5331	Complex GI Procedures	$7,093.10	$6,029.14	
5341	Abdominal/Peritoneal/Biliary and Related Procedures	$5,152.93	$4,379.99	
5361	Level 1 Laparoscopy and Related Services	$7,558.43	$6,424.67	
5362	Level 2 Laparoscopy and Related Services	$12,545.71	$10,663.85	
5371	Level 1 Urology and Related Services	$388.87	$330.54	
5372	Level 2 Urology and Related Services	$988.99	$840.64	
5373	Level 3 Urology and Related Services	$2,960.39	$2,516.33	
5374	Level 4 Urology and Related Services	$4,576.61	$3,890.12	
5375	Level 5 Urology and Related Services	$6,271.22	$5,330.54	
5376	Level 6 Urology and Related Services	$13,414.79	$11,402.57	
5377	Level 7 Urology and Related Services	$25,854.50	$21,976.33	
5401	Dialysis	$994.64	$845.44	
5411	Level 1 Gynecologic Procedures	$273.98	$232.88	
5412	Level 2 Gynecologic Procedures	$496.37	$421.91	
5413	Level 3 Gynecologic Procedures	$1,198.57	$1,018.78	
5414	Level 4 Gynecologic Procedures	$3,753.85	$3,190.77	
5415	Level 5 Gynecologic Procedures	$6,859.53	$5,830.60	
5416	Level 6 Gynecologic Procedures	$10,558.93	$8,975.09	
5431	Level 1 Nerve Procedures	$2,814.16	$2,392.04	
5432	Level 2 Nerve Procedures	$7,473.35	$6,352.35	
5441	Level 1 Nerve Injections	$415.80	$353.43	
5442	Level 2 Nerve Injections	$912.94	$776.00	
5443	Level 3 Nerve Injections	$1,150.07	$977.56	
5461	Level 1 Neurostimulator and Related Procedures	$4,842.83	$4,116.41	
5462	Level 2 Neurostimulator and Related Procedures	$10,341.20	$8,790.02	
5463	Level 3 Neurostimulator and Related Procedures	$32,046.08	$27,239.17	
5464	Level 4 Neurostimulator and Related Procedures	$48,684.80	$41,382.08	
5471	Implantation of Drug Infusion Device	$28,120.63	$23,902.54	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
5481	Laser Eye Procedures	$845.77	$718.90	
5491	Level 1 Intraocular Procedures	$3,283.83	$2,791.26	
5492	Level 2 Intraocular Procedures	$6,153.77	$5,230.70	
5493	Level 3 Intraocular Procedures	$14,762.93	$12,548.49	
5494	Level 4 Intraocular Procedures	$21,685.10	$18,432.34	
5495	Level 5 Intraocular Procedures	$34,185.15	$29,057.38	
5501	Level 1 Extraocular, Repair, and Plastic Eye Procedures	$483.28	$410.79	
5502	Level 2 Extraocular, Repair, and Plastic Eye Procedures	$1,394.23	$1,185.10	
5503	Level 3 Extraocular, Repair, and Plastic Eye Procedures	$3,062.66	$2,603.26	
5504	Level 4 Extraocular, Repair, and Plastic Eye Procedures	$4,994.69	$4,245.49	
5521	Level 1 Imaging without Contrast	$107.75	$91.59	
5522	Level 2 Imaging without Contrast	$202.91	$172.47	
5523	Level 3 Imaging without Contrast	$406.64	$345.64	
5524	Level 4 Imaging without Contrast	$809.42	$688.01	
5571	Level 1 Imaging with Contrast	$477.04	$405.48	
5572	Level 2 Imaging with Contrast	$767.74	$652.58	
5573	Level 3 Imaging with Contrast	$1,182.44	$1,005.07	
5591	Level 1 Nuclear Medicine and Related Services	$599.54	$509.61	
5592	Level 2 Nuclear Medicine and Related Services	$772.43	$656.57	
5593	Level 3 Nuclear Medicine and Related Services	$2,050.09	$1,742.58	
5594	Level 4 Nuclear Medicine and Related Services	$2,378.75	$2,021.94	
5611	Level 1 Therapeutic Radiation Treatment Preparation	$211.66	$179.91	
5612	Level 2 Therapeutic Radiation Treatment Preparation	$560.83	$476.71	
5613	Level 3 Therapeutic Radiation Treatment Preparation	$1,919.23	$1,631.35	
5621	Level 1 Radiation Therapy	$205.83	$174.96	
5622	Level 2 Radiation Therapy	$368.12	$312.90	
5623	Level 3 Radiation Therapy	$890.33	$756.78	
5624	Level 4 Radiation Therapy	$1,329.53	$1,130.10	
5625	Level 5 Radiation Therapy	$1,789.42	$1,521.01	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
5626	Level 6 Radiation Therapy	$2,972.32	$2,526.47	
5627	Level 7 Radiation Therapy	$13,420.78	$11,407.66	
5661	Therapeutic Nuclear Medicine	$390.02	$331.52	
5671	Level 1 Pathology	$71.46	$60.74	
5672	Level 2 Pathology	$186.98	$158.93	
5673	Level 3 Pathology	$331.22	$281.54	
5674	Level 4 Pathology	$817.49	$694.87	
5691	Level 1 Drug Administration	$62.60	$53.21	
5692	Level 2 Drug Administration	$95.71	$81.35	
5693	Level 3 Drug Administration	$323.59	$275.05	
5694	Level 4 Drug Administration	$503.01	$427.56	
5721	Level1 Diagnostic Tests and Related Services	$228.78	$194.46	
5722	Level 2 Diagnostic Tests and Related Services	$418.16	$355.44	
5723	Level 3 Diagnostic Tests and Related Services	$748.57	$636.28	
5724	Level 4 Diagnostic Tests and Related Services	$1,556.17	$1,322.74	
5731	Level 1 Minor Procedures	$22.72	$19.31	
5732	Level 2 Minor Procedures	$51.08	$43.42	
5733	Level 3 Minor Procedures	$98.19	$83.46	
5734	Level 4 Minor Procedures	$180.04	$153.03	
5735	Level 5 Minor Procedures	$474.50	$403.33	
5741	Level 1 Electronic Analysis of Devices	$63.27	$53.78	
5742	Level 2 Electronic Analysis of Devices	$196.60	$167.11	
5743	Level 3 Electronic Analysis of Devices	$454.73	$386.52	
5771	Cardiac Rehabilitation	$198.40	$168.64	
5781	Resuscitation and Cardioversion	$866.41	$736.45	
5791	Pulmonary Treatment	$291.74	$247.98	
5801	Ventilation Initiation and Management	$763.11	$648.64	
5811	Manipulation Therapy	$44.32	N/A	
5821	Level 1 Health and Behavior Services	$45.41	N/A	
5822	Level 2 Health and Behavior Services	$126.47	N/A	
5823	Level 3 Health and Behavior Services	$226.82	N/A	
5853	Partial Hospitalization (3 or more services) for CMHCs	$218.75	N/A	
5863	Partial Hospitalization (3 or more services) for Hospital-based PHPs	$373.25	N/A	
5871	Dental Procedures	$923.53	$785.00	
5881	Ancillary Outpatient Services When Patient Dies	$12,157.83	$10,334.16	
7000	Amifostine	$934.22	$794.09	
7011	Oprelvekin injection	$841.00	$714.85	
7034	Somatropin injection	$146.86	$124.83	
7035	Teniposide	$4,667.02	$3,966.97	
7041	Tirofiban HCl	$17.66	$15.01	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
7043	Infliximab not biosimil 10mg	$154.06	$130.95	
7046	Doxorubicin inj 10mg	$734.67	$624.47	
7048	Alteplase recombinant	$146.43	$124.47	
7308	Aminolevulinic acid hcl top	$662.06	$562.75	
8001	LDR Prostate Brachytherapy Composite	$6,300.45	$5,355.38	
8004	Ultrasound Composite	$519.05	$441.19	
8005	CT and CTA without Contrast Composite	$491.56	$417.83	
8006	CT and CTA with Contrast Composite	$880.87	$748.74	
8007	MRI and MRA without Contrast Composite	$993.15	$844.18	
8008	MRI and MRA with Contrast Composite	$1,533.04	$1,303.08	
8010	Mental Health Services Composite	$373.25	$317.26	
8011	Comprehensive Observation Services	$4,000.75	$3,400.64	
9002	Tenecteplase injection	$184.36	$156.71	
9003	Palivizumab	$317.43	$269.82	
9005	Reteplase injection	$4,143.44	$3,521.92	
9006	Tacrolimus injection	$307.53	$261.40	
9012	Arsenic trioxide injection	$116.87	$99.34	
9018	Inj, rimabotulinumtoxinB	$21.15	$17.98	
9019	Caspofungin acetate	$19.01	$16.16	
9024	Amphotericin b lipid complex	$23.72	$20.16	
9032	Baclofen 10 MG injection	$303.64	$258.09	
9033	Cidofovir injection	$939.82	$798.85	
9038	Inj estrogen conjugate	$501.10	$425.94	
9042	Glucagon hydrochloride	$361.48	$307.26	
9043	Afstyla Factor VIII recomb	$2.56	$2.18	
9044	Ibutilide fumarate injection	$346.50	$294.53	
9052	Fluciciovine F-18	$701.19	$596.01	
9056	Gallium Ga-68	$120.13	$102.11	
9058	Buprenorphine implant 74.2mg	$2,269.06	$1,928.70	
9059	Vonvendi inj 1 iu vwf:rco	$4.09	$3.48	
9060	Diazoxide injection	$1,242.05	$1,055.74	
9061	Inj milrinone lactate / 5 mg	$4.46	$3.79	
9062	Topotecan injection	$2.27	$1.93	
9104	Antithymocyte globuln rabbit	$1,237.99	$1,052.29	
9108	Thyrotropin injection	$2,820.47	$2,397.40	
9119	Injection, pegfilgrastim 6mg	$7,544.41	$6,412.75	
9120	Injection, Fulvestrant	$173.23	$147.25	
9122	Triptorelin pamoate	$657.79	$559.12	
9124	Daptomycin injection	$1.22	$1.04	
9125	Risperidone, long acting	$14.71	$12.50	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
9126	Natalizumab injection	$33.84	$28.76	
9130	Inj, Imm Glob Bivigam, 500mg	$68.96	$58.62	
9131	Inj, Ado-trastuzumab Emt 1mg	$53.14	$45.17	
9132	Kcentra, per i.u.	$3.33	$2.83	
9133	Rabies ig, im/sc	$534.08	$453.97	
9134	Rabies ig, heat treated	$533.41	$453.40	
9135	Varicella-zoster ig, im	$2,215.76	$1,883.40	
9139	Rabies vaccine, im	$485.84	$412.96	
9140	Rabies vaccine, id	$253.84	$215.76	
9171	Factor ix idelvion inj	$7.47	$6.35	
9207	Bortezomib injection	$83.25	$70.76	
9208	Agalsidase beta injection	$298.91	$254.07	
9209	Laronidase injection	$55.10	$46.84	
9210	Palonosetron hcl	$40.73	$34.62	
9213	Pemetrexed injection	$115.27	$97.98	
9214	Bevacizumab injection	$132.48	$112.61	
9215	Cetuximab injection	$101.50	$86.28	
9217	Leuprolide acetate suspnsion	$388.82	$330.50	
9224	Galsulfase injection	$664.96	$565.22	
9225	Fluocinolone acetonide implt	$36,198.70	$30,768.90	
9228	Tigecycline injection	$5.72	$4.86	
9229	Ibandronate sodium injection	$140.92	$119.78	
9230	Abatacept injection	$84.35	$71.70	
9231	Decitabine injection	$32.33	$27.48	
9232	Idursulfase injection	$939.62	$798.68	
9233	Ranibizumab injection	$675.38	$574.07	
9234	Alglucosidase alfa injection	$372.06	$316.25	
9235	Panitumumab injection	$193.88	$164.80	
9236	Eculizumab injection	$407.93	$346.74	
9237	Inj, lanreotide acetate	$97.22	$82.64	
9240	Injection, ixabepilone	$135.65	$115.30	
9242	Injection, fosaprepitant	$3.49	$2.97	
9243	Inj., treanda 1 mg	$50.35	$42.80	
9245	Romiplostim injection	$117.05	$99.49	
9248	Inj, clevidipine butyrate	$3.96	$3.37	
9251	C1 esterase inhibitor inj	$99.95	$84.96	
9252	Plerixafor injection	$561.78	$477.51	
9253	Temozolomide injection	$16.11	$13.69	
9255	Paliperidone palmitate inj	$17.10	$14.54	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
9256	Dexamethasone intra implant	$361.40	$307.19	
9258	Telavancin injection	$9.00	$7.65	
9259	Pralatrexate injection	$429.62	$365.18	
9260	Ofatumumab injection	$96.10	$81.69	
9261	Ustekinumab sub cu inj, 1 mg	$313.56	$266.53	
9263	Ecallantide injection	$758.92	$645.08	
9264	Tocilizumab injection	$7.60	$6.46	
9265	Romidepsin injection	$571.64	$485.89	
9269	C-1 esterase, berinert	$87.66	$74.51	
9270	Gammaplex IVIG	$74.92	$63.68	
9271	Velaglucerase alfa	$616.86	$524.33	
9272	Inj, denosumab	$29.93	$25.44	
9273	Sipuleucel-T auto CD54+	$71,854.22	$61,076.09	
9274	Crotalidae Poly Immune Fab	$5,165.86	$4,390.98	
9276	Cabazitaxel injection	$281.99	$239.69	
9278	Incobotulinumtoxin A	$8.87	$7.54	
9281	Injection, pegloticase	$3,278.75	$2,786.94	
9284	Ipilimumab injection	$260.39	$221.33	
9286	Belatacept injection	$6.89	$5.86	
9287	Brentuximab vedotin inj	$241.47	$205.25	
9289	Erwinaze injection	$724.93	$616.19	
9293	Injection, glucarpidase	$511.60	$434.86	
9294	Inj, Taliglucerace Alfa 10 u	$72.72	$61.81	
9295	Injection, Carfilzomib, 1 mg	$57.96	$49.27	
9296	Inj, ziv-aflibercept, 1mg	$14.62	$12.43	
9297	Inj, Omacetaxine Mep, 0.01mg	$4.90	$4.17	
9298	Inj, Ocriplasmin, 0.125 mg	$1,884.15	$1,601.53	
9300	Omalizumab injection	$60.50	$51.43	
9441	Inj ferric carboxymaltos 1mg	$1.91	$1.62	
9445	Injection, ruconest	$50.29	$42.75	
9448	Netupitant palonosetron oral	$800.84	$680.71	
9449	Injection, blinatumomab	$177.89	$151.21	
9450	Fluocinol acet intravit imp	$883.71	$751.15	
9451	Injection, peramivir	$2.92	$2.48	
9452	Inj ceftolozane tazobactam	$8.53	$7.25	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
9453	Injection, nivolumab	$47.57	$40.43	
9454	Inj, pasireotide long acting	$469.37	$398.96	
9455	Injection, siltuximab	$162.04	$137.73	
9456	Injection, isavuconazonium	$1.13	$0.96	
9457	Inj sulf hexa lipid microsph	$38.90	$33.07	
9458	florbetaben f18 diagnostic	$5,342.40	$4,541.04	
9459	flutemetamol f18 diagnostic	$6,296.40	$5,351.94	
9460	Injection, cangrelor	$27.67	$23.52	
9461	Choline c-11, diagnostic, per study dose up to 20 millicuries	$10,260.00	$8,721.00	
9470	Aripiprazole lauroxil 1mg	$4.30	$3.66	
9471	Hymovis injection 1 mg	$30.17	$25.64	
9472	Inj talimogene laherparepvec	$82.87	$70.44	
9473	Injection, mepolizumab, 1mg	$47.97	$40.77	
9474	Inj irinotecan liposome 1 mg	$71.06	$60.40	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
9475	Injection, necitumumab, 1 mg	$9.45	$8.03	
9476	Injection, daratumumab 10 mg	$86.60	$73.61	
9477	Injection, elotuzumab, 1mg	$11.18	$9.50	
9478	Inj sebelipase alfa 1 mg	$954.00	$810.90	
9479	Instill, ciprofloxacin otic	$53.91	$45.82	
9480	Injection trabectedin 0.1mg	$510.19	$433.66	
9481	Injection, reslizumab	$15.93	$13.54	
9482	Sotalol hydrochloride IV	$17.98	$15.28	
9483	Injection, atezolizumab	$136.12	$115.70	
9484	Injection, eteplirsen	$305.28	$259.49	
9485	Injection, olaratumab	$90.05	$76.54	
9486	Inj, granisetron ext	$9.34	$7.94	
9487	Ustekinumab IV inj, 1 mg	$23.00	$19.55	
9488	Conivaptan HCL	$53.87	$45.79	
9497	Loxapine, inhalation powder	$270.07	$229.56	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
9500	Platelets, irradiated	$301.36	$256.16	
9501	Platelet pheres leukoreduced	$899.91	$764.92	
9502	Platelet pheresis irradiated	$1,001.84	$851.56	
9503	Fr frz plasma donor retested	$120.94	$102.80	
9504	RBC deglycerolized	$690.44	$586.87	
9505	RBC irradiated	$394.11	$334.99	
9507	Platelets, pheresis	$741.78	$630.51	
9508	Plasma 1 donor frz w/in 8 hr	$132.71	$112.80	
9509	Frozen plasma, pooled, sd	$120.28	$102.24	
9510	Whole blood for transfusion	$279.92	$237.93	
9511	Cryoprecipitate each unit	$95.45	$81.13	
9512	RBC leukocytes reduced	$334.48	$284.31	
9513	Plasma, frz between 8-24hour	$133.20	$113.22	
9514	Plasma protein fract,5%,50ml	$35.57	$30.23	
9515	Platelets, each unit	$173.68	$147.63	
9516	Plaelet rich plasma unit	$237.02	$201.47	
9517	Red blood cells unit	$256.25	$217.81	
9518	Washed red blood cells unit	$619.87	$526.89	
9519	Plasmaprotein fract,5%,250ml	$166.81	$141.79	
9520	Blood split unit	$237.56	$201.93	
9521	Platelets leukoreduced irrad	$291.76	$248.00	
9522	RBC leukoreduced irradiated	$479.30	$407.41	
9523	Cryoprecipitatereducedplasma	$113.92	$96.83	
9524	Blood, l/r, cmv-neg	$371.66	$315.91	
9525	Platelets, hla-m, l/r, unit	$1,328.65	$1,129.35	
9526	Platelets leukocytes reduced	$226.31	$192.36	
9527	Blood, l/r, froz/degly/wash	$496.04	$421.63	
9528	Plt, aph/pher, l/r, cmv-neg	$759.60	$645.66	
9529	Blood, l/r, irradiated	$223.87	$190.29	
9530	Plate pheres leukoredu irrad	$1,165.32	$990.52	
9531	Plt, pher, l/r cmv-neg, irr	$1,114.00	$946.90	
9532	RBC, frz/deg/wsh, l/r, irrad	$373.41	$317.40	
9533	RBC, l/r, cmv-neg, irrad	$450.18	$382.65	
9534	Pathogen reduced plasma pool	$133.20	$113.22	
9535	Pathogen reduced plasma sing	$132.71	$112.80	
9536	Pathogen reduced platelets	$1,165.32	$990.52	

Exhibit #5 - Proposed

Rural Health Clinics

find the most updated list at: https://www.colorado.gov/pacific/cdphe/find-and-compare-facilities
(effective 1/1/2018)

Facility	Address	City	State	Zip	County	Contact
AKRON CLINIC	82 MAIN	Akron	CO	80720	Washington	Phone: (970)345-6336, Fax: (970)345-6576
ARKANSAS VALLEY FAMILY PRACTICE, LLC	2317 SAN JUAN AVE	La Junta	CO	81050	Otero	Phone: (719)383-2325, Fax: (719)383-2327
BANNER HEALTH CENTER STERLING	102 HAYS AVE	Sterling	CO	80751	Logan	Phone: (970)521-3223, Fax: (970)521-3266
BASIN CLINIC	421 WEST ADAMS ROAD	Naturita	CO	80723	Montrose	Phone: (970)865-2665, Fax: (970)825-2674
BRUSH FAMILY CLINIC	2400 W EDISON	Brush	CO	81211	Morgan	Phone: (970)842-6740, Fax: (970)842-6241
BUENA VISTA HEALTH CENTER	28374 COUNTY ROAD 317	Buena Vista	CO	81211	Chaffee	Phone: (719)395-9048, Fax: (719)395-9064
BUTTON FAMILY PRACTICE	715 SOUTH 9TH STREET	Canon City	CO	81212	Fremont	Phone: (719)269-8820, Fax: (719)204-0230
CENTENNIAL FAMILY HEALTH CENTER	319 MAIN STREET	Ordway	CO	81063	Crowley	Phone: (719)267-3503, Fax: (719)267-4153
CORTEZ PRIMARY CARE CLINIC	118 NORTH CHESTNUT	Cortez	CO	81321	Montezuma	Phone: (970)564-9777, Fax: (970)564-8833
CREEDE FAMILY PRACTICE OF RIO GRANDE HOSPITAL	802 RIO GRANDE AVENUE	Creede	CO	81130	Mineral	Phone: (719)658-0929, Fax: (719)657-2851
CUSTER COUNTY MEDICAL CENTER	704 EDWARDS	Westcliffe	CO	81252	Custer	Phone: (719)783-2380, Fax: (719)783-2377
EADS MEDICAL CLINIC	1211 LUTHER STREET	Eads	CO	81036	Kiowa	Phone: (719)438-2251, Fax: (719)438-2254
EASTERN PLAINS MEDICAL CLINIC OF	560 CRYSTOLA STREET	Calhan	CO	80808	El Paso	Phone: (719)347-0100,

Facility	Address	City	State	Zip	County	Contact
CALHAN						Fax: (719)347-0551
FAMILY CARE CLINIC	615 FAIRHURST	Sterling	CO	80751	Logan	Phone: (970)521-3223, Fax: (970)521-3266
FAMILY PRACTICE OF HOLYOKE	1001 EAST JOHNSON STREET	Holyoke	CO	80734	Phillips	Phone: (970)854-2500, Fax: (970)854-3440
FLORENCE MEDICAL CENTER	501 W 5TH ST	Florence	CO	81226	Fremont	Phone: (719)784-4816, Fax: (719)784-6014
GRAND RIVER HEALTH CLINIC WEST	201 SIPPERELLE DRIVE	Parachute	CO	81635	Garfield	Phone: (970)285-7046, Fax: (970)285-6064
GRAND RIVER PRIMARY CARE	501 AIRPORT ROAD	Rifle	CO	81650	Garfield	Phone: (970)625-1100, Fax: (970)625-0725
KIT CARSON CLINIC	102 EAST 2ND AVENUE	Kit Carson	CO	80825	Cheyenne	Phone: (719)962-3501, Fax: (719)962-3403
LAKE CITY AREA MEDICAL CENTER	700 N HENSON STREET	Lake City	CO	81235	Hinsdale	Phone: (970)944-2331, Fax: (970)944-2320
LAMAR MEDICAL CLINIC	403 KENDALL DRIVE	Lamar	CO	81052	Prowers	Phone: (719)336-6767, Fax: (719)336-7217
MANCOS VALLEY HEALTH CENTER	111 RAILROAD AVE	Mancos	CO	81328	Montezuma	Phone: (970)564-2104, Fax: (970)564-2134
MEEKER FAMILY HEALTH CENTER	345 CLEVELAND STREET	Meeker	CO	81641	Rio Blanco	Phone: (970)878-4014, Fax: (970)878-3285
MONTE VISTA RHC OF RIO GRANDE HOSPITAL	1033 2ND AVENUE	Monte Vista	CO	81144	Rio Grande	Phone: (719)852-8827, Fax: (719)852-2739
MT SAN RAFAEL HOSPITAL HEALTH CLINIC	400 BENEDICTA STE A	Trinidad	CO	81082	Las Animas	Phone: (719)846-2206, Fax: (719)846-7823
NORTH PARK MEDICAL CENTER - WALDEN	350 MCKINLEY STREET	Walden	CO	80480	Jackson	Phone: (970)723-4255, Fax: (970)723-4268
PAGOSA MOUNTAIN CLINIC	95 SOUTH PAGOSA BLVD	Pagosa Springs	CO	81147	Archuleta	Phone: (970)731-3700, Fax: (970)731-3707
PARKE HEALTH CLINIC	182 16TH ST	Burlington	CO	80807	Kit Carson	Phone: (719)346-9481, Fax: (719)346-9485
PEDIATRIC ASSOCIATION OF CANON CITY	1335 PHAY AVENUE, SUITE A	Canon City	CO	81212	Fremont	Phone: (719)269-1727,

Facility	Address	City	State	Zip	County	Contact
						Fax: (719)269-1730
PRAIRIE VIEW RURAL HEALTH CLINIC	615 WEST 5TH NORTH	Cheyenne Wells	CO	80810	Cheyenne	Phone: (719)767-5669, Fax: (719)767-5098
RIO GRANDE HOSPITAL CLINIC	0310C COUNTY RD 14	Del Norte	CO	81132	Rio Grande	Phone: (719)657-2418, Fax: (719)658-3001
ROCKY FORD FAMILY HEALTH CENTER	1014 ELM AVENUE	Rocky Ford	CO	81067	Otero	Phone: (719)254-7421, Fax: (719)254-6966
SABATINI PEDIATRICS PC	612 YALE PLACE	Canon City	CO	81212	Fremont	Phone: (719)275-3442, Fax: (719)275-2306
SAN LUIS VALLEY HEALTH ANTONITO CLINIC	115 MAIN STREET	Antonito	CO	81120	Conejos	Phone: (719)376-2308, Fax: (719)376-2395
SAN LUIS VALLEY LA JARA MEDICAL CLINIC	509 MAIN STREET	La Jara	CO	81140	Conejos	Phone: (719)274-5000, Fax: (719)274-4111
SOUTHEAST COLORADO PHYSICIANS CLINIC	900 CHURCH STREET	Springfield	CO	81073	Baca	Phone: (719)523-6628, Fax: (719)523-4513
SOUTHWEST MEMORIAL PRIMARY CARE	33 NORTH ELM STREET	Cortez	CO	81321	Montezuma	Phone: (970)565-8556, Fax: (970)564-1134
SOUTHWEST SCHOOL-BASED HEALTH CENTER	418 S SLIGO STREET	Cortez	CO	81321	Montezuma	Phone: (970)564-2104, Fax: (970)564-2134
SOUTHWEST WALK-IN CARE	2095 NORTH DOLORES ROAD, STE C	Cortez	CO	81321	Montezuma	Phone: (970)564-1037, Fax: (970)564-1041
SPANISH PEAKS FAMILY CLINIC	23400 US HIGHWAY 160	Walsenburg	CO	81089	Huerfano	Phone: (719)738-4591, Fax: (719)738-4553
STRATTON MEDICAL CLINIC	500 NEBRASKA AVENUE	Stratton	CO	80836	Kit Carson	Phone: (719)348-4650, Fax: (719)348-4653
SURFACE CREEK FAMILY PRACTICE	255 SW 8TH AVE	Cedaredge	CO	81413	Delta	Phone: (970)856-3146, Fax: (970)856-4385
VALLEY MEDICAL CLINIC	116 E NINTH STREET	Julesburg	CO	80737	Sedgwick	Phone: (970)474-3376, Fax: (970)474-2461
WALSH MEDICAL CLINIC	137 KANSAS STREET	Walsh	CO	81090	Baca	Phone: (719)324-5253, Fax: (719)324-5621
WASHINGTON COUNTY CLINIC	482 ADAMS AVENUE	Akron	CO	80720	Washington	Phone: (970)345-2262,

Facility	Address	City	State	Zip	County	Contact
						Fax: (970)345-2265
YUMA CLINIC	1000 W 8TH AVENUE	Yuma	CO	80759	Yuma	Phone: (970)848-4676, Fax: (970)848-4952

Exhibit #6 – Proposed Dental Fees Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D0120	$67.15
D0140	$112.29
D0145	$104.19
D0150	$118.08
D0160	$237.31
D0170	$78.72
D0171	$71.25
D0180	$128.50
D0190	$62.00
D0191	$44.00
D0210	$187.18
D0220	$37.68
D0230	$34.03
D0240	$58.35
D0250	$71.72
D0251	BR
D0270	$38.89
D0272	$63.21
D0273	$76.58
D0274	$88.74
D0277	$133.71
D0310	$556.70
D0320	$948.10
D0321	BR
D0322	$765.77
D0330	$165.54
D0340	$186.38
D0350	$89.13
D0351	$73.75
D0364	$1,251.00
D0365	$1,251.00
D0366	$1,251.00

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D0367	$1,251.00
D0368	$1,831.00
D0369	$3,274.00
D0370	$1,102.00
D0371	BR
D0380	$998.00
D0381	$998.00
D0382	$998.00
D0383	$998.00
D0384	$1,459.00
D0385	$2,382.00
D0386	$596.00
D0391	BR
D0393	BR
D0394	BR
D0395	BR
D0414	BR
D0415	$72.00
D0416	$106.00
D0417	$97.00
D0418	$100.00
D0422	BR
D0423	BR
D0425	$62.00
D0431	$100.00
D0460	$100.00
D0470	$219.00
D0472	$137.00
D0473	$290.00
D0474	$325.00
D0475	$175.00
D0476	$170.00
D0477	$232.00
D0478	$212.00
D0479	$325.00
D0480	$200.00
D0481	$858.14
D0482	$250.00
D0483	$250.00

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D0484	$375.00
D0485	$517.00
D0486	$240.00
D0502	BR
D0600	BR
D0601	$93.00
D0602	$93.00
D0603	$93.00
D0999	BR
D1110	$120.33
D1120	$83.87
D1206	$72.93
D1208	$45.15
D1310	$70.61
D1320	$77.56
D1330	$97.24
D1351	$78.72
D1352	$94.50
D1353	$80.75
D1354	BR
D1510	$503.57
D1515	$704.99
D1520	$554.51
D1525	$856.64
D1550	$108.82
D1555	$104.19
D1575	BR
D1999	BR
D2140	$262.55
D2150	$339.13
D2160	$410.84
D2161	$500.79
D2330	$239.45
D2331	$306.31
D2332	$374.38
D2335	$443.66
D2390	$491.06
D2391	$280.78
D2392	$368.30

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D2393	$457.03
D2394	$560.35
D2410	$457.26
D2420	$762.88
D2430	$1,322.01
D2510	$1,209.72
D2520	$1,372.95
D2530	$1,582.48
D2542	$1,551.22
D2543	$1,623.00
D2544	$1,687.82
D2610	$1,423.88
D2620	$1,502.60
D2630	$1,601.00
D2642	$1,555.85
D2643	$1,677.40
D2644	$1,779.27
D2650	$935.36
D2651	$1,114.80
D2652	$1,171.52
D2662	$1,016.40
D2663	$1,195.82
D2664	$1,281.49
D2710	$628.41
D2712	$628.41
D2720	$1,548.55
D2721	$1,451.31
D2722	$1,482.92
D2740	$1,588.67
D2750	$1,568.01
D2751	$1,459.83
D2752	$1,495.07
D2780	$1,503.58
D2781	$1,414.85
D2782	$1,461.04
D2783	$1,546.13
D2790	$1,512.09
D2791	$1,433.08
D2792	$1,459.83

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D2794	$1,548.55
D2799	$628.41
D2910	$143.43
D2915	$143.43
D2920	$144.65
D2921	$179.50
D2929	$543.00
D2930	$395.04
D2931	$447.31
D2932	$476.48
D2933	$545.76
D2934	$545.76
D2940	$150.73
D2941	$130.00
D2949	$130.00
D2950	$376.80
D2951	$85.08
D2952	$595.60
D2953	$297.80
D2954	$476.48
D2955	$367.08
D2957	$238.23
D2960	$1,152.30
D2961	$1,306.67
D2962	$1,419.72
D2971	$228.51
D2975	$695.27
D2980	BR
D2981	BR
D2982	BR
D2983	BR
D2990	$94.00
D2999	BR
D3110	$131.25
D3120	$105.35
D3220	$268.80
D3221	$295.20
D3222	$273.20
D3230	$307.52

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D3240	$379.24
D3310	$1,207.00
D3320	$1,479.27
D3330	$1,834.20
D3331	$472.84
D3332	$899.47
D3333	$414.49
D3346	$1,609.34
D3347	$1,893.76
D3348	$2,343.50
D3351	$968.76
D3352	$433.93
D3353	$1,335.84
D3355	$577.25
D3356	$259.00
D3357	BR
D3410	$1,920.50
D3421	$2,138.07
D3425	$2,421.29
D3426	$818.03
D3427	$1,035.75
D3428	$1,509.25
D3429	$1,439.50
D3430	$601.67
D3431	$1,772.25
D3432	$1,523.50
D3450	$1,251.97
D3460	$4,676.05
D3470	$2,388.47
D3910	$334.27
D3920	$951.74
D3950	$433.93
D3999	BR
D4210	$1,603.00
D4211	$712.00
D4212	$570.00
D4230	$2,244.00
D4231	$1,096.39
D4240	$2,030.00

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D4241	$1,175.00
D4245	$1,496.00
D4249	$2,226.00
D4260	$3,383.00
D4261	$1,816.00
D4263	$1,211.00
D4264	$1,033.00
D4265	BR
D4266	$1,247.00
D4267	$1,603.00
D4268	BR
D4270	$2,404.00
D4273	$2,938.00
D4274	$1,667.00
D4275	$2,208.00
D4276	$3,294.00
D4277	$2,493.00
D4278	$819.00
D4283	BR
D4285	BR
D4320	$625.99
D4321	$633.28
D4341	$361.00
D4342	$217.57
D4346	BR
D4355	$246.75
D4381	BR
D4910	$222.44
D4920	$161.66
D4921	BR
D4999	BR
D5110	$2,343.00
D5120	$2,343.00
D5130	$2,555.00
D5140	$2,555.00
D5211	$1,977.00
D5212	$2,298.00
D5213	$2,771.36
D5214	$2,589.00

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D5221	BR
D5222	BR
D5223	BR
D5224	BR
D5225	$1,977.00
D5226	$2,298.00
D5281	$1,509.00
D5410	$128.00
D5411	$128.00
D5421	$128.00
D5422	$128.00
D5510	$274.70
D5520	$214.00
D5610	$278.00
D5620	$316.03
D5630	$363.00
D5640	$235.00
D5650	$321.00
D5660	$385.00
D5670	$1,006.44
D5671	$1,006.44
D5710	$951.00
D5711	$909.00
D5720	$898.00
D5721	$898.00
D5730	$537.00
D5731	$537.00
D5740	$492.00
D5741	$492.00
D5750	$716.00
D5751	$716.00
D5760	$705.00
D5761	$705.00
D5810	$1,133.00
D5811	$1,218.00
D5820	$876.00
D5821	$930.00
D5850	$224.00
D5851	$224.00

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D5862	BR
D5863	$2,295.25
D5864	BR
D5865	$2,295.25
D5866	$3,146.00
D5867	BR
D5875	BR
D5899	BR
D5911	$594.00
D5912	$594.00
D5913	$12,514.00
D5914	$12,514.00
D5915	$16,935.00
D5916	$4,517.00
D5919	BR
D5922	BR
D5923	BR
D5924	BR
D5925	BR
D5926	BR
D5927	BR
D5928	BR
D5929	BR
D5931	$6,738.00
D5932	$12,602.00
D5933	BR
D5934	$11,486.00
D5935	$9,994.00
D5936	$11,225.00
D5937	$1,411.50
D5951	$1,834.00
D5952	$5,956.00
D5953	$11,310.00
D5954	$10,481.00
D5955	$9,694.00
D5958	BR
D5959	BR
D5960	BR
D5982	$997.93

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D5983	$2,416.43
D5984	$2,416.43
D5985	$2,416.43
D5986	$241.00
D5987	$3,627.07
D5988	$641.00
D5991	$246.00
D5992	BR
D5993	BR
D5994	$227.50
D5999	BR
D6010	$3,914.00
D6011	BR
D6012	$3,698.00
D6013	$3,623.00
D6040	$14,418.34
D6050	$10,047.00
D6051	BR
D6052	$1,535.25
D6055	$1,176.00
D6056	$812.00
D6057	$1,005.00
D6058	$2,253.00
D6059	$2,379.96
D6060	$2,249.90
D6061	$2,294.88
D6062	$2,286.36
D6063	$1,963.04
D6064	$2,079.74
D6065	$2,217.00
D6066	$2,311.89
D6067	$2,242.61
D6068	$2,234.00
D6069	$2,379.96
D6070	$2,249.90
D6071	$2,144.00
D6072	$2,343.50
D6073	$2,121.06
D6074	$2,106.00

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D6075	$2,217.00
D6076	$2,311.89
D6077	$2,242.61
D6080	$184.00
D6081	BR
D6085	BR
D6090	BR
D6091	$887.00
D6092	$173.00
D6093	$271.00
D6094	$1,887.68
D6095	BR
D6100	BR
D6101	$587.50
D6102	$769.75
D6103	$672.50
D6104	$672.50
D6110	$2,705.00
D6111	$2,705.00
D6112	$2,705.00
D6113	$2,705.00
D6114	BR
D6115	BR
D6116	BR
D6117	BR
D6190	$395.00
D6194	$1,817.00
D6199	BR
D6205	$1,016.16
D6210	$1,553.41
D6211	$1,454.96
D6212	$1,514.52
D6214	$1,563.15
D6240	$1,533.97
D6241	$1,416.06
D6242	$1,493.86
D6245	$1,582.59
D6250	$1,514.52
D6251	$1,396.62

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D6252	$1,441.59
D6253	$652.72
D6545	$610.19
D6548	$651.00
D6549	$377.21
D6600	$1,186.33
D6601	$1,266.56
D6602	$1,294.51
D6603	$1,424.58
D6604	$1,268.99
D6605	$1,344.35
D6606	$1,248.32
D6607	$1,385.67
D6608	$1,277.00
D6609	$1,355.29
D6610	$1,396.62
D6611	$1,527.89
D6612	$1,389.33
D6613	$1,452.53
D6614	$1,358.93
D6615	$1,413.64
D6624	$1,294.51
D6634	$1,358.93
D6710	$1,345.00
D6720	$1,619.06
D6721	$1,535.18
D6722	$1,563.15
D6740	$1,650.00
D6750	$1,656.73
D6751	$1,546.13
D6752	$1,583.81
D6780	$1,563.15
D6781	$1,516.00
D6782	$1,563.15
D6783	$1,561.00
D6790	$1,599.60
D6791	$1,516.96
D6792	$1,571.65
D6793	$637.00

Exhibit #6 – Proposed Dental Fees Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D6794	$1,571.65
D6920	$420.57
D6930	$245.53
D6940	$556.70
D6950	$1,074.51
D6980	BR
D6985	$934.72
D6999	BR
D7111	$229.73
D7140	$305.09
D7210	$405.98
D7220	$509.29
D7230	$678.25
D7240	$796.15
D7241	$1,000.37
D7250	$429.07
D7251	$770.70
D7260	$3,182.19
D7261	$1,104.60
D7270	$828.45
D7272	$1,104.60
D7280	$772.80
D7282	$386.40
D7283	$331.80
D7285	$1,546.65
D7286	$662.55
D7287	$265.65
D7288	$265.65
D7290	$662.55
D7291	$446.76
D7292	$1,060.50
D7293	$662.55
D7294	$552.30
D7295	BR
D7310	$1,009.00
D7311	$883.00
D7320	$1,640.00
D7321	$1,388.00
D7340	$6,938.00

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D7350	$20,182.00
D7410	$3,027.00
D7411	$4, 793.00
D7412	$5,298.00
D7413	$3,532.00
D7414	$5,298.00
D7415	$5,928.00
D7440	$4,793.00
D7441	$7,064.00
D7450	$3,027.00
D7451	$4,137.00
D7460	$3,027.00
D7461	$4,137.00
D7465	$1,640.00
D7471	$3,749.00
D7472	$4,455.00
D7473	$4,203.00
D7485	$3,749.00
D7490	$30,273.00
D7510	$1,085.00
D7511	$1,640.00
D7520	$5,167.00
D7521	$5,676.00
D7530	$1,862.00
D7540	$2,064.00
D7550	$1,287.00
D7560	$10,217.00
D7610	$16,524.00
D7620	$12,392.00
D7630	$21,484.00
D7640	$13,633.00
D7650	$10,328.00
D7660	$6,090.00
D7670	$4,753.00
D7671	$8,956.00
D7680	$30,984.00
D7710	$19,420.00
D7720	$13,633.00
D7730	$28,093.00

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D7740	$13,900.00
D7750	$17,679.00
D7760	$7,094.00
D7770	$9,612.00
D7771	$7,417.00
D7780	$41,313.00
D7810	$18,174.00
D7820	$2,977.00
D7830	$1,705.00
D7840	$24,773.00
D7850	$21,393.00
D7852	$24,496.00
D7854	$25,278.00
D7856	$17,937.00
D7858	$51,126.00
D7860	$21,792.00
D7865	$35,117.00
D7870	$1,160.00
D7871	$2,321.00
D7872	$12,387.00
D7873	$14,914.00
D7874	$21,393.00
D7875	$23,436.00
D7876	$25,268.00
D7877	$22,301.00
D7880	$2,785.00
D7881	BR
D7899	BR
D7910	$1,655.00
D7911	$4,132.00
D7912	$7,437.00
D7920	$12,185.00
D7921	$1,125.00
D7940	BR
D7941	$31,030.00
D7943	$28,507.00
D7944	$25,404.00
D7945	$33,805.00
D7946	$41,878.00

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D7947	$35,218.00
D7948	$45,712.00
D7949	$59,537.00
D7950	BR
D7951	BR
D7952	BR
D7953	$858.00
D7955	BR
D7960	$1,388.00
D7963	$2,270.00
D7970	$2,018.00
D7971	$757.00
D7972	$2,825.00
D7980	$3,179.00
D7981	BR
D7982	$7,518.00
D7983	$7,215.00
D7990	$6,206.00
D7991	$5,137.00
D7995	BR
D7996	BR
D7997	$1,160.00
D7998	$5,046.00
D7999	BR
D8010	BR
D8020	BR
D8030	BR
D8040	BR
D8050	BR
D8060	BR
D8070	BR
D8080	BR
D8090	BR
D8210	BR
D8220	BR
D8660	$700.13
D8670	$525.09
D8680	$1,154.73
D8681	BR

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D8690	$545.76
D8691	$512.95
D8692	$571.28
D8693	$528.75
D8694	BR
D8999	BR
D9110	$215.15
D9120	$243.11
D9210	$181.65
D9211	$200.55
D9212	$312.90
D9215	$150.15
D9219	BR
D9223	BR
D9230	BR
D9243	BR
D9248	$437.85
D9310	$487.42
D9311	BR
D9410	$557.92
D9420	$903.13
D9430	$151.94
D9440	$305.09
D9450	$151.94
D9610	BR
D9612	BR
D9630	BR
D9910	$103.03
D9911	$144.70
D9920	BR
D9930	BR
D9932	BR
D9933	BR
D9934	BR
D9935	BR
D9940	$940.80
D9941	$307.52
D9942	$354.24
D9943	BR

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D9950	$560.29
D9951	$251.20
D9952	$1,179.62
D9970	$133.13
D9971	$171.33
D9972	$590.39
D9973	$97.24
D9974	$516.31
D9975	$576.00
D9985	BR
D9986	BR
D9987	BR
D9991	BR
D9992	BR
D9993	BR
D9994	BR
D9999	BR

Exhibit 7

Effective for Dates of Service On and After 1/1/2018

Evaluation and Management (E&M) Documentation Guidelines

for

Colorado Workers' Compensation Claims

This E&M Guidelines for Colorado Workers' Compensation Claims is intended for the physicians 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:

1. History (Hx),
2. Examination (Exam), and
3. Medical Decision Making (MDM)

<u>Documentation requirements for any billed office visit:</u>

- 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: The overall level of history is determined based upon all three of the history elements (HPI, ROS, and PMFSW) being at the same level or higher.

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)	Brief 1-3 elements	Brief 1-3 elements	Extended 4+ elements **(Initial visits require(s) an injury causation statement and or an objective functional goal treatment plan. Follow-up visits require objective functional gains/losses, ADLs etc)**	Extended 4+ elements **(Initial visits require(s) an injury causation statement and or an objective functional goal treatment plan. Follow-up visits require objective functional gains/losses, ADLs etc)**
B. Review of Systems (ROS) (not required for established patient visits)	None	Problem pertinent-limited to injured body part	2-9 body parts or body systems	Complete 10+
C. Past Medical, Family and Social/Work History (PMFSH)	None	None	Pertinent 1 of 4 types of histories	2 or more of the 4 types of histories

A. HPI Elements represents the injured worker relaying their 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" or greater HPI* in an initial patient/injured workers visit it is required for the provider to discuss the causality of the patient/injured worker's work related injury(s) to the patient/injured worker's job duties and or create and implement a treatment plan with objective functional measureable goals.

For the provider to achieve an *"extended" or greater HPI* in an established patient/injured worker visit it is required to document a detailed description of the patient's objective functional gains or losses since the last visit with current treatment plan, such as ADLs, physical therapy goals and return to work.

B. Review of Systems (ROS): each system/body part is counted once whether positive or negative. Identify, perform and documentation of all pertinent ROS systems with either a "positive or negative" response is necessary to be counted.

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. PMFSH consists of a review of four areas (NOTE: Employers should **not** have access to any patient's or the family's generic/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 is part of the medical decision making process. The total number of bullets determines the overall level of examination.

Physician's Examination Component	
Level of Examination Performed and Documented	**# of Bullets Required for each level**
Problem Focused	1-5 elements identified by a bullet as indicated in the guideline
Expanded Problem Focused	6 elements identified by a bullet as indicated in this guideline
Detailed	7-12 elements identified by a bullet as indicated in this guideline
Comprehensive	>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: 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)
- Examination of gait and station
- Inspection and/or palpation of digits and nails (e.g., clubbing, cyanosis, inflammatory conditions, petechia, ischemia, infections, nodes)

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:

1. Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities)
2. Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (e.g., Babinski)
3. Examination of sensation (e.g., by touch, pin, vibration, proprioception)
4. One bullet for all of the 12 cranial nerves assessments with notations of any deficits

Cardiovascular:

1. One bullet per extremity examination/assessment of peripheral vascular system by:

a. Observation (e.g., swelling, varicosities)

b. 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:

a. carotid arteries (e.g., pulse amplitude, bruits)

b. abdominal aorta (e.g., size, bruits)

c. 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, ulcers)

Respiratory: (one bullet for each examination/assessment)

1. Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)

2. Percussion of chest (e.g., dullness, flatness, hyperresonance)

3. Palpation of chest (e.g., tactile fremitus)

4. Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)

Gastrointestinal: One bullet for each examination /assessment

1. Examination of abdomen with notation of presence of masses or tenderness and liver and spleen

2. Examination of presence or absence of hernia

3. 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:

a. Attention span and concentration; and

b. Language (e.g., naming objects, repeating phrases, spontaneous speech) orientation to time, place and person; and

c. Recent and remote memory; and

d. Fund of knowledge (e.g., awareness of current events, past history, vocabulary)

Eyes: One bullet for both eyes and all three examinations/assessments

1. Inspection of conjunctivae and lids; and

2. Examination of pupils and irises (e.g., reaction of light and accommodation, size and symmetry); and

3. Opthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)

Ears and Nose, Mouth and Throat:

One bullet for all of the following examination/assessment:

1. External inspection of ears and nose (e.g., overall appearance, scars, lesions, asses)
2. Otoscopic examination of external auditory canals and tympanic membranes
3. 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:

1. Inspection of nasal mucosa, septum and turbinates
2. Inspection of lips, teeth and gums
3. 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 examination of the male genitalia:

1. The scrotal contents (e.g., hydrocele, spermatocele, tenderness of cord, testicular mass)
2. Epididymides (e.g., size, symmetry, masses)
3. Testes (e.g., size symmetry, masses)
4. Urethral meatus (e.g., size location, lesions, discharge)
5. Examination of the penis (e.g., lesions, presence of absence of foreskin, foreskin retract ability, plaque, masses, scarring, deformities)
6. Digital rectal examination of prostate gland (e.g., size, symmetry, nodularity, tenderness)
7. Inspection of anus and perineum

Genitourinary FEMALE –

One bullet for each of the following female pelvic examination(s) (with or without specimen collection for smears and cultures):

1. 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)
2. Examination of urethra (e.g., masses, tenderness, scarring)
3. Examination of bladder (e.g., fullness, masses, tenderness)
4. Cervix (e.g., general appearance, lesions, discharge)
5. Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent or support)
6. Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity)

Chest:

One bullet for both examinations/assessments of both breasts

1. Inspection of breasts (e.g., symmetry, nipple discharge); and
2. 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:

1. Neck
2. Axillae
3. Groin
4. Other

Verify all of the completed examination components listed in the report documents the relevance/relatedness to the injurty 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) is comprised of Tables A, B, AND C. Two of the three highest levels from Tables A., B., and C. determines the overall level of risk)

TABLE III A:

A. Number of Diagnosis & Management Options					
Category of Problem(s)	**Occurrence of Problem(s)**		**Value**		**Total**
Self-limited or minor problem	(max 2)	X	1		
Established problem, stable or improved		X	1		
Established problem, minor worsening with improvement with expected time frames		X	2		
Established problem without improvement within expected time frame that requires treatment plan changes with or without additional workup		X	4		
New problem with no additional workup planned or established patient with worsening of condition and no additional workup planned	(max 1)	X	3		
New problem, additional workup planned or established patient with worsening of condition and no additional workup planned		X	4		

TABLE III B:

B. Amount and/or Complexity of Data Reviewed	
Date Type:	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 (90701-99199) ordered and /or physical therapy records reviewed and commented on progress 9state 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
TOTAL	

TABLE III C:

C. 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) Selected**
Minimal	One self-limited or minor problem, e.g., cold, insect bite, tinea corpori, 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 or simple sprain cyctitis Acute laceration repair	Physiologic tests nor under stress, e.g., PFTs Non-cardiovascular imaging studies w/contrast, e.g., barium enema Superficial needle biopsies Lab tests requiring arterial puncture Skin biopsies	Over-the-counter drugs Minor surgery w/no identified risk factors PT/OT IV fluids w/o additives Simple or layered closure Vaccine injection
Moderate	One of more chronic illnesses with mild exacerabation, 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, stress tests Diagnostic injections Deep needle or incisional biopsies Cardiovascular imaging studies with contrast and no identified risk factors e.g. arteriogram, cardiac cath Obtain fluid from body cavity, e.g. lumbar puncture, thoracentesis, culdocentesis	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 Tx of Fx or dislocation w/o manipulation Inability to return the injured worker to work and requires detailed functional improvement plan.

TABLE III C:

C. 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) Selected**
High	One or more chronic illness with severe exacerbation, progression or side effects of treatment Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g., multiple trauma, acute MI, 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 electrophysiological tests Diagnostic endoscopies with identified risk factors	Elective major surgery 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 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.

IV. Time Component: Time can determine the level of service if:

1. Greater than fifty percent 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; and
2. There is detailed patient specific documentation of the counseling and/or coordination of care, including patient questions and or responses; and
3. The amount of time for the entire office visit and the amount of time counseling and/or coordination of care with the injured worker is documented.

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 their 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
- Self-management of symptoms while at home and/or work
- Correct posture/mechanics to perform work functions
- Job task 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)

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.

Table V: New Patient/Office Consultations Level of Service: CPT consultation criteria must be met before a consultation can be billed for any level of service.

New Patient/Level of Service (Requires all three key components at the same level or higher)	**History**	**Examination**	**Medical Decision Making (MDM)**	**Avg. time (minutes) as listed for the specific CPT code**
99201/99241	Problem Focused (PF)	PF	Straight Forward (SF)	10
99202/99242	Extended Problem Focused (EPF)	EPF	SF	20
99203/99243	Detailed (D)	D	Low	30
99204/99244	Comprehensive(C)	C	Moderate	45
99205/99245	C	C	High	60

Table VI: Established Patient Office Visit Level of Service

Established Patient/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)**	**Avg. time (minutes) as listed for the specific CPT code**
99211	N/A	N/A	N/A	5
99212	PF	PF	SF	10
99213	EPF	EPF	Low	15
99214	D	D	Moderate	25
99215	C	C	High	40

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
36415		5.10	Routine venipuncture
36416		5.10	
78267		18.33	Breath tst attain/anal c-14
78268		157.08	Breath test analysis c-14
80047		19.72	Metabolic panel ionized ca
80047	QW	19.72	Metabolic panel ionized ca
80048		19.72	Metabolic panel total ca
80048	QW	19.72	Metabolic panel total ca
80050		52.75	General Health panel(85025,85004,80053)
80051		16.35	Electrolyte panel
80051	QW	16.35	Electrolyte panel
80053		24.63	Comprehen metabolic panel
80053	QW	24.63	Comprehen metabolic panel
80055		111.49	Obstetric panel
80061		31.23	Lipid panel
80061	QW	31.23	Lipid panel
80069		20.25	Renal function panel
80069	QW	20.25	Renal function panel
80074		111.08	Acute hepatitis panel
80076		19.06	Hepatic function panel
80081		174.57	Obstetric panel
80150		35.16	Assay of amikacin
80155		32.98	Drug screen quant caffeine
80156		33.97	Assay carbamazepine total
80157		30.91	Assay carbamazepine free
80158		42.09	Assay of cyclosporine
80159		43.13	Drug screen quant clozapine
80162		30.96	Assay of digoxin
80163		30.96	Assay of digoxin free
80164		31.59	Assay dipropylacetic acid
80165		31.59	Dipropylacetic acid free
80168		38.10	Assay of ethosuximide
80169		32.03	Drug screen quant everolimus
80170		38.20	Assay of gentamicin
80171		30.91	Drug screen quant gabapentin
80173		33.97	Assay of haloperidol

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
80175		30.91	Drug screen quan lamotrigine
80176		34.26	Assay of lidocaine
80177		30.91	Drug scrn quan levetiracetam
80178		15.42	Assay of lithium
80178	QW	15.42	Assay of lithium
80180		42.09	Drug scrn quan mycophenolate
80183		30.91	Drug scrn quant oxcarbazepin
80184		26.71	Assay of phenobarbital
80185		30.91	Assay of phenytoin total
80186		32.10	Assay of phenytoin free
80188		38.69	Assay of primidone
80190		39.07	Assay of procainamide
80192		39.07	Assay of procainamide
80194		34.05	Assay of quinidine
80195		32.03	Assay of sirolimus
80197		32.03	Assay of tacrolimus
80198		32.98	Assay of theophylline
80199		42.11	Drug screen quant tiagabine
80200		37.60	Assay of tobramycin
80201		27.80	Assay of topiramate
80202		31.59	Assay of vancomycin
80203		30.91	Drug screen quant zonisamide
80299		31.94	Quantitative assay drug
80305		25.43	Drug test prsmv dir opt obs
80306		33.92	Drug test prsmv instrmnt
80307		135.68	Drug test prsmv chem anlyzr
80400		76.06	Acth stimulation panel
80402		202.78	Acth stimulation panel
80406		145.67	Acth stimulation panel
80408		292.66	Aldosterone suppression eval
80410		187.36	Calcitonin stimul panel
80412		768.67	CRH stimulation panel
80414		120.41	Testosterone response
80415		130.32	Estradiol response panel
80416		307.73	Renin stimulation panel
80417		102.58	Renin stimulation panel
80418		1351.60	Pituitary evaluation panel
80420		168.01	Dexamethasone panel

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
80422		107.44	Glucagon tolerance panel
80424		117.76	Glucagon tolerance panel
80426		346.09	Gonadotropin hormone panel
80428		155.55	Growth hormone panel
80430		183.02	Growth hormone panel
80432		275.09	Insulin suppression panel
80434		235.93	Insulin tolerance panel
80435		240.23	Insulin tolerance panel
80436		212.59	Metyrapone panel
80438		117.56	TRH stimulation panel
80439		156.74	TRH stimulation panel
81000		7.40	Urinalysis nonauto w/scope
81001		7.40	Urinalysis auto w/scope
81002		5.95	Urinalysis nonauto w/o scope
81003		5.24	Urinalysis auto w/o scope
81003	QW	5.24	Urinalysis auto w/o scope
81005		5.05	Urinalysis
81007		5.98	Urine screen for bacteria
81007	QW	5.98	Urine screen for bacteria
81015		7.11	Microscopic exam of urine
81020		8.60	Urinalysis glass test
81025		14.74	Urine pregnancy test
81050		7.00	Urinalysis volume measure
81161		239.90	Dmd dup/delet analysis
81162		4255.54	Brca1&2 seq & full dup/del
81170		564.09	Abl1 gene
81206		382.35	Bcr/abl1 gene major bp
81207		337.76	Bcr/abl1 gene minor bp
81208		375.07	Bcr/abl1 gene other bp
81210		306.39	Braf gene
81211		3732.32	Brca1&2 seq & com dup/del
81212		302.06	Brca1&2 185&5385&6174 var
81213		996.05	Brca1&2 uncom dup/del var
81214		2458.23	Brca1 full seq & com dup/del
81215		159.38	Brca1 gene known fam variant
81217		159.38	Brca2 gene known fam variant
81218		564.09	Cebpa gene full sequence
81219		283.63	Calr gene com variants

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
81225		498.78	Cyp2c19 gene com variants
81226		771.92	Cyp2d6 gene com variants
81227		299.25	Cyp2c9 gene com variants
81235		564.09	Egfr gene com variants
81240		114.75	F2 gene
81241		142.49	F5 gene
81245		283.63	Flt3 gene
81246		142.15	Flt3 gene analysis
81256		152.42	Hfe gene
81261		461.70	Igh gene rearrange amp meth
81262		101.80	Igh gene rearrang dir probe
81263		686.80	Igh vari regional mutation
81264		348.21	Igk rearrangeabn clonal pop
81265		501.48	Str markers specimen anal
81267		483.79	Chimerism anal no cell selec
81268		608.14	Chimerism anal w/cell select
81270		213.76	Jak2 gene
81272		564.09	Kit gene targeted seq analys
81273		213.76	Kit gene analys d816 variant
81275		337.57	Kras gene
81276		337.57	Kras gene addl variants
81287		142.24	Mgmt gene methylation anal
81288		273.29	Mlh1 gene
81291		101.80	Mthfr gene
81292		1104.63	Mlh1 gene full seq
81293		442.82	Mlh1 gene known variants
81294		325.92	Mlh1 gene dup/delete variant
81295		259.32	Msh2 gene full seq
81296		221.43	Msh2 gene known variants
81297		259.32	Msh2 gene dup/delete variant
81298		492.00	Msh6 gene full seq
81299		275.62	Msh6 gene known variants
81300		276.37	Msh6 gene dup/delete variant
81301		675.24	Microsatellite instability
81310		422.45	Npm1 gene
81311		506.36	Nras gene variants exon 2&3
81313		445.54	Pca3/klk3 antigen
81314		564.09	Pdgfra gene

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
81315		483.45	Pml/raralpha com breakpoints
81316		737.39	Pml/raralpha 1 breakpoint
81317		1335.49	Pms2 gene full seq analysis
81318		315.55	Pms2 known familial variants
81319		378.90	Pms2 gene dup/delet variants
81321		1026.80	Pten gene full sequence
81322		99.82	Pten gene known fam variant
81323		149.74	Pten gene dup/delet variant
81327		142.24	Sept9 methylation analysis
81332		101.80	Serpina1 gene
81340		487.19	Trb@ gene rearrange amplify
81341		115.63	Trb@ gene rearrange dirprobe
81342		469.88	Trg gene rearrangement anal
81370		937.74	Hla i & ii typing lr
81371		561.29	Hla i & ii type verify lr
81372		515.13	Hla i typing complete lr
81373		259.69	Hla i typing 1 locus lr
81374		169.64	Hla i typing 1 antigen lr
81375		514.76	Hla ii typing ag equiv lr
81376		285.02	Hla ii typing 1 locus lr
81377		214.10	Hla ii type 1 ag equiv lr
81378		805.85	Hla i & ii typing hr
81379		782.10	Hla i typing complete hr
81380		413.34	Hla i typing 1 locus hr
81381		220.56	Hla i typing 1 allele hr
81382		288.42	Hla ii typing 1 loc hr
81383		254.49	Hla ii typing 1 allele hr
81410		0.00	Aortic dysfunction/dilation
81411		0.00	Aortic dysfunction/dilation
81412		1023.57	Ashkenazi jewish assoc dis
81413		1363.96	Car ion chnnlpath inc 10 gns
81414		1363.96	Car ion chnnlpath inc 2 gns
81415		0.00	Exome sequence analysis
81416		0.00	Exome sequence analysis
81417		0.00	Exome re-evaluation
81420		1363.96	Fetal chrmoml aneuploidy
81422		1363.96	Fetal chrmoml microdeltj
81425		0.00	Genome sequence analysis

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
81426		0.00	Genome sequence analysis
81427		0.00	Genome re-evaluation
81430		0.00	Hearing loss sequence analys
81431		0.00	Hearing loss dup/del analys
81432		1583.52	Hrdtry brst ca-rlatd dsordrs
81433		1023.57	Hrdtry brst ca-rlatd dsordrs
81434		1023.57	Hereditary retinal disorders
81435		1363.96	Hereditary colon cancer
81436		1363.96	Hereditary colon ca synd
81437		1023.57	Heredtry nurondcrn tum dsrdr
81438		1023.57	Heredtry nurondcrn tum dsrdr
81439		1363.96	Inherited cardmypthy 5 gns
81440		0.00	Mitochondrial gene
81442		1023.57	Noonan spectrum disorders
81445		1023.57	Targeted genomic seq analys
81450		1110.00	Targeted genomic seq analys
81455		0.00	Targeted genomic seq analys
81460		0.00	Whole mitochondrial genome
81465		0.00	Whole mitochondrial genome
81470		0.00	X-linked intellectual dblt
81471		0.00	X-linked intellectual dblt
81490		1004.04	Autoimmune rheumatoid arthr
81493		1772.00	Cor artery disease mrna
81519		5853.71	Oncology breast mrna
81525		5313.74	Oncology colon mrna
81528		871.13	Oncology colorectal scr
81535		991.98	Oncology gynecologic
81536		303.96	Oncology gynecologic
81538		3615.53	Oncology lung
81539		1023.57	Oncology prostate prob score
81540		4964.51	Oncology tum unknown origin
81545		5478.08	Oncology thyroid
81595		4829.28	Cardiology hrt trnspl mrna
82009		10.54	Test for acetone/ketones
82010		19.06	Acetone assay
82010	QW	19.06	Acetone assay
82013		26.04	Acetylcholinesterase assay
82016		32.35	Acylcarnitines qual

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
82017		6.15	Acylcarnitines quant
82024		90.07	Assay of acth
82030		33.05	Assay of adp & amp
82040		11.54	Assay of serum albumin
82040	QW	11.54	Assay of serum albumin
82042		6.77	Assay of urine albumin
82042	QW	6.77	Assay of urine albumin
82043		13.48	Microalbumin quantitative
82043	QW	13.48	Microalbumin quantitative
82044		10.68	Microalbumin semiquant
82044	QW	10.68	Microalbumin semiquant
82045		76.04	Albumin ischemia modified
82075		28.10	Assay of breath ethanol
82085		22.64	Assay of aldolase
82088		95.03	Assay of aldosterone
82103		31.33	Alpha-1-antitrypsin total
82104		33.73	Alpha-1-antitrypsin pheno
82105		39.12	Alpha-fetoprotein serum
82106		39.12	Alpha-fetoprotein amniotic
82107		150.21	Alpha-fetoprotein l3
82108		59.42	Assay of aluminum
82120		4.03	Amines vaginal fluid qual
82120	QW	4.03	Amines vaginal fluid qual
82127		32.35	Amino acid single qual
82128		32.35	Amino acids mult qual
82131		39.34	Amino acids single quant
82135		38.37	Assay aminolevulinic acid
82136		6.15	Amino acids quant 2-5
82139		6.15	Amino acids quan 6 or more
82140		33.98	Assay of ammonia
82143		16.01	Amniotic fluid scan
82150		15.11	Assay of amylase
82150	QW	15.11	Assay of amylase
82154		34.80	Androstanediol glucuronide
82157		68.27	Assay of androstenedione
82160		58.31	Assay of androsterone
82163		47.86	Assay of angiotensin II
82164		34.05	Angiotensin I enzyme test

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
82172		36.14	Assay of apolipoprotein
82175		44.23	Assay of arsenic
82180		23.05	Assay of ascorbic acid
82190		34.77	Atomic absorption
82232		37.72	Assay of beta-2 protein
82239		19.67	Bile acids total
82240		29.84	Bile acids cholylglycine
82247		11.70	Bilirubin total
82247	QW	11.70	Bilirubin total
82248		11.70	Bilirubin direct
82252		3.26	Fecal bilirubin test
82261		6.15	Assay of biotinidase
82270		7.58	Occult blood feces
82271		7.58	Occult blood other sources
82271	QW	7.58	Occult blood other sources
82272		7.58	Occult bld feces 1-3 tests
82274		37.09	Assay test for blood fecal
82274	QW	37.09	Assay test for blood fecal
82286		16.07	Assay of bradykinin
82300		53.98	Assay of cadmium
82306		69.04	Vitamin d 25 hydroxy
82308		62.48	Assay of calcitonin
82310		12.04	Assay of calcium
82310	QW	12.04	Assay of calcium
82330		31.89	Assay of calcium
82330	QW	31.89	Assay of calcium
82331		12.07	Calcium infusion test
82340		14.06	Assay of calcium in urine
82355		27.00	Calculus analysis qual
82360		30.02	Calculus assay quant
82365		30.07	Calculus spectroscopy
82370		29.21	X-ray assay calculus
82373		42.11	Assay c-d transfer measure
82374		6.63	Assay blood carbon dioxide
82374	QW	6.63	Assay blood carbon dioxide
82375		28.73	Assay carboxyhb quant
82376		11.63	Assay carboxyhb qual
82378		44.22	Carcinoembryonic antigen

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
82379		6.15	Assay of carnitine
82380		21.51	Assay of carotene
82382		40.09	Assay urine catecholamines
82383		58.43	Assay blood catecholamines
82384		58.89	Assay three catecholamines
82387		18.85	Assay of cathepsin-d
82390		25.04	Assay of ceruloplasmin
82397		18.85	Chemiluminescent assay
82415		29.55	Assay of chloramphenicol
82435		6.49	Assay of blood chloride
82435	QW	6.49	Assay of blood chloride
82436		11.73	Assay of urine chloride
82438		11.39	Assay other fluid chlorides
82441		14.01	Test for chlorohydrocarbons
82465		10.15	Assay bld/serum cholesterol
82465	QW	10.15	Assay bld/serum cholesterol
82480		18.36	Assay serum cholinesterase
82482		17.90	Assay rbc cholinesterase
82485		41.41	Assay chondroitin sulfate
82495		47.29	Assay of chromium
82507		64.84	Assay of citrate
82523		43.57	Collagen crosslinks
82523	QW	43.57	Collagen crosslinks
82525		28.93	Assay of copper
82528		52.51	Assay of corticosterone
82530		38.96	Cortisol free
82533		38.01	Total cortisol
82540		10.81	Assay of creatine
82542		42.11	Column chromotography quant
82550		15.18	Assay of ck (cpk)
82550	QW	15.18	Assay of ck (cpk)
82552		31.23	Assay of cpk in blood
82553		26.93	Creatine mb fraction
82554		27.68	Creatine isoforms
82565		11.95	Assay of creatinine
82565	QW	11.95	Assay of creatinine
82570		12.07	Assay of urine creatinine
82570	QW	12.07	Assay of urine creatinine

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
82575		22.05	Creatinine clearance test
82585		16.52	Assay of cryofibrinogen
82595		15.08	Assay of cryoglobulin
82600		45.24	Assay of cyanide
82607		35.16	Vitamin B-12
82608		33.39	B-12 binding capacity
82610		13.21	Cystatin c
82615		19.04	Test for urine cystines
82626		58.94	Dehydroepiandrosterone
82627		51.85	Dehydroepiandrosterone
82633		72.25	Desoxycorticosterone
82634		68.27	Deoxycortisol
82638		28.56	Assay of dibucaine number
82652		89.78	Vit d 1 25-dihydroxy
82656		26.89	Pancreatic elastase fecal
82657		42.11	Enzyme cell activity
82658		42.11	Enzyme cell activity ra
82664		80.10	Electrophoretic test
82668		43.83	Assay of erythropoietin
82670		65.14	Assay of estradiol
82671		75.33	Assay of estrogens
82672		50.59	Assay of estrogen
82677		56.39	Assay of estriol
82679		58.19	Assay of estrone
82679	QW	58.19	Assay of estrone
82693		34.75	Assay of ethylene glycol
82696		55.00	Assay of etiocholanolone
82705		11.88	Fats/lipids feces qual
82710		39.19	Fats/lipids feces quant
82715		23.17	Assay of fecal fat
82725		31.04	Assay of blood fatty acids
82726		42.11	Long chain fatty acids
82728		31.79	Assay of ferritin
82731		150.21	Assay of fetal fibronectin
82735		43.23	Assay of fluoride
82746		34.29	Assay of folic acid serum
82747		40.12	Assay of folic acid rbc
82757		18.17	Assay of semen fructose

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
82759		36.33	Assay of rbc galactokinase
82760		26.11	Assay of galactose
82775		49.13	Assay galactose transferase
82776		13.29	Galactose transferase test
82777		51.29	Galectin-3
82784		13.29	Assay iga/igd/igg/igm each
82785		38.39	Assay of ige
82787		10.71	Igg 1 2 3 or 4 each
82800		19.74	Blood pH
82803		45.12	Blood gases any combination
82805		66.16	Blood gases w/o2 saturation
82810		20.35	Blood gases o2 sat only
82820		22.59	Hemoglobin-oxygen affinity
82930		12.70	Gastric analy w/ph ea spec
82938		41.26	Gastrin test
82941		41.12	Assay of gastrin
82943		33.32	Assay of glucagon
82945		9.16	Glucose other fluid
82946		31.09	Glucagon tolerance test
82947		9.16	Assay glucose blood quant
82947	QW	9.16	Assay glucose blood quant
82948		7.40	Reagent strip/blood glucose
82950		11.07	Glucose test
82950	QW	11.07	Glucose test
82951		14.96	Glucose tolerance test (GTT)
82951	QW	14.96	Glucose tolerance test (GTT)
82952		9.15	GTT-added samples
82952	QW	9.15	GTT-added samples
82955		22.61	Assay of g6pd enzyme
82960		14.11	Test for G6PD enzyme
82962		4.20	Glucose blood test
82963		50.10	Assay of glucosidase
82965		18.02	Assay of gdh enzyme
82977		16.80	Assay of GGT
82977	QW	16.80	Assay of GGT
82978		24.82	Assay of glutathione
82979		16.07	Assay rbc glutathione
82985		35.16	Assay of glycated protein

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
82985	QW	35.16	Assay of glycated protein
83001		43.33	Assay of gonadotropin (fsh)
83001	QW	43.33	Assay of gonadotropin (fsh)
83002		43.18	Assay of gonadotropin (lh)
83002	QW	43.18	Assay of gonadotropin (lh)
83003		38.88	Assay growth hormone (hgh)
83006		51.29	Growth stimulation gene 2
83009		157.08	H pylori (c-13) blood
83010		15.45	Assay of haptoglobin quant
83012		40.09	Assay of haptoglobins
83013		157.08	H pylori (c-13) breath
83014		18.33	H pylori drug admin
83015		43.91	Heavy metal screen
83018		51.22	Quantitative screen metals
83020		27.10	Hemoglobin electrophoresis
83021		42.11	Hemoglobin chromotography
83026		5.51	Hemoglobin copper sulfate
83030		19.28	Fetal hemoglobin chemical
83033		13.91	Fetal hemoglobin assay qual
83036		22.64	Glycosylated hemoglobin test
83036	QW	22.64	Glycosylated hemoglobin test
83037		22.64	Glycosylated hb home device
83037	QW	22.64	Glycosylated hb home device
83045		11.54	Blood methemoglobin test
83050		17.09	Blood methemoglobin assay
83051		8.16	Assay of plasma hemoglobin
83060		19.28	Blood sulfhemoglobin assay
83065		16.07	Assay of hemoglobin heat
83068		19.74	Hemoglobin stability screen
83069		9.21	Assay of urine hemoglobin
83070		11.07	Assay of hemosiderin qual
83080		6.15	Assay of b hexosaminidase
83088		68.87	Assay of histamine
83090		39.34	Assay of homocystine
83150		45.12	Assay of homovanillic acid
83491		40.87	Assay of corticosteroids 17
83497		30.07	Assay of 5-hiaa
83498		63.36	Assay of progesterone 17-d

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
83499		58.79	Assay of progesterone 20-
83500		52.82	Assay free hydroxyproline
83505		56.68	Assay total hydroxyproline
83516		26.89	Immunoassay nonantibody
83516	QW	26.89	Immunoassay nonantibody
83518		19.77	Immunoassay dipstick
83518	QW	19.77	Immunoassay dipstick
83519		31.50	Ria nonantibody
83520		30.19	Immunoassay quant nos nonab
83520	QW	30.19	Immunoassay quant nos nonab
83525		26.66	Assay of insulin
83527		29.53	Assay of insulin
83528		37.09	Assay of intrinsic factor
83540		15.10	Assay of iron
83550		20.38	Iron binding test
83570		20.64	Assay of idh enzyme
83582		33.05	Assay of ketogenic steroids
83586		29.85	Assay 17- ketosteroids
83593		61.34	Fractionation ketosteroids
83605		3.26	Assay of lactic acid
83605	QW	3.26	Assay of lactic acid
83615		14.08	Lactate (LD) (LDH) enzyme
83625		13.86	Assay of ldh enzymes
83630		45.78	Lactoferrin fecal (qual)
83631		45.78	Lactoferrin fecal (quant)
83632		47.16	Placental lactogen
83633		12.82	Test urine for lactose
83655		28.24	Assay of lead
83655	QW	28.24	Assay of lead
83661		23.17	L/s ratio fetal lung
83662		44.10	Foam stability fetal lung
83663		44.10	Fluoro polarize fetal lung
83664		44.10	Lamellar bdy fetal lung
83670		21.37	Assay of lap enzyme
83690		16.07	Assay of lipase
83695		30.19	Assay of lipoprotein(a)
83698		76.04	Assay lipoprotein pla2
83700		23.04	Lipopro bld electrophoretic

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
83701		57.89	Lipoprotein bld hr fraction
83704		73.58	Lipoprotein bld by nmr
83718		19.11	Assay of lipoprotein
83718	QW	19.11	Assay of lipoprotein
83719		27.13	Assay of blood lipoprotein
83721		22.25	Assay of blood lipoprotein
83721	QW	22.25	Assay of blood lipoprotein
83727		40.09	Assay of lrh hormone
83735		15.62	Assay of magnesium
83775		17.19	Assay malate dehydrogenase
83785		57.36	Assay of manganese
83789		42.11	Mass spectrometry quant
83825		37.91	Assay of mercury
83835		39.51	Assay of metanephrines
83857		25.04	Assay of methemalbumin
83861		38.52	Microfluid analy tears
83861	QW	38.52	Microfluid analy tears
83864		46.44	Mucopolysaccharides
83872		13.67	Assay synovial fluid mucin
83873		40.12	Assay of csf protein
83874		30.12	Assay of myoglobin
83876		76.04	Assay myeloperoxidase
83880		76.04	Assay of natriuretic peptide
83880	QW	76.04	Assay of natriuretic peptide
83883		13.21	Assay nephelometry not spec
83885		57.15	Assay of nickel
83915		26.01	Assay of nucleotidase
83916		46.90	Oligoclonal bands
83918		38.37	Organic acids total quant
83919		38.37	Organic acids qual each
83921		38.37	Organic acid single quant
83930		15.42	Assay of blood osmolality
83935		15.90	Assay of urine osmolality
83937		34.80	Assay of osteocalcin
83945		30.02	Assay of oxalate
83950		150.21	Oncoprotein her-2/neu
83951		150.21	Oncoprotein dcp
83970		96.25	Assay of parathormone

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
83986		8.35	Assay ph body fluid nos
83986	QW	8.35	Assay ph body fluid nos
83987		37.04	Exhaled breath condensate
83992		34.29	Assay for phencyclidine
83993		45.78	Assay for calprotectin fecal
84030		12.82	Assay of blood pku
84035		7.14	Assay of phenylketones
84060		17.22	Assay acid phosphatase
84061		18.45	Phosphatase forensic exam
84066		22.53	Assay prostate phosphatase
84075		12.07	Assay alkaline phosphatase
84075	QW	12.07	Assay alkaline phosphatase
84078		17.02	Assay alkaline phosphatase
84080		34.48	Assay alkaline phosphatases
84081		38.52	Assay phosphatidylglycerol
84085		15.73	Assay of rbc pg6d enzyme
84087		24.07	Assay phosphohexose enzymes
84100		11.05	Assay of phosphorus
84105		12.07	Assay of urine phosphorus
84106		9.91	Test for porphobilinogen
84110		19.69	Assay of porphobilinogen
84112		150.21	Placenta alpha micro ig c/v
84119		20.09	Test urine for porphyrins
84120		34.31	Assay of urine porphyrins
84126		59.40	Assay of feces porphyrins
84132		10.73	Assay of serum potassium
84132	QW	10.73	Assay of serum potassium
84133		10.05	Assay of urine potassium
84134		13.21	Assay of prealbumin
84135		44.63	Assay of pregnanediol
84138		44.15	Assay of pregnanetriol
84140		34.80	Assay of pregnenolone
84143		34.80	Assay of 17-hydroxypregneno
84144		36.33	Assay of progesterone
84145		62.48	Procalcitonin (pct)
84146		45.19	Assay of prolactin
84150		58.19	Assay of prostaglandin
84152		42.89	Assay of psa complexed

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
84153		42.89	Assay of psa total
84154		42.89	Assay of psa free
84155		8.55	Assay of protein serum
84155	QW	8.55	Assay of protein serum
84156		8.55	Assay of protein urine
84157		8.55	Assay of protein other
84157	QW	8.55	Assay of protein other
84160		12.07	Assay of protein any source
84163		35.11	Pappa serum
84165		25.04	Protein e-phoresis serum
84166		41.58	Protein e-phoresis/urine/csf
84181		39.71	Western blot test
84182		41.97	Protein western blot test
84202		33.46	Assay RBC protoporphyrin
84203		20.08	Test RBC protoporphyrin
84206		41.41	Assay of proinsulin
84207		65.52	Assay of vitamin b-6
84210		25.31	Assay of pyruvate
84220		22.02	Assay of pyruvate kinase
84228		27.13	Assay of quinine
84233		150.21	Assay of estrogen
84234		151.30	Assay of progesterone
84235		122.04	Assay of endocrine hormone
84238		85.27	Assay nonendocrine receptor
84244		51.29	Assay of renin
84252		47.19	Assay of vitamin b-2
84255		59.53	Assay of selenium
84260		43.37	Assay of serotonin
84270		50.68	Assay of sex hormone globul
84275		31.33	Assay of sialic acid
84285		54.89	Assay of silica
84295		11.22	Assay of serum sodium
84295	QW	11.22	Assay of serum sodium
84300		11.34	Assay of urine sodium
84302		11.34	Assay of sweat sodium
84305		45.80	Assay of somatomedin
84307		42.62	Assay of somatostatin
84311		16.30	Spectrophotometry

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
84315		5.85	Body fluid specific gravity
84375		5.58	Chromatogram assay sugars
84376		12.82	Sugars single qual
84377		12.82	Sugars multiple qual
84378		26.88	Sugars single quant
84379		26.88	Sugars multiple quant
84392		11.07	Assay of urine sulfate
84402		59.40	Assay of free testosterone
84403		60.20	Assay of total testosterone
84410		123.34	Testosterone bioavailable
84425		49.50	Assay of vitamin b-1
84430		27.13	Assay of thiocyanate
84431		39.19	Thromboxane urine
84432		35.65	Assay of thyroglobulin
84436		16.01	Assay of total thyroxine
84437		15.08	Assay of neonatal thyroxine
84439		19.01	Assay of free thyroxine
84442		27.10	Assay of thyroid activity
84443		39.19	Assay thyroid stim hormone
84443	QW	39.19	Assay thyroid stim hormone
84445		118.59	Assay of tsi globulin
84446		33.07	Assay of vitamin e
84449		34.80	Assay of transcortin
84450		12.07	Transferase (AST) (SGOT)
84450	QW	12.07	Transferase (AST) (SGOT)
84460		12.36	Alanine amino (ALT) (SGPT)
84460	QW	12.36	Alanine amino (ALT) (SGPT)
84466		29.77	Assay of transferrin
84478		13.40	Assay of triglycerides
84478	QW	13.40	Assay of triglycerides
84479		15.08	Assay of thyroid (t3 or t4)
84480		33.07	Assay triiodothyronine (t3)
84481		39.51	Free assay (FT-3)
84482		36.75	T3 reverse
84484		15.59	Assay of troponin quant
84485		9.91	Assay duodenal fluid trypsin
84488		9.91	Test feces for trypsin
84490		13.29	Assay of feces for trypsin

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
84510		24.26	Assay of tyrosine
84512		17.95	Assay of troponin qual
84520		9.21	Assay of urea nitrogen
84520	QW	9.21	Assay of urea nitrogen
84525		4.03	Urea nitrogen semi-quant
84540		11.07	Assay of urine/urea-n
84545		15.42	Urea-N clearance test
84550		10.54	Assay of blood/uric acid
84550	QW	10.54	Assay of blood/uric acid
84560		11.07	Assay of urine/uric acid
84577		29.10	Assay of feces/urobilinogen
84578		3.26	Test urine urobilinogen
84580		16.54	Assay of urine urobilinogen
84583		11.73	Assay of urine urobilinogen
84585		36.14	Assay of urine vma
84586		34.80	Assay of vip
84588		76.04	Assay of vasopressin
84590		27.06	Assay of vitamin a
84591		27.06	Assay of nos vitamin
84597		31.99	Assay of vitamin k
84600		37.50	Assay of volatiles
84620		27.63	Xylose tolerance test
84630		26.55	Assay of zinc
84681		40.53	Assay of c-peptide
84702		35.11	Chorionic gonadotropin test
84703		16.30	Chorionic gonadotropin assay
84703	QW	16.30	Chorionic gonadotropin assay
84704		35.11	Hcg free betachain test
84830		23.39	Ovulation tests
85002		10.52	Bleeding time test
85004		11.63	Automated diff wbc count
85007		8.01	Bl smear w/diff wbc count
85008		8.01	Bl smear w/o diff wbc count
85009		8.69	Manual diff wbc count b-coat
85013		5.53	Spun microhematocrit
85014		5.53	Hematocrit
85014	QW	5.53	Hematocrit
85018		5.53	Hemoglobin

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
85018	QW	5.53	Hemoglobin
85025		16.49	Complete cbc w/auto diff wbc
85027		11.63	Complete cbc automated
85032		10.05	Manual cell count each
85041		7.04	Automated rbc count
85044		10.05	Manual reticulocyte count
85045		9.32	Automated reticulocyte count
85046		12.99	Reticyte/hgb concentrate
85048		5.92	Automated leukocyte count
85049		10.44	Automated platelet count
85055		42.19	Reticulated platelet assay
85130		16.49	Chromogenic substrate assay
85170		8.45	Blood clot retraction
85175		10.63	Blood clot lysis time
85210		30.28	Clot factor ii prothrom spec
85220		41.16	Blooc clot factor v test
85230		41.75	Clot factor vii proconvertin
85240		41.75	Clot factor viii ahg 1 stage
85244		47.62	Clot factor viii reltd antgn
85245		53.50	Clot factor viii vw ristoctn
85246		53.50	Clot factor viii vw antigen
85247		53.50	Clot factor viii multimetric
85250		44.40	Clot factor ix ptc/chrstmas
85260		41.75	Clot factor x stuart-power
85270		41.75	Clot factor xi pta
85280		45.12	Clot factor xii hageman
85290		38.10	Clot factor xiii fibrin stab
85291		20.74	Clot factor xiii fibrin scrn
85292		44.15	Clot factor fletcher fact
85293		44.15	Clot factor wght kininogen
85300		27.64	Antithrombin iii activity
85301		25.21	Antithrombin iii antigen
85302		28.02	Clot inhibit prot c antigen
85303		32.27	Clot inhibit prot c activity
85305		27.06	Clot inhibit prot s total
85306		35.73	Clot inhibit prot s free
85307		35.73	Assay activated protein c
85335		21.49	Factor inhibitor test

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
85337		24.31	Thrombomodulin
85345		10.05	Coagulation time lee & white
85347		9.93	Coagulation time activated
85348		8.69	Coagulation time otr method
85360		10.80	Euglobulin lysis
85362		16.07	Fibrin degradation products
85366		20.09	Fibrinogen test
85370		26.49	Fibrinogen test
85378		16.64	Fibrin degrade semiquant
85379		18.89	Fibrin degradation quant
85380		18.89	Fibrin degradj d-dimer
85384		19.81	Fibrinogen activity
85385		19.81	Fibrinogen antigen
85390		9.91	Fibrinolysins screen i&r
85397		53.50	Clotting funct activity
85400		20.64	Fibrinolytic plasmin
85410		16.52	Fibrinolytic antiplasmin
85415		40.09	Fibrinolytic plasminogen
85420		15.23	Fibrinolytic plasminogen
85421		23.75	Fibrinolytic plasminogen
85441		9.79	Heinz bodies direct
85445		15.90	Heinz bodies induced
85460		18.04	Hemoglobin fetal
85461		15.47	Hemoglobin fetal
85475		20.69	Hemolysin acid
85520		24.82	Heparin assay
85525		27.61	Heparin neutralization
85530		33.07	Heparin-protamine tolerance
85536		15.08	Iron stain peripheral blood
85540		20.06	Wbc alkaline phosphatase
85547		20.06	RBC mechanical fragility
85549		43.72	Muramidase
85555		15.59	RBC osmotic fragility
85557		31.14	RBC osmotic fragility
85576		50.10	Blood platelet aggregation
85576	QW	50.10	Blood platelet aggregation
85597		35.84	Phospholipid pltlt neutraliz
85598		35.84	Hexagnal phosph pltlt neutrl

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
85610		9.16	Prothrombin time
85610	QW	9.16	Prothrombin time
85611		9.20	Prothrombin test
85612		22.34	Viper venom prothrombin time
85613		22.34	Russell viper venom diluted
85635		22.97	Reptilase test
85651		8.28	Rbc sed rate nonautomated
85652		6.29	Rbc sed rate automated
85660		12.85	RBC sickle cell test
85670		13.45	Thrombin time plasma
85675		15.96	Thrombin time titer
85705		16.30	Thromboplastin inhibition
85730		14.01	Thromboplastin time partial
85732		15.08	Thromboplastin time partial
85810		27.22	Blood viscosity examination
86000		16.29	Agglutinins febrile antigen
86001		11.17	Allergen specific igg
86003		11.17	Allergen specific IgE
86005		16.34	Allergen specific IgE
86021		35.11	WBC antibody identification
86022		42.84	Platelet antibodies
86023		29.05	Immunoglobulin assay
86038		28.19	Antinuclear antibodies
86039		26.03	Antinuclear antibodies (ANA)
86060		13.12	Antistreptolysin o titer
86063		8.30	Antistreptolysin o screen
86140		12.07	C-reactive protein
86141		30.19	C-reactive protein hs
86146		35.65	Beta-2 glycoprotein antibody
86147		35.65	Cardiolipin antibody ea ig
86148		37.47	Anti-phospholipid antibody
86152		572.97	Cell enumeration & id
86155		36.33	Chemotaxis assay
86156		15.62	Cold agglutinin screen
86157		18.80	Cold agglutinin titer
86160		27.98	Complement antigen
86161		27.98	Complement/function activity
86162		47.40	Complement total (ch50)

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
86171		23.34	Complement fixation each
86185		20.88	Counterimmunoelectrophoresis
86200		30.19	Ccp antibody
86215		30.89	Deoxyribonuclease antibody
86225		32.05	Dna antibody native
86226		28.24	Dna antibody single strand
86235		34.83	Nuclear antigen antibody
86243		47.84	Fc receptor
86255		28.10	Fluorescent antibody screen
86256		28.10	Fluorescent antibody titer
86277		36.70	Growth hormone antibody
86280		19.11	Hemagglutination inhibition
86294		45.76	Immunoassay tumor qual
86294	QW	45.76	Immunoassay tumor qual
86300		48.54	Immunoassay tumor ca 15-3
86301		48.54	Immunoassay tumor ca 19-9
86304		48.54	Immunoassay tumor ca 125
86305		48.54	Human epididymis protein 4
86308		12.07	Heterophile antibody screen
86308	QW	12.07	Heterophile antibody screen
86309		15.08	Heterophile antibody titer
86310		17.19	Heterophile antibody absrbj
86316		48.54	Immunoassay tumor other
86317		34.95	Immunoassay infectious agent
86318		30.19	Immunoassay infectious agent
86318	QW	30.19	Immunoassay infectious agent
86320		52.28	Serum immunoelectrophoresis
86325		52.16	Other immunoelectrophoresis
86327		52.90	Immunoelectrophoresis assay
86329		32.76	Immunodiffusion nes
86331		27.93	Immunodiffusion ouchterlony
86332		40.15	Immune complex assay
86334		52.11	Immunofix e-phoresis serum
86335		68.44	Immunfix e-phorsis/urine/csf
86336		30.21	Inhibin A
86337		49.93	Insulin antibodies
86340		35.16	Intrinsic factor antibody
86341		31.31	Islet cell antibody

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
86343		29.05	Leukocyte histamine release
86344		18.62	Leukocyte phagocytosis
86352		316.83	Cell function assay w/stim
86353		114.33	Lymphocyte transformation
86355		41.41	B cells total count
86356		42.19	Mononuclear cell antigen
86357		41.41	Nk cells total count
86359		41.41	T cells total count
86360		82.81	T cell absolute count/ratio
86361		42.19	T cell absolute count
86367		41.41	Stem cells total count
86376		33.93	Microsomal antibody each
86378		45.92	Migration inhibitory factor
86382		39.44	Neutralization test viral
86384		26.55	Nitroblue tetrazolium dye
86386		37.25	Nuclear matrix protein 22
86386	QW	37.25	Nuclear matrix protein 22
86403		16.30	Particle agglut antbdy scrn
86406		24.80	Particle agglut antbdy titr
86430		13.23	Rheumatoid factor test qual
86431		13.23	Rheumatoid factor quant
86480		144.53	Tb test cell immun measure
86481		174.74	Tb ag response t-cell susp
86590		24.82	Streptokinase antibody
86592		9.96	Syphilis test non-trep qual
86593		10.27	Syphilis test non-trep quant
86602		23.73	Antinomyces antibody
86603		26.16	Adenovirus antibody
86606		32.79	Aspergillus antibody
86609		30.04	Bacterium antibody
86611		23.73	Bartonella antibody
86612		26.16	Blastomyces antibody
86615		30.75	Bordetella antibody
86617		36.13	Lyme disease antibody
86618		39.71	Lyme disease antibody
86618	QW	39.71	Lyme disease antibody
86619		31.20	Borrelia antibody
86622		19.07	Brucella antibody

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
86625		30.60	Campylobacter antibody
86628		28.00	Candida antibody
86631		27.57	Chlamydia antibody
86632		29.58	Chlamydia igm antibody
86635		26.16	Coccidioides antibody
86638		26.16	Q fever antibody
86641		16.30	Cryptococcus antibody
86644		33.56	CMV antibody
86645		33.30	Cmv antibody igm
86648		35.46	Diphtheria antibody
86651		30.75	Encephalitis californ antbdy
86652		30.75	Encephaltis east eqne anbdy
86653		30.75	Encephaltis st louis antbody
86654		30.75	Encephaltis west eqne antbdy
86658		26.16	Enterovirus antibody
86663		30.60	Epstein-barr antibody
86664		33.30	Epstein-barr nuclear antigen
86665		33.30	Epstein-barr capsid vca
86666		23.73	Ehrlichia antibody
86668		18.17	Francisella tularensis
86671		26.16	Fungus nes antibody
86674		33.30	Giardia lamblia antibody
86677		33.83	Helicobacter pylori antibody
86682		24.12	Helminth antibody
86684		16.30	Hemophilus influenza antibdy
86687		19.57	Htlv-i antibody
86688		23.27	Htlv-ii antibody
86689		45.14	Htlv/hiv confirmj antibody
86692		40.02	Hepatitis delta agent antbdy
86694		33.56	Herpes simplex nes antbdy
86695		30.75	Herpes simplex type 1 test
86696		45.14	Herpes simplex type 2 test
86698		26.16	Histoplasma antibody
86701		20.72	Hiv-1antibody
86701	QW	20.72	Hiv-1antibody
86702		23.27	Hiv-2 antibody
86703		23.27	Hiv-1/hiv-2 1 result antbdy
86704		28.10	Hep b core antibody total

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
86705		27.46	Hep b core antibody igm
86706		25.04	Hep b surface antibody
86707		26.98	Hepatitis be antibody
86708		28.88	Hepatitis a total antibody
86709		26.25	Hepatitis a igm antibody
86710		31.60	Influenza virus antibody
86711		33.56	John cunningham antibody
86713		33.30	Legionella antibody
86717		28.56	Leishmania antibody
86720		30.75	Leptospira antibody
86723		30.75	Listeria monocytogenes
86727		26.16	Lymph choriomeningitis ab
86729		27.85	Lympho venereum antibody
86732		30.75	Mucormycosis antibody
86735		30.43	Mumps antibody
86738		30.87	Mycoplasma antibody
86741		30.75	Neisseria meningitidis
86744		30.75	Nocardia antibody
86747		35.05	Parvovirus antibody
86750		30.75	Malaria antibody
86753		24.12	Protozoa antibody nos
86756		30.06	Respiratory virus antibody
86757		45.14	Rickettsia antibody
86759		30.75	Rotavirus antibody
86762		33.56	Rubella antibody
86765		30.04	Rubeola antibody
86768		30.75	Salmonella antibody
86771		30.75	Shigella antibody
86774		34.51	Tetanus antibody
86777		33.56	Toxoplasma antibody
86778		33.30	Toxoplasma antibody igm
86780		30.87	Treponema pallidum
86780	QW	30.87	Treponema pallidum
86784		14.82	Trichinella antibody
86787		30.04	Varicella-zoster antibody
86788		33.30	West nile virus ab igm
86789		33.56	West nile virus antibody
86790		30.04	Virus antibody nos

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
86793		30.75	Yersinia antibody
86800		37.09	Thyroglobulin antibody
86803		33.27	Hepatitis c ab test
86803	QW	33.27	Hepatitis c ab test
86804		36.13	Hep c ab test confirm
86805		121.94	Lymphocytotoxicity assay
86806		110.98	Lymphocytotoxicity assay
86807		92.29	Cytotoxic antibody screening
86808		69.21	Cytotoxic antibody screening
86812		60.18	Hla typing a b or c
86813		74.46	Hla typing a b or c
86816		64.96	Hla typing dr/dq
86817		150.14	Hla typing dr/dq
86821		131.67	Lymphocyte culture mixed
86822		85.26	Lymphocyte culture primed
86825		126.60	Hla x-math non-cytotoxic
86826		42.19	Hla x-match noncytotoxc addl
86828		92.29	Hla class i&ii antibody qual
86829		69.21	Hla class i/ii antibody qual
86830		188.28	Hla class i phenotype qual
86831		161.38	Hla class ii phenotype qual
86832		295.87	Hla class i high defin qual
86833		268.97	Hla class ii high defin qual
86834		833.82	Hla class i semiquant panel
86835		753.13	Hla class ii semiquant panel
86850		8.93	Rbc antibody screen
86880		12.56	Coombs test direct
86885		13.35	Coombs test indirect qual
86886		12.07	Coombs test indirect titer
86900		6.97	Blood typing abo
86901		6.97	Blood typing rh (d)
86902		8.93	Blood type antigen donor ea
86904		22.19	Blood typing patient serum
86905		8.93	Blood typing rbc antigens
86906		14.96	Blood typing rh phenotype
86940		19.13	Hemolysins/agglutinins auto
86941		28.24	Hemolysins/agglutinins
87003		39.27	Small animal inoculation

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
87015		15.57	Specimen infect agnt concntj
87040		24.07	Blood culture for bacteria
87045		22.02	Feces culture aerobic bact
87046		22.02	Stool cultr aerobic bact ea
87070		20.09	Culture othr specimn aerobic
87071		22.02	Culture aerobic quant other
87073		22.02	Culture bacteria anaerobic
87075		22.08	Cultr bacteria except blood
87076		16.52	Culture anaerobe ident each
87077		16.52	Culture aerobic identify
87077	QW	16.52	Culture aerobic identify
87081		15.45	Culture screen only
87084		20.09	Culture of specimen by kit
87086		18.82	Urine culture/colony count
87088		18.87	Urine bacteria culture
87101		17.97	Skin fungi culture
87102		19.60	Fungus isolation culture
87103		21.03	Blood fungus culture
87106		24.07	Fungi identification yeast
87107		24.07	Fungi identification mold
87109		35.89	Mycoplasma
87110		45.70	Chlamydia culture
87116		25.19	Mycobacteria culture
87118		25.52	Mycobacteric identification
87140		12.99	Culture type immunofluoresc
87143		29.21	Culture typing glc/hplc
87147		12.07	Culture type immunologic
87149		46.77	Dna/rna direct probe
87150		81.84	Dna/rna amplified probe
87152		12.21	Culture type pulse field gel
87153		269.01	Dna/rna sequencing
87158		12.21	Culture typing added method
87164		25.04	Dark field examination
87166		26.35	Dark field examination
87168		9.96	Macroscopic exam arthropod
87169		9.96	Macroscopic exam parasite
87172		9.96	Pinworm exam
87176		13.72	Tissue homogenization cultr

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
87177		20.76	Ova and parasites smears
87181		11.07	Microbe susceptible diffuse
87184		16.08	Microbe susceptible disk
87185		11.07	Microbe susceptible enzyme
87186		20.16	Microbe susceptible mic
87187		24.17	Microbe susceptible mlc
87188		15.49	Microbe suscept macrobroth
87190		9.91	Microbe suscept mycobacteri
87197		35.04	Bactericidal level serum
87205		9.96	Smear gram stain
87206		12.56	Smear fluorescent/acid stai
87207		13.29	Smear special stain
87209		39.90	Smear complex stain
87210		9.96	Smear wet mount saline/ink
87210	QW	9.96	Smear wet mount saline/ink
87220		9.96	Tissue exam for fungi
87230		46.04	Assay toxin or antitoxin
87250		45.61	Virus inoculate eggs/animal
87252		60.79	Virus inoculation tissue
87253		47.11	Virus inoculate tissue addl
87254		45.61	Virus inoculation shell via
87255		78.97	Genet virus isolate hsv
87260		27.95	Adenovirus ag if
87265		27.95	Pertussis ag if
87267		27.95	Enterovirus antibody dfa
87269		27.95	Giardia ag if
87270		27.95	Chlamydia trachomatis ag if
87271		27.95	Cytomegalovirus dfa
87272		27.95	Cryptosporidium ag if
87273		27.95	Herpes simplex 2 ag if
87274		27.95	Herpes simplex 1 ag if
87275		27.95	Influenza b ag if
87276		27.95	Influenza a ag if
87277		27.95	Legionella micdadei ag if
87278		27.95	Legion pneumophilia ag if
87279		27.95	Parainfluenza ag if
87280		27.95	Respiratory syncytial ag if
87281		27.95	Pneumocystis carinii ag if

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
87283		27.95	Rubeola ag if
87285		27.95	Treponema pallidum ag if
87290		27.95	Varicella zoster ag if
87299		27.95	Antibody detection nos if
87300		27.95	Ag detection polyval if
87301		27.95	Adenovirus ag eia
87305		27.95	Aspergillus ag eia
87320		27.95	Chylmd trach ag eia
87324		27.95	Clostridium ag eia
87327		27.95	Cryptococcus neoform ag eia
87328		27.95	Cryptosporidium ag eia
87329		27.95	Giardia ag eia
87332		27.95	Cytomegalovirus ag eia
87335		27.95	E coli 0157 ag eia
87336		27.95	Entamoeb hist dispr ag eia
87337		27.95	Entamoeb hist group ag eia
87338		27.98	Hpylori stool eia
87338	QW	27.98	Hpylori stool ia
87339		27.95	H pylori ag eia
87340		24.09	Hepatitis b surface ag eia
87341		24.09	Hepatitis b surface ag eia
87350		26.88	Hepatitis be ag eia
87380		38.27	Hepatitis delta ag eia
87385		27.95	Histoplasma capsul ag eia
87389		56.15	Hiv-1 ag w/hiv-1 & hiv-2 ab
87389	QW	56.15	Hiv-1 ag w/hiv-1 & hiv-2 ab
87390		41.14	Hiv-1 ag eia
87391		41.14	Hiv-2 ag eia
87400		27.95	Influenza a/b ag eia
87420		27.95	Resp syncytial ag eia
87425		27.95	Rotavirus ag eia
87427		27.95	Shiga-like toxin ag eia
87430		27.95	Strep a ag eia
87449		27.95	Ag detect nos eia mult
87449	QW	27.95	Ag detect nos eia mult
87450		22.37	Ag detect nos eia single
87451		22.37	Ag detect polyval eia mult
87470		46.77	Bartonella dna dir probe

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
87471		81.84	Bartonella dna amp probe
87472		99.89	Bartonella dna quant
87475		46.77	Lyme dis dna dir probe
87476		81.84	Lyme dis dna amp probe
87477		99.89	Lyme dis dna quant
87480		46.77	Candida dna dir probe
87481		81.84	Candida dna amp probe
87482		97.38	Candida dna quant
87483		971.92	Cns dna amp probe type 12-25
87485		46.77	Chylmd pneum dna dir probe
87486		81.84	Chylmd pneum dna amp probe
87487		99.89	Chylmd pneum dna quant
87490		46.77	Chylmd trach dna dir probe
87491		81.84	Chylmd trach dna amp probe
87492		81.52	Chylmd trach dna quant
87493		81.84	C diff amplified probe
87495		46.77	Cytomeg dna dir probe
87496		81.84	Cytomeg dna amp probe
87497		99.89	Cytomeg dna quant
87498		81.84	Enterovirus probe&revrs trns
87500		81.84	Vanomycin dna amp probe
87501		119.66	Influenza dna amp prob 1+
87502		198.44	Influenza dna amp probe
87502	QW	198.44	Influenza dna amp probe
87503		48.43	Influenza dna amp prob addl
87505		299.17	Nfct agent detection gi
87506		497.71	Iadna-dna/rna probe tq 6-11
87507		971.92	Iadna-dna/rna probe tq 12-25
87510		46.77	Gardner vag dna dir probe
87511		81.84	Gardner vag dna amp probe
87512		97.38	Gardner vag dna quant
87515		46.77	Hepatitis b dna dir probe
87516		81.84	Hepatitis b dna amp probe
87517		99.89	Hepatitis b dna quant
87520		46.77	Hepatitis c rna dir probe
87521		81.84	Hepatitis c probe&rvrs trnsc
87522		99.89	Hepatitis c revrs trnscrpj
87525		46.77	Hepatitis g dna dir probe

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
87526		81.84	Hepatitis g dna amp probe
87527		97.38	Hepatitis g dna quant
87528		46.77	Hsv dna dir probe
87529		81.84	Hsv dna amp probe
87530		99.89	Hsv dna quant
87531		46.77	Hhv-6 dna dir probe
87532		81.84	Hhv-6 dna amp probe
87533		97.38	Hhv-6 dna quant
87534		46.77	Hiv-1 dna dir probe
87535		81.84	Hiv-1 probe&reverse trnscrpj
87536		198.44	Hiv-1 quant&revrse trnscrpj
87537		46.77	Hiv-2 dna dir probe
87538		81.84	Hiv-2 probe&revrse trnscripj
87539		99.89	Hiv-2 quant&revrse trnscripj
87540		46.77	Legion pneumo dna dir prob
87541		81.84	Legion pneumo dna amp prob
87542		97.38	Legion pneumo dna quant
87550		46.77	Mycobacteria dna dir probe
87551		81.84	Mycobacteria dna amp probe
87552		99.89	Mycobacteria dna quant
87555		46.77	M.tuberculo dna dir probe
87556		81.84	M.tuberculo dna amp probe
87557		99.89	M.tuberculo dna quant
87560		46.77	M.avium-intra dna dir prob
87561		81.84	M.avium-intra dna amp prob
87562		99.89	M.avium-intra dna quant
87580		46.77	M.pneumon dna dir probe
87581		81.84	M.pneumon dna amp probe
87582		97.38	M.pneumon dna quant
87590		46.77	N.gonorrhoeae dna dir prob
87591		81.84	N.gonorrhoeae dna amp prob
87592		99.89	N.gonorrhoeae dna quant
87623		81.84	Hpv low-risk types
87624		81.84	Hpv high-risk types
87625		81.84	Hpv types 16 & 18 only
87631		299.17	Resp virus 3-11 targets
87631	QW	299.17	Resp virus 3-5 targets
87632		497.71	Resp virus 6-11 targets

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
87633		971.92	Resp virus 12-25 targets
87640		81.84	Staph a dna amp probe
87641		81.84	Mr-staph dna amp probe
87650		46.77	Strep a dna dir probe
87650	QW	46.77	Strep a dna dir probe
87651		81.84	Strep a dna amp probe
87651	QW	81.84	Strep a dna amp probe
87652		97.38	Strep a dna quant
87653		81.84	Strep b dna amp probe
87660		46.77	Trichomonas vagin dir probe
87661		81.84	Trichomonas vaginalis amplif
87797		46.77	Detect agent nos dna dir
87798		81.84	Detect agent nos dna amp
87799		99.89	Detect agent nos dna quant
87800		93.55	Detect agnt mult dna direc
87801		163.69	Detect agnt mult dna ampli
87802		27.95	Strep b assay w/optic
87803		27.95	Clostridium toxin a w/optic
87804		27.95	Influenza assay w/optic
87804	QW	27.95	Influenza assay w/optic
87806		56.15	Hiv antigen w/hiv antibodies
87806	QW	56.15	Hiv antigen w/hiv antibodies
87807		27.95	Rsv assay w/optic
87807	QW	27.95	Rsv assay w/optic
87808		27.95	Trichomonas assay w/optic
87808	QW	27.95	Trichomonas assay w/optic
87809		27.95	Adenovirus assay w/optic
87809	QW	27.95	Adenovirus assay w/optic
87810		27.95	Chylmd trach assay w/optic
87850		27.95	N. gonorrhoeae assay w/optic
87880		27.95	Strep a assay w/optic
87880	QW	27.95	Strep a assay w/optic
87899		27.95	Agent nos assay w/optic
87899	QW	27.95	Agent nos assay w/optic
87900		303.96	Phenotype infect agent drug
87901		600.36	Genotype dna hiv reverse t
87902		600.36	Genotype dna/rna hep c
87903		1139.53	Phenotype dna hiv w/culture

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
87904		60.79	Phenotype dna hiv w/clt add
87905		12.22	Sialidase enzyme assay
87905	QW	12.22	Sialidase enzyme assay
87906		300.19	Genotype dna/rna hiv
87910		600.36	Genotype cytomegalovirus
87912		600.36	Genotype dna hepatitis b
88130		35.11	Sex chromatin identification
88140		6.77	Sex chromatin identification
88142		47.24	Cytopath c/v thin layer
88143		47.24	Cytopath c/v thin layer redo
88147		26.54	Cytopath c/v automated
88148		35.43	Cytopath c/v auto rescreen
88150		24.63	Cytopath c/v manual
88152		24.63	Cytopath c/v auto redo
88153		24.63	Cytopath c/v redo
88154		24.63	Cytopath c/v select
88155		13.97	Cytopath c/v index add-on
88164		24.63	Cytopath tbs c/v manual
88165		24.63	Cytopath tbs c/v redo
88166		24.63	Cytopath tbs c/v auto redo
88167		24.63	Cytopath tbs c/v select
88174		49.83	Cytopath c/v auto in fluid
88175		61.78	Cytopath c/v auto fluid redo
88230		85.99	Tissue culture lymphocyte
88233		171.94	Tissue culture skin/biopsy
88235		171.94	Tissue culture placenta
88237		294.54	Tissue culture bone marrow
88239		344.01	Tissue culture tumor
88240		23.55	Cell cryopreserve/storage
88241		23.55	Frozen cell preparation
88245		347.14	Chromosome analysis 20-25
88248		403.84	Chromosome analysis 50-100
88249		403.84	Chromosome analysis 100
88261		412.17	Chromosome analysis 5
88262		290.67	Chromosome analysis 15-20
88263		350.47	Chromosome analysis 45
88264		290.67	Chromosome analysis 20-25
88267		419.24	Chromosome analys placenta

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
88269		387.87	Chromosome analys amniotic
88271		49.95	Cytogenetics dna probe
88272		62.44	Cytogenetics 3-5
88273		74.92	Cytogenetics 10-30
88274		81.18	Cytogenetics 25-99
88275		93.65	Cytogenetics 100-300
88280		58.51	Chromosome karyotype study
88283		159.97	Chromosome banding study
88285		44.30	Chromosome count additional
88289		80.29	Chromosome study additional
88371		51.78	Protein western blot tissue
88372		46.07	Protein analysis w/probe
88720		11.70	Bilirubin total transcut
88738		11.70	Hgb quant transcutaneous
88740		11.70	Transcutaneous carboxyhb
88741		11.70	Transcutaneous methb
89050		9.91	Body fluid cell count
89051		12.84	Body fluid cell count
89055		9.96	Leukocyte assessment fecal
89060		16.68	Exam synovial fluid crystals
89125		10.08	Specimen fat stain
89160		8.30	Exam feces for meat fibers
89190		8.30	Nasal smear for eosinophils
89300		20.83	Semen analysis w/huhner
89300	QW	20.83	Semen analysis w/huhner
89310		14.82	Semen analysis w/count
89320		28.10	Semen anal vol/count/mot
89321		28.10	Semen anal sperm detection
89321	QW	28.10	Semen anal sperm detection
89322		36.14	Semen anal strict criteria
89325		18.17	Sperm antibody test
89329		48.89	Sperm evaluation test
89330		23.07	Evaluation cervical mucus
89331		45.68	Retrograde ejaculation anal
0006M		0.00	Onc hep gene risk classifier
0007M		0.00	Onc gastro 51 gene nomogram
0008M		5853.71	Onc breast risk score
0009M		1023.57	Fetal aneuploidy trisom risk

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
ATP02		12.16	Auto.Test Panel Pricing Code, 1-2 Tests
ATP03		15.50	Auto.Test Panel Pricing Code, 3 Tests
ATP04		16.35	Auto.Test Panel Pricing Code, 4 Tests
ATP05		18.24	Auto.Test Panel Pricing Code, 5 Tests
ATP06		18.29	Auto.Test Panel Pricing Code, 6 Tests
ATP07		19.06	Auto.Test Panel Pricing Code, 7 Tests
ATP08		19.72	Auto.Test Panel Pricing Code, 8 Tests
ATP09		20.25	Auto.Test Panel Pricing Code, 9 Tests
ATP10		20.25	Auto.Test Panel Pricing Code, 10 Tests
ATP11		20.60	Auto.Test Panel Pricing Code, 11 Tests
ATP12		21.06	Auto.Test Panel Pricing Code, 12 Tests
ATP16		24.63	Auto Test Panel Pricing Code 13-16 Test
ATP18		24.82	Auto Test Panel Pricing Code, 17-18 Test
ATP19		25.81	Auto Test Panel Pricing Code, 19 Tests
ATP20		26.62	Auto Test Panel Pricing Code, 20 Tests
ATP21		27.47	Auto Test Panel Pricing Code, 21 Tests
ATP22		28.29	Auto.Test Panel Pricing Code, 22+ Tests
ATP23		28.29	Auto.Test Panel Pricing Code, 23+ Tests
G0027		15.16	Semen analysis
G0103		42.89	PSA screening
G0123		47.24	Screen cerv/vag thin layer
G0143		47.24	Scr c/v cyto,thinlayer,rescr
G0144		49.83	Scr c/v cyto,thinlayer,rescr
G0145		61.78	Scr c/v cyto,thinlayer,rescr
G0147		26.54	Scr c/v cyto, automated sys
G0148		35.43	Scr c/v cyto, autosys, rescr
G0306		16.49	CBC/diffwbc w/o platelet
G0307		11.63	CBC without platelet
G0328		37.09	Fecal blood scrn immunoassay
G0328	QW	37.09	Fecal blood scrn immunoassay
G0432		23.27	EIA HIV-1/HIV-2 screen
G0433		23.27	ELISA HIV-1/HIV-2 screen
G0433	QW	23.27	ELISA HIV-1/HIV-2 screen
G0435		27.95	Oral HIV-1/HIV-2 screen
G0471		8.50	Ven blood coll SNF/HHA
G0472		33.27	Hep c screen high risk/other
G0472	QW	33.27	Hep c screen high risk/other
G0475		56.15	Hiv combination assay

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
G0476		81.84	Hpv combo assay ca screen
G0480		200.01	Drug test def 1-7 classes
G0481		273.68	Drug test def 8-14 classes
G0482		347.38	Drug test def 15-21 classes
G0483		431.58	Drug test def 22+ classes
G0659		135.68	Drug test def simple all cl
G9143		281.50	Warfarin respon genetic test
P2038		11.73	Blood mucoprotein
P3000		24.63	Screen pap by tech w md supv
P9612		5.10	Catheterize for urine spec
P9615		5.10	Urine specimen collect mult
Q0111		9.96	Wet mounts/ w preparations
Q0112		9.96	Potassium hydroxide preps
Q0113		12.61	Pinworm examinations
Q0114		16.68	Fern test
Q0115		23.07	Post-coital mucous exam