# DEPARTMENT OF LABOR AND EMPLOYMENT

## Division of Workers' Compensation

### 7 CCR 1101-3

### WORKERS' COMPENSATION RULES OF PROCEDURE

## Rule 18 MEDICAL FEE SCHEDULE

### 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 herein the 2014 edition of the Relative Values for Physicians (RVP©), developed by Relative Value Studies, Inc., published by OPTUMINSIGHT (Ingenix®), the Current Procedural Terminology CPT® 2014, Professional Edition, published by the American Medical Association (AMA) and Medicare Severity Diagnosis Related Groups (MS-DRGs) Definitions Manual, Version 32.0 developed and published by 3M Health Information Systems using MS-DRGs effective after October 1, 2014. 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 RVP©, 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, 2015. 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® 2014, 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 32.0 incorporated by reference in 18-1.

(D) RVP© – the 2014 edition incorporated by reference in 18-1.

(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 copies of all materials incorporated by reference in Rule 18. Copies of the RVP© may be purchased from Ingenix® OptumInsight, the Current Procedural Terminology, 2014 Edition may be purchased from the AMA, the MS-DRGs Definitions Manual may be purchased from 3M Health Information Systems, and 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 fee. The maximum fee is determined by multiplying the following section CFs by the established relative value unit(s) (RVU) found in the corresponding RVP© sections:

| RVP© SECTION | CF |
|---|---|
| Anesthesia | $ 53.73/RVU |
| Surgery | $ 99.83/RVU |
| Radiology | $ 18.41/RVU |
| Pathology | $ 13.72/RVU |
| Medicine | $ 8.33/RVU |
| Physical Medicine (Physical Medicine and Rehabilitation, Medical Nutrition Therapy and Acupuncture) | $ 6.23/RVU |
| Evaluation & Management (E&M) | $ 10.16/RVU |

## 18-5 INSTRUCTIONS AND/OR MODIFICATIONS TO THE DOCUMENTS INCORPORATED BY REFERENCE IN RULE 18-1

(A) Maximum allowance for all providers under Rule 16-5 is 100% of the RVP© value or as defined in this Rule.

(B) Unless modified herein, the RVP© is adopted for RVUs and reimbursement. Interim relative value procedures (marked by an "I" in the left-hand margin of the RVP©) are accepted as a basis of payment for services; however deleted CPT® codes (marked by an "M" in the RVP©) are not, unless otherwise advised by this Rule. Division created codes (Zxxxx) and values supersede CPT® or RVP© codes and reimbursement levels. Those codes listed with RVUs of "BR" (by report) and "RNE" (relativity not established) require prior authorization as explained in Rule 16. The CPT® 2014 is adopted for codes, descriptions, parenthetical notes and coding guidelines, unless modified in this Rule.

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).

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.

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

(D) Surgery/Anesthesia

(1) Anesthesia Section:

(a) All anesthesia base values shall be established by the use of the codes as set forth in the RVP©, Anesthesia Section. 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:

1) CRNAs not under the medical direction of an anesthesiologist, reimbursement shall be 90% of the maximum anesthesia value;

2) 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;

3) Medical direction for administering the anesthesia includes performing the following activities:

a) Performs a pre-anesthesia examination and evaluation,

b) Prescribes the anesthesia plan,

c) Personally participates in the most demanding procedures in the anesthesia plan including induction and emergence,

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

e) Monitors the course of anesthesia administration at frequent intervals,

f) Remains physically present and available for immediate diagnosis and treatment of emergencies, and

g) Provides indicated post-anesthesia care.

(b) Anesthesia physical status modifiers and qualifying circumstances are reimbursed using the anesthesia CF and unit values found in the RVP©, Anesthesia section’s Guidelines XI “Physical Status Modifiers” and XII, “Qualifying Circumstances.”

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

AA – anesthesia services performed personally by the anesthesiologist

AD – greater than four (4) concurrent (occurring at the same time) anesthesia service cases being supervised by an anesthesiologist

QK – anesthesiologist providing direction to qualified individuals of two (2) to four (4) concurrent anesthesia cases

QX – CRNA or AA service; with medical direction by a physician

QZ – CRNA service; without medical direction by a physician

QY – Medical direction of one CRNA or AA by an anesthesiologist

QS – Monitored anesthesia care service (MAC)

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

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

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

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

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

(f) Qualifying circumstance codes are reimbursed using the medicine conversion factor:

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

(g) 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.

(h) 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.

(i) Calculation of Maximum Fees for Anesthesia

Base Anesthesia value from the RVP© Anesthesia Guidelines

+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

"Qualifying circumstance" codes are reimbursed under section 18-5(D)(1)(f) of this Rule.

(j) Non-time based Anesthesia Procedures

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

The relative value units are located in the RVP© Anesthesia Guidelines, Paragraph XIV

(2) Surgical Section:

(a) The use of assistant surgeons shall be limited according to the American College Of Surgeons' Physicians as Assistants at Surgery: 2013 Study (January 2013), 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 16-9) is required.

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

(c) No payment shall be made for more than one (1) assistant surgeon or minimum assistant surgeon without prior authorization for payment (see Rule 16-9) unless a trauma team was activated due to the emergency nature of the injury(ies).

(d) 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 16-11(B)(4).

(e) 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, such as a physician's assistant, a nurse practitioner, or a clinical nurse specialist, is indicated by modifier -81 and reimbursed at 10% of the surgeon's fees.

(f) Global Period

1) All surgical procedures include the following:

a) Local infiltration, metacarpal/metatarsal/digital block or typical anesthesia;

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

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

d) Immediate postoperative care, including dictating operative notes, talking with the family and other physicians;

e) Evaluating the patient in the post-anesthesia recovery room;

f) Post-surgical pain management by the surgeon;

g) Typical postoperative follow-up care during the global period of the surgery that is related to recovery from the surgery as identified in RVP© 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 RVP©, begins the day after surgery and continues for the defined period.

h) Supplies – Except for those identified as exclusions;

i) 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, nasograstric and rectal tubes; changes and removal of tracheostomy tubes;

j) Applicable Surgical Modifiers:

- 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.

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

a) E&M services unrelated to the primary surgical procedure.

b) Services necessary to stabilize the patient for the primary surgical procedure.

c) 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.

d) 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.

e) Unusual circumstances, complications, exacerbations, or recurrences.

f) Unrelated diseases or injuries.

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

3) Separate identifiable services shall use an appropriate CPT®/RVP© modifier in conjunction with the billed service.

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

Multiple procedure guidelines do not apply to codes specifically identified as add-on procedures or to those specifically identified as exempt from modifier -51.

Bilateral procedures shall be billed on one line with one (1) unit and the modifier -50 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.

(h) The “Services with Significant Direct Costs” section of the RVP© is not adopted. Supplies shall be reimbursed as set out in section 18-6(H).

(i) 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.

(j) 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 is 11.8 RVUs and is paid using the surgical conversion factor.

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. G0289 is subject to the 50% multiple surgical reduction guidelines.

(k) Relative value units listed in the 2014 RVP© Surgery Section listed below shall be replaced as follows:

1) Epidural for blood or clot patch injection = 1.9

2) Epidurals diagnostic or therapeutic injections substance(s) including anesthetic antispasmodic, opioid, steroid, other solutions (NOT neurolytic substances) for subarachnoid

a) Cervical or thoracic level = 2.0

b) Lumbar or sacral (caudal) = 1.65

3) Epidurals (including indwelling catheter placement), for continuous infusion or intermittent bolus of diagnostic or therapeutic substance(s) including anesthetic, antispasmodic, opioid, steroid, other solutions (NOT neurolytic substances) for subarachnoid

   a) Cervical or thoracic level =1.85

   b) Lumbar or sacral (caudal) = 1.77

4) Somatic nerve injections:

   a) Greater occipital nerve= 1.5

   b) Spinal accessory nerve = 1.5

   c) Injection brachial plexus, continuous infusion by catheter (including catheter placement) = 1.0

   d) Regional block (intercostal) = 1.7

   e) Sciatic nerve, continuous infusion = 1.3

   f) Femoral nerve, single = 1.5

   g) Injection, femoral nerve, continuous infusion by catheter (including catheter placement) = 1.2

   h) Lumbar plexus, posterior approach, continuous infusion = 2.0

   i) Other peripheral nerve or branch = 1.25

5) Paravertebral facet joint injections:

   a) Single level cervical/thoracic levels = 2.0

   b) Second levels at cervical/thoracic = 1.25

   c) Third and any additional levels at cervical/thoracic = 1.10

6) Paravertebral facet joint injections:

   a) Single level lumbar/sacral levels = 1.75

   b) Second levels at lumbar/sacral = 1.0

   c) Third and any additional levels at lumbar/sacral = 1.0

7) Autonomic nerve injection

   a) Anesthetic agent, superior hypogastric plexus = 1.3

b) Anesthetic agent, lumbar or thoracic (paravertebral sympathetic) = 2.0

8) Destruction of nerve by neurolytic agent:

a) Trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch, second and third division branches at foramen ovale = 5.5

b) Intercostal nerve = 3.0

c) Pudendal nerve = 3.0

d) Paravertebral facet joints at cervical and thoracic single level = 4.4

e) Paravertebral facet joints at cervical and thoracic each additional level = 2.0

f) Paravertebral facet joints at lumbar or sacral single level = 4.2

g) Paravertebral facet joints at lumbar or sacral single each additional level = 1.8

h) Other peripheral nerve or branch = 1.6

i) Celiac plexus = 2.9

9) Functional Assessments related to spinal or sacroiliac joint injections shall be reimbursed in accordance with 18-6(G)(6).

10) Tympanic Membrane surgery:

a) Tympanic membrane repair, with or without site preparation of perforation for closure, with or without patch = 11.7

(I) Venipuncture for clinical laboratory testing maximum fee allowance is covered under Exhibit #8 of this Rule.

(E) Radiology Section:

(1) General

(a) The cost of dyes and contrast shall be reimbursed in accordance with 18-6(K)(2)c)4).

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

(c) The payer may use available billing information such as provider credential(s) and clinical record(s) to determine if an appropriate RVP©

modifier should have been used on the bill. To modify a billed code, refer to Rule 16-11(B)(4).

(d) 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.

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.

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.

(2) 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:

American Academy of Thermology;

American Chiropractic College of Infrared Imaging.

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

Complex Regional Pain Syndrome/Reflex Sympathetic Dystrophy (CRPS/RSD);

Sympathetically Maintained Pain (SMP);

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:

DoWC Z0200 Upper body w/ Autonomic Stress Testing $865.37

DoWC Z0201 Lower body w/Autonomic Stress Testing $865.37

(e) Prior authorization for payment (see Rule 16-9) 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).

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

(F) Pathology Section:

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 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 do not append the QW modifier to claim lines.

(1) 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 RVP© 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:

- physician blood bank services,
- cytopathology and cell marker study interpretations,
- cytogenics or molecular cytogenics interpretation and report,
- surgical pathology gross and microscopic and special stain groups 1 and 2 and histochemical stain, blood or bone marrow interpretations, and
- 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 RVP©, not DoWC Z0755.

(2) Drug Testing Codes and Values

(a) G0434 (Drug screen, other than chromatographic; any number of drug classes, by Clinical Laboratory Improvement Amendments (CLIA) waived test or moderate complexity test, per patient encounter) will be used to report very simple testing methods, such as dipsticks, cups, cassettes, and cards, that are interpreted visually, with the assistance of a scanner, or are read utilizing a moderately complex reader device outside the instrumented laboratory setting (i.e., non-instrumented devices). This code is also used to report any other type of drug screen testing using test(s) that are classified as CLIA moderate complexity test(s), keeping the following points in mind:

G0434 includes qualitative drug screen tests that are waived under CLIA as well as dipsticks, cups, cards, cassettes, etc. that are not CLIA waived.

(b) Only one (1) unit of service for code G0434 can be billed per patient encounter regardless of the number of drug classes tested and irrespective of the use or presence of the QW modifier on claim lines.

(c) G0431 (Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter) will be used to report more complex testing methods, such as multi-channel chemistry analyzers, where a more complex instrumented device is required to perform some or all of the screening tests for the patient. This code may only be reported if the drug screen test(s) is classified as CLIA high complexity test(s) with the following restrictions:

G0431 may only be reported when tests are performed using instrumented systems (i.e., durable systems capable of withstanding repeated use).

CLIA waived tests and comparable non-waived tests may not be reported under test code G0431; they must be reported under test code G0434.

CLIA moderate complexity tests should be reported under test code G0434 with one (1) Unit of Service (UOS).

G0431 may only be reported once per patient encounter.

Laboratories billing G0431 must not append the QW modifier to claim lines.

Maximum Fee Schedule values are listed under Exhibit #8 of this Rule.

(d) Drug testing shall be done prior to the initial long-term drug prescription being implemented 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:

(1) Concern regarding the functional status of the patient

(2) Abnormal results on previous testing

(3) Change in management of dosage or pain

(4) Chronic daily opioid dosage above 150 mg of morphine or equivalent

(e) Qualitative testing must meet one of the following criteria before performing a quantitative review:

(1) The results of the qualitative screen are presumptively positive; or

(2) Results of the qualitative screen are negative and this negative finding is inconsistent with the patient's medical history.

(f) Codes G0431 and G0434 in section 18-5(F)(2) are to be billed and used to determine Maximum Fee Schedule values instead of the codes listed under the "Drug Testing" subsection in the "Pathology and Laboratory Section" of CPT® and RVP©. Specific quantitative drug testing codes listed under other sections of the "Pathology and Laboratory Section" of CPT® and RVP© are still recognized.

(G) Medicine Section:

(1) Medicine home therapy services in the RVP© are not adopted. For appropriate codes see section 18-6(L), Home Therapy.

(2) Anesthesia qualifying circumstance values are reimbursed in accordance with the section 18-5(D)(1).

(3) Biofeedback

Prior authorization for payment (see Rule 16-9) shall be required from the payer for any treatment exceeding the treatment guidelines. A licensed physician or psychologist shall prescribe all services and include the number of sessions. Session notes shall be periodically reviewed by the prescribing physician or psychologist to determine the continued need for the service. All services shall be provided or supervised by an appropriate recognized provider as listed under Rule 16-5. Supervision shall be as defined in Rule 17, Medical Treatment Guidelines. Persons providing biofeedback shall be certified by the Biofeedback Certification International Alliance (BCIA), or be a licensed physician or psychologist, as listed under Rule 16-5(A)(1)(a) and (b) with evidence of equivalent biofeedback training. Providers who are performing Individual Psychophysiological therapy that incorporates Biofeedback with psychotherapy must be appropriately licensed by DORA to perform psychotherapy.

Maximum Fee Schedule values for biofeedback services shall be consistent with the values published in the RVP Errata Quarter 2 2014 as follows:

| | |
|---|---|
| Biofeedback training by any modality | 0.3/min |
| Biofeedback peri/uro/rectal | 0.3/min |

(4) Appendix J of the 2014 CPT® identifies mixed, motor and sensory nerve conduction studies and their appropriate billing.

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

(a) Prior authorization for payment (see Rule 16-9) 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 16-9) 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.

(6) Psychiatric/Psychological Services:

(a) A licensed psychologist (PsyD, PhD, EdD) is reimbursed a maximum of 100% of the medical fee listed in the RVP©. Other non-physician providers performing psychological/psychiatric services shall be paid at 75% of the fee allowed for physicians.

(b) Prior authorization for payment (see Rule 16-9) is required any time the following limitations are exceeded on a single day:

Psychiatric diagnostic evaluation, with or without medical services, per episode limit: 2 hours (bill the appropriate CPT® code for each hour.)

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

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

(c) Psychotherapy services limit: 60 min. per visit

Prior authorization for payment (see Rule 16-9) is required any time the 60 minutes per visit limitation is exceeded.

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 16-9) except where specifically addressed in Rule 17, Medical Treatment Guidelines.

(d) 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.

(7) Hyperbaric Oxygen Therapy Services

The maximum unit value shall be 24 units per session, instead of 14 units as listed in the RVP©.

(8) 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 RVP© 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.

(9) 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:

1) Resting Sweat Test

2) Stimulated Sweat Test

3) Resting Skin Temperature Test

4) 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 $1,007.00

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

(10) 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

1) 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

2) Professional/Supervisory /Interpretive

A specifically neurophysiology trained Colorado licensed physician 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 neuromonitoring physician, unless he/she is utilized in a specific case.

3) 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.

(11) Speech Therapy/Evaluation and Treatment

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

(12) 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.

(13) 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®/RVP© 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(L)(1).

(H) Physical Medicine and Rehabilitation:

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

(1) Prior authorization for payment (see Rule 16-9) is required for medical nutrition therapy.

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

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

The authorized treating provider shall obtain prior authorization for payment (see Rule 16-9) 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 16-9) 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.

(4) Interdisciplinary Rehabilitation Programs – Requires Prior Authorization for Payment (see Rule 16-9).

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.

(5) 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 16-9) 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.

Aquatic Therapy Services

The maximum unit value shall be 5 units per 15-minutes instead of the 4.5 units as listed in the RVP©.

Dry Needling of Trigger Points, Single or multiple needles,

DoWC Z0501 - initial 15 minutes of dry needling 5.4 RVUs

DoWC Z0502 - each add'l 15 minutes of dry needling 4.5 RVUs

(6) Modalities

RVP© 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 shall be billed using the education code in the Medicine section of the RVP©. Rental or purchase of a TENS unit requires prior authorization for payment (see Rule 16-9). For Maximum Fee Schedule value, see 18-6(H).

(7) 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. 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.

(b) 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. Physicians shall bill the appropriate E&M code from the E&M section of the RVP©.

(c) 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.

(d) Reimbursement to PTs, OTs, speech language pathologists and audiologists for coordination of care with professionals shall be based upon the telephone codes for qualified non-physician providers found in the RVP© Medicine Section. Coordination of care reimbursement is limited to telephone calls made to professionals outside of the therapist's/pathologist's/ audiologist's employment facility(ies) and/or to the injured worker or their family.

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

(8) Special Tests

The following respective tests are considered special tests:

- Job Site Evaluation
- Functional Capacity Evaluation
- Assistive Technology Assessment
- Speech
- Computer Enhanced Evaluation (DoWC Z0503)
- Work Tolerance Screening (DoWC Z0504)

(a) Billing Restrictions:

1) Job Site Evaluations require prior authorization for payment (see Rule 16-9) 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.

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

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

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

5) Data from computerized equipment shall always include the supporting analysis developed by the physical medicine professional before it is payable as a special test.

(b) 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.

(9) Supplies

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

(10) 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 1.5 RVU

(11) Non-Medical Facility

Fees, such as gyms, pools, etc., and training or supervision by non-medical providers require prior authorization for payment (see Rule 16-9) and a written negotiated fee.

(12) Unlisted Service Physical Medicine

All unlisted services or procedures require a report.

(13) 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 16-9).

(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 16-9).

(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:

1) 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.

2) If the frequency and duration is expected to exceed the Medical Treatment Guidelines' recommendation, prior authorization for payment is required (see Rule 16-9).

3) Provider Restrictions: All procedures must be performed by or under the onsite supervision of a physician, psychologist, PT, OT, speech language pathologist or audiologist.

(I) Evaluation and Management Section (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 assistants (PA). Medical record documentation shall encompass the "E&M Documentation Guidelines" criteria as adopted in Exhibit #7 of this Rule, to justify the billed level of E&M service. If 50% of the time spent for an E&M visit is shared decision making, disability counseling or coordination of care, then time can determine the level of E&M service. Documented telephonic or on-line communication time with the patient or other healthcare providers one (1) day prior or seven (7) days following the scheduled E&M visit, may be included in the calculation of total time.

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.

(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 16-9). The E&M Guideline criteria as specified in the RVP© E&M Section shall be used in all office visits to determine the appropriate level.

(4) Treating Physician Telephone or On-line Services

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 medical records/documentation specifies all the following:

1) The amount of time and date;

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

3) The specifics of the discussion and/or decision made during the communication.

(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) 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: $65.00 per 15 minutes billed to the requesting party.

(7) 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)).

(8) A consultation occurs when a treating physician seeks an opinion from another physician regarding a patient's diagnosis or treatment and meets the CPT® requirements for a consultation. 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).

(9) When 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.

(J) Telehealth

(1) Closely associated with telemedicine is the term "telehealth", which is often used to encompass a broader definition of remote health care that does not always involve clinical services. Videoconferencing, transmission of still images, e-health including patient portals, remote monitoring of vital signs and continuing medical education are all considered part of telemedicine and telehealth.

Telemental Health is a broad term that refers to providing mental healthcare from a distance. Video conferencing, transmission of still images, e-health including

patient portals, remote monitoring of vital signs and continuing medical education are all considered part of telemental health.

Services provided via telecommunications technologies are not covered if the client has access to a comparable service within 30 miles of his/her place of residence.

(2) Telehealth facilities can bill for the originating fee only if the patient's originating site is located in a:

(a) County outside of 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 within the Health Resources and Services Administration (HRSA).

Telehealth originating site facility fee:

Q3014 $35.00 /per 15 minutes

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

(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. Authorized originating sites are:

(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) 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 is acceptable 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) Communication Protocol

(a) Video conferencing is an advanced communication technology that may be used for telehealth.

(b) It is the originating site's required responsibility to establish provider and patient identity verification.

(7) Payment for telehealth services

(a) Telehealth consultations, emergency department or initial inpatient; 30 minutes communicating via telehealth

G0425 $187.95

(b) Telehealth consultations, emergency department or initial inpatient; 50 minutes communicating via telehealth

G0426 $256.69

(c) Telehealth consultations, emergency department or initial inpatient; 70 minutes communicating via telehealth

G0427 $375.88

(d) Follow up inpatient telehealth consultations;

| | | |
|---|---|---|
| G0406 | Follow up inpatient, limited (typically 15 min.) | $54.81 |
| G0407 | Follow up inpatient, intermediate (typically 25 min.) | $97.45 |
| G0408 | Follow up inpatient, complex (typically 35 min.) | $140.09 |

Subsequent inpatient hospital care services are limited to one telehealth visit every 3 days.

Subsequent nursing facility care services are limited to one telehealth visit every 30 days.

(e) For all other physician / psychologist telehealth services, the physician / psychologist shall bill the appropriate RVP© 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) physician / psychologist billed CPT® or HCPCS indicates the service was performed via interactive audio and video telecommunication systems. 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 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 16-9).

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

(1) Each meeting shall be at a minimum 15 minutes.

(2) A report or written record signed by the physician is required and shall include the following:

(a) Who was present at the meeting and their role at the meeting;

(b) Purpose of the meeting;

(c) A brief statement of recommendations and actions at the conclusion of the meeting;

(d) Documented time (both start and end times); and

(e) Billing code DoWC Z0701.

$75.00 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.

(B) Cancellation Fees for Payer Made Appointments

(1) A cancellation fee is payable only when a payer schedules an appointment the injured worker fails to keep, and the payer has not canceled three (3) business days prior to the appointment. The payer shall pay:

One-half of the usual fee for the scheduled services, or $150.00, whichever is less.

Cancellation Fee Billing Code: DoWC Z0720

(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. Reasonable cost for paper copies shall not exceed $18.53 for the first 10 or fewer pages, $0.85 per page for pages 11-40, and $0.57 per page thereafter. Actual postage or shipping costs and applicable sales tax, if any, may also be charged. The per-page fee for records copied from microfilm shall be $1.50 per page.

If the requester and provider agree, the copy may be provided on a disc. The fee will not exceed $14.00 per disc.

If the requester and provider agree and appropriate security is in place, including, but not limited to, compatible encryption, the copies may be submitted electronically. Requester and provider should attempt to agree on a reasonable fee. Absent an agreement to the contrary, the fee shall be $0.10 per page.

Copying charges do not apply for the initial submission of records that are part of the required documentation for billing.

Copying Fee Billing Code: DoWC Z0721

(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, 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

(3) Deposition:

Payment for a treating or non-treating provider's testimony at a deposition shall not exceed $325.00 per hour, billed in half-hour increments. Calculation of the provider's time shall be "portal to portal."

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: DoWC Z0734 $325.00 per hr.

Billed in half-hour increments

(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: DoWC Z0738 $450.00 per hour

(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

When physicians determine the injured worker is at MMI and has no permanent impairment, the physicians should be reimbursed an appropriate level of E&M service. The authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient should complete the Physician's Report of Workers' Compensation Injury (Closing Report), WC164 (see section 18-6(G)(2)). Reimbursement for the appropriate level of E&M service is only applicable if the physician examines the injured worker and meets the criteria as defined in the RVP©.

(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:

1) Fee for the Level II Accredited Authorized Treating Physician Providing Primary Care:

Bill DoWC Z0759 $355.00.

2) Fee for the Referral, Level II Accredited Authorized Physician:

Bill DoWC Z0760 $575.00.

(3) 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 RVP©.

4) Fee for a Multiple Impairment Evaluation Requiring More Than One (1) Level II Accredited Physician:

All physicians providing consulting services for the completion of a whole person impairment rating shall bill using the appropriate E&M consultation code and shall forward their portion of the rating to the authorized physician determining the combined whole person rating.

(G) Report Preparation

(1) Routine Reports

Providers shall submit routine reports free of charge as directed in Rule 16-7(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:

- Diagnostic testing
- Procedure reports
- Progress notes
- Office notes
- Operative reports
- 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 room 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:

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

2) The name of the 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.

(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 $47.00 Initial Report

DoWC Z0751 $47.00 Progress Report (Payer Requested or Provider Initiated)

DoWC Z0752 $47.00 Closing Report

DoWC Z0753 $47.00 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 $47.00 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) 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)(7)). 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 |
| IME/Report with patient exam | DoWC Code: | Z0756 |
| Lengthy Form Completion | DoWC Code: | Z0757 |
| 18-5(I)(7) meeting and report with Non-treating Physician | DoWC Code: | Z0758 |

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

| | | |
|---|---|---|
| CRS 8-43-404 IME Audio Recording | DoWC Code: $30.00 per exam | Z0766 |
| CRS 8-43-404 IME Audio copying fee | DoWC Code: $20.00 per copy | Z0767 |

(5) Chronic Opioid Management Report

(a) When the authorized treating physician prescribes long-term opioid treatment, s/he shall use the Division of Workers' Compensation Chronic Pain Disorder Medical Treatment Guidelines and also review the Colorado State Board of Medical Examiners' Policy #10-14, "Guidelines for the Use of Controlled Substances for the Treatment of Pain." Urine drug tests for chronic opioid management 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 chronic opioid compliance monitoring.

1) Drug testing shall be done prior to the initial long-term drug prescription being implemented and randomly repeated at least annually.

2) When drug screen tests are ordered, the authorized treating physician shall utilize the Colorado Prescription Drug Monitoring Program (PDMP).

3) 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:

   a) Concern regarding the functional status of the patient

   b) Abnormal results on previous testing

   c) Change in management of dosage or pain

   d) Chronic daily opioid dosage above 150 mg of morphine or equivalent

4) The opioids prescribed for long-term treatment (opioids being prescribed for >30 days for non-surgical cases and >30 days post procedure for surgical cases) shall be provided through a pharmacy.

5) The prescribing authorized treating physician shall review and integrate the screening results, PDMP, and the injured worker's past and current functional status on the prescribed levels of medications. A written report will document the treating physician's assessment of the patient's past and current functional status of work, leisure activities and activities of daily living competencies.

(b) Codes and maximum fees for the authorized treating physician for a written report with all the following review services completed and documented:

1) Ordering and reviewing drug tests

2) Ordering and reviewing PDMP results

3) Reviewing the medical records

4) Reviewing the injured workers' current functional status

5) Determining what actions, if any, need to be taken

6) Appropriate chronic pain diagnostic code (International Classification of Diseases (ICD))

Bill using code DoWC Z0765 $75.00 per 15 minutes
– maximum of 30 minutes per report

NOTE: This code is not to be used for acute or subacute pain management.

(6) Functional Assessments

(a) Pre-and post-injection assessments by a trained physician, nurse, physician's assistant, occupational therapist, physical therapist, or a medical assistant may be billed with spinal or sacroiliac (SI) joint injection codes. The following 3 elements are required:

1) A brief commentary on the procedures, including the anesthesia used in the injection and verification of the needle placement by fluoroscopy, CT or MRI.

2) 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.

3) 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.

(b) If all three elements are documented, the billing code and maximum fee is

as follows:

DoWC Z0770 $91.44 per episode of care; pre-and post, functional assessment related to spinal or SI joint injections.

(H) Supplies, Durable Medical Equipment (DME), 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, DME or drugs, including injectables, using Medicare's HCPCS Level II codes, when one exists, as established in the January 2014 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) schedule or 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 (last checked 08/14/14). The Medicare Part B Drug Average Sale Price (ASP) fees can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html.

(3) Payers shall pay medical professionals using Medicare's January 2014 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, the payer shall pay 120% of the cost for the item as indicated on the provider's invoice.

(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 2014 DMEPOS schedule. Otherwise, the supplier shall be reimbursed at 100% of Colorado Medicaid's July 2014 fee schedule. The Colorado Medicaid Fee Schedule can be found at: 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.

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

(6) 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.

(7) 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.

(8) 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) The maximum fee schedule allowance for CRT is 100% of Medicare's January 2014 DMEPOS Colorado HCPCS Level II listed fee values. The DMEPOS schedule can be found at:http://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html

(d) If no Medicare fee schedule value exists for the billed CRT HCPCS code, the Maximum Fee Schedule value is the published Manufacturer's Suggested Retail Price (MSRP), less 20%.

(I) Inpatient Hospital Facility Fees

(1) Provider Restrictions

All non-emergency, inpatient admissions require prior authorization for payment (see Rule 16-9).

(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:

1) Children's hospitals

2) Veterans' Administration hospitals

3) State psychiatric hospitals

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

1) Medicare certified Critical Access Hospitals (CAH) (listed in Exhibit #3 of this Rule)

2) Medicare certified long-term care hospitals

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

4) CDPHE licensed psychiatric facilities that are privately owned.

5) CDPHE licensed skilled nursing facilities (SNF).

(c) 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:

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

2) For trauma center activation allowance, (revenue codes 680-685) see section18-6(J)(6)(b)5).

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

(d) 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:

1) 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.

2) Each hospital's cost-to-charge ratio is given in Exhibit #2 of this Rule.

3) The “Difference” = “Hospital’s Cost” – “Maximum Fee Allowance” excluding any trauma center activation or organ acquisition allowance (see (c) above).

4) If the “Difference” is greater than $25,799.00, additional reimbursement is warranted. The additional reimbursement is determined by the following equation:

“Difference” x .80 = additional fee allowance

(e) Inpatient combined with Emergency Room Department (ERD), Trauma Center or organ acquisition reimbursement

1) If an injured worker is admitted to the hospital, the ERD reimbursement is included in the inpatient reimbursement under section 18-6 (I)(3),

2) 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)).

(f) 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.

(g) To comply with Rule 16-6(B), the payer shall compare each billed charge type:

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

- The trauma center activation billed charge to the trauma center activation allowance; and

- The organ acquisition charges to the organ acquisition maximum fees under section 18-6(I)(3)(h).

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.

(h) 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 16-9).

(b) A separate facility fee is only payable if the facility is licensed as a hospital 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 RVP© 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, ERD, Clinics, Urgent Care (UC) and diagnostic testing in the Radiology, Pathology or Medicine section of CPT®/RVP©.

(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):

1) Children’s hospitals

2) Veterans’ Administration hospitals

3) State psychiatric hospitals

(b) The following types of outpatient facilities are reimbursed at 80% of billed outpatient clinic facility charges only, except for any associated professional fees:

1) CAH facilities listed in Exhibit #3 of this Rule.

(c) Exhibit #4 to this Rule

Hospital reimbursement is based upon Medicare’s 2014 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:

- Column 1 lists the APC code number.

- Column 2 lists APC code description.
- Column 3 is used to determine maximum fees for all Outpatient Hospital Emergency Room Departments (ERDs).
- Column 4 is used to determine maximum fees for all hospital facilities not listed under sections18-6(J)(3)(a) and (b).
- Column 5 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 2014 Addendum B. Grouper code 210 in Exhibit #4 was created by the Division to reimburse RVP© spinal fusion codes not listed in Medicare's Hospital Outpatient Prospective Payment System, Addendum B.

(4) The APC Exhibit #4 values include the following packaged revenue codes inclusive of the following services and may not be billed separately (all surgically implanted items that remain in the body post-surgery are separately payable at cost to the facility):

(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.

| 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; except surgically implanted items |
| 0279 | Medical/Surgical Supplies and Devices; except surgically implanted items |
| 0280 | Oncology; General Classification |
| 0289 | Oncology; Other Oncology |

| Packaged Services | |
|---|---|
| Revenue Code | Description |
| 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 |

| Packaged Services | |
|---|---|
| Revenue Code | Description |
| 0824 | Hemodialysis-Outpatient or Home; Maintenance - 100% |
| 0825 | Hemodialysis-Outpatient or Home; Support Services |
| 0829 | Hemodialysis-Outpatient or Home; Other OP Hemodialysis |
| 0942 | Other Therapeutic Services (also see 095X, an extension of 094x); Education/Training |
| 0943 | Other Therapeutic Services (also see 095X, an extension of 094X), Cardiac Rehabilitation |
| 0948 | Other Therapeutic Services (also see 095X, an extension of 094X), Pulmonary Rehabilitation |

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

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

(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 16-9.

(d) "F" means corneal tissue acquisition, 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.

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

(f) "H" means a "Pass-Through Device" that is separately payable under Exhibit #4 based upon cost to the facility. Any surgically implanted items are allowed at "cost" to the facility.

(g) "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.

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

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

(j) "M" means not separately payable unless separate fees are applicable under another section of this Rule, such as home health.

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

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

(m) "R" means separate payment for blood and blood products.

(n) "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.

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

(p) "X" represents Ancillary Services and is separately payable.

(q) "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:

- Hospital Outpatient ERD bills are reimbursed based upon Column 3;
- Hospitals are reimbursed based upon Column 4.
- ASCs are reimbursed based upon Column 5.

(b) Fees in addition to section 18-6(J)(6) and requirements necessary to be reimbursed under Column 3 from Exhibit #4 for an Outpatient Hospital ERD Column:

1) Outpatient ERDs within Colorado must be physically located within a hospital licensed by the CDPHE as a general hospital; or

2) Free-standing ERD, must have equivalent operations as a licensed ERD; or

3) Meets the out-of-state facility's state's licensure requirements.

4) The ERD "Level of Care" is identified based upon one (1) of five (5) levels of care. 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 (ERD 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 ERD levels or critical care codes shall be paid).

5) 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

a) These fees are in addition to ERD and inpatient fees.

b) Activation fees mean a trauma team has been activated, not just alerted.

c) The level of trauma activation shall be determined by CDPHE's assigned hospital trauma level designation.

6) The hospital shall be paid an outlier threshold payment if the hospital's cost is greater than its maximum fee per billed line by $500.00. The outlier calculation is as follows:

- "Cost" is calculated by taking the individual hospital's "CCR" rate listed in Exhibit #2 of this Rule and multiplying it by the hospital's line charge.
- "Difference" is equal to the Hospital's line cost subtracted from the line maximum fee.
- If the line "difference" is greater than $500.00, then the maximum outlier dollar is 80% of the difference. If the difference is equal to or less than $500.00 then no additional outlier dollars are warranted.

7) For the purposes of Rule 16-6 (B), the sum of all outpatient ERD fees charged, less any amounts charged for professional fees found on the same bill, is to be compared to the maximum reimbursement allowed by the calculated value of seciton18-6(J)(6)(b). The lesser of the two (2) amounts shall be the maximum facility allowance for the ERD episode of care. A line by line comparison is not appropriate.

8) If an injured worker is admitted to the hospital through that hospital's ERD, the ERD reimbursement is included in the inpatient reimbursement under section 18-6(I)(3).

(c) Multiple APCs identified by multiple CPT® codes are to be indicated by the use of modifiers –51 and –50, respectively. The 50% reduction applies to all lower valued procedures, even if they are identified in the RVP© as modifier -51 exempt. The reduction also applies to the second "primary" procedure of bilateral procedures.

1) 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.

2) 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.

3) 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.

4) 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.

5) 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.

(d) 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 RVP©.

(e) Observation room Maximum Fee Schedule value is limited to six (6) hours without prior authorization for payment (see Rule 16-9). 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.

(f) 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:

- ambulance services (Revenue Code 540), see section18-6(Q)
- blood, blood plasma, platelets (Revenue Codes 380X)
- Physician or physician assistant services
- Nurse practitioner services
- Licensed clinical psychologist
- Licensed social workers
- Rehabilitation services (PT, OT, Respiratory or Speech/Language, Revenue Codes 420, 430,440) are paid based upon the RVP© unit value multiplied by the applicable conversion factor.

(g) 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(M).

(h) Outpatient Hospital Clinic and Urgent Care (Form Locator (FL) 4 are 07xx and revenue codes 51x-53x) Facility Fees

Clinic Visit fees are limited for all facilities in accordance with the following:

1) No separate facility fees are allowed for follow-up care visits. Subsequent care for an initial diagnosis does not qualify for a separate facility fee. To receive another facility fee, any subsequent diagnosis shall be a new acute care situation entirely different from the initial diagnosis.

2) 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.

3) Any specialty care clinic (wound/infections) that require expensive drugs/supplies that are typically not provided by a physician’s office may be allowed a separate clinic fee with prior approval from the payer as outlined in Exhibit #4.

4) Clinics designated as critical access hospitals (CAH) as listed in Exhibit #3 or rural health facilities as listed in Exhibit #5 (FL4 071x) of this Rule, may be reimbursed a separate clinic fee at 80% of billed charges regardless of whether the clinic is designated by the employer or the time of day or urgency of the episode of care.

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

(i) IV Infusions Performed in Outpatient Hospital Facilities

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

(K) Freestanding (Not Affiliated with a Hospital) Outpatient Diagnostic Testing or Treatment Facilities

(1) Types of facilities

(a) Ambulatory Surgery Centers licensed by the CDPHE

(b) Physician offices

(c) Freestanding Radiology Imaging Cardiovascular Testing and Procedure Centers

(d) Freestanding Clinical Laboratory Centers

(e) Urgent Care - facility fees are only payable if the facility qualifies as an Urgent Care facility. Facilities licensed by the CDPHE as a Community Clinic (CC) or a Community Clinic and Emergency Center (CCEC) under 6 CCR 1011-1, Chapter IX should still provide evidence of these qualifications to be reimbursed as an Urgent Care facility. The facility shall meet all of the following criteria to be eligible for a separate Urgent Care facility fee:

1) Separate facility dedicated to providing initial walk-in urgent care;

2) Access without appointment during all operating hours;

3) State licensed physician on-site at all times exclusively to evaluate walk-in patients;

4) Support staff dedicated to urgent walk-in visits with certifications in Basic Life Support (BLS);

5) Advanced Cardiac Life Support (ACLS) certified life support capabilities to stabilize emergencies including, but not limited to, EKG, defibrillator, oxygen and respiratory support equipment (full crash cart), etc.;

6) Ambulance access;

7) Professional staff on-site at the facility certified in ACLS;

8) Extended hours including evening and some weekend hours;

9) Basic x-ray availability on-site during all operating hours;

10) Clinical Laboratory Improvement Amendments (CLIA) certified laboratory on-site for basic diagnostic labs or ability to obtain basic laboratory results within 1 hour;

11) Capabilities include, but are not limited to, suturing, minor procedures, splinting, IV medications and hydration; and

12) Written procedures exist for the facility's stabilization and transport processes.

(2) Billing and Maximum Fees

(a) ASCs are reimbursed in accordance with section18-6(J) and Column 5 from Exhibit #4 of this Rule.

(b) Maximum reimbursement for physicians performing diagnostic testing in their offices during the course of their care shall be based upon the appropriate RVP© unit value multiplied by the applicable 18-4 conversion factor.

(c) Maximum Fees for all Freestanding Diagnostic Testing Facilities:

1) All providers should indicate whether they are billing for the professional component only (26 modifier) or technical component only (TC modifier) for any diagnostic test or procedure by listing the appropriate RVP© modifier on the required billing form CMS-1500.

2) Shall be based upon the appropriate RVP© unit value multiplied by the applicable 18-4 conversion factor.

3) All radiology and cardiovascular codes are reimbursed at 90% of the modified or not modified RVP© unit value multiplied by the radiology 18-4 conversion factor. A maximum of four (4) radiology codes may be used in one (1) episode of outpatient diagnostic testing. The highest valued radiology code is allowed at 100% of the maximum value and the remaining three (3) lower valued codes are allowed at 50% of the maximum radiology value.

4) Diagnostic testing dyes, contrasts, supplies and drugs are not separately payable.

5) Fluoroscopy is generally considered incidental when used for guidance when performing higher valued radiology tests. Refer to CPT® for specific billing instructions.

6) The maximum fees for all clinical laboratory testing shall be reimbursed according the fees as outlined under Pathology, section 18-5(F).

7) All observation services must be prior approved by the payer if time is greater than three (3) hours.

G0378 Observation rate: $45.00 per hour

(d) Urgent Care Facility Reimbursement

1) The total maximum value for an urgent care episode of care includes:

a) An Urgent Care facility fee maximum allowance of $75.00; and

b) Prior agreement or authorization is recommended for all facilities billing a separate Urgent Care fee. Facilities must provide documentation of the required Urgent Care facility criteria as listed in section 18-6(K) if requested by the payer.

c) All other services/procedures provided in an Urgent Care facility are reimbursed according the appropriate CPT® code relative weight from RVP© multiplied by the appropriate 18-4 conversion factor.

d) The Observation Room allowance shall not exceed a rate of $45.00 per hour and is limited to a maximum of three (3) hours without prior authorization for payment (see Rule 16-9).

G0378 Observation rate: $45.00 per hour

e) All supplies are included in the facility fee for Urgent Care facilities.

g) 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 section18-6(M).

2) No separate facility fees are allowed for follow-up care. Subsequent care for an initial diagnosis does not qualify for a separate facility fee. To receive another facility fee any subsequent diagnosis shall be a new acute care situation entirely different from the initial diagnosis.

3) 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.

(L) Home Care Services

Prior authorization for payment (see Rule 16-9) 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 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(M).

(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(M)) 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 16-9).

(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(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 16-9) and shall not exceed $30.00 per hour.

DoWC code: Z0773

(M) 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, the parties should take the average 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 prescriptions, except compounded topical prescriptions, written within 30 days from the date of injury, reimbursement shall be AWP + $4.00.

(b) For prescriptions, except compounded topical prescriptions, written after 30 days from the date of injury, 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.

(c) 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).

(d) 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.

(4) Compounded Drugs

All prescriptions shall be billed using the DoWC Z code corresponding with the applicable category for compounded topical products, including prepackaged compounded medications, as follows:

Category I Z0790 Fee $ 75.00 per 30 day supply

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

Category II Z0791 Fee $150.00 per 30 day supply

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

Category III Z0792 Fee $250.00 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 $350.00 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. 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.

(5) 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 16-11(G).

(6) 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.

(7) 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.

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

(8) Required Billing Forms

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

1) 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 RVP© supply code; or

2) WC-M4 form or equivalent – each item on the form shall be completed; or

3) 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.

(b) Items prescribed for the work-related injury that do not have an NDC code shall be billed as a supply, using the RVP© 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 patient or his/her authorized representative has received the prescription.

(9) 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.

(N) 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 16-9). Refer to Rule 17, Medical Treatment Guidelines for the specific types of CAM modalities.

(O) 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 16-9).

(b) Unless the provider’s medical records reflect medical necessity and the provider obtains prior authorization for payment (see Rule 16-9), 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 RVP©.

(b) Non-Physician evaluation services

1) 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 16-11)

2) LAc new patient visit: DOWC Z0800
Maximum value $99.68

3) LAc established patient visit: DOWC Z0801
Maximum value $67.28

(c) Herbs require prior authorization for payment (see Rule 16-9) and fee agreements as per section18-6(M)(6).

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

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

(P) Use of an Interpreter

Rates and terms shall be negotiated. Prior authorization for payment (see Rule 16-9) is required except for emergency treatment. Use DoWC Z0722 to bill.

(Q) 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.

| | | Urban | Rural (R = Zip Code) First 17 miles or > if not a Super Rural | Super Rural (B =Zip code) |
|---|---|---|---|---|
| Ground Ambulance | HCPCS Code Description | Medicare Rate *250% | Medicare Rate *250% | Medicare Rate *250% |
| A0425 | Ground mileage, per statue mile | $ 17.90 | $ 18.08 | $ 18.08 |
| A0426 | Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1-Non-Emergency) | $ 671.89 | $ 678.48 | $ 831.82 |
| A0427 | Ambulance service, advanced life support, emergency transport, level 1 (ALS1-Emergency) | $1,063.83 | $1,074.26 | $1,317.04 |
| A0428 | Ambulance service, basic life support, non-emergency transport (BLS) | $ 559.91 | $565.40 | $ 693.18 |
| A0429 | Ambulance service, basic life support, emergency transport (BLS-Emergency) | $ 895.86 | $ 904.64 | $1,109.09 |
| A0433 | Advanced life support, level 2 (ALS2) | $1,539.75 | $1,554.85 | $1,906.25 |
| A0434 | Specialty care transport (SCT) | $1,819.71 | $1,837.55 | $2,252.84 |
| A0432 | Paramedic intercept (PI), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers. | $ 979.84 | $ 989.45 | $ 989.45 |

The "urban" base rate(s) and mileage rate(s) as indicated in section 18-6(Q) 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:<br>- Hospital administered/Hospital located<br>- Non-Hospital administered/Hospital located |
| H | Hospital |
| I | Site of transfer (e.g., airport, ferry, or helicopter pad) between modes of ambulance transport |
| J | Non-hospital-based dialysis facility<br>- Non-Hospital administered/Non-Hospital located<br>- Hospital administered/Non-Hospital located |
| N | Skilled Nursing Facility (SNF) (1819 Facility) |
| P | Physician’s Office (includes HMO non-hospital facility, clinic, etc.) |
| R | Residence |
| S | Scene of Accident or Acute Event |
| X | Destination Code Only (Intermediate stop at physician’s office enroute 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, 2014 (CDT-2014). However, surgical treatment for dental trauma and subsequent,

related procedures may be billed using medical codes from the RVP©. If billed using medical codes as listed in the RVP©, reimbursement shall be in accordance with the Surgery/Anesthesia section of the RVP© 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-2014 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.

| *Exhibit #1* | | | | | | |
|---|---|---|---|---|---|---|
| **For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015** | | | | | | |
| **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 | 25.3920 | 28.2 | 36.1 |
| 2 | PRE | SURG | HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W/O MCC | 15.6820 | 15.8 | 18.7 |
| 3 | PRE | SURG | ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R. | 17.6399 | 26.2 | 32.0 |
| 4 | PRE | SURG | TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R. | 10.8533 | 20.2 | 24.5 |
| 5 | PRE | SURG | LIVER TRANSPLANT W MCC OR INTESTINAL TRANSPLANT | 10.4973 | 15.1 | 20.5 |
| 6 | PRE | SURG | LIVER TRANSPLANT W/O MCC | 4.7461 | 7.9 | 8.8 |
| 7 | PRE | SURG | LUNG TRANSPLANT | 9.2986 | 15.8 | 18.3 |
| 8 | PRE | SURG | SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT | 5.3302 | 9.8 | 11.4 |
| 10 | PRE | SURG | PANCREAS TRANSPLANT | 4.0849 | 7.9 | 9.7 |
| 11 | PRE | SURG | TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W MCC | 4.7380 | 11.3 | 14.1 |
| 12 | PRE | SURG | TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W CC | 3.3293 | 8.3 | 10.0 |
| 13 | PRE | SURG | TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W/O CC/MCC | 2.1357 | 5.8 | 6.6 |
| 14 | PRE | SURG | ALLOGENEIC BONE MARROW TRANSPLANT | 10.9883 | 19.7 | 24.8 |
| 16 | PRE | SURG | AUTOLOGOUS BONE MARROW TRANSPLANT W CC/MCC | 5.8780 | 17.5 | 19.1 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| 17 | PRE | SURG | AUTOLOGOUS BONE MARROW TRANSPLANT W/O CC/MCC | 4.1603 | 8.8 | 12.3 |
| 20 | 1 | SURG | INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W MCC | 9.4423 | 13.9 | 16.7 |
| 21 | 1 | SURG | INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W CC | 7.1555 | 11.9 | 13.4 |
| 22 | 1 | SURG | INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W/O CC/MCC | 4.4934 | 6.4 | 7.9 |
| 23 | 1 | SURG | CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W MCC OR CHEMO IMPLANT | 5.2939 | 7.9 | 11.0 |
| 24 | 1 | SURG | CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W/O MCC | 3.7461 | 4.4 | 6.3 |
| 25 | 1 | SURG | CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W MCC | 4.3374 | 7.4 | 9.7 |
| 26 | 1 | SURG | CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W CC | 3.0011 | 4.7 | 6.1 |
| 27 | 1 | SURG | CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W/O CC/MCC | 2.2824 | 2.5 | 3.3 |
| 28 | 1 | SURG | SPINAL PROCEDURES W MCC | 5.3968 | 9.5 | 12.2 |
| 29 | 1 | SURG | SPINAL PROCEDURES W CC OR SPINAL NEUROSTIMULATORS | 3.1573 | 4.8 | 6.4 |
| 30 | 1 | SURG | SPINAL PROCEDURES W/O CC/MCC | 1.7835 | 2.6 | 3.3 |
| 31 | 1 | SURG | VENTRICULAR SHUNT PROCEDURES W MCC | 4.1493 | 7.7 | 10.9 |
| 32 | 1 | SURG | VENTRICULAR SHUNT PROCEDURES W CC | 2.0325 | 3.3 | 4.6 |
| 33 | 1 | SURG | VENTRICULAR SHUNT PROCEDURES W/O | 1.5602 | 2.0 | 2.5 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| **MS-DRG** | **MDC** | **TYPE** | **MS-DRG Title** | **Weights** | **Geometric mean LOS** | **Arithmetic mean LOS** |
| | | | CC/MCC | | | |
| 34 | 1 | SURG | CAROTID ARTERY STENT PROCEDURE W MCC | 3.7008 | 4.5 | 6.7 |
| 35 | 1 | SURG | CAROTID ARTERY STENT PROCEDURE W CC | 2.2109 | 2.0 | 2.9 |
| 36 | 1 | SURG | CAROTID ARTERY STENT PROCEDURE W/O CC/MCC | 1.7313 | 1.3 | 1.5 |
| 37 | 1 | SURG | EXTRACRANIAL PROCEDURES W MCC | 3.1459 | 5.5 | 8.0 |
| 38 | 1 | SURG | EXTRACRANIAL PROCEDURES W CC | 1.5870 | 2.3 | 3.4 |
| 39 | 1 | SURG | EXTRACRANIAL PROCEDURES W/O CC/MCC | 1.0582 | 1.3 | 1.6 |
| 40 | 1 | SURG | PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W MCC | 3.7960 | 8.1 | 11.0 |
| 41 | 1 | SURG | PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W CC OR PERIPH NEUROSTIM | 2.1267 | 4.7 | 6.1 |
| 42 | 1 | SURG | PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W/O CC/MCC | 1.8586 | 2.5 | 3.3 |
| 52 | 1 | MED | SPINAL DISORDERS & INJURIES W CC/MCC | 1.5813 | 4.2 | 5.7 |
| 53 | 1 | MED | SPINAL DISORDERS & INJURIES W/O CC/MCC | 0.9294 | 2.7 | 3.5 |
| 54 | 1 | MED | NERVOUS SYSTEM NEOPLASMS W MCC | 1.3048 | 3.9 | 5.3 |
| 55 | 1 | MED | NERVOUS SYSTEM NEOPLASMS W/O MCC | 1.0191 | 3.0 | 4.1 |
| 56 | 1 | MED | DEGENERATIVE NERVOUS SYSTEM DISORDERS W MCC | 1.7615 | 5.2 | 7.0 |
| 57 | 1 | MED | DEGENERATIVE NERVOUS SYSTEM DISORDERS W/O MCC | 1.0099 | 3.5 | 4.8 |
| 58 | 1 | MED | MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA | 1.6336 | 5.2 | 7.0 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| | | | W MCC | | | |
| 59 | 1 | MED | MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W CC | 1.0290 | 3.8 | 4.6 |
| 60 | 1 | MED | MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W/O CC/MCC | 0.7867 | 3.0 | 3.5 |
| 61 | 1 | MED | ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W MCC | 2.7571 | 5.7 | 7.4 |
| 62 | 1 | MED | ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W CC | 1.8555 | 4.1 | 4.8 |
| 63 | 1 | MED | ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W/O CC/MCC | 1.5098 | 3.0 | 3.4 |
| 64 | 1 | MED | INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC | 1.7381 | 4.6 | 6.2 |
| 65 | 1 | MED | INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS | 1.0643 | 3.4 | 4.2 |
| 66 | 1 | MED | INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W/O CC/MCC | 0.7530 | 2.4 | 2.8 |
| 67 | 1 | MED | NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W MCC | 1.4527 | 4.0 | 5.3 |
| 68 | 1 | MED | NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W/O MCC | 0.8395 | 2.3 | 2.9 |
| 69 | 1 | MED | TRANSIENT ISCHEMIA | 0.6985 | 2.0 | 2.5 |
| 70 | 1 | MED | NONSPECIFIC CEREBROVASCULAR DISORDERS W MCC | 1.6438 | 4.8 | 6.5 |
| 71 | 1 | MED | NONSPECIFIC CEREBROVASCULAR DISORDERS W CC | 0.9748 | 3.4 | 4.4 |
| 72 | 1 | MED | NONSPECIFIC CEREBROVASCULAR | 0.6947 | 2.2 | 2.8 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| | | | DISORDERS W/O CC/MCC | | | |
| 73 | 1 | MED | CRANIAL & PERIPHERAL NERVE DISORDERS W MCC | 1.3290 | 3.9 | 5.3 |
| 74 | 1 | MED | CRANIAL & PERIPHERAL NERVE DISORDERS W/O MCC | 0.8847 | 2.9 | 3.7 |
| 75 | 1 | MED | VIRAL MENINGITIS W CC/MCC | 1.6595 | 5.2 | 6.6 |
| 76 | 1 | MED | VIRAL MENINGITIS W/O CC/MCC | 0.8629 | 3.2 | 3.7 |
| 77 | 1 | MED | HYPERTENSIVE ENCEPHALOPATHY W MCC | 1.6245 | 4.6 | 5.9 |
| 78 | 1 | MED | HYPERTENSIVE ENCEPHALOPATHY W CC | 0.9361 | 3.2 | 4.0 |
| 79 | 1 | MED | HYPERTENSIVE ENCEPHALOPATHY W/O CC/MCC | 0.6677 | 2.2 | 2.7 |
| 80 | 1 | MED | NONTRAUMATIC STUPOR & COMA W MCC | 1.2790 | 3.7 | 5.1 |
| 81 | 1 | MED | NONTRAUMATIC STUPOR & COMA W/O MCC | 0.7850 | 2.6 | 3.5 |
| 82 | 1 | MED | TRAUMATIC STUPOR & COMA, COMA >1 HR W MCC | 1.9142 | 3.2 | 5.4 |
| 83 | 1 | MED | TRAUMATIC STUPOR & COMA, COMA >1 HR W CC | 1.2401 | 3.3 | 4.2 |
| 84 | 1 | MED | TRAUMATIC STUPOR & COMA, COMA >1 HR W/O CC/MCC | 0.8592 | 2.1 | 2.6 |
| 85 | 1 | MED | TRAUMATIC STUPOR & COMA, COMA <1 HR W MCC | 1.9770 | 4.7 | 6.5 |
| 86 | 1 | MED | TRAUMATIC STUPOR & COMA, COMA <1 HR W CC | 1.1181 | 3.2 | 4.1 |
| 87 | 1 | MED | TRAUMATIC STUPOR & COMA, COMA <1 HR W/O CC/MCC | 0.7460 | 2.1 | 2.6 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| **MS-DRG** | **MDC** | **TYPE** | **MS-DRG Title** | **Weights** | **Geometric mean LOS** | **Arithmetic mean LOS** |
| 88 | 1 | MED | CONCUSSION W MCC | 1.5708 | 3.7 | 5.2 |
| 89 | 1 | MED | CONCUSSION W CC | 0.9588 | 2.6 | 3.2 |
| 90 | 1 | MED | CONCUSSION W/O CC/MCC | 0.7353 | 1.8 | 2.2 |
| 91 | 1 | MED | OTHER DISORDERS OF NERVOUS SYSTEM W MCC | 1.5978 | 4.2 | 5.8 |
| 92 | 1 | MED | OTHER DISORDERS OF NERVOUS SYSTEM W CC | 0.8989 | 3.0 | 3.8 |
| 93 | 1 | MED | OTHER DISORDERS OF NERVOUS SYSTEM W/O CC/MCC | 0.6783 | 2.1 | 2.6 |
| 94 | 1 | MED | BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W MCC | 3.3357 | 8.2 | 10.7 |
| 95 | 1 | MED | BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W CC | 2.3844 | 5.9 | 7.6 |
| 96 | 1 | MED | BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W/O CC/MCC | 2.0726 | 4.5 | 5.3 |
| 97 | 1 | MED | NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W MCC | 3.1625 | 8.5 | 10.9 |
| 98 | 1 | MED | NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W CC | 1.7189 | 5.4 | 6.9 |
| 99 | 1 | MED | NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W/O CC/MCC | 1.1609 | 3.8 | 4.7 |
| 100 | 1 | MED | SEIZURES W MCC | 1.5304 | 4.1 | 5.6 |
| 101 | 1 | MED | SEIZURES W/O MCC | 0.7567 | 2.5 | 3.2 |
| 102 | 1 | MED | HEADACHES W MCC | 1.0073 | 2.9 | 3.9 |
| 103 | 1 | MED | HEADACHES W/O MCC | 0.6915 | 2.2 | 2.8 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| **MS-DRG** | **MDC** | **TYPE** | **MS-DRG Title** | **Weights** | **Geometric mean LOS** | **Arithmetic mean LOS** |
| 113 | 2 | SURG | ORBITAL PROCEDURES W CC/MCC | 1.8611 | 3.7 | 5.1 |
| 114 | 2 | SURG | ORBITAL PROCEDURES W/O CC/MCC | 1.1568 | 2.2 | 2.9 |
| 115 | 2 | SURG | EXTRAOCULAR PROCEDURES EXCEPT ORBIT | 1.2780 | 3.3 | 4.4 |
| 116 | 2 | SURG | INTRAOCULAR PROCEDURES W CC/MCC | 1.4005 | 3.2 | 4.5 |
| 117 | 2 | SURG | INTRAOCULAR PROCEDURES W/O CC/MCC | 0.8239 | 1.7 | 2.1 |
| 121 | 2 | MED | ACUTE MAJOR EYE INFECTIONS W CC/MCC | 1.0635 | 3.9 | 5.0 |
| 122 | 2 | MED | ACUTE MAJOR EYE INFECTIONS W/O CC/MCC | 0.6352 | 3.1 | 3.8 |
| 123 | 2 | MED | NEUROLOGICAL EYE DISORDERS | 0.6732 | 2.0 | 2.4 |
| 124 | 2 | MED | OTHER DISORDERS OF THE EYE W MCC | 1.1432 | 3.4 | 4.6 |
| 125 | 2 | MED | OTHER DISORDERS OF THE EYE W/O MCC | 0.6852 | 2.4 | 3.1 |
| 129 | 3 | SURG | MAJOR HEAD & NECK PROCEDURES W CC/MCC OR MAJOR DEVICE | 2.3284 | 3.8 | 5.3 |
| 130 | 3 | SURG | MAJOR HEAD & NECK PROCEDURES W/O CC/MCC | 1.2599 | 2.2 | 2.7 |
| 131 | 3 | SURG | CRANIAL/FACIAL PROCEDURES W CC/MCC | 2.3703 | 4.0 | 5.6 |
| 132 | 3 | SURG | CRANIAL/FACIAL PROCEDURES W/O CC/MCC | 1.4248 | 2.0 | 2.6 |
| 133 | 3 | SURG | OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W CC/MCC | 1.8644 | 3.6 | 5.3 |
| 134 | 3 | SURG | OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W/O CC/MCC | 1.0083 | 1.7 | 2.2 |
| 135 | 3 | SURG | SINUS & MASTOID PROCEDURES W CC/MCC | 1.9150 | 4.2 | 5.7 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| 136 | 3 | SURG | SINUS & MASTOID PROCEDURES W/O CC/MCC | 1.0509 | 1.6 | 2.2 |
| 137 | 3 | SURG | MOUTH PROCEDURES W CC/MCC | 1.3735 | 3.6 | 4.8 |
| 138 | 3 | SURG | MOUTH PROCEDURES W/O CC/MCC | 0.7888 | 1.8 | 2.3 |
| 139 | 3 | SURG | SALIVARY GLAND PROCEDURES | 0.9856 | 1.4 | 1.8 |
| 146 | 3 | MED | EAR, NOSE, MOUTH & THROAT MALIGNANCY W MCC | 1.9749 | 5.8 | 8.2 |
| 147 | 3 | MED | EAR, NOSE, MOUTH & THROAT MALIGNANCY W CC | 1.2869 | 3.8 | 5.3 |
| 148 | 3 | MED | EAR, NOSE, MOUTH & THROAT MALIGNANCY W/O CC/MCC | 0.8205 | 2.2 | 2.9 |
| 149 | 3 | MED | DYSEQUILIBRIUM | 0.6342 | 2.0 | 2.4 |
| 150 | 3 | MED | EPISTAXIS W MCC | 1.2943 | 3.6 | 4.8 |
| 151 | 3 | MED | EPISTAXIS W/O MCC | 0.6690 | 2.2 | 2.7 |
| 152 | 3 | MED | OTITIS MEDIA & URI W MCC | 1.0162 | 3.5 | 4.4 |
| 153 | 3 | MED | OTITIS MEDIA & URI W/O MCC | 0.6884 | 2.6 | 3.2 |
| 154 | 3 | MED | OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W MCC | 1.3703 | 4.0 | 5.4 |
| 155 | 3 | MED | OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W CC | 0.8848 | 3.1 | 3.9 |
| 156 | 3 | MED | OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W/O CC/MCC | 0.6516 | 2.2 | 2.8 |
| 157 | 3 | MED | DENTAL & ORAL DISEASES W MCC | 1.5814 | 4.6 | 6.3 |
| 158 | 3 | MED | DENTAL & ORAL DISEASES W CC | 0.8519 | 2.9 | 3.8 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| 159 | 3 | MED | DENTAL & ORAL DISEASES W/O CC/MCC | 0.5935 | 2.0 | 2.5 |
| 163 | 4 | SURG | MAJOR CHEST PROCEDURES W MCC | 5.0332 | 10.7 | 13.1 |
| 164 | 4 | SURG | MAJOR CHEST PROCEDURES W CC | 2.6010 | 5.4 | 6.6 |
| 165 | 4 | SURG | MAJOR CHEST PROCEDURES W/O CC/MCC | 1.8220 | 3.2 | 3.9 |
| 166 | 4 | SURG | OTHER RESP SYSTEM O.R. PROCEDURES W MCC | 3.6610 | 8.7 | 11.1 |
| 167 | 4 | SURG | OTHER RESP SYSTEM O.R. PROCEDURES W CC | 1.9818 | 5.1 | 6.5 |
| 168 | 4 | SURG | OTHER RESP SYSTEM O.R. PROCEDURES W/O CC/MCC | 1.3291 | 2.9 | 3.8 |
| 175 | 4 | MED | PULMONARY EMBOLISM W MCC | 1.5271 | 5.2 | 6.3 |
| 176 | 4 | MED | PULMONARY EMBOLISM W/O MCC | 0.9670 | 3.5 | 4.2 |
| 177 | 4 | MED | RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC | 1.9492 | 6.2 | 7.7 |
| 178 | 4 | MED | RESPIRATORY INFECTIONS & INFLAMMATIONS W CC | 1.3909 | 5.0 | 6.0 |
| 179 | 4 | MED | RESPIRATORY INFECTIONS & INFLAMMATIONS W/O CC/MCC | 0.9693 | 3.6 | 4.4 |
| 180 | 4 | MED | RESPIRATORY NEOPLASMS W MCC | 1.6869 | 5.3 | 6.9 |
| 181 | 4 | MED | RESPIRATORY NEOPLASMS W CC | 1.1582 | 3.7 | 4.8 |
| 182 | 4 | MED | RESPIRATORY NEOPLASMS W/O CC/MCC | 0.8088 | 2.4 | 3.1 |
| 183 | 4 | MED | MAJOR CHEST TRAUMA W MCC | 1.5101 | 4.8 | 6.0 |
| 184 | 4 | MED | MAJOR CHEST TRAUMA W CC | 0.9889 | 3.3 | 4.0 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| **MS-DRG** | **MDC** | **TYPE** | **MS-DRG Title** | **Weights** | **Geometric mean LOS** | **Arithmetic mean LOS** |
| 185 | 4 | MED | MAJOR CHEST TRAUMA W/O CC/MCC | 0.6628 | 2.4 | 2.8 |
| 186 | 4 | MED | PLEURAL EFFUSION W MCC | 1.5452 | 4.8 | 6.2 |
| 187 | 4 | MED | PLEURAL EFFUSION W CC | 1.0691 | 3.5 | 4.5 |
| 188 | 4 | MED | PLEURAL EFFUSION W/O CC/MCC | 0.7609 | 2.5 | 3.2 |
| 189 | 4 | MED | PULMONARY EDEMA & RESPIRATORY FAILURE | 1.2136 | 3.9 | 5.0 |
| 190 | 4 | MED | CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC | 1.1743 | 4.2 | 5.1 |
| 191 | 4 | MED | CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC | 0.9370 | 3.4 | 4.2 |
| 192 | 4 | MED | CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC | 0.7190 | 2.7 | 3.3 |
| 193 | 4 | MED | SIMPLE PNEUMONIA & PLEURISY W MCC | 1.4491 | 4.9 | 6.0 |
| 194 | 4 | MED | SIMPLE PNEUMONIA & PLEURISY W CC | 0.9688 | 3.8 | 4.5 |
| 195 | 4 | MED | SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC | 0.7044 | 2.9 | 3.4 |
| 196 | 4 | MED | INTERSTITIAL LUNG DISEASE W MCC | 1.6635 | 5.4 | 6.9 |
| 197 | 4 | MED | INTERSTITIAL LUNG DISEASE W CC | 1.0615 | 3.7 | 4.6 |
| 198 | 4 | MED | INTERSTITIAL LUNG DISEASE W/O CC/MCC | 0.8054 | 2.7 | 3.3 |
| 199 | 4 | MED | PNEUMOTHORAX W MCC | 1.8345 | 5.8 | 7.5 |
| 200 | 4 | MED | PNEUMOTHORAX W CC | 1.0084 | 3.4 | 4.3 |
| 201 | 4 | MED | PNEUMOTHORAX W/O CC/MCC | 0.7096 | 2.5 | 3.2 |
| 202 | 4 | MED | BRONCHITIS & ASTHMA W CC/MCC | 0.8775 | 3.2 | 3.9 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| **For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015** | | | | | | |
| **MS-DRG** | **MDC** | **TYPE** | **MS-DRG Title** | **Weights** | **Geometric mean LOS** | **Arithmetic mean LOS** |
| 203 | 4 | MED | BRONCHITIS & ASTHMA W/O CC/MCC | 0.6535 | 2.5 | 3.0 |
| 204 | 4 | MED | RESPIRATORY SIGNS & SYMPTOMS | 0.7041 | 2.1 | 2.7 |
| 205 | 4 | MED | OTHER RESPIRATORY SYSTEM DIAGNOSES W MCC | 1.3999 | 4.0 | 5.3 |
| 206 | 4 | MED | OTHER RESPIRATORY SYSTEM DIAGNOSES W/O MCC | 0.7942 | 2.4 | 3.1 |
| 207 | 4 | MED | RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS | 5.3425 | 12.4 | 14.4 |
| 208 | 4 | MED | RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS | 2.2969 | 5.0 | 6.9 |
| 215 | 5 | SURG | OTHER HEART ASSIST SYSTEM IMPLANT | 15.4348 | 11.3 | 17.3 |
| 216 | 5 | SURG | CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W MCC | 9.5238 | 13.0 | 15.8 |
| 217 | 5 | SURG | CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W CC | 6.3291 | 8.7 | 9.9 |
| 218 | 5 | SURG | CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W/O CC/MCC | 5.5693 | 6.4 | 7.3 |
| 219 | 5 | SURG | CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W MCC | 7.7067 | 9.8 | 11.9 |
| 220 | 5 | SURG | CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W CC | 5.2056 | 6.6 | 7.3 |
| 221 | 5 | SURG | CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH | 4.6347 | 4.9 | 5.4 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| | | | W/O CC/MCC | | | |
| 222 | 5 | SURG | CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W MCC | 8.6570 | 9.9 | 11.9 |
| 223 | 5 | SURG | CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W/O MCC | 6.2924 | 4.4 | 6.0 |
| 224 | 5 | SURG | CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W MCC | 7.6733 | 7.9 | 9.8 |
| 225 | 5 | SURG | CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W/O MCC | 5.8610 | 4.1 | 4.9 |
| 226 | 5 | SURG | CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W MCC | 6.9573 | 6.3 | 8.7 |
| 227 | 5 | SURG | CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W/O MCC | 5.4493 | 2.2 | 3.3 |
| 228 | 5 | SURG | OTHER CARDIOTHORACIC PROCEDURES W MCC | 7.3113 | 11.2 | 13.5 |
| 229 | 5 | SURG | OTHER CARDIOTHORACIC PROCEDURES W CC | 4.4606 | 6.5 | 7.4 |
| 230 | 5 | SURG | OTHER CARDIOTHORACIC PROCEDURES W/O CC/MCC | 4.0755 | 4.3 | 4.9 |
| 231 | 5 | SURG | CORONARY BYPASS W PTCA W MCC | 7.7247 | 10.6 | 12.5 |
| 232 | 5 | SURG | CORONARY BYPASS W PTCA W/O MCC | 5.5976 | 7.9 | 8.6 |
| 233 | 5 | SURG | CORONARY BYPASS W CARDIAC CATH W MCC | 7.3493 | 11.8 | 13.3 |
| 234 | 5 | SURG | CORONARY BYPASS W CARDIAC CATH W/O MCC | 4.8816 | 8.0 | 8.6 |
| 235 | 5 | SURG | CORONARY BYPASS W/O CARDIAC CATH W MCC | 5.7089 | 9.0 | 10.3 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| 236 | 5 | SURG | CORONARY BYPASS W/O CARDIAC CATH W/O MCC | 3.7952 | 6.0 | 6.5 |
| 237 | 5 | SURG | MAJOR CARDIOVASC PROCEDURES W MCC | 5.0843 | 6.7 | 9.6 |
| 238 | 5 | SURG | MAJOR CARDIOVASC PROCEDURES W/O MCC | 3.4241 | 2.6 | 3.7 |
| 239 | 5 | SURG | AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W MCC | 4.7590 | 10.6 | 13.5 |
| 240 | 5 | SURG | AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W CC | 2.7594 | 7.2 | 8.8 |
| 241 | 5 | SURG | AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W/O CC/MCC | 1.4111 | 4.4 | 5.2 |
| 242 | 5 | SURG | PERMANENT CARDIAC PACEMAKER IMPLANT W MCC | 3.7242 | 5.8 | 7.4 |
| 243 | 5 | SURG | PERMANENT CARDIAC PACEMAKER IMPLANT W CC | 2.6695 | 3.6 | 4.5 |
| 244 | 5 | SURG | PERMANENT CARDIAC PACEMAKER IMPLANT W/O CC/MCC | 2.1555 | 2.4 | 2.9 |
| 245 | 5 | SURG | AICD GENERATOR PROCEDURES | 4.6485 | 3.2 | 4.6 |
| 246 | 5 | SURG | PERC CARDIOVASC PROC W DRUG-ELUTING STENT W MCC OR 4+ VESSELS/STENTS | 3.2368 | 3.9 | 5.3 |
| 247 | 5 | SURG | PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC | 2.0586 | 2.0 | 2.4 |
| 248 | 5 | SURG | PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W MCC OR 4+ VES/STENTS | 3.0411 | 4.8 | 6.4 |
| 249 | 5 | SURG | PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MCC | 1.8808 | 2.4 | 2.9 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| **MS-DRG** | **MDC** | **TYPE** | **MS-DRG Title** | **Weights** | **Geometric mean LOS** | **Arithmetic mean LOS** |
| 250 | 5 | SURG | PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W MCC | 2.9885 | 5.0 | 6.9 |
| 251 | 5 | SURG | PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W/O MCC | 2.0399 | 2.1 | 2.8 |
| 252 | 5 | SURG | OTHER VASCULAR PROCEDURES W MCC | 3.2646 | 5.3 | 7.8 |
| 253 | 5 | SURG | OTHER VASCULAR PROCEDURES W CC | 2.5532 | 3.9 | 5.4 |
| 254 | 5 | SURG | OTHER VASCULAR PROCEDURES W/O CC/MCC | 1.7304 | 2.1 | 2.7 |
| 255 | 5 | SURG | UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W MCC | 2.6051 | 6.5 | 8.4 |
| 256 | 5 | SURG | UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W CC | 1.6986 | 5.3 | 6.5 |
| 257 | 5 | SURG | UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W/O CC/MCC | 1.0558 | 3.0 | 3.9 |
| 258 | 5 | SURG | CARDIAC PACEMAKER DEVICE REPLACEMENT W MCC | 2.7613 | 4.9 | 6.2 |
| 259 | 5 | SURG | CARDIAC PACEMAKER DEVICE REPLACEMENT W/O MCC | 1.9924 | 2.6 | 3.4 |
| 260 | 5 | SURG | CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W MCC | 3.7456 | 7.9 | 10.6 |
| 261 | 5 | SURG | CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W CC | 1.8552 | 3.4 | 4.5 |
| 262 | 5 | SURG | CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W/O CC/MCC | 1.3978 | 2.3 | 2.9 |
| 263 | 5 | SURG | VEIN LIGATION & STRIPPING | 1.8664 | 3.4 | 5.3 |
| 264 | 5 | SURG | OTHER CIRCULATORY SYSTEM O.R. | 2.8292 | 5.4 | 8.1 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| **MS-DRG** | **MDC** | **TYPE** | **MS-DRG Title** | **Weights** | **Geometric mean LOS** | **Arithmetic mean LOS** |
| | | | PROCEDURES | | | |
| 265 | 5 | SURG | AICD LEAD PROCEDURES | 2.8641 | 2.7 | 4.1 |
| 266 | 5 | SURG | ENDOVASCULAR CARDIAC VALVE REPLACEMENT W MCC | 8.9920 | 8.4 | 10.6 |
| 267 | 5 | SURG | ENDOVASCULAR CARDIAC VALVE REPLACEMENT W/O MCC | 6.7517 | 5.0 | 5.8 |
| 280 | 5 | MED | ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC | 1.7289 | 4.7 | 6.0 |
| 281 | 5 | MED | ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W CC | 1.0247 | 3.0 | 3.7 |
| 282 | 5 | MED | ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W/O CC/MCC | 0.7562 | 2.0 | 2.4 |
| 283 | 5 | MED | ACUTE MYOCARDIAL INFARCTION, EXPIRED W MCC | 1.6753 | 3.0 | 4.7 |
| 284 | 5 | MED | ACUTE MYOCARDIAL INFARCTION, EXPIRED W CC | 0.7703 | 1.8 | 2.4 |
| 285 | 5 | MED | ACUTE MYOCARDIAL INFARCTION, EXPIRED W/O CC/MCC | 0.5065 | 1.3 | 1.6 |
| 286 | 5 | MED | CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W MCC | 2.1240 | 5.0 | 6.7 |
| 287 | 5 | MED | CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O MCC | 1.1290 | 2.3 | 3.1 |
| 288 | 5 | MED | ACUTE & SUBACUTE ENDOCARDITIS W MCC | 2.7138 | 7.6 | 9.4 |
| 289 | 5 | MED | ACUTE & SUBACUTE ENDOCARDITIS W CC | 1.6991 | 5.8 | 7.0 |
| 290 | 5 | MED | ACUTE & SUBACUTE ENDOCARDITIS W/O CC/MCC | 1.2476 | 3.9 | 4.9 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| 291 | 5 | MED | HEART FAILURE & SHOCK W MCC | 1.5097 | 4.6 | 5.9 |
| 292 | 5 | MED | HEART FAILURE & SHOCK W CC | 0.9824 | 3.6 | 4.4 |
| 293 | 5 | MED | HEART FAILURE & SHOCK W/O CC/MCC | 0.6762 | 2.6 | 3.1 |
| 294 | 5 | MED | DEEP VEIN THROMBOPHLEBITIS W CC/MCC | 1.0480 | 4.1 | 5.0 |
| 295 | 5 | MED | DEEP VEIN THROMBOPHLEBITIS W/O CC/MCC | 0.6926 | 3.1 | 3.7 |
| 296 | 5 | MED | CARDIAC ARREST, UNEXPLAINED W MCC | 1.2347 | 1.8 | 2.8 |
| 297 | 5 | MED | CARDIAC ARREST, UNEXPLAINED W CC | 0.6475 | 1.3 | 1.6 |
| 298 | 5 | MED | CARDIAC ARREST, UNEXPLAINED W/O CC/MCC | 0.4227 | 1.1 | 1.2 |
| 299 | 5 | MED | PERIPHERAL VASCULAR DISORDERS W MCC | 1.4094 | 4.4 | 5.7 |
| 300 | 5 | MED | PERIPHERAL VASCULAR DISORDERS W CC | 0.9770 | 3.5 | 4.4 |
| 301 | 5 | MED | PERIPHERAL VASCULAR DISORDERS W/O CC/MCC | 0.6776 | 2.6 | 3.2 |
| 302 | 5 | MED | ATHEROSCLEROSIS W MCC | 1.0311 | 2.8 | 3.9 |
| 303 | 5 | MED | ATHEROSCLEROSIS W/O MCC | 0.6101 | 1.8 | 2.3 |
| 304 | 5 | MED | HYPERTENSION W MCC | 1.0016 | 3.2 | 4.2 |
| 305 | 5 | MED | HYPERTENSION W/O MCC | 0.6272 | 2.1 | 2.5 |
| 306 | 5 | MED | CARDIAC CONGENITAL & VALVULAR DISORDERS W MCC | 1.3687 | 3.9 | 5.1 |
| 307 | 5 | MED | CARDIAC CONGENITAL & VALVULAR DISORDERS W/O MCC | 0.7698 | 2.4 | 3.1 |
| 308 | 5 | MED | CARDIAC ARRHYTHMIA & CONDUCTION | 1.2107 | 3.8 | 4.9 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| | | | DISORDERS W MCC | | | |
| 309 | 5 | MED | CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC | 0.7865 | 2.6 | 3.3 |
| 310 | 5 | MED | CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC/MCC | 0.5493 | 1.9 | 2.2 |
| 311 | 5 | MED | ANGINA PECTORIS | 0.5662 | 1.8 | 2.2 |
| 312 | 5 | MED | SYNCOPE & COLLAPSE | 0.7423 | 2.3 | 2.8 |
| 313 | 5 | MED | CHEST PAIN | 0.6138 | 1.6 | 2.0 |
| 314 | 5 | MED | OTHER CIRCULATORY SYSTEM DIAGNOSES W MCC | 1.9195 | 4.9 | 6.7 |
| 315 | 5 | MED | OTHER CIRCULATORY SYSTEM DIAGNOSES W CC | 0.9613 | 3.0 | 3.9 |
| 316 | 5 | MED | OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC/MCC | 0.6210 | 1.9 | 2.4 |
| 326 | 6 | SURG | STOMACH, ESOPHAGEAL & DUODENAL PROC W MCC | 5.3847 | 11.2 | 14.5 |
| 327 | 6 | SURG | STOMACH, ESOPHAGEAL & DUODENAL PROC W CC | 2.6532 | 5.8 | 7.7 |
| 328 | 6 | SURG | STOMACH, ESOPHAGEAL & DUODENAL PROC W/O CC/MCC | 1.4949 | 2.4 | 3.2 |
| 329 | 6 | SURG | MAJOR SMALL & LARGE BOWEL PROCEDURES W MCC | 5.0776 | 11.7 | 14.4 |
| 330 | 6 | SURG | MAJOR SMALL & LARGE BOWEL PROCEDURES W CC | 2.5491 | 7.1 | 8.4 |
| 331 | 6 | SURG | MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC | 1.6580 | 4.3 | 4.8 |

| *Exhibit #1* | | | | | | |
|---|---|---|---|---|---|---|
| **For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015** | | | | | | |
| **MS-DRG** | **MDC** | **TYPE** | **MS-DRG Title** | **Weights** | **Geometric mean LOS** | **Arithmetic mean LOS** |
| 332 | 6 | SURG | RECTAL RESECTION W MCC | 4.7048 | 10.5 | 12.8 |
| 333 | 6 | SURG | RECTAL RESECTION W CC | 2.4728 | 6.3 | 7.3 |
| 334 | 6 | SURG | RECTAL RESECTION W/O CC/MCC | 1.6032 | 3.6 | 4.2 |
| 335 | 6 | SURG | PERITONEAL ADHESIOLYSIS W MCC | 4.2881 | 10.9 | 13.1 |
| 336 | 6 | SURG | PERITONEAL ADHESIOLYSIS W CC | 2.3539 | 6.8 | 8.3 |
| 337 | 6 | SURG | PERITONEAL ADHESIOLYSIS W/O CC/MCC | 1.5596 | 3.9 | 4.8 |
| 338 | 6 | SURG | APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W MCC | 3.0701 | 7.5 | 9.2 |
| 339 | 6 | SURG | APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC | 1.7340 | 5.0 | 5.9 |
| 340 | 6 | SURG | APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC/MCC | 1.2137 | 2.9 | 3.4 |
| 341 | 6 | SURG | APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W MCC | 2.2862 | 4.7 | 6.4 |
| 342 | 6 | SURG | APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC | 1.3112 | 2.6 | 3.4 |
| 343 | 6 | SURG | APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC/MCC | 0.9404 | 1.6 | 1.8 |
| 344 | 6 | SURG | MINOR SMALL & LARGE BOWEL PROCEDURES W MCC | 3.3079 | 8.7 | 11.2 |
| 345 | 6 | SURG | MINOR SMALL & LARGE BOWEL PROCEDURES W CC | 1.7107 | 5.4 | 6.4 |
| 346 | 6 | SURG | MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC | 1.1991 | 3.8 | 4.3 |
| 347 | 6 | SURG | ANAL & STOMAL PROCEDURES W MCC | 2.6226 | 6.3 | 8.7 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| 348 | 6 | SURG | ANAL & STOMAL PROCEDURES W CC | 1.3825 | 3.9 | 5.0 |
| 349 | 6 | SURG | ANAL & STOMAL PROCEDURES W/O CC/MCC | 0.9078 | 2.3 | 2.9 |
| 350 | 6 | SURG | INGUINAL & FEMORAL HERNIA PROCEDURES W MCC | 2.4665 | 5.5 | 7.5 |
| 351 | 6 | SURG | INGUINAL & FEMORAL HERNIA PROCEDURES W CC | 1.4024 | 3.4 | 4.3 |
| 352 | 6 | SURG | INGUINAL & FEMORAL HERNIA PROCEDURES W/O CC/MCC | 0.9288 | 1.9 | 2.3 |
| 353 | 6 | SURG | HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W MCC | 2.9077 | 6.2 | 8.2 |
| 354 | 6 | SURG | HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W CC | 1.6915 | 3.9 | 4.8 |
| 355 | 6 | SURG | HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W/O CC/MCC | 1.2521 | 2.4 | 2.9 |
| 356 | 6 | SURG | OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W MCC | 3.8573 | 8.4 | 11.3 |
| 357 | 6 | SURG | OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC | 2.1072 | 5.1 | 6.6 |
| 358 | 6 | SURG | OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC | 1.3737 | 2.9 | 3.8 |
| 368 | 6 | MED | MAJOR ESOPHAGEAL DISORDERS W MCC | 1.8641 | 4.9 | 6.4 |
| 369 | 6 | MED | MAJOR ESOPHAGEAL DISORDERS W CC | 1.0703 | 3.4 | 4.1 |
| 370 | 6 | MED | MAJOR ESOPHAGEAL DISORDERS W/O CC/MCC | 0.7390 | 2.3 | 2.8 |
| 371 | 6 | MED | MAJOR GASTROINTESTINAL DISORDERS & | 1.8633 | 6.0 | 7.8 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| **For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015** | | | | | | |
| **MS-DRG** | **MDC** | **TYPE** | **MS-DRG Title** | **Weights** | **Geometric mean LOS** | **Arithmetic mean LOS** |
| | | | PERITONEAL INFECTIONS W MCC | | | |
| 372 | 6 | MED | MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC | 1.1343 | 4.6 | 5.6 |
| 373 | 6 | MED | MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W/O CC/MCC | 0.8013 | 3.4 | 4.1 |
| 374 | 6 | MED | DIGESTIVE MALIGNANCY W MCC | 2.0182 | 6.0 | 7.9 |
| 375 | 6 | MED | DIGESTIVE MALIGNANCY W CC | 1.2429 | 4.1 | 5.2 |
| 376 | 6 | MED | DIGESTIVE MALIGNANCY W/O CC/MCC | 0.9021 | 2.7 | 3.4 |
| 377 | 6 | MED | G.I. HEMORRHAGE W MCC | 1.7775 | 4.7 | 6.1 |
| 378 | 6 | MED | G.I. HEMORRHAGE W CC | 1.0021 | 3.2 | 3.8 |
| 379 | 6 | MED | G.I. HEMORRHAGE W/O CC/MCC | 0.6776 | 2.3 | 2.7 |
| 380 | 6 | MED | COMPLICATED PEPTIC ULCER W MCC | 1.9265 | 5.4 | 7.0 |
| 381 | 6 | MED | COMPLICATED PEPTIC ULCER W CC | 1.0875 | 3.5 | 4.3 |
| 382 | 6 | MED | COMPLICATED PEPTIC ULCER W/O CC/MCC | 0.7591 | 2.6 | 3.1 |
| 383 | 6 | MED | UNCOMPLICATED PEPTIC ULCER W MCC | 1.3215 | 4.2 | 5.2 |
| 384 | 6 | MED | UNCOMPLICATED PEPTIC ULCER W/O MCC | 0.8510 | 2.8 | 3.4 |
| 385 | 6 | MED | INFLAMMATORY BOWEL DISEASE W MCC | 1.7649 | 5.9 | 7.8 |
| 386 | 6 | MED | INFLAMMATORY BOWEL DISEASE W CC | 1.0040 | 3.9 | 4.8 |
| 387 | 6 | MED | INFLAMMATORY BOWEL DISEASE W/O CC/MCC | 0.7449 | 2.9 | 3.6 |
| 388 | 6 | MED | G.I. OBSTRUCTION W MCC | 1.6100 | 5.3 | 6.9 |
| 389 | 6 | MED | G.I. OBSTRUCTION W CC | 0.8717 | 3.5 | 4.4 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| **MS-DRG** | **MDC** | **TYPE** | **MS-DRG Title** | **Weights** | **Geometric mean LOS** | **Arithmetic mean LOS** |
| 390 | 6 | MED | G.I. OBSTRUCTION W/O CC/MCC | 0.6034 | 2.6 | 3.1 |
| 391 | 6 | MED | ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W MCC | 1.1976 | 3.7 | 5.0 |
| 392 | 6 | MED | ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC | 0.7388 | 2.7 | 3.3 |
| 393 | 6 | MED | OTHER DIGESTIVE SYSTEM DIAGNOSES W MCC | 1.6893 | 4.6 | 6.5 |
| 394 | 6 | MED | OTHER DIGESTIVE SYSTEM DIAGNOSES W CC | 0.9448 | 3.3 | 4.2 |
| 395 | 6 | MED | OTHER DIGESTIVE SYSTEM DIAGNOSES W/O CC/MCC | 0.6574 | 2.3 | 2.9 |
| 405 | 7 | SURG | PANCREAS, LIVER & SHUNT PROCEDURES W MCC | 5.5387 | 10.7 | 14.3 |
| 406 | 7 | SURG | PANCREAS, LIVER & SHUNT PROCEDURES W CC | 2.8067 | 5.9 | 7.5 |
| 407 | 7 | SURG | PANCREAS, LIVER & SHUNT PROCEDURES W/O CC/MCC | 1.9472 | 3.9 | 4.8 |
| 408 | 7 | SURG | BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W MCC | 3.8967 | 10.0 | 12.2 |
| 409 | 7 | SURG | BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC | 2.2218 | 6.3 | 7.5 |
| 410 | 7 | SURG | BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC/MCC | 1.6206 | 4.4 | 5.1 |
| 411 | 7 | SURG | CHOLECYSTECTOMY W C.D.E. W MCC | 3.6261 | 9.4 | 11.6 |
| 412 | 7 | SURG | CHOLECYSTECTOMY W C.D.E. W CC | 2.4166 | 6.3 | 7.4 |
| 413 | 7 | SURG | CHOLECYSTECTOMY W C.D.E. W/O CC/MCC | 1.7708 | 4.2 | 5.1 |

| *Exhibit #1* | | | | | | |
|---|---|---|---|---|---|---|
| **For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015** | | | | | | |
| **MS-DRG** | **MDC** | **TYPE** | **MS-DRG Title** | **Weights** | **Geometric mean LOS** | **Arithmetic mean LOS** |
| 414 | 7 | SURG | CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W MCC | 3.5545 | 8.7 | 10.6 |
| 415 | 7 | SURG | CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC | 2.0267 | 5.6 | 6.5 |
| 416 | 7 | SURG | CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC/MCC | 1.3465 | 3.6 | 4.1 |
| 417 | 7 | SURG | LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W MCC | 2.4353 | 5.8 | 7.3 |
| 418 | 7 | SURG | LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC | 1.6600 | 3.9 | 4.7 |
| 419 | 7 | SURG | LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC/MCC | 1.2316 | 2.4 | 2.9 |
| 420 | 7 | SURG | HEPATOBILIARY DIAGNOSTIC PROCEDURES W MCC | 3.4621 | 8.0 | 11.3 |
| 421 | 7 | SURG | HEPATOBILIARY DIAGNOSTIC PROCEDURES W CC | 1.7699 | 3.9 | 5.4 |
| 422 | 7 | SURG | HEPATOBILIARY DIAGNOSTIC PROCEDURES W/O CC/MCC | 1.2352 | 2.7 | 3.2 |
| 423 | 7 | SURG | OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W MCC | 4.1961 | 9.8 | 13.1 |
| 424 | 7 | SURG | OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W CC | 2.2993 | 6.1 | 7.8 |
| 425 | 7 | SURG | OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W/O CC/MCC | 1.3793 | 3.7 | 4.4 |
| 432 | 7 | MED | CIRRHOSIS & ALCOHOLIC HEPATITIS W MCC | 1.6710 | 4.7 | 6.1 |
| 433 | 7 | MED | CIRRHOSIS & ALCOHOLIC HEPATITIS W CC | 0.9173 | 3.3 | 4.0 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| 434 | 7 | MED | CIRRHOSIS & ALCOHOLIC HEPATITIS W/O CC/MCC | 0.6229 | 2.3 | 2.8 |
| 435 | 7 | MED | MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W MCC | 1.7524 | 5.1 | 6.7 |
| 436 | 7 | MED | MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W CC | 1.1640 | 3.8 | 4.9 |
| 437 | 7 | MED | MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W/O CC/MCC | 0.8971 | 2.6 | 3.4 |
| 438 | 7 | MED | DISORDERS OF PANCREAS EXCEPT MALIGNANCY W MCC | 1.7023 | 5.0 | 6.8 |
| 439 | 7 | MED | DISORDERS OF PANCREAS EXCEPT MALIGNANCY W CC | 0.9071 | 3.5 | 4.4 |
| 440 | 7 | MED | DISORDERS OF PANCREAS EXCEPT MALIGNANCY W/O CC/MCC | 0.6423 | 2.7 | 3.2 |
| 441 | 7 | MED | DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W MCC | 1.8835 | 4.9 | 6.8 |
| 442 | 7 | MED | DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC | 0.9266 | 3.3 | 4.2 |
| 443 | 7 | MED | DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC/MCC | 0.6512 | 2.5 | 3.0 |
| 444 | 7 | MED | DISORDERS OF THE BILIARY TRACT W MCC | 1.6212 | 4.6 | 6.1 |
| 445 | 7 | MED | DISORDERS OF THE BILIARY TRACT W CC | 1.0654 | 3.3 | 4.2 |
| 446 | 7 | MED | DISORDERS OF THE BILIARY TRACT W/O CC/MCC | 0.7569 | 2.3 | 2.8 |
| 453 | 8 | SURG | COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W MCC | 11.1637 | 9.4 | 11.6 |

| *Exhibit #1* | | | | | | |
|---|---|---|---|---|---|---|
| **For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015** | | | | | | |
| **MS-DRG** | **MDC** | **TYPE** | **MS-DRG Title** | **Weights** | **Geometric mean LOS** | **Arithmetic mean LOS** |
| 454 | 8 | SURG | COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W CC | 8.0184 | 4.9 | 5.8 |
| 455 | 8 | SURG | COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W/O CC/MCC | 6.2503 | 3.1 | 3.5 |
| 456 | 8 | SURG | SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W MCC | 9.4039 | 9.9 | 12.0 |
| 457 | 8 | SURG | SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W CC | 6.9074 | 5.5 | 6.5 |
| 458 | 8 | SURG | SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W/O CC/MCC | 5.2637 | 3.4 | 3.8 |
| 459 | 8 | SURG | SPINAL FUSION EXCEPT CERVICAL W MCC | 6.6686 | 6.8 | 8.5 |
| 460 | 8 | SURG | SPINAL FUSION EXCEPT CERVICAL W/O MCC | 3.9998 | 3.0 | 3.5 |
| 461 | 8 | SURG | BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W MCC | 5.0202 | 6.3 | 7.6 |
| 462 | 8 | SURG | BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W/O MCC | 3.4905 | 3.4 | 3.7 |
| 463 | 8 | SURG | WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W MCC | 5.3345 | 10.6 | 14.1 |
| 464 | 8 | SURG | WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W CC | 3.0085 | 6.2 | 7.8 |
| 465 | 8 | SURG | WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W/O CC/MCC | 1.9463 | 3.7 | 4.7 |
| 466 | 8 | SURG | REVISION OF HIP OR KNEE REPLACEMENT W MCC | 5.1513 | 6.7 | 8.2 |
| 467 | 8 | SURG | REVISION OF HIP OR KNEE REPLACEMENT W CC | 3.4231 | 3.8 | 4.3 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| 468 | 8 | SURG | REVISION OF HIP OR KNEE REPLACEMENT W/O CC/MCC | 2.7652 | 2.9 | 3.1 |
| 469 | 8 | SURG | MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W MCC | 3.3905 | 6.1 | 7.2 |
| 470 | 8 | SURG | MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC | 2.1137 | 3.0 | 3.2 |
| 471 | 8 | SURG | CERVICAL SPINAL FUSION W MCC | 4.8737 | 6.3 | 8.6 |
| 472 | 8 | SURG | CERVICAL SPINAL FUSION W CC | 2.9166 | 2.4 | 3.4 |
| 473 | 8 | SURG | CERVICAL SPINAL FUSION W/O CC/MCC | 2.2655 | 1.5 | 1.8 |
| 474 | 8 | SURG | AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W MCC | 3.5943 | 8.5 | 10.9 |
| 475 | 8 | SURG | AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W CC | 2.0504 | 5.8 | 7.2 |
| 476 | 8 | SURG | AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W/O CC/MCC | 1.1187 | 3.1 | 3.9 |
| 477 | 8 | SURG | BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC | 3.1638 | 8.5 | 10.4 |
| 478 | 8 | SURG | BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC | 2.2441 | 5.4 | 6.6 |
| 479 | 8 | SURG | BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC | 1.7312 | 3.2 | 4.0 |
| 480 | 8 | SURG | HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC | 3.0052 | 6.9 | 8.0 |
| 481 | 8 | SURG | HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC | 1.9776 | 4.7 | 5.1 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| **MS-DRG** | **MDC** | **TYPE** | **MS-DRG Title** | **Weights** | **Geometric mean LOS** | **Arithmetic mean LOS** |
| 482 | 8 | SURG | HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC | 1.6243 | 3.8 | 4.1 |
| 483 | 8 | SURG | MAJOR JOINT/LIMB REATTACHMENT PROCEDURE OF UPPER EXTREMITIES | 2.4205 | 2.0 | 2.4 |
| 485 | 8 | SURG | KNEE PROCEDURES W PDX OF INFECTION W MCC | 3.0949 | 7.9 | 9.5 |
| 486 | 8 | SURG | KNEE PROCEDURES W PDX OF INFECTION W CC | 2.0656 | 5.5 | 6.2 |
| 487 | 8 | SURG | KNEE PROCEDURES W PDX OF INFECTION W/O CC/MCC | 1.5630 | 3.9 | 4.6 |
| 488 | 8 | SURG | KNEE PROCEDURES W/O PDX OF INFECTION W CC/MCC | 1.7225 | 3.4 | 4.1 |
| 489 | 8 | SURG | KNEE PROCEDURES W/O PDX OF INFECTION W/O CC/MCC | 1.3186 | 2.3 | 2.6 |
| 492 | 8 | SURG | LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W MCC | 3.1873 | 6.4 | 7.9 |
| 493 | 8 | SURG | LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W CC | 2.0354 | 3.9 | 4.6 |
| 494 | 8 | SURG | LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W/O CC/MCC | 1.5397 | 2.6 | 3.0 |
| 495 | 8 | SURG | LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W MCC | 3.0476 | 7.2 | 9.5 |
| 496 | 8 | SURG | LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W CC | 1.7289 | 3.9 | 5.0 |
| 497 | 8 | SURG | LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W/O CC/MCC | 1.2230 | 2.0 | 2.5 |
| 498 | 8 | SURG | LOCAL EXCISION & REMOVAL INT FIX | 2.1416 | 5.2 | 7.0 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| | | | DEVICES OF HIP & FEMUR W CC/MCC | | | |
| 499 | 8 | SURG | LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W/O CC/MCC | 1.0753 | 2.0 | 2.5 |
| 500 | 8 | SURG | SOFT TISSUE PROCEDURES W MCC | 3.2420 | 7.6 | 10.1 |
| 501 | 8 | SURG | SOFT TISSUE PROCEDURES W CC | 1.6474 | 4.2 | 5.4 |
| 502 | 8 | SURG | SOFT TISSUE PROCEDURES W/O CC/MCC | 1.1597 | 2.3 | 2.8 |
| 503 | 8 | SURG | FOOT PROCEDURES W MCC | 2.3338 | 6.8 | 8.4 |
| 504 | 8 | SURG | FOOT PROCEDURES W CC | 1.5691 | 4.8 | 5.8 |
| 505 | 8 | SURG | FOOT PROCEDURES W/O CC/MCC | 1.2474 | 2.6 | 3.3 |
| 506 | 8 | SURG | MAJOR THUMB OR JOINT PROCEDURES | 1.2881 | 3.2 | 4.1 |
| 507 | 8 | SURG | MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W CC/MCC | 1.9154 | 4.1 | 5.1 |
| 508 | 8 | SURG | MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W/O CC/MCC | 1.5198 | 1.9 | 2.4 |
| 509 | 8 | SURG | ARTHROSCOPY | 1.5494 | 3.1 | 4.1 |
| 510 | 8 | SURG | SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W MCC | 2.2857 | 4.7 | 5.8 |
| 511 | 8 | SURG | SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W CC | 1.6509 | 3.2 | 3.8 |
| 512 | 8 | SURG | SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W/O CC/MCC | 1.2963 | 1.9 | 2.3 |
| 513 | 8 | SURG | HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W CC/MCC | 1.4462 | 3.5 | 4.7 |
| 514 | 8 | SURG | HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W/O CC/MCC | 0.8996 | 2.1 | 2.6 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| **MS-DRG** | **MDC** | **TYPE** | **MS-DRG Title** | **Weights** | **Geometric mean LOS** | **Arithmetic mean LOS** |
| 515 | 8 | SURG | OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W MCC | 3.2235 | 7.1 | 9.1 |
| 516 | 8 | SURG | OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC | 2.0434 | 4.3 | 5.3 |
| 517 | 8 | SURG | OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC/MCC | 1.7251 | 2.6 | 3.2 |
| 518 | 8 | SURG | BACK & NECK PROC EXC SPINAL FUSION W MCC OR DISC DEVICE/NEUROSTIM | 3.0628 | 4.2 | 6.5 |
| 519 | 8 | SURG | BACK & NECK PROC EXC SPINAL FUSION W CC | 1.6468 | 3.0 | 3.9 |
| 520 | 8 | SURG | BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC | 1.1396 | 1.7 | 2.1 |
| 533 | 8 | MED | FRACTURES OF FEMUR W MCC | 1.4495 | 4.3 | 5.7 |
| 534 | 8 | MED | FRACTURES OF FEMUR W/O MCC | 0.7594 | 2.9 | 3.5 |
| 535 | 8 | MED | FRACTURES OF HIP & PELVIS W MCC | 1.2410 | 4.1 | 5.2 |
| 536 | 8 | MED | FRACTURES OF HIP & PELVIS W/O MCC | 0.7201 | 3.0 | 3.5 |
| 537 | 8 | MED | SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W CC/MCC | 0.8975 | 3.3 | 4.0 |
| 538 | 8 | MED | SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W/O CC/MCC | 0.6917 | 2.5 | 3.0 |
| 539 | 8 | MED | OSTEOMYELITIS W MCC | 1.8276 | 6.1 | 8.1 |
| 540 | 8 | MED | OSTEOMYELITIS W CC | 1.2967 | 4.7 | 5.9 |
| 541 | 8 | MED | OSTEOMYELITIS W/O CC/MCC | 0.9218 | 3.5 | 4.4 |
| 542 | 8 | MED | PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W | 1.9472 | 6.0 | 7.8 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| | | | MCC | | | |
| 543 | 8 | MED | PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W CC | 1.1227 | 4.0 | 5.1 |
| 544 | 8 | MED | PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W/O CC/MCC | 0.7936 | 3.1 | 3.6 |
| 545 | 8 | MED | CONNECTIVE TISSUE DISORDERS W MCC | 2.5341 | 6.0 | 8.4 |
| 546 | 8 | MED | CONNECTIVE TISSUE DISORDERS W CC | 1.1711 | 3.9 | 4.9 |
| 547 | 8 | MED | CONNECTIVE TISSUE DISORDERS W/O CC/MCC | 0.7985 | 2.8 | 3.4 |
| 548 | 8 | MED | SEPTIC ARTHRITIS W MCC | 1.9123 | 6.1 | 7.7 |
| 549 | 8 | MED | SEPTIC ARTHRITIS W CC | 1.1514 | 4.4 | 5.5 |
| 550 | 8 | MED | SEPTIC ARTHRITIS W/O CC/MCC | 0.8390 | 3.1 | 3.8 |
| 551 | 8 | MED | MEDICAL BACK PROBLEMS W MCC | 1.5556 | 4.7 | 6.1 |
| 552 | 8 | MED | MEDICAL BACK PROBLEMS W/O MCC | 0.8698 | 3.0 | 3.7 |
| 553 | 8 | MED | BONE DISEASES & ARTHROPATHIES W MCC | 1.2187 | 4.1 | 5.3 |
| 554 | 8 | MED | BONE DISEASES & ARTHROPATHIES W/O MCC | 0.7274 | 2.8 | 3.4 |
| 555 | 8 | MED | SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W MCC | 1.2636 | 3.8 | 5.0 |
| 556 | 8 | MED | SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC | 0.7183 | 2.5 | 3.1 |
| 557 | 8 | MED | TENDONITIS, MYOSITIS & BURSITIS W MCC | 1.4269 | 5.0 | 6.1 |
| 558 | 8 | MED | TENDONITIS, MYOSITIS & BURSITIS W/O MCC | 0.8522 | 3.4 | 4.0 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| **MS-DRG** | **MDC** | **TYPE** | **MS-DRG Title** | **Weights** | **Geometric mean LOS** | **Arithmetic mean LOS** |
| 559 | 8 | MED | AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC | 1.8555 | 4.9 | 6.7 |
| 560 | 8 | MED | AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC | 1.0756 | 3.4 | 4.3 |
| 561 | 8 | MED | AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC | 0.6688 | 2.0 | 2.4 |
| 562 | 8 | MED | FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W MCC | 1.3706 | 4.3 | 5.5 |
| 563 | 8 | MED | FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W/O MCC | 0.7756 | 2.9 | 3.5 |
| 564 | 8 | MED | OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W MCC | 1.5036 | 4.7 | 6.2 |
| 565 | 8 | MED | OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W CC | 0.9398 | 3.5 | 4.3 |
| 566 | 8 | MED | OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W/O CC/MCC | 0.6871 | 2.4 | 3.0 |
| 570 | 9 | SURG | SKIN DEBRIDEMENT W MCC | 2.3952 | 7.1 | 9.2 |
| 571 | 9 | SURG | SKIN DEBRIDEMENT W CC | 1.4664 | 5.1 | 6.2 |
| 572 | 9 | SURG | SKIN DEBRIDEMENT W/O CC/MCC | 0.9919 | 3.7 | 4.3 |
| 573 | 9 | SURG | SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W MCC | 3.7074 | 8.5 | 12.7 |
| 574 | 9 | SURG | SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W CC | 2.6298 | 7.0 | 9.3 |
| 575 | 9 | SURG | SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W/O CC/MCC | 1.4926 | 4.2 | 5.4 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| 576 | 9 | SURG | SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W MCC | 4.1423 | 7.6 | 11.3 |
| 577 | 9 | SURG | SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W CC | 1.9812 | 3.7 | 5.4 |
| 578 | 9 | SURG | SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W/O CC/MCC | 1.3162 | 2.3 | 3.1 |
| 579 | 9 | SURG | OTHER SKIN, SUBCUT TISS & BREAST PROC W MCC | 2.7263 | 6.9 | 9.1 |
| 580 | 9 | SURG | OTHER SKIN, SUBCUT TISS & BREAST PROC W CC | 1.5727 | 3.8 | 5.1 |
| 581 | 9 | SURG | OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC/MCC | 1.1338 | 2.0 | 2.5 |
| 582 | 9 | SURG | MASTECTOMY FOR MALIGNANCY W CC/MCC | 1.3003 | 2.0 | 2.6 |
| 583 | 9 | SURG | MASTECTOMY FOR MALIGNANCY W/O CC/MCC | 1.0932 | 1.5 | 1.7 |
| 584 | 9 | SURG | BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W CC/MCC | 1.7682 | 3.5 | 4.9 |
| 585 | 9 | SURG | BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W/O CC/MCC | 1.3752 | 1.9 | 2.3 |
| 592 | 9 | MED | SKIN ULCERS W MCC | 1.4249 | 5.1 | 6.6 |
| 593 | 9 | MED | SKIN ULCERS W CC | 1.0196 | 4.2 | 5.1 |
| 594 | 9 | MED | SKIN ULCERS W/O CC/MCC | 0.7124 | 3.0 | 3.8 |
| 595 | 9 | MED | MAJOR SKIN DISORDERS W MCC | 1.9629 | 5.5 | 7.5 |
| 596 | 9 | MED | MAJOR SKIN DISORDERS W/O MCC | 0.9527 | 3.5 | 4.5 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| 597 | 9 | MED | MALIGNANT BREAST DISORDERS W MCC | 1.6758 | 5.3 | 7.1 |
| 598 | 9 | MED | MALIGNANT BREAST DISORDERS W CC | 1.1235 | 3.7 | 5.1 |
| 599 | 9 | MED | MALIGNANT BREAST DISORDERS W/O CC/MCC | 0.7259 | 2.4 | 3.0 |
| 600 | 9 | MED | NON-MALIGNANT BREAST DISORDERS W CC/MCC | 0.9803 | 3.8 | 4.7 |
| 601 | 9 | MED | NON-MALIGNANT BREAST DISORDERS W/O CC/MCC | 0.6314 | 2.6 | 3.2 |
| 602 | 9 | MED | CELLULITIS W MCC | 1.4557 | 5.0 | 6.2 |
| 603 | 9 | MED | CELLULITIS W/O MCC | 0.8447 | 3.5 | 4.2 |
| 604 | 9 | MED | TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W MCC | 1.2624 | 3.8 | 5.0 |
| 605 | 9 | MED | TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W/O MCC | 0.7664 | 2.5 | 3.1 |
| 606 | 9 | MED | MINOR SKIN DISORDERS W MCC | 1.3664 | 4.1 | 5.7 |
| 607 | 9 | MED | MINOR SKIN DISORDERS W/O MCC | 0.7296 | 2.7 | 3.5 |
| 614 | 10 | SURG | ADRENAL & PITUITARY PROCEDURES W CC/MCC | 2.4642 | 4.1 | 5.6 |
| 615 | 10 | SURG | ADRENAL & PITUITARY PROCEDURES W/O CC/MCC | 1.4243 | 2.2 | 2.6 |
| 616 | 10 | SURG | AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W MCC | 4.1611 | 10.7 | 13.1 |
| 617 | 10 | SURG | AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W CC | 1.9956 | 6.0 | 7.1 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| **For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015** | | | | | | |
| **MS-DRG** | **MDC** | **TYPE** | **MS-DRG Title** | **Weights** | **Geometric mean LOS** | **Arithmetic mean LOS** |
| 618 | 10 | SURG | AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W/O CC/MCC | 1.3512 | 4.0 | 5.0 |
| 619 | 10 | SURG | O.R. PROCEDURES FOR OBESITY W MCC | 3.2890 | 4.2 | 6.4 |
| 620 | 10 | SURG | O.R. PROCEDURES FOR OBESITY W CC | 1.8470 | 2.5 | 3.1 |
| 621 | 10 | SURG | O.R. PROCEDURES FOR OBESITY W/O CC/MCC | 1.5434 | 1.8 | 2.0 |
| 622 | 10 | SURG | SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W MCC | 3.8047 | 9.1 | 12.5 |
| 623 | 10 | SURG | SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W CC | 1.8308 | 5.6 | 6.9 |
| 624 | 10 | SURG | SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W/O CC/MCC | 1.1314 | 3.6 | 4.3 |
| 625 | 10 | SURG | THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W MCC | 2.4896 | 4.5 | 7.1 |
| 626 | 10 | SURG | THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W CC | 1.3080 | 2.1 | 3.0 |
| 627 | 10 | SURG | THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W/O CC/MCC | 0.8663 | 1.3 | 1.4 |
| 628 | 10 | SURG | OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W MCC | 3.2935 | 6.6 | 9.4 |
| 629 | 10 | SURG | OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC | 2.2471 | 6.1 | 7.4 |
| 630 | 10 | SURG | OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC/MCC | 1.4305 | 3.1 | 4.0 |
| 637 | 10 | MED | DIABETES W MCC | 1.3944 | 4.1 | 5.5 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| 638 | 10 | MED | DIABETES W CC | 0.8261 | 3.0 | 3.7 |
| 639 | 10 | MED | DIABETES W/O CC/MCC | 0.6068 | 2.2 | 2.6 |
| 640 | 10 | MED | MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W MCC | 1.1044 | 3.2 | 4.4 |
| 641 | 10 | MED | MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W/O MCC | 0.7051 | 2.6 | 3.3 |
| 642 | 10 | MED | INBORN AND OTHER DISORDERS OF METABOLISM | 1.1429 | 3.3 | 4.6 |
| 643 | 10 | MED | ENDOCRINE DISORDERS W MCC | 1.6460 | 5.4 | 6.8 |
| 644 | 10 | MED | ENDOCRINE DISORDERS W CC | 1.0199 | 3.8 | 4.6 |
| 645 | 10 | MED | ENDOCRINE DISORDERS W/O CC/MCC | 0.7180 | 2.7 | 3.3 |
| 652 | 11 | SURG | KIDNEY TRANSPLANT | 3.1502 | 5.7 | 6.6 |
| 653 | 11 | SURG | MAJOR BLADDER PROCEDURES W MCC | 5.7958 | 12.1 | 15.0 |
| 654 | 11 | SURG | MAJOR BLADDER PROCEDURES W CC | 3.0973 | 7.6 | 8.7 |
| 655 | 11 | SURG | MAJOR BLADDER PROCEDURES W/O CC/MCC | 2.2590 | 4.8 | 5.5 |
| 656 | 11 | SURG | KIDNEY & URETER PROCEDURES FOR NEOPLASM W MCC | 3.4517 | 6.9 | 9.0 |
| 657 | 11 | SURG | KIDNEY & URETER PROCEDURES FOR NEOPLASM W CC | 2.0111 | 4.3 | 5.2 |
| 658 | 11 | SURG | KIDNEY & URETER PROCEDURES FOR NEOPLASM W/O CC/MCC | 1.5299 | 2.6 | 3.0 |
| 659 | 11 | SURG | KIDNEY & URETER PROCEDURES FOR NON- | 3.3813 | 7.5 | 10.0 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| | | | NEOPLASM W MCC | | | |
| 660 | 11 | SURG | KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W CC | 1.8888 | 4.1 | 5.4 |
| 661 | 11 | SURG | KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W/O CC/MCC | 1.3494 | 2.2 | 2.6 |
| 662 | 11 | SURG | MINOR BLADDER PROCEDURES W MCC | 3.0042 | 7.7 | 10.2 |
| 663 | 11 | SURG | MINOR BLADDER PROCEDURES W CC | 1.5285 | 3.8 | 5.0 |
| 664 | 11 | SURG | MINOR BLADDER PROCEDURES W/O CC/MCC | 1.2406 | 1.8 | 2.3 |
| 665 | 11 | SURG | PROSTATECTOMY W MCC | 3.1585 | 9.1 | 11.7 |
| 666 | 11 | SURG | PROSTATECTOMY W CC | 1.7512 | 4.5 | 6.1 |
| 667 | 11 | SURG | PROSTATECTOMY W/O CC/MCC | 0.9690 | 2.0 | 2.6 |
| 668 | 11 | SURG | TRANSURETHRAL PROCEDURES W MCC | 2.4989 | 6.4 | 8.6 |
| 669 | 11 | SURG | TRANSURETHRAL PROCEDURES W CC | 1.2662 | 2.9 | 4.0 |
| 670 | 11 | SURG | TRANSURETHRAL PROCEDURES W/O CC/MCC | 0.8957 | 1.9 | 2.4 |
| 671 | 11 | SURG | URETHRAL PROCEDURES W CC/MCC | 1.6170 | 4.0 | 5.7 |
| 672 | 11 | SURG | URETHRAL PROCEDURES W/O CC/MCC | 0.8496 | 1.8 | 2.2 |
| 673 | 11 | SURG | OTHER KIDNEY & URINARY TRACT PROCEDURES W MCC | 3.5023 | 6.8 | 10.2 |
| 674 | 11 | SURG | OTHER KIDNEY & URINARY TRACT PROCEDURES W CC | 2.2600 | 5.1 | 6.9 |
| 675 | 11 | SURG | OTHER KIDNEY & URINARY TRACT PROCEDURES W/O CC/MCC | 1.4443 | 2.0 | 2.7 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| 682 | 11 | MED | RENAL FAILURE W MCC | 1.5194 | 4.6 | 6.1 |
| 683 | 11 | MED | RENAL FAILURE W CC | 0.9512 | 3.5 | 4.4 |
| 684 | 11 | MED | RENAL FAILURE W/O CC/MCC | 0.6085 | 2.4 | 2.9 |
| 685 | 11 | MED | ADMIT FOR RENAL DIALYSIS | 1.0025 | 2.5 | 3.4 |
| 686 | 11 | MED | KIDNEY & URINARY TRACT NEOPLASMS W MCC | 1.7637 | 5.2 | 7.0 |
| 687 | 11 | MED | KIDNEY & URINARY TRACT NEOPLASMS W CC | 1.0054 | 3.5 | 4.5 |
| 688 | 11 | MED | KIDNEY & URINARY TRACT NEOPLASMS W/O CC/MCC | 0.6911 | 2.0 | 2.5 |
| 689 | 11 | MED | KIDNEY & URINARY TRACT INFECTIONS W MCC | 1.1172 | 4.2 | 5.1 |
| 690 | 11 | MED | KIDNEY & URINARY TRACT INFECTIONS W/O MCC | 0.7794 | 3.1 | 3.8 |
| 691 | 11 | MED | URINARY STONES W ESW LITHOTRIPSY W CC/MCC | 1.6238 | 2.8 | 3.7 |
| 692 | 11 | MED | URINARY STONES W ESW LITHOTRIPSY W/O CC/MCC | 1.1286 | 1.6 | 2.0 |
| 693 | 11 | MED | URINARY STONES W/O ESW LITHOTRIPSY W MCC | 1.3433 | 3.8 | 5.1 |
| 694 | 11 | MED | URINARY STONES W/O ESW LITHOTRIPSY W/O MCC | 0.6859 | 1.9 | 2.3 |
| 695 | 11 | MED | KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W MCC | 1.2450 | 4.0 | 5.3 |
| 696 | 11 | MED | KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W/O MCC | 0.6619 | 2.4 | 3.0 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| 697 | 11 | MED | URETHRAL STRICTURE | 0.9229 | 2.5 | 3.3 |
| 698 | 11 | MED | OTHER KIDNEY & URINARY TRACT DIAGNOSES W MCC | 1.5625 | 5.1 | 6.4 |
| 699 | 11 | MED | OTHER KIDNEY & URINARY TRACT DIAGNOSES W CC | 1.0170 | 3.5 | 4.4 |
| 700 | 11 | MED | OTHER KIDNEY & URINARY TRACT DIAGNOSES W/O CC/MCC | 0.7110 | 2.6 | 3.2 |
| 707 | 12 | SURG | MAJOR MALE PELVIC PROCEDURES W CC/MCC | 1.8155 | 2.9 | 3.9 |
| 708 | 12 | SURG | MAJOR MALE PELVIC PROCEDURES W/O CC/MCC | 1.3262 | 1.4 | 1.6 |
| 709 | 12 | SURG | PENIS PROCEDURES W CC/MCC | 2.1341 | 4.0 | 6.7 |
| 710 | 12 | SURG | PENIS PROCEDURES W/O CC/MCC | 1.2949 | 1.5 | 1.8 |
| 711 | 12 | SURG | TESTES PROCEDURES W CC/MCC | 2.2547 | 5.7 | 8.1 |
| 712 | 12 | SURG | TESTES PROCEDURES W/O CC/MCC | 1.0632 | 2.3 | 3.4 |
| 713 | 12 | SURG | TRANSURETHRAL PROSTATECTOMY W CC/MCC | 1.4828 | 3.2 | 4.5 |
| 714 | 12 | SURG | TRANSURETHRAL PROSTATECTOMY W/O CC/MCC | 0.7933 | 1.6 | 1.9 |
| 715 | 12 | SURG | OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W CC/MCC | 2.0051 | 4.6 | 6.4 |
| 716 | 12 | SURG | OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W/O CC/MCC | 1.1857 | 1.5 | 1.7 |
| 717 | 12 | SURG | OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W CC/MCC | 1.7717 | 4.6 | 6.5 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| 718 | 12 | SURG | OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W/O CC/MCC | 1.0099 | 2.2 | 2.8 |
| 722 | 12 | MED | MALIGNANCY, MALE REPRODUCTIVE SYSTEM W MCC | 1.7569 | 5.6 | 7.4 |
| 723 | 12 | MED | MALIGNANCY, MALE REPRODUCTIVE SYSTEM W CC | 1.0635 | 3.8 | 4.9 |
| 724 | 12 | MED | MALIGNANCY, MALE REPRODUCTIVE SYSTEM W/O CC/MCC | 0.6412 | 2.1 | 2.8 |
| 725 | 12 | MED | BENIGN PROSTATIC HYPERTROPHY W MCC | 1.1790 | 4.3 | 5.6 |
| 726 | 12 | MED | BENIGN PROSTATIC HYPERTROPHY W/O MCC | 0.7029 | 2.6 | 3.2 |
| 727 | 12 | MED | INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W MCC | 1.4195 | 4.9 | 6.2 |
| 728 | 12 | MED | INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W/O MCC | 0.8006 | 3.2 | 3.8 |
| 729 | 12 | MED | OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W CC/MCC | 1.0390 | 3.4 | 4.5 |
| 730 | 12 | MED | OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W/O CC/MCC | 0.6660 | 2.2 | 2.9 |
| 734 | 13 | SURG | PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W CC/MCC | 2.5704 | 4.5 | 6.5 |
| 735 | 13 | SURG | PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W/O CC/MCC | 1.2265 | 1.8 | 2.2 |
| 736 | 13 | SURG | UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W MCC | 4.4341 | 10.1 | 12.5 |
| 737 | 13 | SURG | UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W CC | 2.0198 | 5.2 | 6.1 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| **For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015** | | | | | | |
| **MS-DRG** | **MDC** | **TYPE** | **MS-DRG Title** | **Weights** | **Geometric mean LOS** | **Arithmetic mean LOS** |
| 738 | 13 | SURG | UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W/O CC/MCC | 1.2746 | 2.9 | 3.3 |
| 739 | 13 | SURG | UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W MCC | 3.3133 | 6.6 | 9.1 |
| 740 | 13 | SURG | UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC | 1.6069 | 3.0 | 3.9 |
| 741 | 13 | SURG | UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC/MCC | 1.1846 | 1.7 | 2.0 |
| 742 | 13 | SURG | UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC/MCC | 1.5436 | 2.9 | 3.9 |
| 743 | 13 | SURG | UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC | 0.9954 | 1.7 | 1.9 |
| 744 | 13 | SURG | D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W CC/MCC | 1.7484 | 4.1 | 5.7 |
| 745 | 13 | SURG | D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W/O CC/MCC | 0.9553 | 1.8 | 2.3 |
| 746 | 13 | SURG | VAGINA, CERVIX & VULVA PROCEDURES W CC/MCC | 1.4219 | 3.1 | 4.5 |
| 747 | 13 | SURG | VAGINA, CERVIX & VULVA PROCEDURES W/O CC/MCC | 0.8892 | 1.5 | 1.8 |
| 748 | 13 | SURG | FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES | 1.0845 | 1.5 | 1.8 |
| 749 | 13 | SURG | OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W CC/MCC | 2.5541 | 6.0 | 8.3 |
| 750 | 13 | SURG | OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC | 1.1904 | 2.1 | 2.6 |
| 754 | 13 | MED | MALIGNANCY, FEMALE REPRODUCTIVE | 1.9626 | 5.9 | 8.2 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| | | | SYSTEM W MCC | | | |
| 755 | 13 | MED | MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC | 1.1066 | 3.6 | 4.9 |
| 756 | 13 | MED | MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC | 0.6652 | 2.1 | 2.8 |
| 757 | 13 | MED | INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W MCC | 1.5397 | 5.7 | 7.1 |
| 758 | 13 | MED | INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W CC | 1.0518 | 4.3 | 5.3 |
| 759 | 13 | MED | INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC | 0.6931 | 3.0 | 3.7 |
| 760 | 13 | MED | MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W CC/MCC | 0.8399 | 2.7 | 3.5 |
| 761 | 13 | MED | MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W/O CC/MCC | 0.4988 | 1.7 | 2.1 |
| 765 | 14 | SURG | CESAREAN SECTION W CC/MCC | 1.0924 | 3.8 | 4.7 |
| 766 | 14 | SURG | CESAREAN SECTION W/O CC/MCC | 0.7562 | 2.9 | 3.0 |
| 767 | 14 | SURG | VAGINAL DELIVERY W STERILIZATION &/OR D&C | 0.8513 | 2.7 | 3.4 |
| 768 | 14 | SURG | VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C | 1.1184 | 4.7 | 5.8 |
| 769 | 14 | SURG | POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE | 1.8930 | 3.5 | 5.7 |
| 770 | 14 | SURG | ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY | 0.8029 | 1.7 | 2.2 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| 774 | 14 | MED | VAGINAL DELIVERY W COMPLICATING DIAGNOSES | 0.7168 | 2.6 | 3.1 |
| 775 | 14 | MED | VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES | 0.5643 | 2.1 | 2.3 |
| 776 | 14 | MED | POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE | 0.8117 | 2.7 | 3.6 |
| 777 | 14 | MED | ECTOPIC PREGNANCY | 1.0145 | 1.7 | 2.2 |
| 778 | 14 | MED | THREATENED ABORTION | 0.5638 | 2.1 | 3.2 |
| 779 | 14 | MED | ABORTION W/O D&C | 0.6389 | 1.5 | 2.0 |
| 780 | 14 | MED | FALSE LABOR | 0.2880 | 1.2 | 1.3 |
| 781 | 14 | MED | OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS | 0.7546 | 2.6 | 3.9 |
| 782 | 14 | MED | OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS | 0.4057 | 1.7 | 2.2 |
| 789 | 15 | MED | NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY | 1.5547 | 1.8 | 1.8 |
| 790 | 15 | MED | EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE | 5.1268 | 17.9 | 17.9 |
| 791 | 15 | MED | PREMATURITY W MAJOR PROBLEMS | 3.5015 | 13.3 | 13.3 |
| 792 | 15 | MED | PREMATURITY W/O MAJOR PROBLEMS | 2.1127 | 8.6 | 8.6 |
| 793 | 15 | MED | FULL TERM NEONATE W MAJOR PROBLEMS | 3.5968 | 4.7 | 4.7 |
| 794 | 15 | MED | NEONATE W OTHER SIGNIFICANT PROBLEMS | 1.2731 | 3.4 | 3.4 |
| 795 | 15 | MED | NORMAL NEWBORN | 0.1724 | 3.1 | 3.1 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| 799 | 16 | SURG | SPLENECTOMY W MCC | 5.0131 | 9.4 | 12.2 |
| 800 | 16 | SURG | SPLENECTOMY W CC | 2.6403 | 5.5 | 7.0 |
| 801 | 16 | SURG | SPLENECTOMY W/O CC/MCC | 1.5477 | 2.7 | 3.4 |
| 802 | 16 | SURG | OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W MCC | 3.3601 | 7.9 | 10.8 |
| 803 | 16 | SURG | OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W CC | 1.8440 | 4.4 | 5.9 |
| 804 | 16 | SURG | OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W/O CC/MCC | 1.2265 | 2.3 | 3.0 |
| 808 | 16 | MED | MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W MCC | 2.2260 | 6.0 | 8.0 |
| 809 | 16 | MED | MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W CC | 1.2037 | 3.7 | 4.7 |
| 810 | 16 | MED | MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W/O CC/MCC | 0.8409 | 2.6 | 3.2 |
| 811 | 16 | MED | RED BLOOD CELL DISORDERS W MCC | 1.2829 | 3.6 | 4.9 |
| 812 | 16 | MED | RED BLOOD CELL DISORDERS W/O MCC | 0.8162 | 2.6 | 3.4 |
| 813 | 16 | MED | COAGULATION DISORDERS | 1.6534 | 3.5 | 4.9 |
| 814 | 16 | MED | RETICULOENDOTHELIAL & IMMUNITY DISORDERS W MCC | 1.7048 | 4.9 | 6.8 |
| 815 | 16 | MED | RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC | 0.9948 | 3.3 | 4.2 |
| 816 | 16 | MED | RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC/MCC | 0.6882 | 2.3 | 2.9 |
| 820 | 17 | SURG | LYMPHOMA & LEUKEMIA W MAJOR O.R. | 5.5226 | 11.6 | 15.3 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| | | | PROCEDURE W MCC | | | |
| 821 | 17 | SURG | LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC | 2.3064 | 4.5 | 6.3 |
| 822 | 17 | SURG | LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/O CC/MCC | 1.2805 | 2.1 | 2.8 |
| 823 | 17 | SURG | LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W MCC | 4.4622 | 11.4 | 14.6 |
| 824 | 17 | SURG | LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC | 2.2951 | 5.8 | 7.6 |
| 825 | 17 | SURG | LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC/MCC | 1.3803 | 2.7 | 3.7 |
| 826 | 17 | SURG | MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W MCC | 5.0900 | 10.4 | 13.8 |
| 827 | 17 | SURG | MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC | 2.3214 | 5.1 | 6.7 |
| 828 | 17 | SURG | MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC/MCC | 1.5321 | 2.8 | 3.4 |
| 829 | 17 | SURG | MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC W CC/MCC | 3.4231 | 6.7 | 10.3 |
| 830 | 17 | SURG | MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC W/O CC/MCC | 1.2523 | 2.2 | 2.9 |
| 834 | 17 | MED | ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W MCC | 5.2735 | 10.1 | 16.5 |
| 835 | 17 | MED | ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W CC | 2.1042 | 4.7 | 7.6 |
| 836 | 17 | MED | ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W/O CC/MCC | 1.1693 | 2.7 | 4.0 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| 837 | 17 | MED | CHEMO W ACUTE LEUKEMIA AS SDX OR W HIGH DOSE CHEMO AGENT W MCC | 6.4631 | 16.3 | 22.2 |
| 838 | 17 | MED | CHEMO W ACUTE LEUKEMIA AS SDX W CC OR HIGH DOSE CHEMO AGENT | 2.7923 | 6.8 | 9.9 |
| 839 | 17 | MED | CHEMO W ACUTE LEUKEMIA AS SDX W/O CC/MCC | 1.2525 | 4.9 | 5.7 |
| 840 | 17 | MED | LYMPHOMA & NON-ACUTE LEUKEMIA W MCC | 3.1058 | 7.6 | 10.5 |
| 841 | 17 | MED | LYMPHOMA & NON-ACUTE LEUKEMIA W CC | 1.6226 | 4.7 | 6.1 |
| 842 | 17 | MED | LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC/MCC | 1.0777 | 2.9 | 3.8 |
| 843 | 17 | MED | OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W MCC | 1.7902 | 5.5 | 7.4 |
| 844 | 17 | MED | OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC | 1.2058 | 4.1 | 5.4 |
| 845 | 17 | MED | OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC/MCC | 0.8551 | 2.9 | 3.7 |
| 846 | 17 | MED | CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W MCC | 2.3264 | 5.5 | 7.7 |
| 847 | 17 | MED | CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W CC | 1.1569 | 2.9 | 3.5 |
| 848 | 17 | MED | CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W/O CC/MCC | 0.8454 | 2.4 | 2.9 |
| 849 | 17 | MED | RADIOTHERAPY | 1.4657 | 4.4 | 5.7 |
| 853 | 18 | SURG | INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC | 5.2068 | 10.8 | 13.9 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| **MS-DRG** | **MDC** | **TYPE** | **MS-DRG Title** | **Weights** | **Geometric mean LOS** | **Arithmetic mean LOS** |
| 854 | 18 | SURG | INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W CC | 2.3877 | 6.7 | 8.1 |
| 855 | 18 | SURG | INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W/O CC/MCC | 1.7057 | 3.3 | 4.7 |
| 856 | 18 | SURG | POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W MCC | 4.8177 | 10.0 | 13.3 |
| 857 | 18 | SURG | POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W CC | 2.0500 | 5.6 | 7.0 |
| 858 | 18 | SURG | POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W/O CC/MCC | 1.3390 | 3.7 | 4.6 |
| 862 | 18 | MED | POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W MCC | 1.8506 | 5.5 | 7.2 |
| 863 | 18 | MED | POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W/O MCC | 0.9836 | 3.7 | 4.5 |
| 864 | 18 | MED | FEVER | 0.8419 | 2.8 | 3.5 |
| 865 | 18 | MED | VIRAL ILLNESS W MCC | 1.5131 | 4.2 | 5.8 |
| 866 | 18 | MED | VIRAL ILLNESS W/O MCC | 0.7425 | 2.7 | 3.4 |
| 867 | 18 | MED | OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W MCC | 2.7245 | 7.0 | 9.5 |
| 868 | 18 | MED | OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W CC | 1.0897 | 3.9 | 4.9 |
| 869 | 18 | MED | OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W/O CC/MCC | 0.6877 | 2.7 | 3.2 |
| 870 | 18 | MED | SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS | 5.8698 | 12.6 | 14.7 |
| 871 | 18 | MED | SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ | 1.8072 | 5.1 | 6.6 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| | | | HOURS W MCC | | | |
| 872 | 18 | MED | SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC | 1.0528 | 4.0 | 4.7 |
| 876 | 19 | SURG | O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS | 3.3533 | 7.4 | 14.9 |
| 880 | 19 | MED | ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION | 0.6704 | 2.2 | 3.0 |
| 881 | 19 | MED | DEPRESSIVE NEUROSES | 0.6464 | 3.3 | 4.4 |
| 882 | 19 | MED | NEUROSES EXCEPT DEPRESSIVE | 0.6935 | 3.2 | 4.5 |
| 883 | 19 | MED | DISORDERS OF PERSONALITY & IMPULSE CONTROL | 1.3062 | 4.4 | 8.2 |
| 884 | 19 | MED | ORGANIC DISTURBANCES & MENTAL RETARDATION | 1.0783 | 4.1 | 5.9 |
| 885 | 19 | MED | PSYCHOSES | 1.0217 | 5.4 | 7.4 |
| 886 | 19 | MED | BEHAVIORAL & DEVELOPMENTAL DISORDERS | 0.8288 | 3.8 | 6.1 |
| 887 | 19 | MED | OTHER MENTAL DISORDER DIAGNOSES | 0.9329 | 3.0 | 4.7 |
| 894 | 20 | MED | ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA | 0.4450 | 2.1 | 2.9 |
| 895 | 20 | MED | ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY | 1.2152 | 9.6 | 12.3 |
| 896 | 20 | MED | ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W MCC | 1.5244 | 4.7 | 6.5 |
| 897 | 20 | MED | ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O MCC | 0.6905 | 3.2 | 4.0 |
| 901 | 21 | SURG | WOUND DEBRIDEMENTS FOR INJURIES W | 3.9929 | 8.9 | 13.2 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| | | | MCC | | | |
| 902 | 21 | SURG | WOUND DEBRIDEMENTS FOR INJURIES W CC | 1.7433 | 4.9 | 6.8 |
| 903 | 21 | SURG | WOUND DEBRIDEMENTS FOR INJURIES W/O CC/MCC | 1.1280 | 3.0 | 4.1 |
| 904 | 21 | SURG | SKIN GRAFTS FOR INJURIES W CC/MCC | 3.3637 | 7.0 | 10.6 |
| 905 | 21 | SURG | SKIN GRAFTS FOR INJURIES W/O CC/MCC | 1.3889 | 3.3 | 4.4 |
| 906 | 21 | SURG | HAND PROCEDURES FOR INJURIES | 1.1789 | 2.3 | 3.3 |
| 907 | 21 | SURG | OTHER O.R. PROCEDURES FOR INJURIES W MCC | 3.7873 | 7.4 | 10.2 |
| 908 | 21 | SURG | OTHER O.R. PROCEDURES FOR INJURIES W CC | 1.9575 | 4.2 | 5.6 |
| 909 | 21 | SURG | OTHER O.R. PROCEDURES FOR INJURIES W/O CC/MCC | 1.2556 | 2.5 | 3.2 |
| 913 | 21 | MED | TRAUMATIC INJURY W MCC | 1.1410 | 3.4 | 4.7 |
| 914 | 21 | MED | TRAUMATIC INJURY W/O MCC | 0.7009 | 2.3 | 2.9 |
| 915 | 21 | MED | ALLERGIC REACTIONS W MCC | 1.5381 | 3.6 | 5.0 |
| 916 | 21 | MED | ALLERGIC REACTIONS W/O MCC | 0.5137 | 1.7 | 2.0 |
| 917 | 21 | MED | POISONING & TOXIC EFFECTS OF DRUGS W MCC | 1.4051 | 3.4 | 4.8 |
| 918 | 21 | MED | POISONING & TOXIC EFFECTS OF DRUGS W/O MCC | 0.6412 | 2.1 | 2.7 |
| 919 | 21 | MED | COMPLICATIONS OF TREATMENT W MCC | 1.6750 | 4.3 | 6.0 |
| 920 | 21 | MED | COMPLICATIONS OF TREATMENT W CC | 0.9850 | 3.0 | 3.9 |

| *Exhibit #1* | | | | | | |
|---|---|---|---|---|---|---|
| **For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015** | | | | | | |
| **MS-DRG** | **MDC** | **TYPE** | **MS-DRG Title** | **Weights** | **Geometric mean LOS** | **Arithmetic mean LOS** |
| 921 | 21 | MED | COMPLICATIONS OF TREATMENT W/O CC/MCC | 0.6602 | 2.1 | 2.7 |
| 922 | 21 | MED | OTHER INJURY, POISONING & TOXIC EFFECT DIAG W MCC | 1.4953 | 3.8 | 5.6 |
| 923 | 21 | MED | OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O MCC | 0.7348 | 2.2 | 3.3 |
| 927 | 22 | SURG | EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W SKIN GRAFT | 15.5499 | 23.0 | 29.0 |
| 928 | 22 | SURG | FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC/MCC | 5.3820 | 11.0 | 15.0 |
| 929 | 22 | SURG | FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W/O CC/MCC | 2.3344 | 5.4 | 7.1 |
| 933 | 22 | MED | EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W/O SKIN GRAFT | 2.7557 | 2.3 | 5.5 |
| 934 | 22 | MED | FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ | 1.5748 | 4.0 | 5.7 |
| 935 | 22 | MED | NON-EXTENSIVE BURNS | 1.4717 | 3.2 | 4.9 |
| 939 | 23 | SURG | O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W MCC | 2.7647 | 6.0 | 8.8 |
| 940 | 23 | SURG | O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W CC | 1.8274 | 3.5 | 5.0 |
| 941 | 23 | SURG | O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W/O CC/MCC | 1.3531 | 2.1 | 2.7 |
| 945 | 23 | MED | REHABILITATION W CC/MCC | 1.2709 | 8.5 | 10.4 |
| 946 | 23 | MED | REHABILITATION W/O CC/MCC | 1.0662 | 6.5 | 7.6 |

| Exhibit #1 | | | | | | |
|---|---|---|---|---|---|---|
| For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015 | | | | | | |
| MS-DRG | MDC | TYPE | MS-DRG Title | Weights | Geometric mean LOS | Arithmetic mean LOS |
| 947 | 23 | MED | SIGNS & SYMPTOMS W MCC | 1.1368 | 3.5 | 4.7 |
| 948 | 23 | MED | SIGNS & SYMPTOMS W/O MCC | 0.7131 | 2.6 | 3.2 |
| 949 | 23 | MED | AFTERCARE W CC/MCC | 1.0525 | 2.9 | 4.4 |
| 950 | 23 | MED | AFTERCARE W/O CC/MCC | 0.5508 | 2.3 | 3.1 |
| 951 | 23 | MED | OTHER FACTORS INFLUENCING HEALTH STATUS | 0.9188 | 2.4 | 5.3 |
| 955 | 24 | SURG | CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA | 5.5727 | 8.0 | 11.6 |
| 956 | 24 | SURG | LIMB REATTACHMENT, HIP & FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA | 3.6692 | 6.6 | 8.0 |
| 957 | 24 | SURG | OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W MCC | 6.8453 | 10.0 | 14.0 |
| 958 | 24 | SURG | OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W CC | 3.8602 | 7.3 | 8.9 |
| 959 | 24 | SURG | OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC | 2.5447 | 4.6 | 5.7 |
| 963 | 24 | MED | OTHER MULTIPLE SIGNIFICANT TRAUMA W MCC | 2.7071 | 5.6 | 8.3 |
| 964 | 24 | MED | OTHER MULTIPLE SIGNIFICANT TRAUMA W CC | 1.4769 | 4.2 | 5.2 |
| 965 | 24 | MED | OTHER MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC | 0.9418 | 2.9 | 3.6 |
| 969 | 25 | SURG | HIV W EXTENSIVE O.R. PROCEDURE W MCC | 6.0815 | 12.3 | 16.9 |
| 970 | 25 | SURG | HIV W EXTENSIVE O.R. PROCEDURE W/O MCC | 2.2085 | 5.4 | 7.1 |

| *Exhibit #1* | | | | | | |
|---|---|---|---|---|---|---|
| **For Hospital Inpatient Discharges Dates of Service on and After 1/1/2015** | | | | | | |
| **MS-DRG** | **MDC** | **TYPE** | **MS-DRG Title** | **Weights** | **Geometric mean LOS** | **Arithmetic mean LOS** |
| 974 | 25 | MED | HIV W MAJOR RELATED CONDITION W MCC | 2.6849 | 6.7 | 9.3 |
| 975 | 25 | MED | HIV W MAJOR RELATED CONDITION W CC | 1.3047 | 4.5 | 5.8 |
| 976 | 25 | MED | HIV W MAJOR RELATED CONDITION W/O CC/MCC | 0.8774 | 3.1 | 3.9 |
| 977 | 25 | MED | HIV W OR W/O OTHER RELATED CONDITION | 1.1305 | 3.5 | 4.7 |
| 981 | | SURG | EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC | 4.9968 | 9.9 | 13.1 |
| 982 | | SURG | EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC | 2.8150 | 5.7 | 7.4 |
| 983 | | SURG | EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC | 1.8039 | 2.7 | 3.6 |
| 984 | | SURG | PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC | 3.4344 | 9.4 | 12.9 |
| 985 | | SURG | PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC | 1.8509 | 5.0 | 6.9 |
| 986 | | SURG | PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC | 1.0453 | 2.4 | 3.2 |
| 987 | | SURG | NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W MCC | 3.3008 | 8.3 | 11.1 |
| 988 | | SURG | NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W CC | 1.7643 | 4.7 | 6.3 |
| 989 | | SURG | NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC | 1.0454 | 2.2 | 3.0 |
| 998 | | ** | PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS | | | |
| 999 | | ** | UNGROUPABLE | | | |

| Exhibit #2 | | | |
|---|---|---|---|
| **Hospital Base Rates and Cost to Charge Ratio's (CCR)** | | | |
| ***Effective for In-Patient Hospital Discharges Occurring on and after January 1, 2015*** | | | |
| **Provider Number** | **Provider Name** | **Base Rate** | **CCR** |
| 60001 | NORTH COLORADO MEDICAL CENTER | $6,437.87 | 0.266 |
| 60003 | LONGMONT UNITED HOSPITAL | $5,986.39 | 0.343 |
| 60004 | PLATTE VALLEY MEDICAL CENTER | $6,126.47 | 0.392 |
| 60006 | MONTROSE MEMORIAL HOSPITAL | $5,798.58 | 0.412 |
| 60008 | SAN LUIS VALLEY REGIONAL MEDICAL CENTER | $5,809.45 | 0.426 |
| 60009 | EXEMPLA LUTHERAN MEDICAL CENTER | $6,116.57 | 0.229 |
| 60010 | POUDRE VALLEY HOSPITAL | $5,991.95 | 0.352 |
| 60011 | DENVER HEALTH MEDICAL CENTER | $7,848.87 | 0.309 |
| 60012 | CENTURA HEALTH-ST MARY CORWIN MEDICAL CENTER | $6,184.18 | 0.245 |
| 60013 | MERCY REGIONAL MEDICAL CENTER | $7,596.82 | 0.382 |
| 60014 | PRESBYTERIAN ST LUKES MEDICAL CENTER | $6,591.12 | 0.199 |
| 60015 | CENTURA HEALTH-ST ANTHONY HOSPITAL | $6,062.53 | 0.228 |
| 60016 | CENTURA HEALTH-ST THOMAS MORE HOSPITAL | $6,645.33 | 0.412 |
| 60020 | PARKVIEW MEDICAL CENTER INC | $5,857.10 | 0.186 |
| 60022 | UNIVERSITY COLO HEALTH MEMORIAL HOSPITAL CENTRAL | $5,829.41 | 0.291 |

| 60023 | ST MARYS HOSPITAL AND MEDICAL CENTER | $6,617.45 | 0.354 |
|---|---|---|---|
| 60024 | UNIVERSITY OF COLORADO HOSPITAL ANSCHUTZ INPATIENT | $8,288.06 | 0.197 |
| 60027 | BOULDER COMMUNITY HOSPITAL | $5,895.14 | 0.255 |
| 60028 | EXEMPLA SAINT JOSEPH HOSPITAL | $6,671.47 | 0.222 |
| 60030 | MCKEE MEDICAL CENTER | $5,756.16 | 0.349 |
| 60031 | CENTURA HEALTH-PENROSE ST FRANCIS HEALTH SERVICES | $6,004.53 | 0.242 |
| 60032 | ROSE MEDICAL CENTER | $6,508.14 | 0.18 |
| 60034 | SWEDISH MEDICAL CENTER | $6,204.04 | 0.173 |
| 60036 | ARKANSAS VALLEY REGIONAL MEDICAL CENTER | $5,809.45 | 0.477 |
| 60043 | KEEFE MEMORIAL HOSPITAL | $15,160.85 | 0.409 |
| 60044 | COLORADO PLAINS MEDICAL CENTER | $6,264.58 | 0.294 |
| 60049 | YAMPA VALLEY MEDICAL CENTER | $9,176.20 | 0.596 |
| 60054 | COMMUNITY HOSPITAL | $5,725.76 | 0.439 |
| 60064 | CENTURA HEALTH-PORTER ADVENTIST HOSPITAL | $5,972.04 | 0.215 |
| 60065 | NORTH SUBURBAN MEDICAL CENTER | $6,225.30 | 0.161 |
| 60071 | DELTA COUNTY MEMORIAL HOSPITAL | $5,714.48 | 0.474 |
| 60075 | VALLEY VIEW HOSPITAL ASSOCIATION | $7,852.40 | 0.491 |
| 60076 | STERLING REGIONAL MEDCENTER | $7,449.71 | 0.54 |

| | | | |
|---|---|---|---|
| 60096 | VAIL VALLEY MEDICAL CENTER | $11,497.98 | 0.475 |
| 60100 | MEDICAL CENTER OF AURORA, THE | $6,097.05 | 0.19 |
| 60103 | CENTURA HEALTH-AVISTA ADVENTIST HOSPITAL | $6,160.21 | 0.289 |
| 60104 | CENTURA HEALTH-ST ANTHONY NORTH HOSPITAL | $6,729.17 | 0.245 |
| 60107 | NATIONAL JEWISH HEALTH | $6,126.47 | 0.249 |
| 60112 | SKY RIDGE MEDICAL CENTER | $5,971.87 | 0.156 |
| 60113 | CENTURA HEALTH-LITTLETON ADVENTIST HOSPITAL | $5,970.33 | 0.198 |
| 60114 | PARKER ADVENTIST HOSPITAL | $5,972.14 | 0.216 |
| 60116 | EXEMPLA GOOD SAMARITAN MEDICAL CENTER LLC | $5,888.91 | 0.202 |
| 60117 | ANIMAS SURGICAL HOSPITAL, LLC | $5,652.38 | 0.392 |
| 60118 | ST ANTHONY SUMMIT MEDICAL CENTER | $5,992.00 | 0.329 |
| 60119 | MEDICAL CENTER OF THE ROCKIES | $5,671.58 | 0.331 |
| 60124 | ORTHOCOLORADO HOSPITAL AT ST ANTHONY MED CAMPUS | $5,960.88 | 0.235 |
| 60125 | CASTLE ROCK ADVENTIST HOSPITAL | $5,960.88 | 0.249 |
| 69999 | Any New Hospital | $5,884.64 | 0.29426 |

**Exhibit #3**

**Effective January 1, 2015**

**Critical Access Hospitals**

| ***Name*** | ***Location in Colorado*** |
|---|---|
| Aspen Valley Hospital | Aspen |
| East Morgan County Hospital | Brush |
| Estes Park Medical Center | Estes Park |
| Family Health West | Fruita |
| 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 |
| Rangeley District Hospital | Rangely |
| Rio Grande Hospital | Del Norte |
| San Luis Valley Health | La Jara |
| Sedgwick County Health Center | Julesburg |
| Southeast Colorado Hospital District | Springfield |
| Southwest Memorial Hospital | Cortez |
| Spanish Peaks Regional Health Center | Walsenburg |
| St. Vincent General Hospital District | Leadville |
| The Memorial Hospital at Craig | Craig |
| Weisbrod Memorial County Hospital | Eads |
| Wray Community District Hospital | Wray |
| Yuma District Hospital | Yuma |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| **Effective for Dates of Service on and After 1/1/2015** | | | | |
| ***Col#1*** <br> ***APC*** | ***Column #2*** <br> ***APC Code Description*** | ***Column #3*** <br> ***Outpatient Emergency Room Department Facility Payment Rate *260%*** | ***Column #4*** <br> ***Outpatient Hospital Facility Payment Rate *170%*** | ***Column #5*** <br> ***Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4)*** |
| 1 | Level I Photochemotherapy | $ 98.98 | $ 64.72 | $ 55.01 |
| 4 | Level I Needle Biopsy/ Aspiration Except Bone Marrow | $ 1,069.22 | $ 697.50 | $ 592.88 |
| 5 | Level II Needle Biopsy/Aspiration Except Bone Marrow | $ 1,825.41 | $ 1,142.21 | $ 970.88 |
| 6 | Level I Incision & Drainage | $ 415.12 | $ 270.17 | $ 229.65 |
| 7 | Level II Incision & Drainage | $ 2,195.83 | $ 1,421.81 | $ 1,208.54 |
| 8 | Level III Incision and Drainage | $ 4,080.65 | $ 2,650.51 | $ 2,252.93 |
| 12 | Level I Debridement & Destruction | $ 158.16 | $ 103.41 | $ 87.90 |
| 13 | Level II Debridement & Destruction | $ 217.70 | $ 142.34 | $ 120.99 |
| 15 | Level III Debridement & Destruction | $ 383.21 | $ 250.51 | $ 212.94 |
| 16 | Level IV Debridement & Destruction | $ 714.51 | $ 467.04 | $ 396.98 |
| 17 | Level V Debridement & Destruction | $ 3,928.81 | $ 2,561.90 | $ 2,177.62 |
| 19 | Level I Excision/ Biopsy | $ 828.85 | $ 541.62 | $ 460.38 |
| 20 | Level II Excision/ Biopsy | $ 1,666.37 | $ 1,086.28 | $ 923.34 |
| 21 | Level III Excision/ Biopsy | $ 2,980.48 | $ 1,941.76 | $ 1,650.50 |
| 22 | Level IV Excision/ Biopsy | $ 4,514.98 | $ 2,930.55 | $ 2,490.97 |
| 28 | Level I Breast and Skin Surgery | $ 5,133.08 | $ 3,345.17 | $ 2,843.39 |
| 29 | Level II Breast and Skin Surgery | $ 6,904.48 | $ 4,450.36 | $ 3,782.81 |
| 30 | Level III Breast and Skin Surgery | $ 9,325.65 | $ 5,741.45 | $ 4,880.23 |
| 31 | Level I Health and Behavior Services | $ 62.19 | $ 40.66 | 0 |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1<br><br>APC | Column #2<br><br>APC Code Description | Column #3<br><br>Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4<br><br>Outpatient Hospital Facility Payment Rate *170% | Column #5<br><br>Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 35 | Vascular Puncture and Minor Diagnostic Procedures | $ 57.49 | $ 37.59 | $ 31.95 |
| 37 | Level IV Needle Biopsy/Aspiration Except Bone Marrow | $ 3,180.45 | $ 1,978.88 | $ 1,682.04 |
| 39 | Level I Implantation of Neurostimulator Generator | $ 44,805.54 | $ 4,028.19 | $ 3,423.96 |
| 40 | Level I Implantation/Revision/Replacement of Neurostimulator Electrodes | $ 12,028.90 | $ 3,550.28 | $ 3,017.74 |
| 41 | Level I Arthroscopy | $ 5,604.74 | $ 3,652.91 | $ 3,104.98 |
| 42 | Level II Arthroscopy | $ 11,073.43 | $ 6,200.61 | $ 5,270.52 |
| 45 | Bone/Joint Manipulation Under Anesthesia | $ 3,001.57 | $ 1,957.85 | $ 1,664.18 |
| 47 | Arthroplasty without Prosthesis | $ 8,118.37 | $ 4,330.40 | $ 3,680.84 |
| 48 | Level I Arthroplasty or Implantation with Prosthesis | $ 12,061.11 | $ 4,512.43 | $ 3,835.57 |
| 49 | Level I Musculoskeletal Procedures Except Hand and Foot | $ 4,261.58 | $ 2,768.86 | $ 2,353.53 |
| 50 | Level II Musculoskeletal Procedures Except Hand and Foot | $ 6,697.34 | $ 3,939.81 | $ 3,348.84 |
| 51 | Level III Musculoskeletal Procedures Except Hand and Foot | $ 9,832.26 | $ 5,131.46 | $ 4,361.74 |
| 52 | Level IV Musculoskeletal Procedures Except Hand and Foot | $ 16,918.10 | $ 8,234.43 | $ 6,999.26 |
| 53 | Level I Hand Musculoskeletal Procedures | $ 3,251.59 | $ 2,118.38 | $ 1,800.63 |
| 54 | Level II Hand Musculoskeletal Procedures | $ 5,794.75 | $ 3,546.01 | $ 3,014.11 |
| 55 | Level I Foot Musculoskeletal Procedures | $ 4,377.75 | $ 2,774.50 | $ 2,358.33 |
| 56 | Level II Foot Musculoskeletal Procedures | $ 12,660.15 | $ 5,143.82 | $ 4,372.25 |
| 57 | Bunion Procedures | $ 6,796.74 | $ 3,727.64 | $ 3,168.50 |
| 58 | Level I Cast Application | $ 260.55 | $ 170.34 | $ 144.79 |
| 59 | Level I Strapping | $ 145.21 | $ 94.95 | $ 80.70 |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| **Effective for Dates of Service on and After 1/1/2015** | | | | |
| **Col#1**<br>**APC** | **Column #2**<br>**APC Code Description** | **Column #3**<br>**Outpatient Emergency Room Department Facility Payment Rate *260%** | **Column #4**<br>**Outpatient Hospital Facility Payment Rate *170%** | **Column #5**<br>**Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4)** |
| 60 | Manipulation Therapy | $ 45.76 | $ 29.92 | $ 25.43 |
| 61 | Level II Implantation/Revision/Replacement of Neurostimulator Electrodes | $ 19,303.67 | $ 4,286.31 | $ 3,643.36 |
| 62 | Level I Treatment Fracture/Dislocation | $ 5,231.69 | $ 3,185.04 | $ 2,707.28 |
| 63 | Level II Treatment Fracture/Dislocation | $ 10,724.53 | $ 5,155.37 | $ 4,382.06 |
| 64 | Level III Treatment Fracture/Dislocation | $ 13,997.46 | $ 5,221.32 | $ 4,438.12 |
| 65 | IORT, MRgFUS, and MEG | $ 3,245.53 | $ 2,114.86 | $ 1,797.63 |
| 66 | Level I Stereotactic Radiosurgery | $ 4,995.38 | $ 3,266.21 | $ 2,776.28 |
| 67 | Level II Stereotactic Radiosurgery | $ 9,338.29 | $ 6,105.81 | $ 5,189.93 |
| 69 | Thoracoscopy | $ 6,864.31 | $ 4,463.97 | $ 3,794.37 |
| 70 | Thoracentesis/Lavage Procedures | $ 1,261.49 | $ 798.59 | $ 678.80 |
| 71 | Level I Endoscopy Upper Airway | $ 391.09 | $ 255.64 | $ 217.29 |
| 72 | Level II Endoscopy Upper Airway | $ 960.88 | $ 626.26 | $ 532.32 |
| 73 | Level III Endoscopy Upper Airway | $ 3,162.38 | $ 2,026.36 | $ 1,722.40 |
| 74 | Level IV Endoscopy Upper Airway | $ 4,889.12 | $ 3,127.04 | $ 2,657.99 |
| 75 | Level V Endoscopy Upper Airway | $ 7,934.58 | $ 4,751.16 | $ 4,038.49 |
| 76 | Level I Endoscopy Lower Airway | $ 2,474.21 | $ 1,614.68 | $ 1,372.48 |
| 77 | Level I Pulmonary Treatment | $ 102.31 | $ 66.90 | $ 56.86 |
| 78 | Level III Pulmonary Treatment | $ 352.04 | $ 230.13 | $ 195.61 |
| 79 | Ventilation Initiation and Management | $ 907.95 | $ 591.64 | $ 502.89 |
| 80 | Diagnostic Cardiac Catheterization | $ 6,726.15 | $ 3,870.12 | $ 3,289.60 |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1<br>APC | Column #2<br>APC Code Description | Column #3<br>Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4<br>Outpatient Hospital Facility Payment Rate *170% | Column #5<br>Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 82 | Coronary or Non-Coronary Atherectomy | $ 22,990.92 | $ 10,985.77 | $ 9,337.90 |
| 83 | Coronary Angioplasty, Valvuloplasty, and Level I Endovascular Revascularization of the Lower Extremity | $ 11,467.07 | $ 5,501.81 | $ 4,676.54 |
| 84 | Level I Electrophysiologic Procedures | $ 1,961.18 | $ 1,270.64 | $ 1,080.04 |
| 85 | Level II Electrophysiologic Procedures | $ 11,005.15 | $ 4,850.60 | $ 4,123.01 |
| 88 | Thrombectomy | $ 8,506.06 | $ 5,028.29 | $ 4,274.05 |
| 89 | Insertion/Replacement of Permanent Pacemaker and Electrodes | $ 22,854.78 | $ 4,616.05 | $ 3,923.64 |
| 90 | Level I Insertion/Replacement of Permanent Pacemaker | $ 19,118.09 | $ 4,117.59 | $ 3,499.96 |
| 93 | Vascular Reconstruction/Fistula Repair | $ 7,401.39 | $ 3,128.65 | $ 2,659.36 |
| 94 | Level I Resuscitation and Cardioversion | $ 415.09 | $ 271.30 | $ 230.60 |
| 95 | Cardiac Rehabilitation | $ 268.55 | $ 175.59 | $ 149.25 |
| 96 | Level II Noninvasive Physiologic Studies | $ 340.76 | $ 222.74 | $ 189.32 |
| 97 | Level I Noninvasive Physiologic Studies | $ 182.47 | $ 119.31 | $ 101.41 |
| 99 | Electrocardiograms/Cardiography | $ 70.51 | $ 46.10 | $ 39.19 |
| 100 | Cardiac Stress Tests | $ 634.95 | $ 415.16 | $ 352.88 |
| 101 | Tilt Table Evaluation | $ 844.17 | $ 551.79 | 0 |
| 102 | Level II Pulmonary Treatment | $ 203.29 | $ 132.80 | $ 112.88 |
| 103 | Miscellaneous Vascular Procedures | $ 3,962.74 | $ 2,504.48 | $ 2,128.81 |
| 104 | Transcatheter Placement of Intracoronary Stents | $ 16,545.75 | $ 5,330.21 | $ 4,530.68 |
| 105 | Repair/Revision/Removal of Pacemakers, AICDs, or Vascular Devices | $ 6,026.02 | $ 2,727.72 | $ 2,318.57 |
| 106 | Insertion/Replacement/Repair of Pacemaker Generator, Leads, and/or Electrodes | $ 11,965.15 | $ 4,133.08 | $ 3,513.12 |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1<br>APC | Column #2<br>APC Code Description | Column #3<br>Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4<br>Outpatient Hospital Facility Payment Rate *170% | Column #5<br>Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 107 | Level I Implantation of Cardioverter-Defibrillators (ICDs) | $ 65,047.27 | $ 8,114.90 | $ 6,897.66 |
| 108 | Level II Implantation of Cardioverter-Defibrillators (ICDs) | $ 83,576.87 | $ 9,666.95 | $ 8,216.91 |
| 110 | Transfusion | $ 741.44 | $ 484.64 | $ 411.95 |
| 111 | Blood Product Exchange | $ 2,821.94 | $ 1,844.93 | $ 1,568.19 |
| 112 | Apheresis and Stem Cell Procedures | $ 7,970.77 | $ 5,209.57 | $ 4,428.14 |
| 113 | Excision Lymphatic System | $ 5,270.07 | $ 3,433.41 | $ 2,918.40 |
| 114 | Thyroid/Lymphadenectomy Procedures | $ 10,330.92 | $ 6,702.14 | $ 5,696.82 |
| 115 | Cannula/Access Device Procedures | $ 7,390.16 | $ 3,766.08 | $ 3,201.17 |
| 121 | Level I Tube or Catheter Changes or Repositioning | $ 1,212.87 | $ 752.11 | $ 639.30 |
| 126 | Level I Urinary and Anal Procedures | $ 206.13 | $ 134.72 | $ 114.51 |
| 129 | Level I Closed Treatment Fracture | $ 281.24 | $ 183.83 | $ 156.26 |
| 130 | Level I Laparoscopy | $ 7,620.57 | $ 4,710.13 | $ 4,003.61 |
| 131 | Level II Laparoscopy | $ 9,486.07 | $ 5,995.89 | $ 5,096.51 |
| 132 | Level III Laparoscopy | $ 13,950.09 | $ 7,403.69 | $ 6,293.14 |
| 138 | Level II Closed Treatment Fracture | $ 451.00 | $ 294.35 | $ 250.20 |
| 139 | Level III Closed Treatment Fracture | $ 1,167.19 | $ 753.17 | $ 640.19 |
| 141 | Level I Upper GI Procedures | $ 1,743.22 | $ 1,136.04 | $ 965.63 |
| 142 | Level I Small Intestine Endoscopy | $ 2,176.67 | $ 1,396.31 | $ 1,186.86 |
| 143 | Lower GI Endoscopy | $ 1,915.78 | $ 1,250.75 | $ 1,063.14 |
| 146 | Level I Sigmoidoscopy and Anoscopy | $ 1,198.60 | $ 782.45 | $ 665.08 |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1<br><br>APC | Column #2<br><br>APC Code Description | Column #3<br><br>Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4<br><br>Outpatient Hospital Facility Payment Rate *170% | Column #5<br><br>Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 147 | Level II Sigmoidoscopy and Anoscopy | $ 2,026.31 | $ 1,289.79 | $ 1,096.32 |
| 148 | Level I Anal/Rectal Procedures | $ 1,229.44 | $ 800.73 | $ 680.62 |
| 149 | Level III Anal/Rectal Procedures | $ 4,963.97 | $ 3,231.39 | $ 2,746.68 |
| 150 | Level IV Anal/Rectal Procedures | $ 6,503.41 | $ 4,091.92 | $ 3,478.13 |
| 151 | Endoscopic Retrograde Cholangio-Pancreatography (ERCP) | $ 5,027.59 | $ 2,945.73 | $ 2,503.87 |
| 152 | Level I Percutaneous Abdominal and Biliary Procedures | $ 4,649.74 | $ 2,463.48 | $ 2,093.96 |
| 153 | Peritoneal and Abdominal Procedures | $ 4,774.61 | $ 3,045.38 | $ 2,588.57 |
| 154 | Hernia/Hydrocele Procedures | $ 6,759.06 | $ 3,857.68 | $ 3,279.03 |
| 155 | Level II Anal/Rectal Procedures | $ 3,691.82 | $ 2,408.33 | $ 2,047.08 |
| 156 | Level III Urinary and Anal Procedures | $ 1,089.82 | $ 706.37 | $ 600.42 |
| 157 | Colorectal Cancer Screening: Barium Enema | $ 753.90 | $ 492.93 | $ 418.99 |
| 158 | Colorectal Cancer Screening: Colonoscopy | $ 1,681.50 | $ 1,099.33 | $ 934.43 |
| 159 | Colorectal Cancer Screening: Flexible Sigmoidoscopy | $ 1,198.94 | $ 783.53 | $ 666.00 |
| 160 | Level I Cystourethroscopy and other Genitourinary Procedures | $ 1,401.43 | $ 913.29 | $ 776.30 |
| 161 | Level II Cystourethroscopy and other Genitourinary Procedures | $ 3,132.48 | $ 1,992.86 | $ 1,693.93 |
| 162 | Level III Cystourethroscopy and other Genitourinary Procedures | $ 5,219.03 | $ 3,250.35 | $ 2,762.80 |
| 163 | Level IV Cystourethroscopy and other Genitourinary Procedures | $ 7,553.03 | $ 4,830.36 | $ 4,105.81 |
| 164 | Level II Urinary and Anal Procedures | $ 548.86 | $ 355.14 | $ 301.87 |
| 165 | Level IV Urinary and Anal Procedures | $ 3,689.43 | $ 2,243.45 | $ 1,906.94 |
| 166 | Level I Urethral Procedures | $ 3,975.89 | $ 2,587.14 | $ 2,199.07 |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1<br>APC | Column #2<br>APC Code Description | Column #3<br>Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4<br>Outpatient Hospital Facility Payment Rate *170% | Column #5<br>Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 168 | Level II Urethral Procedures | $ 6,592.09 | $ 2,792.59 | $ 2,373.70 |
| 169 | Lithotripsy | $ 7,776.96 | $ 5,073.24 | $ 4,312.26 |
| 170 | Dialysis | $ 1,586.68 | $ 1,034.12 | $ 879.00 |
| 174 | Level IV Laparoscopy | $ 22,342.84 | $ 11,692.87 | $ 9,938.94 |
| 177 | Level I Echocardiogram with Contrast | $ 1,301.48 | $ 850.54 | $ 722.96 |
| 178 | Level II Echocardiogram with Contrast | $ 1,701.05 | $ 1,112.11 | $ 945.30 |
| 181 | Level II Male Genital Procedures | $ 5,655.81 | $ 3,675.10 | $ 3,123.83 |
| 183 | Level I Male Genital Procedures | $ 4,511.75 | $ 2,943.80 | $ 2,502.23 |
| 184 | Prostate Biopsy | $ 2,761.17 | $ 1,801.59 | $ 1,531.35 |
| 188 | Level II Female Reproductive Proc | $ 329.34 | $ 214.91 | $ 182.67 |
| 189 | Level III Female Reproductive Proc | $ 492.52 | $ 321.77 | $ 273.51 |
| 190 | Level I Hysteroscopy | $ 4,584.76 | $ 2,978.54 | $ 2,531.76 |
| 191 | Level I Female Reproductive Proc | $ 26.86 | $ 17.56 | $ 14.93 |
| 192 | Level IV Female Reproductive Proc | $ 959.82 | $ 627.51 | $ 533.38 |
| 193 | Level V Female Reproductive Proc | $ 3,575.52 | $ 2,330.59 | $ 1,981.00 |
| 195 | Level VI Female Reproductive Procedures | $ 6,558.71 | $ 4,027.22 | $ 3,423.14 |
| 202 | Level VII Female Reproductive Procedures | $ 9,279.14 | $ 3,798.02 | $ 3,228.32 |
| 203 | Level IV Nerve Injections | $ 4,017.18 | $ 2,622.42 | $ 2,229.05 |
| 204 | Level I Nerve Injections | $ 525.75 | $ 343.72 | $ 292.16 |
| 205 | Level III Male Genital Procedures | $ 9,238.94 | $ 4,954.10 | $ 4,210.98 |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| **Col#1**<br><br>**APC** | **Column #2**<br><br>**APC Code Description** | **Column #3**<br><br>**Outpatient Emergency Room Department Facility Payment Rate *260%** | **Column #4**<br><br>**Outpatient Hospital Facility Payment Rate *170%** | **Column #5**<br><br>**Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4)** |
| 206 | Level II Nerve Injections | $ 920.37 | $ 601.42 | $ 511.21 |
| 207 | Level III Nerve Injections | $ 1,741.77 | $ 1,137.71 | $ 967.05 |
| 208 | Laminotomies and Laminectomies | $ 10,408.61 | $ 6,591.25 | $ 5,602.56 |
| 209 | Level II Extended EEG, Sleep, and Cardiovascular Studies | $ 1,144.31 | $ 748.20 | $ 635.97 |
| 210 | Spinal Fusions | $ 10,408.61 | $ 6,591.25 | $ 5,602.56 |
| 213 | Level I Extended EEG, Sleep, and Cardiovascular Studies | $ 472.16 | $ 308.69 | $ 262.39 |
| 215 | Level I Nerve and Muscle Services | $ 130.78 | $ 85.51 | $ 72.68 |
| 216 | Level III Nerve and Muscle Services | $ 563.65 | $ 367.55 | $ 312.42 |
| 218 | Level II Nerve and Muscle Services | $ 332.15 | $ 217.15 | $ 184.58 |
| 219 | Vascular Ligation | $ 5,561.63 | $ 3,307.72 | $ 2,811.56 |
| 220 | Level I Nerve Procedures | $ 3,598.11 | $ 2,346.50 | $ 1,994.52 |
| 221 | Level II Nerve Procedures | $ 7,445.80 | $ 4,246.23 | $ 3,609.29 |
| 224 | Implantation of Catheter/Reservoir/Shunt | $ 8,880.69 | $ 4,167.40 | $ 3,542.29 |
| 227 | Implantation of Drug Infusion Device | $ 38,089.40 | $ 4,679.58 | $ 3,977.64 |
| 229 | Level II Endovascular Revascularization of the Lower Extremity | $ 23,711.22 | $ 8,564.13 | $ 7,279.51 |
| 230 | Level I Eye Tests & Treatments | $ 134.03 | $ 87.64 | $ 74.49 |
| 231 | Level III Eye Tests & Treatments | $ 472.97 | $ 309.22 | $ 262.83 |
| 232 | Level I Anterior Segment Eye Procedures | $ 448.19 | $ 292.93 | $ 248.99 |
| 233 | Level III Anterior Segment Eye Procedures | $ 3,102.22 | $ 1,984.76 | $ 1,687.05 |
| 234 | Level IV Anterior Segment Eye Procedures | $ 4,547.27 | $ 2,787.39 | $ 2,369.28 |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| **Effective for Dates of Service on and After 1/1/2015** | | | | |
| **Col#1**<br><br>**APC** | **Column #2**<br><br>**APC Code Description** | **Column #3**<br><br>**Outpatient Emergency Room Department Facility Payment Rate *260%** | **Column #4**<br><br>**Outpatient Hospital Facility Payment Rate *170%** | **Column #5**<br><br>**Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4)** |
| 235 | Level I Posterior Segment Eye Procedures | $ 1,116.93 | $ 730.23 | $ 620.70 |
| 237 | Level II Posterior Segment Eye Procedures | $ 4,458.71 | $ 2,820.86 | $ 2,397.73 |
| 238 | Level I Repair and Plastic Eye Procedures | $ 663.94 | $ 433.68 | $ 368.63 |
| 239 | Level II Repair and Plastic Eye Procedures | $ 1,673.65 | $ 1,085.01 | $ 922.25 |
| 240 | Level III Repair and Plastic Eye Procedures | $ 3,769.79 | $ 2,445.39 | $ 2,078.58 |
| 241 | Level IV Repair and Plastic Eye Procedures | $ 5,165.94 | $ 3,241.95 | $ 2,755.65 |
| 242 | Level V Repair and Plastic Eye Procedures | $ 8,119.67 | $ 4,548.23 | $ 3,866.00 |
| 243 | Strabismus/Muscle Procedures | $ 5,062.49 | $ 3,307.77 | $ 2,811.60 |
| 244 | Corneal and Amniotic Membrane Transplant | $ 8,393.22 | $ 4,476.46 | $ 3,804.99 |
| 246 | Cataract Procedures with IOL Insert | $ 4,591.63 | $ 2,544.08 | $ 2,162.47 |
| 247 | Laser Eye Procedures | $ 1,113.42 | $ 727.35 | $ 618.25 |
| 249 | Cataract Procedures without IOL Insert | $ 5,601.31 | $ 3,483.30 | $ 2,960.81 |
| 250 | Level I ENT Procedures | $ 218.71 | $ 142.93 | $ 121.49 |
| 251 | Level II ENT Procedures | $ 678.83 | $ 443.54 | $ 377.01 |
| 252 | Level III ENT Procedures | $ 1,417.36 | $ 920.53 | $ 782.45 |
| 253 | Level IV ENT Procedures | $ 3,166.36 | $ 2,039.05 | $ 1,733.19 |
| 254 | Level V ENT Procedures | $ 4,834.13 | $ 3,131.70 | $ 2,661.94 |
| 255 | Level II Anterior Segment Eye Procedures | $ 1,939.29 | $ 1,255.32 | $ 1,067.02 |
| 256 | Level VI ENT Procedures | $ 9,268.19 | $ 5,872.11 | $ 4,991.30 |
| 259 | Level VII ENT Procedures | $ 79,979.85 | $ 8,215.47 | $ 6,983.15 |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| **Effective for Dates of Service on and After 1/1/2015** | | | | |
| **Col#1**<br><br>**APC** | **Column #2**<br><br>**APC Code Description** | **Column #3**<br><br>**Outpatient Emergency Room Department Facility Payment Rate *260%** | **Column #4**<br><br>**Outpatient Hospital Facility Payment Rate *170%** | **Column #5**<br><br>**Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4)** |
| 260 | Level I Plain Film Except Teeth | $ 149.11 | $ 97.50 | $ 82.87 |
| 261 | Level II Plain Film Except Teeth Including Bone Density Measurement | $ 236.31 | $ 154.51 | $ 131.34 |
| 262 | Plain Film of Teeth | $ 110.84 | $ 72.47 | $ 61.60 |
| 263 | Level I Miscellaneous Radiology Procedures | $ 826.57 | $ 527.04 | $ 447.99 |
| 265 | Level I Diagnostic and Screening Ultrasound | $ 234.13 | $ 153.09 | $ 130.12 |
| 266 | Level II Diagnostic and Screening Ultrasound | $ 349.88 | $ 228.75 | $ 194.43 |
| 267 | Level III Diagnostic and Screening Ultrasound | $ 496.18 | $ 324.40 | $ 275.74 |
| 269 | Level II Echocardiogram Without Contrast | $ 1,110.90 | $ 726.36 | $ 617.41 |
| 270 | Level III Echocardiogram Without Contrast | $ 1,545.47 | $ 1,009.89 | $ 858.41 |
| 272 | Fluoroscopy | $ 407.34 | $ 244.53 | $ 207.85 |
| 274 | Myelography | $ 1,553.27 | $ 1,015.29 | $ 863.00 |
| 275 | Arthrography | $ 882.26 | $ 576.80 | $ 490.28 |
| 276 | Level I Digestive Radiology | $ 264.78 | $ 173.13 | $ 147.16 |
| 277 | Level II Digestive Radiology | $ 393.20 | $ 256.83 | $ 218.31 |
| 278 | Diagnostic Urography | $ 669.76 | $ 432.97 | $ 368.03 |
| 279 | Level II Angiography and Venography | $ 6,698.74 | $ 3,661.20 | $ 3,112.02 |
| 280 | Level III Angiography and Venography | $ 11,735.41 | $ 6,824.50 | $ 5,800.83 |
| 282 | Miscellaneous Computed Axial Tomography | $ 206.86 | $ 135.14 | $ 114.87 |
| 283 | Computed Tomography with Contrast | $ 647.40 | $ 423.26 | $ 359.77 |
| 284 | Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast | $ 1,108.87 | $ 724.96 | $ 616.22 |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1<br>APC | Column #2<br>APC Code Description | Column #3<br>Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4<br>Outpatient Hospital Facility Payment Rate *170% | Column #5<br>Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 288 | Bone Density:Axial Skeleton | $ 234.42 | $ 153.27 | $ 130.28 |
| 293 | Level VI Anterior Segment Eye Procedures | $ 20,014.59 | $ 4,628.68 | $ 3,934.38 |
| 299 | Hyperthermia and Radiation Treatment Procedures | $ 1,074.37 | $ 702.47 | $ 597.10 |
| 300 | Level I Radiation Therapy | $ 271.08 | $ 177.24 | $ 150.66 |
| 301 | Level II Radiation Therapy | $ 499.93 | $ 326.88 | $ 277.84 |
| 303 | Treatment Device Construction | $ 555.07 | $ 362.90 | $ 308.46 |
| 304 | Level I Therapeutic Radiation Treatment Preparation | $ 298.09 | $ 194.91 | $ 165.67 |
| 305 | Level II Therapeutic Radiation Treatment Preparation | $ 809.56 | $ 529.33 | $ 449.93 |
| 308 | Positron Emission Tomography (PET) imaging | $ 3,407.56 | $ 2,227.80 | $ 1,893.63 |
| 310 | Level III Therapeutic Radiation Treatment Preparation | $ 2,694.61 | $ 1,749.00 | $ 1,486.65 |
| 312 | Radioelement Applications | $ 939.35 | $ 610.88 | $ 519.24 |
| 313 | Brachytherapy | $ 1,907.88 | $ 1,247.21 | $ 1,060.13 |
| 315 | Level II Implantation of Neurostimulator Generator | $ 60,042.35 | $ 4,758.12 | $ 4,044.41 |
| 317 | Level II Miscellaneous Radiology Procedures | $ 1,920.59 | $ 1,198.26 | $ 1,018.52 |
| 318 | Implantation of Neurostimulator Pulse Generator and Electrode | $ 71,837.09 | $ 6,031.00 | $ 5,126.35 |
| 319 | Level III Endovascular Revascularization of the Lower Extremity | $ 40,325.97 | $ 12,669.34 | $ 10,768.94 |
| 320 | Electroconvulsive Therapy | $ 1,132.33 | $ 740.37 | $ 629.31 |
| 322 | Brief Individual Psychotherapy | $ 219.41 | $ 143.46 | $ 121.94 |
| 323 | Extended Individual Psychotherapy | $ 298.66 | $ 195.28 | $ 165.99 |
| 324 | Family Psychotherapy | $ 336.02 | $ 219.71 | $ 186.75 |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1<br><br>APC | Column #2<br><br>APC Code Description | Column #3<br><br>Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4<br><br>Outpatient Hospital Facility Payment Rate *170% | Column #5<br><br>Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 325 | Group Psychotherapy | $ 180.28 | $ 117.88 | $ 100.20 |
| 326 | Level I Skin Repair | $ 517.48 | $ 338.22 | $ 287.48 |
| 327 | Level II Skin Repair | $ 1,064.47 | $ 695.23 | $ 590.95 |
| 328 | Level III Skin Repair | $ 3,565.09 | $ 2,326.59 | $ 1,977.60 |
| 329 | Level IV Skin Repair | $ 5,877.20 | $ 3,797.05 | $ 3,227.49 |
| 330 | Dental Procedures | $ 1,181.91 | $ 772.55 | $ 656.67 |
| 331 | Combined Abdomen and Pelvis CT without Contrast | $ 628.65 | $ 410.92 | $ 349.28 |
| 332 | Computed Tomography without Contrast | $ 328.82 | $ 214.98 | $ 182.73 |
| 333 | Computed Tomography without Contrast followed by Contrast | $ 729.04 | $ 476.63 | $ 405.14 |
| 334 | Combined Abdomen and Pelvis CT with Contrast | $ 1,014.34 | $ 663.15 | $ 563.68 |
| 336 | Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast | $ 766.43 | $ 501.13 | $ 425.96 |
| 337 | Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast | $ 1,281.59 | $ 837.55 | $ 711.91 |
| 340 | Level I Minor Procedures | $ 138.94 | $ 90.81 | $ 77.19 |
| 341 | Skin Tests | $ 32.50 | $ 21.25 | $ 18.06 |
| 342 | Level I Pathology | $ 51.58 | $ 33.73 | $ 28.67 |
| 343 | Level III Pathology | $ 159.82 | $ 104.50 | $ 88.82 |
| 344 | Level IV Pathology | $ 467.14 | $ 303.58 | $ 258.04 |
| 345 | Level I Transfusion Laboratory Procedures | $ 31.51 | $ 20.60 | $ 17.51 |
| 346 | Level II Transfusion Laboratory Procedures | $ 82.08 | $ 53.65 | $ 45.60 |
| 347 | Level III Transfusion Laboratory Procedures | $ 157.20 | $ 102.47 | $ 87.10 |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1<br>APC | Column #2<br>APC Code Description | Column #3<br>Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4<br>Outpatient Hospital Facility Payment Rate *170% | Column #5<br>Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 351 | Level VII Anterior Segment Eye Procedures | $ 40,433.20 | $ 4,002.58 | $ 3,402.19 |
| 360 | Level I Alimentary Tests | $ 377.39 | $ 246.71 | $ 209.70 |
| 361 | Level II Alimentary Tests | $ 840.61 | $ 545.72 | $ 463.87 |
| 363 | Level I Otorhinolaryngologic Function Tests | $ 193.47 | $ 126.50 | $ 107.52 |
| 364 | Level I Audiometry | $ 85.59 | $ 55.96 | $ 47.57 |
| 365 | Level II Audiometry | $ 199.55 | $ 130.48 | $ 110.90 |
| 366 | Level III Audiometry | $ 305.81 | $ 199.95 | $ 169.96 |
| 367 | Level I Pulmonary Test | $ 149.16 | $ 97.02 | $ 82.47 |
| 368 | Level II Pulmonary Tests | $ 230.72 | $ 150.84 | $ 128.22 |
| 369 | Level III Pulmonary Tests | $ 633.65 | $ 413.52 | $ 351.49 |
| 370 | Multiple Allergy Tests | $ 107.46 | $ 70.26 | $ 59.72 |
| 373 | Level I Neuropsychological Testing | $ 284.88 | $ 186.25 | $ 158.31 |
| 377 | Level II Cardiac Imaging | $ 2,999.41 | $ 1,961.15 | $ 1,666.98 |
| 378 | Level II Pulmonary Imaging | $ 1,120.26 | $ 732.33 | $ 622.48 |
| 381 | Single Allergy Tests | $ 90.90 | $ 59.43 | $ 50.52 |
| 382 | Level II Neuropsychological Testing | $ 530.97 | $ 347.17 | $ 295.10 |
| 383 | Cardiac Computed Tomographic Imaging | $ 577.23 | $ 377.23 | $ 320.64 |
| 384 | GI Procedures with Stents | $ 6,165.64 | $ 2,791.33 | $ 2,372.63 |
| 385 | Level I Prosthetic Urological Procedures | $ 21,573.08 | $ 5,166.84 | $ 4,391.81 |
| 386 | Level II Prosthetic Urological Procedures | $ 35,158.68 | $ 6,882.72 | $ 5,850.31 |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| **Col#1** APC | **Column #2** APC Code Description | **Column #3** Outpatient Emergency Room Department Facility Payment Rate *260% | **Column #4** Outpatient Hospital Facility Payment Rate *170% | **Column #5** Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 387 | Level II Hysteroscopy | $ 7,325.68 | $ 4,555.64 | $ 3,872.30 |
| 388 | Discography | $ 7,178.63 | $ 4,682.92 | $ 3,980.48 |
| 389 | Level I Non-imaging Nuclear Medicine | $ 365.01 | $ 238.66 | $ 202.86 |
| 390 | Level I Endocrine Imaging | $ 476.84 | $ 311.78 | $ 265.01 |
| 391 | Level II Endocrine Imaging | $ 746.04 | $ 487.80 | $ 414.63 |
| 392 | Level II Non-imaging Nuclear Medicine | $ 669.32 | $ 437.19 | $ 371.61 |
| 393 | Hematologic Processing & Studies | $ 1,471.47 | $ 961.25 | $ 817.06 |
| 394 | Hepatobiliary Imaging | $ 968.68 | $ 633.31 | $ 538.31 |
| 395 | GI Tract Imaging | $ 841.83 | $ 550.37 | $ 467.82 |
| 396 | Bone Imaging | $ 842.24 | $ 550.70 | $ 468.09 |
| 398 | Level I Cardiac Imaging | $ 996.06 | $ 651.14 | $ 553.47 |
| 400 | Hematopoietic Imaging | $ 900.48 | $ 588.07 | $ 499.86 |
| 401 | Level I Pulmonary Imaging | $ 795.63 | $ 519.49 | $ 441.57 |
| 402 | Level II Nervous System Imaging | $ 1,386.27 | $ 906.41 | $ 770.45 |
| 403 | Level I Nervous System Imaging | $ 422.97 | $ 276.56 | $ 235.07 |
| 404 | Renal and Genitourinary Studies | $ 1,084.25 | $ 708.79 | $ 602.47 |
| 406 | Level I Tumor/Infection Imaging | $ 995.20 | $ 650.71 | $ 553.10 |
| 407 | Level I Radionuclide Therapy | $ 665.11 | $ 434.75 | $ 369.53 |
| 408 | Level III Tumor/Infection Imaging | $ 3,009.29 | $ 1,967.61 | $ 1,672.47 |
| 412 | Level III Radiation Therapy | $ 1,327.20 | $ 867.78 | $ 737.61 |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1<br>APC | Column #2<br>APC Code Description | Column #3<br>Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4<br>Outpatient Hospital Facility Payment Rate *170% | Column #5<br>Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 413 | Level II Radionuclide Therapy | $ 927.37 | $ 604.48 | $ 513.80 |
| 414 | Level II Tumor/Infection Imaging | $ 1,708.12 | $ 1,116.74 | $ 949.23 |
| 415 | Level II Endoscopy Lower Airway | $ 5,201.01 | $ 3,285.04 | $ 2,792.28 |
| 419 | Level II Upper GI Procedures | $ 2,633.93 | $ 1,588.37 | $ 1,350.12 |
| 420 | Level II Minor Procedures | $ 255.45 | $ 166.59 | $ 141.60 |
| 422 | Level III Upper GI Procedures | $ 5,118.75 | $ 2,506.47 | $ 2,130.50 |
| 423 | Level II Percutaneous Abdominal and Biliary Procedures | $ 10,676.09 | $ 5,209.56 | $ 4,428.13 |
| 424 | Level II Small Intestine Endoscopy | $ 3,205.90 | $ 2,044.81 | $ 1,738.09 |
| 425 | Level II Arthroplasty or Implantation with Prosthesis | $ 25,303.38 | $ 6,629.39 | $ 5,634.98 |
| 426 | Level II Strapping and Cast Application | $ 359.61 | $ 235.13 | $ 199.86 |
| 427 | Level II Tube or Catheter Changes or Repositioning | $ 3,396.09 | $ 1,712.91 | $ 1,455.97 |
| 428 | Level III Sigmoidoscopy and Anoscopy | $ 4,308.54 | $ 2,795.43 | $ 2,376.11 |
| 429 | Level V Cystourethroscopy and other Genitourinary Procedures | $ 8,591.15 | $ 5,558.87 | $ 4,725.04 |
| 431 | Level IV Closed Treatment Fracture | $ 3,255.59 | $ 1,985.61 | $ 1,687.77 |
| 432 | Level II Health and Behavior Services | $ 127.71 | $ 83.50 | $ 70.98 |
| 433 | Level II Pathology | $ 94.98 | $ 62.10 | $ 52.79 |
| 434 | Cardiac Defect Repair | $ 33,247.89 | $ 7,171.70 | $ 6,095.94 |
| 435 | Level III Extended EEG, Sleep, and Cardiovascular Studies | $ 2,242.53 | $ 1,466.27 | $ 1,246.33 |
| 436 | Level I Drug Administration | $ 76.70 | $ 50.15 | $ 42.63 |
| 437 | Level II Drug Administration | $ 113.83 | $ 74.43 | $ 63.26 |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1<br><br>APC | Column #2<br><br>APC Code Description | Column #3<br><br>Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4<br><br>Outpatient Hospital Facility Payment Rate *170% | Column #5<br><br>Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 438 | Level III Drug Administration | $ 275.34 | $ 179.96 | $ 152.96 |
| 439 | Level IV Drug Administration | $ 447.67 | $ 292.62 | $ 248.73 |
| 440 | Level V Drug Administration | $ 778.78 | $ 509.10 | $ 432.73 |
| 442 | Dosimetric Drug Administration | $ 4,738.08 | $ 3,097.98 | $ 2,633.28 |
| 609 | Level 1 Type A Emergency Visits | $ 144.69 | 0 | 0 |
| 613 | Level 2 Type A Emergency Visits | $ 262.37 | 0 | 0 |
| 614 | Level 3 Type A Emergency Visits | $ 432.77 | 0 | 0 |
| 615 | Level 4 Type A Emergency Visits | $ 763.65 | 0 | 0 |
| 616 | Level 5 Type A Emergency Visits | $ 1,185.42 | 0 | 0 |
| 617 | Critical Care | $ 1,650.84 | 0 | 0 |
| 618 | Trauma Response with Critical Care | 0 | 0 | 0 |
| 621 | Level I Vascular Access Procedures | $ 2,209.25 | $ 1,241.26 | $ 1,055.08 |
| 622 | Level II Vascular Access Procedures | $ 5,002.35 | $ 2,165.25 | $ 1,840.46 |
| 623 | Level III Vascular Access Procedures | $ 6,100.74 | $ 2,848.51 | $ 2,421.23 |
| 624 | Phlebotomy and Minor Vascular Access Device Procedures | $ 210.55 | $ 137.60 | $ 116.96 |
| 626 | Level 1 Type B Emergency Visits | $ 134.99 | $ 88.26 | $ 75.02 |
| 627 | Level 2 Type B Emergency Visits | $ 160.34 | $ 104.84 | $ 89.11 |
| 628 | Level 3 Type B Emergency Visits | $ 238.45 | $ 155.91 | $ 132.52 |
| 629 | Level 4 Type B Emergency Visits | $ 424.50 | $ 277.56 | $ 235.93 |
| 630 | Level 5 Type B Emergency Visits | $ 812.32 | $ 531.08 | $ 451.42 |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| **Effective for Dates of Service on and After 1/1/2015** | | | | |
| **Col#1**<br><br>**APC** | **Column #2**<br><br>**APC Code Description** | **Column #3**<br><br>**Outpatient Emergency Room Department Facility Payment Rate *260%** | **Column #4**<br><br>**Outpatient Hospital Facility Payment Rate *170%** | **Column #5**<br><br>**Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4)** |
| 631 | Level 1 Examinations & Related Services | $ 196.53 | $ 128.50 | $ 109.23 |
| 632 | Level 2 Examinations & Related Services | $ 250.98 | $ 164.08 | $ 139.47 |
| 633 | Level 3 Examinations & Related Services | $ 852.41 | $ 556.62 | $ 473.13 |
| 634 | Hospital Clinic Visits | $ 240.58 | $ 157.29 | $ 133.69 |
| 648 | Level IV Breast and Skin Surgery | $ 12,601.45 | $ 4,371.01 | $ 3,715.35 |
| 651 | Complex Interstitial Radiation Source Application | $ 2,594.54 | $ 1,556.64 | $ 1,323.15 |
| 652 | Insertion of Intraperitoneal and Pleural Catheters | $ 6,283.84 | $ 3,444.29 | $ 2,927.65 |
| 653 | Vascular Reconstruction/Fistula Repair with Device | $ 8,015.44 | $ 4,085.25 | $ 3,472.46 |
| 654 | Level II Insertion/Replacement of Permanent Pacemaker | $ 21,807.58 | $ 4,299.03 | $ 3,654.17 |
| 655 | Insertion/Replacement/Conversion of a Permanent Dual Chamber Pacemaker or Pacing Electrode | $ 27,529.84 | $ 4,948.28 | $ 4,206.04 |
| 656 | Transcatheter Placement of Intracoronary Drug-Eluting Stents | $ 20,056.45 | $ 5,305.86 | $ 4,509.98 |
| 659 | Hyperbaric Oxygen | $ 288.42 | $ 188.58 | $ 160.29 |
| 660 | Level II Otorhinolaryngologic Function Tests | $ 359.76 | $ 235.23 | $ 199.94 |
| 661 | Level V Pathology | $ 723.40 | $ 472.66 | $ 401.76 |
| 662 | CT Angiography | $ 759.10 | $ 496.03 | $ 421.63 |
| 664 | Level I Proton Beam Radiation Therapy | $ 2,268.16 | $ 1,483.03 | $ 1,260.57 |
| 665 | Bone Density:AppendicularSkeleton | $ 133.15 | $ 87.06 | $ 74.00 |
| 667 | Level II Proton Beam Radiation Therapy | $ 3,133.70 | $ 2,048.96 | $ 1,741.62 |
| 668 | Level I Angiography and Venography | $ 2,150.07 | $ 1,214.48 | $ 1,032.31 |
| 672 | Level III Posterior Segment Eye Procedures | $ 7,956.86 | $ 5,106.83 | $ 4,340.81 |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| **Effective for Dates of Service on and After 1/1/2015** | | | | |
| **Col#1**<br>**APC** | **Column #2**<br>**APC Code Description** | **Column #3**<br>**Outpatient Emergency Room Department Facility Payment Rate *260%** | **Column #4**<br>**Outpatient Hospital Facility Payment Rate *170%** | **Column #5**<br>**Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4)** |
| 673 | Level V Anterior Segment Eye Procedures | $ 7,897.16 | $ 3,590.72 | $ 3,052.11 |
| 674 | Prostate Cryoablation | $ 21,329.65 | $ 6,008.07 | $ 5,106.86 |
| 676 | Thrombolysis and Other Device Revisions | $ 477.78 | $ 307.24 | $ 261.15 |
| 678 | External Counterpulsation | $ 282.20 | $ 184.52 | $ 156.84 |
| 679 | Level II Resuscitation and Cardioversion | $ 1,147.72 | $ 749.68 | $ 637.23 |
| 680 | Insertion of Patient Activated Event Recorders | $ 16,178.58 | $ 2,753.53 | $ 2,340.50 |
| 683 | Level II Photochemotherapy | $ 558.82 | $ 365.38 | $ 310.57 |
| 685 | Level III Needle Biopsy/Aspiration Except Bone Marrow | $ 1,970.18 | $ 1,282.91 | $ 1,090.47 |
| 687 | Revision/Removal of Neurostimulator Electrodes | $ 4,448.00 | $ 2,846.36 | $ 2,419.41 |
| 688 | Revision/Removal of Neurostimulator Pulse Generator Receiver | $ 5,777.64 | $ 3,623.56 | $ 3,080.03 |
| 690 | Level I Electronic Analysis of Devices | $ 93.99 | $ 61.46 | $ 52.24 |
| 691 | Level III Electronic Analysis of Devices | $ 717.29 | $ 468.67 | $ 398.37 |
| 692 | Level II Electronic Analysis of Devices | $ 301.13 | $ 196.56 | $ 167.08 |
| 694 | Mohs Surgery | $ 1,134.15 | $ 741.56 | $ 630.32 |
| 697 | Level I Echocardiogram Without Contrast | $ 651.74 | $ 425.88 | $ 362.00 |
| 698 | Level II Eye Tests & Treatments | $ 201.47 | $ 131.73 | $ 111.97 |
| 699 | Level IV Eye Tests & Treatments | $ 3,111.08 | $ 2,011.59 | $ 1,709.85 |
| 701 | Sr89 strontium | $ 2,868.61 | $ - | $ - |
| 726 | Dexrazoxane HCl injection | $ 352.87 | $ - | $ - |
| 731 | Sargramostim injection | $ 77.30 | $ - | $ - |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1<br><br>APC | Column #2<br><br>APC Code Description | Column #3<br><br>Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4<br><br>Outpatient Hospital Facility Payment Rate *170% | Column #5<br><br>Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 736 | Amphotericin b liposome inj | $ 42.09 | $ - | $ - |
| 738 | Rasburicase | $ 557.41 | $ - | $ - |
| 747 | Chlorothiazide sodium inj | $ 394.52 | $ - | $ - |
| 751 | Mechlorethamine hcl inj | $ 402.22 | $ - | $ - |
| 752 | Dactinomycin injection | $ 1,678.95 | $ - | $ - |
| 759 | Naltrexone, depot form | $ 7.15 | $ - | $ - |
| 800 | Leuprolide acetate | $ 1,946.15 | $ - | $ - |
| 802 | Etoposide oral | $ 152.85 | $ - | $ - |
| 807 | Aldesleukin injection | $ 4,345.09 | $ - | $ - |
| 809 | Bcg live intravesical vac | $ 310.49 | $ - | $ - |
| 810 | Goserelin acetate implant | $ 505.49 | $ - | $ - |
| 812 | Carmustine injection | $ 3,703.08 | $ - | $ - |
| 814 | Asparaginase, NOS | $ 167.88 | $ - | $ - |
| 820 | Daunorubicin injection | $ 67.91 | $ - | $ - |
| 821 | Daunorubicin citrate inj | $ 633.88 | $ - | $ - |
| 823 | Docetaxel injection | $ 10.35 | $ - | $ - |
| 825 | Nelarabine injection | $ 340.00 | $ - | $ - |
| 827 | Floxuridine injection | $ 180.41 | $ - | $ - |
| 831 | Ifosfamide injection | $ 93.11 | $ - | $ - |
| 832 | Idarubicin hcl injection | $ 92.77 | $ - | $ - |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1<br>APC | Column #2<br>APC Code Description | Column #3<br>Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4<br>Outpatient Hospital Facility Payment Rate *170% | Column #5<br>Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 835 | Cosyntropin injection NOS | $ 264.37 | $ - | $ - |
| 836 | Interferon alfa-2b inj | $ 53.69 | $ - | $ - |
| 838 | Interferon gamma 1-b inj | $ 7,005.88 | $ - | $ - |
| 840 | Inj melphalan hydrochl | $ 3,246.72 | $ - | $ - |
| 842 | Fludarabine phosphate inj | $ 184.81 | $ - | $ - |
| 843 | Pegaspargase injection | $ 15,619.19 | $ - | $ - |
| 844 | Pentostatin injection | $ 3,700.35 | $ - | $ - |
| 849 | Rituximab injection | $ 1,802.74 | $ - | $ - |
| 850 | Streptozocin injection | $ 723.94 | $ - | $ - |
| 851 | Thiotepa injection | $ 1,639.82 | $ - | $ - |
| 856 | Porfimer sodium injection | $ 50,247.03 | $ - | $ - |
| 858 | Inj cladribine | $ 57.88 | $ - | $ - |
| 861 | Leuprolide acetate injeciton | $ 22.78 | $ - | $ - |
| 864 | Mitoxantrone hydrochl | $ 87.65 | $ - | $ - |
| 868 | Oral aprepitant | $ 17.63 | $ - | $ - |
| 873 | Hyalgan/supartz inj per dose | $ 237.43 | $ - | $ - |
| 874 | Synvisc or synvisc-one | $ 33.44 | $ - | $ - |
| 875 | Euflexxa inj per dose | $ 395.25 | $ - | $ - |
| 877 | Orthovisc inj per dose | $ 459.29 | $ - | $ - |
| 887 | Azathioprine parenteral | $ 564.98 | $ - | $ - |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1<br>APC | Column #2<br>APC Code Description | Column #3<br>Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4<br>Outpatient Hospital Facility Payment Rate *170% | Column #5<br>Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 890 | Lymphocyte immune globulin | $ 1,917.34 | $ - | $ - |
| 901 | Alpha 1 proteinase inhibitor | $ 10.48 | $ - | $ - |
| 902 | Injection,onabotulinumtoxinA | $ 14.14 | $ - | $ - |
| 903 | Cytomegalovirus imm IV /vial | $ 2,636.06 | $ - | $ - |
| 910 | Interferon beta-1b / .25 MG | $ 755.38 | $ - | $ - |
| 913 | Ganciclovir long act implant | $ 44,096.00 | $ - | $ - |
| 925 | Factor viii | $ 2.44 | $ - | $ - |
| 927 | Factor viii recombinant | $ 2.96 | $ - | $ - |
| 928 | Factor ix complex | $ 2.86 | $ - | $ - |
| 929 | Anti-inhibitor | $ 4.26 | $ - | $ - |
| 931 | Factor IX non-recombinant | $ 2.52 | $ - | $ - |
| 932 | Factor IX recombinant | $ 3.46 | $ - | $ - |
| 933 | Gamma globulin > 10 CC inj | $ 623.51 | $ - | $ - |
| 934 | Capecitabine, oral | $ 86.71 | $ - | $ - |
| 943 | Octagam injection | $ 79.61 | $ - | $ - |
| 944 | Gammagard liquid injection | $ 102.28 | $ - | $ - |
| 945 | Rhophylac injection | $ 12.27 | $ - | $ - |
| 946 | Hepagam b im injection | $ 133.35 | $ - | $ - |
| 947 | Flebogamma injection | $ 93.76 | $ - | $ - |
| 948 | Gamunex-C/Gammaked | $ 103.40 | $ - | $ - |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1<br>APC | Column #2<br>APC Code Description | Column #3<br>Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4<br>Outpatient Hospital Facility Payment Rate *170% | Column #5<br>Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 949 | Frozen plasma, pooled, sd | $ 186.16 | $ - | $ - |
| 950 | Whole blood for transfusion | $ 508.69 | $ - | $ - |
| 952 | Cryoprecipitate each unit | $ 170.38 | $ - | $ - |
| 954 | RBC leukocytes reduced | $ 495.85 | $ - | $ - |
| 955 | Plasma, frz between 8-24hour | $ 180.99 | $ - | $ - |
| 956 | Plasma protein fract,5%,50ml | $ 43.60 | $ - | $ - |
| 957 | Platelets, each unit | $ 305.89 | $ - | $ - |
| 958 | Plaelet rich plasma unit | $ 431.44 | $ - | $ - |
| 959 | Red blood cells unit | $ 393.87 | $ - | $ - |
| 960 | Washed red blood cells unit | $ 752.47 | $ - | $ - |
| 961 | Albumin (human),5%, 50ml | $ 54.44 | $ - | $ - |
| 963 | Albumin (human), 5%, 250 ml | $ 177.37 | $ - | $ - |
| 964 | Albumin (human), 25%, 20 ml | $ 88.74 | $ - | $ - |
| 965 | Albumin (human), 25%, 50ml | $ 180.88 | $ - | $ - |
| 966 | Plasmaprotein fract,5%,250ml | $ 96.28 | $ - | $ - |
| 967 | Blood split unit | $ 264.32 | $ - | $ - |
| 968 | Platelets leukoreduced irrad | $ 418.16 | $ - | $ - |
| 969 | RBC leukoreduced irradiated | $ 723.87 | $ - | $ - |
| 1009 | Cryoprecipitatereducedplasma | $ 223.60 | $ - | $ - |
| 1010 | Blood, l/r, cmv-neg | $ 441.45 | $ - | $ - |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1 APC | Column #2 APC Code Description | Column #3 Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4 Outpatient Hospital Facility Payment Rate *170% | Column #5 Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 1011 | Platelets, hla-m, l/r, unit | $ 2,032.63 | $ - | $ - |
| 1013 | Platelets leukocytes reduced | $ 307.50 | $ - | $ - |
| 1015 | Injection glatiramer acetate | $ 393.67 | $ - | $ - |
| 1016 | Blood, l/r, froz/degly/wash | $ 589.71 | $ - | $ - |
| 1017 | Plt, aph/pher, l/r, cmv-neg | $ 1,124.66 | $ - | $ - |
| 1018 | Blood, l/r, irradiated | $ 429.88 | $ - | $ - |
| 1019 | Plate pheres leukoredu irrad | $ 1,741.14 | $ - | $ - |
| 1020 | Plt, pher, l/r cmv-neg, irr | $ 1,821.09 | $ - | $ - |
| 1021 | RBC, frz/deg/wsh, l/r, irrad | $ 1,129.91 | $ - | $ - |
| 1022 | RBC, l/r, cmv-neg, irrad | $ 754.88 | $ - | $ - |
| 1023 | Pralidoxime chloride inj | $ 232.86 | $ - | $ - |
| 1052 | Injection, voriconazole | $ 10.66 | $ - | $ - |
| 1064 | I131 iodide cap, rx | $ 48.15 | $ - | $ - |
| 1083 | Adalimumab injection | $ 1,480.10 | $ - | $ - |
| 1084 | Denileukin diftitox inj | $ 4,280.07 | $ - | $ - |
| 1086 | Temozolomide | $ 25.19 | $ - | $ - |
| 1138 | Hepagam b intravenous, inj | $ 133.35 | $ - | $ - |
| 1139 | Protein c concentrate | $ 37.08 | $ - | $ - |
| 1142 | Supprelin LA implant | $ 43,243.28 | $ - | $ - |
| 1150 | I131 iodide sol, rx | $ 28.08 | $ - | $ - |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1<br>APC | Column #2<br>APC Code Description | Column #3<br>Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4<br>Outpatient Hospital Facility Payment Rate *170% | Column #5<br>Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 1166 | Cytarabine liposome inj | $ 1,415.80 | $ - | $ - |
| 1168 | Inj, temsirolimus | $ 148.23 | $ - | $ - |
| 1178 | Busulfan injection | $ 66.48 | $ - | $ - |
| 1203 | Verteporfin injection | $ 27.64 | $ - | $ - |
| 1207 | Octreotide injection, depot | $ 356.93 | $ - | $ - |
| 1213 | Antihemophilic viii/vwf comp | $ 2.44 | $ - | $ - |
| 1214 | Inj IVIG privigen 500 mg | $ 95.50 | $ - | $ - |
| 1232 | Mitomycin injection | $ 61.26 | $ - | $ - |
| 1235 | Valrubicin injection | $ 2,756.18 | $ - | $ - |
| 1236 | Levoleucovorin injection | $ 4.55 | $ - | $ - |
| 1237 | Inj iron dextran | $ 31.30 | $ - | $ - |
| 1238 | Topotecan oral | $ 232.21 | $ - | $ - |
| 1253 | Triamcinolone A inj PRS-free | $ 9.62 | $ - | $ - |
| 1263 | Antithrombin iii injection | $ 8.14 | $ - | $ - |
| 1268 | Xyntha inj | $ 2.96 | $ - | $ - |
| 1272 | Acetylcysteine injection | $ 6.86 | $ - | $ - |
| 1274 | Edetate calcium disodium inj | $ 523.64 | $ - | $ - |
| 1280 | Corticotropin injection | $ 8,230.35 | $ - | $ - |
| 1281 | Bevacizumab injection | $ 4.26 | $ - | $ - |
| 1289 | AbobotulinumtoxinA | $ 19.55 | $ - | $ - |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1<br><br>APC | Column #2<br><br>APC Code Description | Column #3<br><br>Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4<br><br>Outpatient Hospital Facility Payment Rate *170% | Column #5<br><br>Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 1291 | Rilonacept injection | $ 62.63 | $ - | $ - |
| 1295 | Sm 153 lexidronam | $ 20,590.08 | $ - | $ - |
| 1296 | Degarelix injection | $ 9.15 | $ - | $ - |
| 1297 | Ferumoxytol, non-esrd | $ 1.79 | $ - | $ - |
| 1311 | Canakinumab injection | $ 236.63 | $ - | $ - |
| 1312 | Hizentra injection | $ 19.89 | $ - | $ - |
| 1327 | Imiglucerase injection | $ 109.20 | $ - | $ - |
| 1331 | Olanzapine long-acting inj | $ 7.15 | $ - | $ - |
| 1332 | Antithrombin recombinant | $ 268.71 | $ - | $ - |
| 1338 | Methyl aminolevulinate, top | $ 217.59 | $ - | $ - |
| 1340 | Collagenase, clost hist inj | $ 99.35 | $ - | $ - |
| 1341 | Amobarbital 125 MG inj | $ 467.66 | $ - | $ - |
| 1343 | Ganciclovir sodium injection | $ 187.46 | $ - | $ - |
| 1350 | Topotecan injection | $ 6.16 | $ - | $ - |
| 1352 | Wilate injection | $ 2.34 | $ - | $ - |
| 1353 | Belimumab injection | $ 100.88 | $ - | $ - |
| 1354 | Hydroxyprogesterone caproate | $ 7.02 | $ - | $ - |
| 1356 | Zoledronic Acid 1mg | $ 274.09 | $ - | $ - |
| 1361 | Enfuvirtide injection | $ 1.43 | $ - | $ - |
| 1408 | Cyclophosphamide 100 MG inj | $ 136.40 | $ - | $ - |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1<br>APC | Column #2<br>APC Code Description | Column #3<br>Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4<br>Outpatient Hospital Facility Payment Rate *170% | Column #5<br>Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 1413 | Lumizyme injection | $ 399.36 | $ - | $ - |
| 1415 | Glassia injection | $ 10.43 | $ - | $ - |
| 1416 | Factor XIII anti-hem factor | $ 17.52 | $ - | $ - |
| 1417 | Gel-one | $ 1,445.57 | $ - | $ - |
| 1419 | Dermacell | $ 198.07 | $ - | $ - |
| 1420 | Aflibercept injection | $ 2,549.30 | $ - | $ - |
| 1421 | Imported lipodox inj | $ 1,295.48 | $ - | $ - |
| 1422 | Anthrax vaccine sc or im | $ 244.53 | $ - | $ - |
| 1424 | Nabilone oral | $ 70.38 | $ - | $ - |
| 1426 | Eribulin mesylate injection | $ 255.42 | $ - | $ - |
| 1431 | Centruroides immune f(ab) | $ 9,501.88 | $ - | $ - |
| 1433 | Calcitonin salmon injection | $ 179.61 | $ - | $ - |
| 1439 | Aprotonin, 10,000 kiu | $ 8.89 | $ - | $ - |
| 1440 | Inj desmopressin acetate | $ 13.78 | $ - | $ - |
| 1442 | Non-HEU TC-99M add-on/dose | $ 26.00 | $ - | $ - |
| 1443 | Icatibant injection | $ 662.77 | $ - | $ - |
| 1445 | Methylnaltrexone injection | $ 1.22 | $ - | $ - |
| 1448 | Opthalmic mitomycin | $ 986.62 | $ - | $ - |
| 1449 | Talymed | $ 35.83 | $ - | $ - |
| 1454 | Mumps vaccine sc | $ 422.08 | $ - | $ - |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1<br>APC | Column #2<br>APC Code Description | Column #3<br>Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4<br>Outpatient Hospital Facility Payment Rate *170% | Column #5<br>Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 1455 | Foscarnet sodium injection | $ 34.63 | $ - | $ - |
| 1456 | Pentobarbital sodium inj | $ 83.82 | $ - | $ - |
| 1457 | Totazoline hcl injection | $ 104.03 | $ - | $ - |
| 1458 | Phentolaine mesylate inj | $ 301.81 | $ - | $ - |
| 1459 | Urea injection | $ 318.24 | $ - | $ - |
| 1460 | Interferon alfa-2a inj | $ 139.52 | $ - | $ - |
| 1463 | Tc99 Tilmanocept diag 0.5mci | $ 624.00 | $ - | $ - |
| 1464 | Factor VIII (porcine) | $ 0.52 | $ - | $ - |
| 1465 | Tacrolimus ex rel oral 0.1mg | $ 1.09 | $ - | $ - |
| 1466 | Inj, vincristine sul lip 1mg | $ 5,374.20 | $ - | $ - |
| 1467 | Factor IX recombinant | $ 3.30 | $ - | $ - |
| 1468 | Inj Aripiprazole Ext Rel 1mg | $ 9.80 | $ - | $ - |
| 1469 | Inj, Filgrastim G-CSF 1mcg | $ 2.57 | $ - | $ - |
| 1471 | Injection, Pertuzumab, 1 mg | $ 26.55 | $ - | $ - |
| 1472 | Inj beta interferon im 1 mcg | $ 85.36 | $ - | $ - |
| 1473 | Interferon alfa-n3 inj | $ 82.68 | $ - | $ - |
| 1474 | Certolizumab pegol inj 1mg | $ 13.34 | $ - | $ - |
| 1475 | Golimumab for iv use 1mg | $ 63.39 | $ - | $ - |
| 1605 | Abciximab injection | $ 1,777.07 | $ - | $ - |
| 1607 | Eptifibatide injection | $ 72.12 | $ - | $ - |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1<br>APC | Column #2<br>APC Code Description | Column #3<br>Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4<br>Outpatient Hospital Facility Payment Rate *170% | Column #5<br>Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 1608 | Etanercept injection | $ 696.62 | $ - | $ - |
| 1609 | Rho(D) immune globulin h, sd | $ 49.11 | $ - | $ - |
| 1612 | Daclizumab, parenteral | $ 1,368.48 | $ - | $ - |
| 1613 | Trastuzumab injection | $ 209.53 | $ - | $ - |
| 1630 | Hep b ig, im | $ 292.86 | $ - | $ - |
| 1631 | Baclofen intrathecal trial | $ 197.18 | $ - | $ - |
| 1633 | Alefacept | $ 108.26 | $ - | $ - |
| 1643 | Y90 ibritumomab, rx | $ 109,479.14 | $ - | $ - |
| 1645 | #N/A | $ 78,490.26 | $ - | $ - |
| 1670 | Tetanus immune globulin inj | $ 713.49 | $ - | $ - |
| 1675 | P32 Na phosphate | $ 579.98 | $ - | $ - |
| 1676 | P32 chromic phosphate | $ 821.78 | $ - | $ - |
| 1683 | Basiliximab | $ 6,418.39 | $ - | $ - |
| 1684 | Corticorelin ovine triflutal | $ 20.20 | $ - | $ - |
| 1685 | Darbepoetin alfa, non-esrd | $ 9.57 | $ - | $ - |
| 1686 | Epoetin alfa, non-esrd | $ 29.59 | $ - | $ - |
| 1687 | Digoxin immune fab (ovine) | $ 3,257.67 | $ - | $ - |
| 1688 | Ethanolamine oleate | $ 779.84 | $ - | $ - |
| 1689 | Fomepizole | $ 18.10 | $ - | $ - |
| 1690 | Hemin | $ 42.87 | $ - | $ - |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1<br><br>APC | Column #2<br><br>APC Code Description | Column #3<br><br>Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4<br><br>Outpatient Hospital Facility Payment Rate *170% | Column #5<br><br>Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 1693 | Lepirudin | $ 667.50 | $ - | $ - |
| 1694 | Ziconotide injection | $ 17.16 | $ - | $ - |
| 1695 | Nesiritide injection | $ 157.59 | $ - | $ - |
| 1696 | Palifermin injection | $ 37.47 | $ - | $ - |
| 1697 | Pegaptanib sodium injection | $ 2,675.32 | $ - | $ - |
| 1700 | Inj secretin synthetic human | $ 71.47 | $ - | $ - |
| 1701 | Treprostinil injection | $ 159.22 | $ - | $ - |
| 1704 | Humate-P, inj | $ 2.34 | $ - | $ - |
| 1705 | Factor viia | $ 4.37 | $ - | $ - |
| 1709 | Azacitidine injection | $ 14.14 | $ - | $ - |
| 1710 | Clofarabine injection | $ 337.01 | $ - | $ - |
| 1711 | Vantas implant | $ 7,648.78 | $ - | $ - |
| 1712 | Paclitaxel protein bound | $ 24.75 | $ - | $ - |
| 1716 | Brachytx, non-str, Gold-198 | $ 120.41 | $ - | $ - |
| 1717 | Brachytx, non-str, HDR Ir-192 | $ 723.45 | $ - | $ - |
| 1719 | Brachytx, NS, Non-HDRIr-192 | $ 87.20 | $ - | $ - |
| 1738 | Oxaliplatin | $ 0.70 | $ - | $ - |
| 1739 | Pegademase bovine, 25 iu | $ 717.29 | $ - | $ - |
| 1741 | Urofollitropin, 75 iu | $ 179.24 | $ - | $ - |
| 1841 | Retinal prosth int/ext comp | $ - | | |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1<br>APC | Column #2<br>APC Code Description | Column #3<br>Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4<br>Outpatient Hospital Facility Payment Rate *170% | Column #5<br>Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 2616 | Brachytx, non-str,Yttrium-90 | $ 43,755.74 | $ - | $ - |
| 2632 | Iodine I-125 sodium iodide | $ 49.32 | $ - | $ - |
| 2634 | Brachytx, non-str, HA, I-125 | $ 192.74 | $ - | $ - |
| 2635 | Brachytx, non-str, HA, P-103 | $ 69.32 | $ - | $ - |
| 2636 | Brachy linear, non-str,P-103 | $ 104.88 | $ - | $ - |
| 2638 | Brachytx, stranded, I-125 | $ 125.89 | $ - | $ - |
| 2639 | Brachytx, non-stranded,I-125 | $ 105.33 | $ - | $ - |
| 2640 | Brachytx, stranded, P-103 | $ 186.78 | $ - | $ - |
| 2641 | Brachytx, non-stranded,P-103 | $ 178.75 | $ - | $ - |
| 2642 | Brachytx, stranded, C-131 | $ 361.43 | $ - | $ - |
| 2643 | Brachytx, non-stranded,C-131 | $ 163.85 | $ - | $ - |
| 2698 | Brachytx, stranded, NOS | $ 125.89 | $ - | $ - |
| 2699 | Brachytx, non-stranded, NOS | $ 69.32 | $ - | $ - |
| 2731 | Immune globulin, powder | $ 95.81 | $ - | $ - |
| 2770 | Quinupristin/dalfopristin | $ 516.36 | $ - | $ - |
| 3041 | Bivalirudin | $ 8.35 | $ - | $ - |
| 3043 | Gamma globulin 1 CC inj | $ 62.35 | $ - | $ - |
| 7000 | Amifostine | $ 781.77 | $ - | $ - |
| 7011 | Oprelvekin injection | $ 719.34 | $ - | $ - |
| 7035 | Teniposide | $ 902.07 | $ - | $ - |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1<br><br>APC | Column #2<br><br>APC Code Description | Column #3<br><br>Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4<br><br>Outpatient Hospital Facility Payment Rate *170% | Column #5<br><br>Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 7038 | Monoclonal antibodies | $ 17.21 | $ - | $ - |
| 7041 | Tirofiban HCl | $ 23.35 | $ - | $ - |
| 7042 | Capecitabine, oral | $ 26.05 | $ - | $ - |
| 7043 | Infliximab injection | $ 182.29 | $ - | $ - |
| 7046 | Doxorubicin inj 10mg | $ 1,335.05 | $ - | $ - |
| 7048 | Alteplase recombinant | $ 155.01 | $ - | $ - |
| 7308 | Aminolevulinic acid hcl top | $ 647.66 | $ - | $ - |
| 8000 | Cardiac Electrophysiologic Evaluation and Ablation Composite | $ 34,099.16 | $ 14,541.19 | $ 12,360.01 |
| 9001 | Linezolid injection | $ 105.59 | $ - | $ - |
| 9002 | Tenecteplase injection | $ 205.45 | $ - | $ - |
| 9003 | Palivizumab | $ 3,401.84 | $ - | $ - |
| 9004 | Gemtuzumab ozogamicin inj | $ 7,130.73 | $ - | $ - |
| 9005 | Reteplase injection | $ 5,984.97 | $ - | $ - |
| 9006 | Tacrolimus injection | $ 354.02 | $ - | $ - |
| 9012 | Arsenic trioxide injection | $ 128.02 | $ - | $ - |
| 9018 | Inj, rimabotulinumtoxinB | $ 29.09 | $ - | $ - |
| 9019 | Caspofungin acetate | $ 33.20 | $ - | $ - |
| 9024 | Amphotericin b lipid complex | $ 27.22 | $ - | $ - |
| 9032 | Baclofen 10 MG injection | $ 432.93 | $ - | $ - |
| 9033 | Cidofovir injection | $ 1,698.29 | $ - | $ - |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1<br>APC | Column #2<br>APC Code Description | Column #3<br>Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4<br>Outpatient Hospital Facility Payment Rate *170% | Column #5<br>Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 9038 | Inj estrogen conjugate | $ 424.22 | $ - | $ - |
| 9042 | Glucagon hydrochloride | $ 345.83 | $ - | $ - |
| 9044 | Ibutilide fumarate injection | $ 227.50 | $ - | $ - |
| 9104 | Antithymocyte globuln rabbit | $ 1,484.78 | $ - | $ - |
| 9108 | Thyrotropin injection | $ 3,146.44 | $ - | $ - |
| 9110 | Alemtuzumab injection | $ 1,513.98 | $ - | $ - |
| 9119 | Injection, pegfilgrastim 6mg | $ 8,388.48 | $ - | $ - |
| 9120 | Injection, Fulvestrant | $ 233.09 | $ - | $ - |
| 9121 | Injection, argatroban | $ 46.67 | $ - | $ - |
| 9122 | Triptorelin pamoate | $ 482.92 | $ - | $ - |
| 9124 | Daptomycin injection | $ 1.66 | $ - | $ - |
| 9125 | Risperidone, long acting | $ 15.44 | $ - | $ - |
| 9126 | Natalizumab injection | $ 36.37 | $ - | $ - |
| 9130 | Inj, Imm Glob Bivigam, 500mg | $ 100.46 | $ - | $ - |
| 9131 | Inj, Ado-trastuzumab Emt 1mg | $ 75.84 | $ - | $ - |
| 9132 | Kcentra, per i.u. | $ 4.00 | $ - | $ - |
| 9133 | Rabies ig, im/sc | $ 568.91 | $ - | $ - |
| 9134 | Rabies ig, heat treated | $ 555.49 | $ - | $ - |
| 9135 | Varicella-zoster ig, im | $ 1,755.57 | $ - | $ - |
| 9137 | Bcg vaccine, percut | $ 310.49 | $ - | $ - |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1<br>APC | Column #2<br>APC Code Description | Column #3<br>Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4<br>Outpatient Hospital Facility Payment Rate *170% | Column #5<br>Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 9139 | Rabies vaccine, im | $ 613.65 | $ - | $ - |
| 9140 | Rabies vaccine, id | $ 411.89 | $ - | $ - |
| 9143 | Meningococcal vaccine, sc | $ 276.87 | $ - | $ - |
| 9144 | Encephalitis vaccine, sc | $ 270.74 | $ - | $ - |
| 9145 | Meningococcal vaccine, im | $ 253.68 | $ - | $ - |
| 9207 | Bortezomib injection | $ 118.48 | $ - | $ - |
| 9208 | Agalsidase beta injection | $ 380.09 | $ - | $ - |
| 9209 | Laronidase injection | $ 73.61 | $ - | $ - |
| 9210 | Palonosetron hcl | $ 50.31 | $ - | $ - |
| 9213 | Pemetrexed injection | $ 156.18 | $ - | $ - |
| 9214 | Bevacizumab injection | $ 170.72 | $ - | $ - |
| 9215 | Cetuximab injection | $ 136.60 | $ - | $ - |
| 9217 | Leuprolide acetate suspnsion | $ 543.63 | $ - | $ - |
| 9224 | Galsulfase injection | $ 936.75 | $ - | $ - |
| 9225 | Fluocinolone acetonide implt | $ 50,297.00 | $ - | $ - |
| 9227 | Micafungin sodium injection | $ 2.52 | $ - | $ - |
| 9228 | Tigecycline injection | $ 4.60 | $ - | $ - |
| 9229 | Ibandronate sodium injection | $ 410.62 | $ - | $ - |
| 9230 | Abatacept injection | $ 60.92 | $ - | $ - |
| 9231 | Decitabine injection | $ 83.82 | $ - | $ - |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1<br><br>APC | Column #2<br><br>APC Code Description | Column #3<br><br>Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4<br><br>Outpatient Hospital Facility Payment Rate *170% | Column #5<br><br>Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 9232 | Idursulfase injection | $ 1,219.63 | $ - | $ - |
| 9233 | Ranibizumab injection | $ 1,032.72 | $ - | $ - |
| 9234 | Alglucosidase alfa injection | $ 537.24 | $ - | $ - |
| 9235 | Panitumumab injection | $ 237.20 | $ - | $ - |
| 9236 | Eculizumab injection | $ 532.01 | $ - | $ - |
| 9237 | Inj, lanreotide acetate | $ 98.51 | $ - | $ - |
| 9240 | Injection, ixabepilone | $ 178.49 | $ - | $ - |
| 9242 | Injection, fosaprepitant | $ 4.47 | $ - | $ - |
| 9243 | Bendamustine injection | $ 55.51 | $ - | $ - |
| 9245 | Romiplostim injection | $ 134.19 | $ - | $ - |
| 9250 | Artiss fibrin sealant | $ 111.46 | $ - | $ - |
| 9251 | C1 esterase inhibitor inj | $ 127.97 | $ - | $ - |
| 9252 | Plerixafor injection | $ 776.83 | $ - | $ - |
| 9253 | Temozolomide injection | $ 13.36 | $ - | $ - |
| 9255 | Paliperidone palmitate inj | $ 19.89 | $ - | $ - |
| 9256 | Dexamethasone intra implant | $ 509.26 | $ - | $ - |
| 9258 | Telavancin injection | $ 10.69 | $ - | $ - |
| 9259 | Pralatrexate injection | $ 498.29 | $ - | $ - |
| 9260 | Ofatumumab injection | $ 122.67 | $ - | $ - |
| 9261 | Ustekinumab injection | $ 384.46 | $ - | $ - |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
| Col#1<br>APC | Column #2<br>APC Code Description | Column #3<br>Outpatient Emergency Room Department Facility Payment Rate *260% | Column #4<br>Outpatient Hospital Facility Payment Rate *170% | Column #5<br>Outpatient ASC Facility: 85% of OP Hospital Facility Payment Rate (Col #4) |
| 9263 | Ecallantide injection | $ 924.14 | $ - | $ - |
| 9264 | Tocilizumab injection | $ 9.62 | $ - | $ - |
| 9265 | Romidepsin injection | $ 677.69 | $ - | $ - |
| 9268 | Capsaicin 8% patch | $ 66.43 | $ - | $ - |
| 9269 | C-1 esterase, berinert | $ 85.02 | $ - | $ - |
| 9270 | Gammaplex IVIG | $ 97.16 | $ - | $ - |
| 9271 | Velaglucerase alfa | $ 923.34 | $ - | $ - |
| 9272 | Inj, denosumab | $ 37.15 | $ - | $ - |
| 9273 | Sipuleucel-T auto CD54+ | $ 87,050.42 | $ - | $ - |
| 9274 | Crotalidae Poly Immune Fab | $ 6,148.27 | $ - | $ - |
| 9276 | Cabazitaxel injection | $ 361.50 | $ - | $ - |
| 9278 | Incobotulinumtoxin A | $ 11.65 | $ - | $ - |
| 9281 | Injection, pegloticase | $ 1,482.00 | $ - | $ - |
| 9284 | Ipilimumab injection | $ 335.32 | $ - | $ - |
| 9286 | Belatacept injection | $ 9.88 | $ - | $ - |
| 9287 | Brentuximab vedotin inj | $ 277.84 | $ - | $ - |
| 9289 | Erwinaze injection | $ 895.39 | $ - | $ - |
| 9290 | Inj, bupivacaine liposome | $ 2.86 | $ - | $ - |
| 9293 | Injection, glucarpidase | $ 638.09 | $ - | $ - |
| 9294 | Inj, Taliglucerace Alfa 10 u | $ 80.34 | $ - | $ - |

| Exhibit #4 | | | | |
|---|---|---|---|---|
| Effective for Dates of Service on and After 1/1/2015 | | | | |
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| 9295 | Injection, Carfilzomib, 1 mg | $ 76.15 | $ - | $ - |
| 9296 | Inj, ziv-aflibercept, 1mg | $ 24.36 | $ - | $ - |
| 9297 | Inj, Omacetaxine Mep, 0.01mg | $ 6.45 | $ - | $ - |
| 9298 | Inj, Ocriplasmin, 0.125 mg | $ 2,721.55 | $ - | $ - |
| 9300 | Omalizumab injection | $ 66.61 | $ - | $ - |
| 9366 | Epifix | $ 554.32 | $ - | $ - |
| 9368 | Grafix core | $ 333.22 | $ - | $ - |
| 9369 | Grafix prime | $ 299.49 | $ - | $ - |
| 9441 | Inj, ferric carboxymaltose | $ 2.76 | $ - | $ - |
| 9497 | Loxapine, inhalation powder | $ 399.62 | $ - | $ - |
| 9500 | Platelets, irradiated | $ 437.89 | $ - | $ - |
| 9501 | Platelet pheres leukoreduced | $ 1,299.17 | $ - | $ - |
| 9502 | Platelet pheresis irradiated | $ 1,518.84 | $ - | $ - |
| 9503 | Fr frz plasma donor retested | $ 158.68 | $ - | $ - |
| 9504 | RBC deglycerolized | $ 987.61 | $ - | $ - |
| 9505 | RBC irradiated | $ 570.28 | $ - | $ - |
| 9506 | Granulocytes, pheresis unit | $ 4,906.64 | $ - | $ - |
| 9507 | Platelets, pheresis | $ 1,045.77 | $ - | $ - |
| 9508 | Plasma 1 donor frz w/in 8 hr | $ 205.82 | $ - | $ - |

| Exhibit #5 |
| --- |
| **Effective January 1, 2015** |
| **Rural Health Facilities** |
| |
| Akron Clinic |
| 82 Main |
| Akron, CO  80720 – Washington County |
| Telephone:  (970) 345-6336, Fax:  (970) 345-6576 |
| |
| Arkansas Valley Family Practice, LLC |
| 2317 San Juan Avenue |
| La Junta, CO  81050 – Otero County |
| Telephone:  (719) 383-2325, Fax:  (719) 383-2327 |
| |
| Basin Clinic |
| 421 West Adams Road |
| Naturita, CO  81422 – Montrose County |
| Telephone:  (970) 865-2665, Fax:  (970) 825-2674 |
| |
| Brush Family Clinic |
| 2400 W Edison |
| Brush, CO 80723 - Morgan County |
| Telephone: (970) 842-2833, Fax: (970) 842-6241 |
| |
| Buena Vista Health Center |
| 28374 County Road 317 |
| Buena Vista, CO 81211 - Chaffee County |
| Telephone: (719) 395-9048, Fax: (719) 395-9064 |
| |
| Button Family Practice |
| 715 South 9th Street |
| Cannon City, CO 81212 – Fremont County |
| Telephone:  (719) 269-8820, Fax:  (719) 204-0230 |
| |
| Centennial Family Health Center |
| 319 Main Street |
| Ordway, CO 81063 – Crowley County |
| Telephone:  (719) 267-3503, Fax:  (719) 267-4153 |
| |

| Exhibit #5 |
| --- |
| **Effective January 1, 2015** |
| **Rural Health Facilities** |
| |
| Cortez Primary Care Clinic |
| 118 North Chestnut |
| Cortez, CO 81321 – Montezuma County |
| Telephone: (970) 564-9777, Fax: (970) 564-8833 |
| |
| Creed Family Practice Of Rio Grande Hospital |
| 802 Rio Grande Avenue |
| Creed, CO 81130 – Mineral County |
| Telephone: (719) 658-0929, Fax: (719) 657-2851 |
| |
| Custer County Medical Clinic |
| 704 Edwards |
| Westcliffe, CO 81252 - Custer County |
| Telephone: (719) 783-2380, Fax: (719) 783-2377 |
| |
| Dolores Medical Center |
| 507 Central Avenue |
| Dolores, CO 81323 - Montezuma County |
| Telephone: (970) 882-7221, Fax: (970) 882-4243 |
| |
| Eads Medical Clinic |
| 1211 Luther Street |
| Eads, CO 81036 - Kiowa County |
| Telephone: (719) 438-2251, Fax: (719) 438-2254 |
| |
| Eastern Plains Medical Clinic Of Calhan |
| 560 Crystola Street |
| Calhan, CO 80808 - El Paso County |
| Telephone: (719) 347-0100, Fax: (719) 347-0551 |
| |
| Family Care Clinic |
| 615 Fairhurst |
| Sterling, CO 80751 - Logan County |
| Telephone: (970) 521-3223, Fax: (970) 521-3266 |
| |
| |

| Exhibit #5 |
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| Effective January 1, 2015 |
| Rural Health Facilities |
| |
| Family Practice Of Holyoke |
| 1001 East Johnson Street |
| Holyoke, CO 80734 - Phillips County |
| Telephone: (970) 854-2500, Fax: (970) 854-3440 |
| |
| Florence Medical Center |
| 501 W 5th St |
| Florence, CO 81226 - Fremont County |
| Telephone: (719) 784-4816, Fax: (719) 784-6014 |
| |
| Fort Morgan Pediatric Clinic, PC |
| 1000 Lincoln Street, Ste. 202 |
| Fort Morgan, CO 80701 – Morgan County |
| Telephone: (970) 542-9187, Fax: (970) 867-9187 |
| |
| Grand River Health Clinic West |
| 201 Sipperelle Drive |
| Parachute, CO 81635 – Garfield County |
| Telephone: (970) 285-7046, Fax: (970) 285-6064 |
| |
| Grand River Primary Care |
| 501 Airport Road |
| Rifle, CO 81650 - Garfield County |
| Telephone: (970) 625-1100, Fax: (970) 625-0725 |
| |
| Kit Carson Clinic |
| 102 East 2nd Avenue |
| Kit Carson, CO 80825 - Cheyenne County |
| Telephone: (719) 962-3501, Fax: (719) 962-3403 |
| |
| Lake City Area Medical Center |
| 700 N Henson Street |
| Lake City, CO 81235 - Hinsdale County |
| Telephone: (970) 944-2331, Fax: (970) 944-2320 |
| |
| |

| Exhibit #5 |
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| **Effective January 1, 2015** |
| **Rural Health Facilities** |
| |
| Lamar Medical Clinic |
| 403 Kendall Drive |
| Lamar, CO 81052 – Prowers County |
| Telephone: (719) 336-6767; Fax: (719) 336-7217 |
| |
| Las Animas Family Practice |
| 304 Carson Avenue |
| Las Animas, CO 81054 – Bent County |
| Telephone: (719) 456-6000; Fax: (719) 456-9701 |
| |
| Mancos Valley Health Center |
| 111 Railroad Aveneu |
| Mancos, CO 81328 – Montezuma County |
| Telephone: (970) 564-2104, Fax: (970) 564-2134 |
| |
| Meeker Family Health Center |
| 345 Cleveland Street |
| Meeker, CO 81641 - Rio Blanco County |
| Telephone: (970) 878-4014, Fax: (970) 878-3285 |
| |
| Mountain Medical Center Of Buena Vista, P.C |
| 36 Oak St |
| Buena Vista, CO 81211 - Chaffee County |
| Telephone: (719) 395-8632, Fax: (719) 395-4971 |
| |
| Mt San Rafael Hospital Health Clinic |
| 400 Benedicta, Suite A |
| Trinidad, CO 81082 – Las Animas County |
| Telephone: (719) 846-2206, Fax: (719) 846-7823 |
| |
| North Park Medical Center - Walden |
| 350 McKinley Street |
| Walden, CO 80480 - Jackson County |
| Telephone: (970) 723-4255, Fax: (970) 723-4268 |
| |
| |

| Exhibit #5 |
|---|
| Effective January 1, 2015 |
| Rural Health Facilities |
| |
| Pagosa Mountain Clinic |
| 95 South Pagosa Blvd. |
| Pagosa Springs, CO 81147 – Archuleta County |
| Telephone: (970) 731-3700, Fax: (970) 731-3707 |
| |
| Parke Health Clinic |
| 182 16th St |
| Burlington, CO 80807 - Kit Carson County |
| Telephone: (719) 346-9481, Fax: (719) 346-9485 |
| |
| Pediatric Associates, The |
| 947 South 5th Street |
| Montrose, CO 81401 – Montrose County |
| Telephone: (970) 249-2421, Fax: (970) 249-8897 |
| |
| Pediatric Association Of Canon City |
| 1335 Phay Avenue, Suite A |
| Canon City, CO 81212 - Fremont County |
| Telephone: (719) 269-1727, Fax: (719) 269-1730 |
| |
| Prairie View Rural Health Clinic |
| 615 West 5th North |
| Cheyenne Wells, CO 80810 - Cheyenne County |
| Telephone: (719) 767-5669, Fax: (719) 767-8042 |
| |
| R and D Medical Management Corp. |
| 109 Latigo Lane, Suite C |
| Canon City, CO 81212 – Fremont County |
| Telephone: (719) 276-3211; Fax: (719) 276-3011 |
| |
| Rio Grande Hospital Clinic |
| 0310C County Road 14 |
| Del Norte CO 81132 – Rio Grande County |
| Telephone: (719) 657-2418, Fax: (719) 658-3001 |
| |
| |

| Exhibit #5 |
| --- |
| Effective January 1, 2015 |
| Rural Health Facilities |
| |
| Rocky Ford Family Health Center |
| 1014 Elm Avenue |
| Rocky Ford, CO 81067 - Otero County |
| Telephone: (719) 254-7421, Fax: (719) 254-6966 |
| |
| Sabatini Pediatrics, PC |
| 612 Yale Place |
| Canon City, CO 81212 – Fremont County |
| Telephone: (719) 275-3442, Fax: (719) 275-2306 |
| |
| San Luis Valley Health Antonio Clinic |
| 115 Main Street |
| Antonio, CO 81120 – Conejos County |
| Telephone: (719) 376-2308, Fax: (719) 376-2395 |
| |
| San Luis Valley La Jara Medical Clinic |
| 509 Main Street |
| La Jara, CO 81140 – Conejos County |
| Telephone: (719) 274-5000, Fax: (719) 274-4111 |
| |
| Southeast Colorado Physician's Clinic |
| 900 Church Street |
| Springfield, CO 81073 - Baca County |
| Telephone: (719) 523-6628, Fax: (719) 523-4513 |
| |
| Southwest Memorial Primary Care |
| 33 North Elm Street |
| Cortez, CO 81321 – Montezuma County |
| Telephone: (970) 565-8556, Fax: (970) 564-1134 |
| |
| Southwest Walk-In Care |
| 2095 North Dolores Road, Suite C |
| Cortez, CO 81321 – Montezuma County |
| Telephone: (970) 564-1037, Fax: (970) 564-1041 |
| |
| |

| Exhibit #5 |
| --- |
| Effective January 1, 2015 |
| Rural Health Facilities |
| |
| Spanish Peaks Family Clinic |
| 23400 US Highway 160 |
| Walsenburg, CO  81089 – Huerfano County |
| Telephone: (719) 738-4591, Fax: (719) 738-4553 |
| |
| Stratton Medical Clinic |
| 500 Nebraska Avenue |
| Stratton, CO 80836 - Kit Carson County |
| Telephone: (719) 348-4650, Fax: (719) 348-4653 |
| |
| Surface Creek Family Practice |
| 255 SW 8th Ave |
| Cedaredge, CO 81413 - Delta County |
| Telephone: (970) 856-3146, Fax: (970) 856-4385 |
| |
| Trinidad Family Medical Center |
| 1502 E Main St |
| Trinidad, CO 81082 - Las Animas County |
| Telephone: (719) 846-3305, Fax: (719) 846-4922 |
| |
| Valley Medical Clinic |
| 116 E Ninth Street |
| Julesburg, CO 80737 - Sedgwick County |
| Telephone: (970) 474-3376, Fax: (970) 474-2461 |
| |
| Walsh Medical Clinic |
| 137 Kansas Street |
| Walsh, CO 81090 – Baca County |
| Telephone:  (719) 324-5253, Fax:  (719) 324-5621 |
| |
| Washington County Clinic |
| 482 Adams Avenue |
| Akron, CO 80720 - Washington County |
| Telephone:  (970) 345-2262, Fax:  (970) 345-2265 |
| |
| |

| Exhibit #5 |
|---|
| **Effective January 1, 2015** |
| **Rural Health Facilities** |
| |
| Yuma Clinic |
| 1000 W 8th Avenue |
| Yuma, CO  80759 |
| Telephone:  (970) 8848-4792, Fax:  (970) 848-5405 |

# Exhibit # 6
# Dental Free Schedule
# Effective January 1, 2015

| CDT 2014 | 2015 Fees |
|---|---|
| D0120 | $67.15 |
| D0140 | $112.29 |
| D0145 | $104.19 |
| D0150 | $118.08 |
| D0160 | $237.31 |
| D0170 | $78.72 |
| D0180 | $128.50 |
| D0190 | $62.00 |
| D0191 | $44.00 |
| D0210 | $187.18 |
| D0220 | $37.68 |
| D0230 | $34.03 |
| D0240 | $58.35 |
| D0250 | $71.72 |
| D0260 | $65.64 |
| D0270 | $38.89 |
| D0272 | $63.21 |
| D0273 | $76.58 |
| D0274 | $88.74 |
| D0277 | $133.71 |
| D0290 | $218.79 |
| D0310 | $556.70 |
| D0320 | $948.10 |
| D0321 | BR |
| D0322 | $765.77 |
| D0330 | $165.54 |
| D0340 | $186.38 |
| D0350 | $89.13 |
| D0360 | $1,067.34 |
| D0362 | $853.17 |

| CDT 2014 | 2015 Fees |
|---|---|
| D0363 | $889.06 |
| D0364 | $1,251.00 |
| D0365 | $1,251.00 |
| D0366 | $1,251.00 |
| 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 |
| D0415 | $72.00 |
| D0416 | $106.00 |
| D0417 | $97.00 |
| D0418 | $100.00 |
| D0421 | $72.00 |
| D0425 | $62.00 |
| D0431 | $100.00 |
| D0460 | $100.00 |
| D0470 | $219.00 |
| D0472 | $137.00 |
| D0473 | $290.00 |
| D0474 | $325.00 |
| D0475 | $175.00 |

| CDT 2014 | 2015 Fees |
|---|---|
| D0476 | $170.00 |
| D0477 | $232.00 |
| D0478 | $212.00 |
| D0479 | $325.00 |
| D0480 | $200.00 |
| D0481 | $858.14 |
| D0482 | $250.00 |
| D0483 | $250.00 |
| D0484 | $375.00 |
| D0485 | $517.00 |
| D0486 | $240.00 |
| D0502 | BR |
| 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 |
| D1510 | $503.57 |
| D1515 | $704.99 |
| D1520 | $554.51 |
| D1525 | $856.64 |
| D1550 | $108.82 |
| D1555 | $104.19 |
| D2140 | $262.55 |
| D2150 | $339.13 |

| CDT 2014 | 2015 Fees |
|---|---|
| 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 |
| 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 |

| CDT 2014 | 2015 Fees |
|---|---|
| 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 |
| D2794 | $1,548.55 |
| D2799 | $628.41 |
| D2910 | $143.43 |
| D2915 | $143.43 |
| D2920 | $144.65 |
| D2929 | $543.00 |
| D2930 | $395.04 |
| D2931 | $447.31 |
| D2932 | $476.48 |
| D2933 | $545.76 |
| D2934 | $545.76 |
| D2940 | $150.73 |
| 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 |
| D2970 | $357.36 |
| D2971 | $228.51 |

| CDT 2014 | 2015 Fees |
|---|---|
| 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 |
| 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 |
| D3354 | BR |
| D3410 | $1,920.50 |
| D3421 | $2,138.07 |
| D3425 | $2,421.29 |
| D3426 | $818.03 |
| D3430 | $601.67 |
| D3450 | $1,251.97 |
| D3460 | $4,676.05 |
| D3470 | $2,388.47 |
| D3910 | $334.27 |

| CDT 2014 | 2015 Fees |
|---|---|
| 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 |
| 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 |
| D4320 | $625.99 |
| D4321 | $633.28 |
| D4341 | $361.00 |
| D4342 | $217.57 |
| D4355 | $246.75 |
| D4381 | BR |
| D4910 | $222.44 |
| D4920 | $161.66 |
| D4999 | BR |

| CDT 2014 | 2015 Fees |
|---|---|
| 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 |
| 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 |

| CDT 2014 | 2015 Fees |
|---|---|
| D5761 | $705.00 |
| D5810 | $1,133.00 |
| D5811 | $1,218.00 |
| D5820 | $876.00 |
| D5821 | $930.00 |
| D5850 | $224.00 |
| D5851 | $224.00 |
| D5860 | BR |
| D5861 | BR |
| D5862 | BR |
| 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 | $1,411.00 |
| D5951 | $1,834.00 |

| CDT 2014 | 2015 Fees |
| --- | --- |
| 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 |
| D5983 | $2,416.43 |
| D5984 | $2,416.43 |
| D5985 | $2,416.43 |
| D5986 | $214.00 |
| D5987 | $3,627.07 |
| D5988 | $641.00 |
| D5991 | $246.00 |
| D5992 | BR |
| D5993 | BR |
| D5999 | BR |
| D6101 | BR |
| D6102 | BR |
| D6103 | BR |
| D6104 | BR |
| D6010 | $3,914.00 |
| D6012 | $3,698.00 |
| D6040 | $14,418.34 |
| D6050 | $10,047.00 |
| D6051 | BR |
| D6053 | $2,922.00 |
| D6054 | $2,922.00 |
| 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 |

| CDT 2014 | 2015 Fees |
| --- | --- |
| 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 |
| D6075 | $2,217.00 |
| D6076 | $2,311.89 |
| D6077 | $2,242.61 |
| D6078 | BR |
| D6079 | BR |
| D6080 | $184.00 |
| D6090 | BR |
| D6091 | $887.00 |
| D6092 | $173.00 |
| D6093 | $271.00 |
| D6094 | $1,887.68 |
| D6095 | BR |
| D6100 | 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 |

| CDT 2014 | 2015 Fees |
| --- | --- |
| D6242 | $1,493.86 |
| D6245 | $1,582.59 |
| D6250 | $1,514.52 |
| D6251 | $1,396.62 |
| D6252 | $1,441.59 |
| D6253 | $652.72 |
| D6545 | $610.19 |
| D6548 | $651.00 |
| 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 |

| CDT 2014 | 2015 Fees |
|---|---|
| D6782 | $1,563.15 |
| D6783 | $1,561.00 |
| D6790 | $1,599.60 |
| D6791 | $1,516.96 |
| D6792 | $1,571.65 |
| D6793 | $637.00 |
| D6794 | $1,571.65 |
| D6920 | $420.57 |
| D6930 | $245.53 |
| D6940 | $556.70 |
| D6950 | $1,074.51 |
| D6975 | $1,191.19 |
| 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 |

| CDT 2014 | 2015 Fees |
|---|---|
| D7291 | $466.76 |
| 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 |
| 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 |

| CDT 2014 | 2015 Fees |
|---|---|
| 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 |
| 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 |

| CDT 2014 | 2015 Fees |
|---|---|
| D7876 | $25,268.00 |
| D7877 | $22,301.00 |
| D7880 | $2,785.00 |
| 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 |
| 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 | $15,137.00 |
| D7995 | BR |
| D7996 | BR |

| CDT 2014 | 2015 Fees |
|---|---|
| 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 |
| D8690 | $545.76 |
| D8691 | $512.95 |
| D8692 | $571.28 |
| D8693 | $528.75 |
| D8999 | BR |
| D9110 | $215.15 |
| D9120 | $243.11 |
| D9210 | $181.65 |
| D9211 | $200.55 |
| D9212 | $312.90 |
| D9215 | $150.15 |
| D9220 | $1,815.45 |
| D9221 | $813.75 |
| D9230 | $300.30 |
| D9241 | $1,408.05 |
| D9242 | $688.80 |
| D9248 | $437.85 |
| D9310 | $487.42 |
| D9410 | $557.92 |

| CDT 2014 | 2015 Fees |
|---|---|
| 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 |
| D9940 | $940.80 |
| D9941 | $307.52 |
| D9942 | $354.24 |
| 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 |
| D9999 | BR |

# Exhibit # 7
**(Effective January 1, 2015)**
**Evaluation and Management (E&M) 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 use the "1997 Documentation Guidelines for Evaluation and Management Services" as developed by Medicare and available on Medicare's web site when indicated in this Exhibit.

1. History (Hx), 2. Examination (Exam), and 3. Medical Decision Making (MDM) Determines the Level of Service:

New Patient/Office Consultations

| Level of Service (Requires all three key components at the same level or higher) | 1. Hx | 2. Exam | 3. 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 |

Established Patient Office Visit

| Level of Service (Requires at least two of the three key components at the same level or higher) | 1. Hx | 2. Exam | 3. 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 |

NOTES: Documentation of a chief complaint is required for any billed office visit.

CPT® criteria for a consultation is still required to bill a consultation code.

1. History Component – To qualify for a given level of history all three elements in the table below must be met and documented in the record. Documentation must be patient specific and pertain directly to the current visit. Information copied directly from prior records without change is not considered current nor counted.

| History Elements | Requirements for a Problem Focused (PF) History Level | Requirements for an Expanded Problem Focused (EPF) History Level | Requirements for a Detailed (D) History Level | Requirements for a Comprehensive (C) History Level |
|---|---|---|---|---|
| History of Present Illness/Injury (HPI) | Brief 1-3 elements | Brief 1-3 elements | Extended 4+ elements (required a detailed patient specific description of the patient's progress with the current TX plan, which should include objective functional gains/losses, ADLs) | Extended 4+ elements (requires a detailed patient specific description of the patient's progress with the current TX plan, which should include objective functional gains/losses, ADLs) |
| Review of Systems (ROS) is not required for established patient visits. | None | Problem pertinent – limited to injured body part | 2 to 9 body parts or body systems | Complete 10+ |
| 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?)
6. Context (what ADLs or functions aggravates/relieves?)**
7. Modifying factors (doing what?)
8. Associated signs (nausea, when?)

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

For the provider to achieve an “extended” HPI in an initial patient/injured worker’s visit it is necessary 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.

B. Review of Systems (ROS) each system/body part is counted once whether positive or negative:

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

Identify, perform and documentation of all pertinent ROS systems with either a “positive or negative” response is necessary to be counted.

C. The 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 – 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.

2. Pertinent Physician's Examination Component – Each bullet is counted only when it is pertinent and related to the workers' compensation injury and the medical decision making process.

The 1997 Evaluation and Management (E&M) guidelines may be used for specialist examination.

Content and Documentation Requirements

| Level of Examination Performed and Documented | # of Bullets Required for each Level |
|---|---|
| Problem Focused | 1 to 5 elements identified by a bullet as indicated in this 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 |

Constitutional Measurement

Vital signs (may be measured and recorded by ancillary staff) – any of three 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:

1. Inspection, percussion and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions

2. Assessment of range of motion with notation of any pain (e.g., straight leg raising), crepitation or contracture

3. Assessment of stability with notation of any dislocation (luxation), subluxation or laxity

4. Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (fasciculation, tardive dyskinesia)

7. Examination of gait and station

Neck – one bullet for both examinations

1. Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus)

2. 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); and

    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, cafeau-lait pots, 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

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

3. Medical Decision Making (MDM) Component

Documentation must be patient specific and pertain directly to the current visit. Information copied directly from prior records without change is not considered current nor counted.

| Level of Risk | 1. # of Points for the # of Dxs and Management Options) | 2. # of Points for Amount and Complexity of Data) | 3. Level of Risk |
|---|---|---|---|
| Straightforward | 0-1 | 0-1 | Minimal |
| Low | 2 | 2 | Low |
| Moderate | 3 | 3 | Moderate |
| High | 4+ | 4+ | High |

Overall MDM is determined by the highest 2 out of the 3 above categories.

| 1. 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 | | X | 2 | = | |
| New problem with no additional workup planned or established patient with worsening of condition and no additional workup planned | (max1) | X | 3 | = | |
| New problem, additional workup planned or established patient with worsening of condition and additional workup planned. | | X | 4 | = | |

| 2. 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 reports reviewed and commented on progress (state whether the patient is progressing and how they are functionally progressing or not and document any planned changes to the plan of care) | 2 |
| Review and summary of old records and/or discussion with other health provider | 2 |
| Independent visualization of images, tracing or specimen | 2 |
| TOTAL | |

| 3. Table of Risk (the highest one in any one category determines the overall risk for this portion) | | | |
|---|---|---|---|
| Level of Risk | Presenting Problem(s) | Diagnostic Procedure(s) Ordered | 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<br>Chest x-rays<br>EKG/EEG<br>Urinalysis<br>Ultrasound<br>KOH prep | Rest<br>Gargles<br>Elastic bandages<br>Superficial dressings |
| Low | Two or more self-limited or minor problems<br>One stable chronic illness, e.g., well-controlled HTN, NIDDM, cataract, BPH<br>Acute, uncomplicated illness or injury, e.g., allergic rhinitis or simple sprain cyctitis<br>Acute laceration repair | Physiologic tests nor under stress, e.g., PFTs<br>Non-cardiovascular imaging studies w/contrast, e.g., barium enema<br>Superficial needle biopsies<br>Lab tests requiring arterial puncture<br>Skin biopsies | Over-the-counter drugs<br>Minor surgery w/no identified risk factors<br>PT/OT<br>IV fluids w/o additives<br>Simple or layered closure<br>Vaccine injection |
| Moderate | One of more chronic illnesses with mild exacerabation, progression or side effects of treatment<br>Two or more stable chronic illnesses<br>Undiagnosed new problem with uncertain prognosis, e.g., new extremity neurologic complaints<br>Acute illness with systemic symptoms, e.g., pyelonephritis, | Physiologic tests under stress, e.g. cardiac stress test,<br>Discography, stress tests<br>Diagnostic injections<br>Deep needle or incisional biopsies<br>Cardiovascular imaging studies with | Minor surgery with identified risk factors<br>Elective major surgery (open, percutaneous, or endoscopic) with no identified risk factors<br>Prescription drug management<br>Therapeutic nuclear medicine IV fluids with |

| | | | |
|---|---|---|---|
| | colitis<br>Acute complicated injury, e.g., head injury with brief loss of consciousness | contrast and no identified risk factors e.g. arteriogram, cardiac cath<br>Obtain fluid from body cavity, e.g. lumbar puncture, thoracentesis, culdocentesis | additives<br>Closed Tx of Fx or dislocation w/o manipulation<br>Inability to return the injured worker to work and requires detailed functional improvement plan. |
| High | One or more chronic illness with severe exacerbation, progression or side effects of treatment<br>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;<br>An abrupt change in neurological status, e.g., seizure, TIA, weakness, sensory loss | Cardiovascular imaging studies with contrast with identified risk factors<br>Cardiac electrophysiological tests<br>Diagnostic endoscopies with identified risk factors | Elective major surgery with identified risk factors<br>Emergency major surgery<br>Parenteral controlled substances<br>Drug therapy requiring intensive monitoring for toxicity<br>Decision not to resuscitate or to de-escalate care because of poor prognosis,<br>Potential for significant permanent work restrictions or total disability<br>Management of addiction behavior or other significant psychiatric condition<br>Treatment plan for patients with symptoms causing severe functional deficits without supporting physiological \findings or verified related medical diagnosis. |

If 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 there is detailed patient specific documentation of the counseling and/or coordination of care, then time can determine the level of service.

The total time spent face-to-face with the patient and/or coordination of care must be documented in the record and the total visit time.

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.

Documentation must be patient specific and pertain directly to the current visit. Information copied directly from prior records without change is not considered current nor counted.

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.

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:

1. Injury/disease education that includes discussion of diagnostic tests results and a disease specific treatment plan.
2. Return to work
3. Temporary and/or permanent restrictions
4. Self-management of symptoms while at home and/or work
5. Correct posture/mechanics to perform work functions
6. Job task exercises for muscle strengthening and stretching
7. Appropriate tool and equipment use to prevent re-injury and/or worsening of the existing injury/condition
8. Patient/injured worker expectations and specific goals
9. Family and other interpersonal relationships and how they relate to psychological/social issues
10. Discussion of pharmaceutical management (includes drug dosage, specific drug side effects and potential of addiction /problems
11. Assessment of vocational plans (i.e., restrictions as they relate to current and future employment job requirements)

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.**

**The counseling or coordination of care activities must be done 24 hours prior to the actual patient encounter or within seven (7) business days after the actual patient encounter. If these activities are done outside of the 24 hours prior to or 7 business days after the patient encounter, then Rule 18-5(I)(4) "Treating Physician Telephone or On-line Services" or Rule 18-6(A) "Face-to-Face or Telephonic meeting by a Treating Physician with the Employer … With or Without the Injured Workers" is applicable.**

## Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 36415 | | Routine venipuncture | $ 6.48 |
| 78267 | | Breath tst attain/anal c-14 | $ 23.18 |
| 78268 | | Breath test analysis c-14 | $ 198.48 |
| 80047 | QW | Metabolic panel ionized ca | $ 24.93 |
| 80047 | | Metabolic panel ionized ca | $ 24.93 |
| 80048 | QW | Metabolic panel total ca | $ 24.93 |
| 80048 | | Metabolic panel total ca | $ 24.93 |
| 80050 | QW | Health Panel | $ 116.16 |
| 80050 | | Health Panel | $ 116.16 |
| 80051 | QW | Electrolyte panel | $ 20.67 |
| 80051 | | Electrolyte panel | $ 20.67 |
| 80053 | QW | Comprehen metabolic panel | $ 31.13 |
| 80053 | | Comprehen metabolic panel | $ 31.13 |
| 80061 | QW | Lipid panel | $ 39.46 |
| 80061 | | Lipid panel | $ 39.46 |
| 80069 | QW | Renal function panel | $ 25.60 |
| 80069 | | Renal function panel | $ 25.60 |
| 80074 | | Acute hepatitis panel | $ 140.38 |
| 80076 | | Hepatic function panel | $ 24.06 |
| 80102 | | Drug confirmation | $ 39.03 |
| 80150 | | Assay of amikacin | $ 44.41 |
| 80152 | | Assay of amitriptyline | $ 52.75 |
| 80154 | | Assay of benzodiazepines | $ 54.50 |

## Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 80155 | | Drug screen quant caffeine | $ 41.69 |
| 80156 | | Assay carbamazepine total | $ 42.92 |
| 80157 | | Assay carbamazepine free | $ 39.07 |
| 80158 | | Assay of cyclosporine | $ 53.20 |
| 80159 | | Drug screen quant clozapine | $ 54.50 |
| 80160 | | Assay of desipramine | $ 50.72 |
| 80162 | | Assay of digoxin | $ 39.14 |
| 80164 | | Assay dipropylacetic acid | $ 39.94 |
| 80166 | | Assay of doxepin | $ 45.66 |
| 80168 | | Assay of ethosuximide | $ 48.17 |
| 80169 | | Drug screen quant everolimus | $ 40.46 |
| 80170 | | Assay of gentamicin | $ 48.30 |
| 80171 | | Drug screen quant gabapentin | $ 39.07 |
| 80172 | | Assay of gold | $ 48.00 |
| 80173 | | Assay of haloperidol | $ 42.92 |
| 80174 | | Assay of imipramine | $ 50.72 |
| 80175 | | Drug screen quan lamotrigine | $ 39.07 |
| 80176 | | Assay of lidocaine | $ 43.29 |
| 80177 | | Drug scrn quan levetiracetam | $ 39.07 |
| 80178 | QW | Assay of lithium | $ 19.48 |
| 80178 | | Assay of lithium | $ 19.48 |
| 80180 | | Drug scrn quan mycophenolate | $ 53.20 |
| 80182 | | Assay of nortriptyline | $ 39.94 |

# Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 80183 | | Drug scrn quant oxcarbazepin | $ 39.07 |
| 80184 | | Assay of phenobarbital | $ 33.74 |
| 80185 | | Assay of phenytoin total | $ 39.07 |
| 80186 | | Assay of phenytoin free | $ 40.56 |
| 80188 | | Assay of primidone | $ 48.90 |
| 80190 | | Assay of procainamide | $ 49.36 |
| 80192 | | Assay of procainamide | $ 49.36 |
| 80194 | | Assay of quinidine | $ 43.03 |
| 80195 | | Assay of sirolimus | $ 40.46 |
| 80196 | | Assay of salicylate | $ 20.91 |
| 80197 | | Assay of tacrolimus | $ 40.46 |
| 80198 | | Assay of theophylline | $ 41.69 |
| 80199 | | Drug screen quant tiagabine | $ 53.20 |
| 80200 | | Assay of tobramycin | $ 47.50 |
| 80201 | | Assay of topiramate | $ 35.14 |
| 80202 | | Assay of vancomycin | $ 39.94 |
| 80203 | | Drug screen quant zonisamide | $ 39.07 |
| 80299 | | Quantitative assay drug | $ 40.35 |
| 80400 | | Acth stimulation panel | $ 96.12 |
| 80402 | | Acth stimulation panel | $ 256.24 |
| 80406 | | Acth stimulation panel | $ 184.05 |
| 80408 | | Aldosterone suppression eval | $ 369.81 |
| 80410 | | Calcitonin stimul panel | $ 236.74 |

## Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 80412 | | CRH stimulation panel | $ 971.33 |
| 80414 | | Testosterone response | $ 152.17 |
| 80415 | | Estradiol response panel | $ 164.68 |
| 80416 | | Renin stimulation panel | $ 388.86 |
| 80417 | | Renin stimulation panel | $ 129.62 |
| 80418 | | Pituitary evaluation panel | $ 1,707.96 |
| 80420 | | Dexamethasone panel | $ 212.31 |
| 80422 | | Glucagon tolerance panel | $ 135.78 |
| 80424 | | Glucagon tolerance panel | $ 148.80 |
| 80426 | | Gonadotropin hormone panel | $ 437.34 |
| 80428 | | Growth hormone panel | $ 196.56 |
| 80430 | | Growth hormone panel | $ 231.27 |
| 80432 | | Insulin suppression panel | $ 347.63 |
| 80434 | | Insulin tolerance panel | $ 298.14 |
| 80435 | | Insulin tolerance panel | $ 303.57 |
| 80436 | | Metyrapone panel | $ 268.64 |
| 80438 | | TRH stimulation panel | $ 148.54 |
| 80439 | | TRH stimulation panel | $ 198.07 |
| 80440 | | TRH stimulation panel | $ 171.33 |
| 81000 | | Urinalysis nonauto w/scope | $ 9.33 |
| 81001 | | Urinalysis auto w/scope | $ 9.33 |
| 81002 | | Urinalysis nonauto w/o scope | $ 7.54 |
| 81003 | QW | Urinalysis auto w/o scope | $ 6.61 |

## Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 81003 | | Urinalysis auto w/o scope | $ 6.61 |
| 81005 | | Urinalysis | $ 6.39 |
| 81007 | QW | Urine screen for bacteria | $ 7.56 |
| 81007 | | Urine screen for bacteria | $ 7.56 |
| 81015 | | Microscopic exam of urine | $ 8.96 |
| 81020 | | Urinalysis glass test | $ 10.86 |
| 81025 | | Urine pregnancy test | $ 18.64 |
| 81050 | | Urinalysis volume measure | $ 8.83 |
| 81161 | | Dmd dup/delet analysis | $ - |
| 81201 | 0 | | $ 1,619.83 |
| 81202 | 0 | | $ 202.91 |
| 81203 | 0 | | $ 1,231.31 |
| 81206 | | Bcr/abl1 gene major bp | $ 483.17 |
| 81207 | | Bcr/abl1 gene minor bp | $ 426.79 |
| 81208 | | Bcr/abl1 gene other bp | $ 473.97 |
| 81210 | | Braf gene | $ 387.18 |
| 81211 | | Brca1&2 seq & com dup/del | $ 4,716.36 |
| 81212 | | Brca1&2 185&5385&6174 var | $ 381.67 |
| 81213 | | Brca1&2 uncom dup/del var | $ 1,258.68 |
| 81214 | | Brca1 full seq & com dup/del | $ 3,106.38 |
| 81215 | | Brca1 gene known fam variant | $ 201.40 |
| 81217 | | Brca2 gene known fam variant | $ 201.40 |
| 81225 | | Cyp2c19 gene com variants | $ 630.29 |

# Exhibit #8, Pathology Laboratory Maximum Fees

For Dates of Service on and After 1/1/2015

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 81226 | | Cyp2d6 gene com variants | $ 975.43 |
| 81227 | | Cyp2c9 gene com variants | $ 378.17 |
| 81235 | | Egfr gene com variants | $ 712.82 |
| 81240 | | F2 gene | $ 145.00 |
| 81241 | | F5 gene | $ 180.08 |
| 81245 | | Flt3 gene | $ 358.39 |
| 81256 | | Hfe gene | $ 192.61 |
| 81261 | | Igh gene rearrange amp meth | $ 583.44 |
| 81262 | | Igh gene rearrang dir probe | $ 128.63 |
| 81263 | | Igh vari regional mutation | $ 867.87 |
| 81264 | | Igk rearrangeabn clonal pop | $ 440.04 |
| 81265 | | Str markers specimen anal | $ 633.70 |
| 81266 | 0 | | $ 344.74 |
| 81267 | | Chimerism anal no cell selec | $ 611.34 |
| 81268 | | Chimerism anal w/cell select | $ 768.48 |
| 81270 | | Jak2 gene | $ 270.13 |
| 81275 | | Kras gene | $ 426.56 |
| 81287 | | Mgmt gene methylation anal | $ - |
| 81291 | | Mthfr gene | $ 128.63 |
| 81292 | | Mlh1 gene full seq | $ 1,395.88 |
| 81293 | | Mlh1 gene known variants | $ 559.57 |
| 81294 | | Mlh1 gene dup/delete variant | $ 411.87 |
| 81295 | | Msh2 gene full seq | $ 327.69 |

| Exhibit #8, Pathology Laboratory Maximum Fees | | | |
|---|---|---|---|
| For Dates of Service on and After 1/1/2015 | | | |
| HCPCS | Modifier | SHORTDESC | 216% |
| 81296 | | Msh2 gene known variants | $ 279.78 |
| 81297 | | Msh2 gene dup/delete variant | $ 327.69 |
| 81298 | | Msh6 gene full seq | $ 621.71 |
| 81299 | | Msh6 gene known variants | $ 348.28 |
| 81300 | | Msh6 gene dup/delete variant | $ 349.23 |
| 81301 | | Microsatellite instability | $ 853.29 |
| 81310 | | Npm1 gene | $ 533.82 |
| 81315 | | Pml/raralpha com breakpoints | $ 610.91 |
| 81316 | | Pml/raralpha 1 breakpoint | $ 931.80 |
| 81317 | | Pms2 gene full seq analysis | $ 1,687.59 |
| 81318 | | Pms2 known familial variants | $ 398.76 |
| 81319 | | Pms2 gene dup/delet variants | $ 478.79 |
| 81321 | | Pten gene full sequence | $ 1,297.51 |
| 81322 | | Pten gene known fam variant | $ 126.14 |
| 81323 | | Pten gene dup/delet variant | $ 189.22 |
| 81332 | | Serpina1 gene | $ 128.63 |
| 81340 | | Trb@ gene rearrange amplify | $ 615.64 |
| 81341 | | Trb@ gene rearrange dirprobe | $ 146.12 |
| 81342 | | Trg gene rearrangement anal | $ 593.78 |
| 81370 | | Hla i & ii typing lr | $ 1,184.98 |
| 81371 | | Hla i & ii type verify lr | $ 709.26 |
| 81372 | | Hla i typing complete lr | $ 650.94 |
| 81373 | | Hla i typing 1 locus lr | $ 328.17 |

## Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 81374 | | Hla i typing 1 antigen lr | $ 214.38 |
| 81375 | | Hla ii typing ag equiv lr | $ 650.48 |
| 81376 | | Hla ii typing 1 locus lr | $ 360.16 |
| 81377 | | Hla ii type 1 ag equiv lr | $ 270.54 |
| 81378 | | Hla i & ii typing hr | $ 1,018.31 |
| 81379 | | Hla i typing complete hr | $ 988.29 |
| 81380 | | Hla i typing 1 locus hr | $ 522.31 |
| 81381 | | Hla i typing 1 allele hr | $ 278.70 |
| 81382 | | Hla ii typing 1 loc hr | $ 364.46 |
| 81383 | | Hla ii typing 1 allele hr | $ 321.58 |
| 82000 | | Assay of blood acetaldehyde | $ 36.50 |
| 82003 | | Assay of acetaminophen | $ 56.42 |
| 82009 | | Test for acetone/ketones | $ 13.31 |
| 82010 | QW | Acetone assay | $ 24.08 |
| 82010 | | Acetone assay | $ 24.08 |
| 82013 | | Acetylcholinesterase assay | $ 32.92 |
| 82016 | | Acylcarnitines qual | $ 40.85 |
| 82017 | | Acylcarnitines quant | $ 7.78 |
| 82024 | | Assay of acth | $ 113.83 |
| 82030 | | Assay of adp & amp | $ 41.75 |
| 82040 | QW | Assay of serum albumin | $ 14.58 |
| 82040 | | Assay of serum albumin | $ 14.58 |
| 82042 | QW | Assay of urine albumin | $ 8.55 |

## Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 82042 | | Assay of urine albumin | $ 8.55 |
| 82043 | QW | Microalbumin quantitative | $ 17.04 |
| 82043 | | Microalbumin quantitative | $ 17.04 |
| 82044 | QW | Microalbumin semiquant | $ 13.48 |
| 82044 | | Microalbumin semiquant | $ 13.48 |
| 82045 | | Albumin ischemia modified | $ 96.10 |
| 82055 | QW | Assay of ethanol | $ 31.84 |
| 82055 | | Assay of ethanol | $ 31.84 |
| 82075 | | Assay of breath ethanol | $ 35.51 |
| 82085 | | Assay of aldolase | $ 28.60 |
| 82088 | | Assay of aldosterone | $ 120.10 |
| 82101 | | Assay of urine alkaloids | $ 88.45 |
| 82103 | | Alpha-1-antitrypsin total | $ 39.59 |
| 82104 | | Alpha-1-antitrypsin pheno | $ 42.62 |
| 82105 | | Alpha-fetoprotein serum | $ 49.44 |
| 82106 | | Alpha-fetoprotein amniotic | $ 49.44 |
| 82107 | | Alpha-fetoprotein l3 | $ 189.82 |
| 82108 | | Assay of aluminum | $ 75.08 |
| 82120 | QW | Amines vaginal fluid qual | $ 5.10 |
| 82120 | | Amines vaginal fluid qual | $ 5.10 |
| 82127 | | Amino acid single qual | $ 40.85 |
| 82128 | | Amino acids mult qual | $ 40.85 |
| 82131 | | Amino acids single quant | $ 49.70 |

## Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 82135 | | Assay aminolevulinic acid | $ 48.49 |
| 82136 | | Amino acids quant 2-5 | $ 7.78 |
| 82139 | | Amino acids quan 6 or more | $ 7.78 |
| 82140 | | Assay of ammonia | $ 42.94 |
| 82143 | | Amniotic fluid scan | $ 20.24 |
| 82145 | | Assay of amphetamines | $ 45.79 |
| 82150 | QW | Assay of amylase | $ 19.09 |
| 82150 | | Assay of amylase | $ 19.09 |
| 82154 | | Androstanediol glucuronide | $ 43.98 |
| 82157 | | Assay of androstenedione | $ 86.27 |
| 82160 | | Assay of androsterone | $ 73.68 |
| 82163 | | Assay of angiotensin II | $ 60.46 |
| 82164 | | Angiotensin I enzyme test | $ 43.03 |
| 82172 | | Assay of apolipoprotein | $ 45.66 |
| 82175 | | Assay of arsenic | $ 55.92 |
| 82180 | | Assay of ascorbic acid | $ 29.12 |
| 82190 | | Atomic absorption | $ 43.93 |
| 82205 | | Assay of barbiturates | $ 33.74 |
| 82232 | | Assay of beta-2 protein | $ 47.67 |
| 82239 | | Bile acids total | $ 24.86 |
| 82240 | | Bile acids cholylglycine | $ 37.69 |
| 82247 | QW | Bilirubin total | $ 14.77 |
| 82247 | | Bilirubin total | $ 14.77 |

| Exhibit #8, Pathology Laboratory Maximum Fees | | | |
|---|---|---|---|
| For Dates of Service on and After 1/1/2015 | | | |
| **HCPCS** | **Modifier** | **SHORTDESC** | **216%** |
| 82248 | | Bilirubin direct | $ 14.77 |
| 82252 | | Fecal bilirubin test | $ 4.13 |
| 82261 | | Assay of biotinidase | $ 7.78 |
| 82270 | | Occult blood feces | $ 9.59 |
| 82271 | QW | Occult blood other sources | $ 9.59 |
| 82271 | | Occult blood other sources | $ 9.59 |
| 82272 | QW | Occult bld feces 1-3 tests | $ 9.59 |
| 82272 | | Occult bld feces 1-3 tests | $ 9.59 |
| 82274 | QW | Assay test for blood fecal | $ 46.87 |
| 82274 | | Assay test for blood fecal | $ 46.87 |
| 82286 | | Assay of bradykinin | $ 20.30 |
| 82300 | | Assay of cadmium | $ 68.21 |
| 82306 | | Vitamin d 25 hydroxy | $ 87.26 |
| 82308 | | Assay of calcitonin | $ 78.93 |
| 82310 | QW | Assay of calcium | $ 15.21 |
| 82310 | | Assay of calcium | $ 15.21 |
| 82330 | QW | Assay of calcium | $ 40.28 |
| 82330 | | Assay of calcium | $ 40.28 |
| 82331 | | Calcium infusion test | $ 15.25 |
| 82340 | | Assay of calcium in urine | $ 17.78 |
| 82355 | | Calculus analysis qual | $ 34.11 |
| 82360 | | Calculus assay quant | $ 37.93 |
| 82365 | | Calculus spectroscopy | $ 37.99 |

# Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 82370 | | X-ray assay calculus | $ 36.91 |
| 82373 | | Assay c-d transfer measure | $ 53.20 |
| 82374 | QW | Assay blood carbon dioxide | $ 8.38 |
| 82374 | | Assay blood carbon dioxide | $ 8.38 |
| 82375 | | Assay carboxyhb quant | $ 36.31 |
| 82376 | | Assay carboxyhb qual | $ 14.69 |
| 82378 | | Carcinoembryonic antigen | $ 55.90 |
| 82379 | | Assay of carnitine | $ 7.78 |
| 82380 | | Assay of carotene | $ 27.17 |
| 82382 | | Assay urine catecholamines | $ 50.67 |
| 82383 | | Assay blood catecholamines | $ 73.85 |
| 82384 | | Assay three catecholamines | $ 74.41 |
| 82387 | | Assay of cathepsin-d | $ 23.82 |
| 82390 | | Assay of ceruloplasmin | $ 31.64 |
| 82397 | | Chemiluminescent assay | $ 23.82 |
| 82415 | | Assay of chloramphenicol | $ 37.35 |
| 82435 | QW | Assay of blood chloride | $ 8.21 |
| 82435 | | Assay of blood chloride | $ 8.21 |
| 82436 | | Assay of urine chloride | $ 14.82 |
| 82438 | | Assay other fluid chlorides | $ 14.41 |
| 82441 | | Test for chlorohydrocarbons | $ 17.69 |
| 82465 | QW | Assay bld/serum cholesterol | $ 12.81 |
| 82465 | | Assay bld/serum cholesterol | $ 12.81 |

## Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 82480 | | Assay serum cholinesterase | $ 23.22 |
| 82482 | | Assay rbc cholinesterase | $ 22.64 |
| 82485 | | Assay chondroitin sulfate | $ 52.34 |
| 82486 | | Gas/liquid chromatography | $ 53.20 |
| 82487 | | Paper chromatography | $ 47.07 |
| 82488 | | Paper chromatography | $ 62.96 |
| 82489 | | Thin layer chromatography | $ 54.50 |
| 82491 | | Chromotography quant sing | $ 53.20 |
| 82492 | | Chromotography quant mult | $ 53.20 |
| 82495 | | Assay of chromium | $ 59.77 |
| 82507 | | Assay of citrate | $ 81.93 |
| 82520 | | Assay of cocaine | $ 44.67 |
| 82523 | QW | Collagen crosslinks | $ 55.08 |
| 82523 | | Collagen crosslinks | $ 55.08 |
| 82525 | | Assay of copper | $ 36.57 |
| 82528 | | Assay of corticosterone | $ 66.36 |
| 82530 | | Cortisol free | $ 49.25 |
| 82533 | | Total cortisol | $ 48.04 |
| 82540 | | Assay of creatine | $ 13.65 |
| 82541 | | Column chromotography qual | $ 53.20 |
| 82542 | | Column chromotography quant | $ 53.20 |
| 82543 | | Column chromotograph/isotope | $ 53.20 |

| Exhibit #8, Pathology Laboratory Maximum Fees | | | |
|---|---|---|---|
| For Dates of Service on and After 1/1/2015 | | | |
| HCPCS | Modifier | SHORTDESC | 216% |
| 82544 | | Column chromotograph/isotope | $ 53.20 |
| 82550 | QW | Assay of ck (cpk) | $ 19.18 |
| 82550 | | Assay of ck (cpk) | $ 19.18 |
| 82552 | | Assay of cpk in blood | $ 39.48 |
| 82553 | | Creatine mb fraction | $ 34.02 |
| 82554 | | Creatine isoforms | $ 34.97 |
| 82565 | QW | Assay of creatinine | $ 15.10 |
| 82565 | | Assay of creatinine | $ 15.10 |
| 82570 | QW | Assay of urine creatinine | $ 15.25 |
| 82570 | | Assay of urine creatinine | $ 15.25 |
| 82575 | | Creatinine clearance test | $ 27.84 |
| 82585 | | Assay of cryofibrinogen | $ 20.87 |
| 82595 | | Assay of cryoglobulin | $ 19.07 |
| 82600 | | Assay of cyanide | $ 57.15 |
| 82607 | | Vitamin B-12 | $ 44.41 |
| 82608 | | B-12 binding capacity | $ 42.21 |
| 82610 | | Cystatin c | $ 16.70 |
| 82615 | | Test for urine cystines | $ 24.06 |
| 82626 | | Dehydroepiandrosterone | $ 74.48 |
| 82627 | | Dehydroepiandrosterone | $ 65.51 |
| 82633 | | Desoxycorticosterone | $ 91.28 |
| 82634 | | Deoxycortisol | $ 86.27 |

# Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 82638 | | Assay of dibucaine number | $ 36.09 |
| 82646 | | Assay of dihydrocodeinone | $ 60.85 |
| 82649 | | Assay of dihydromorphinone | $ 75.75 |
| 82651 | | Assay of dihydrotestosterone | $ 56.42 |
| 82652 | | Vit d 1 25-dihydroxy | $ 113.46 |
| 82654 | | Assay of dimethadione | $ 40.80 |
| 82656 | | Pancreatic elastase fecal | $ 34.00 |
| 82657 | | Enzyme cell activity | $ 53.20 |
| 82658 | | Enzyme cell activity ra | $ 53.20 |
| 82664 | | Electrophoretic test | $ 101.24 |
| 82666 | | Assay of epiandrosterone | $ 63.31 |
| 82668 | | Assay of erythropoietin | $ 55.40 |
| 82670 | | Assay of estradiol | $ 82.34 |
| 82671 | | Assay of estrogens | $ 95.19 |
| 82672 | | Assay of estrogen | $ 63.94 |
| 82677 | | Assay of estriol | $ 71.26 |
| 82679 | QW | Assay of estrone | $ 73.55 |
| 82679 | | Assay of estrone | $ 73.55 |
| 82690 | | Assay of ethchlorvynol | $ 50.93 |
| 82693 | | Assay of ethylene glycol | $ 43.89 |
| 82696 | | Assay of etiocholanolone | $ 69.51 |
| 82705 | | Fats/lipids feces qual | $ 14.99 |
| 82710 | | Fats/lipids feces quant | $ 49.53 |

| Exhibit #8, Pathology Laboratory Maximum Fees | | | |
|---|---|---|---|
| For Dates of Service on and After 1/1/2015 | | | |
| **HCPCS** | **Modifier** | **SHORTDESC** | **216%** |
| 82715 | | Assay of fecal fat | $ 29.29 |
| 82725 | | Assay of blood fatty acids | $ 39.23 |
| 82726 | | Long chain fatty acids | $ 53.20 |
| 82728 | | Assay of ferritin | $ 40.15 |
| 82731 | | Assay of fetal fibronectin | $ 189.82 |
| 82735 | | Assay of fluoride | $ 54.63 |
| 82742 | | Assay of flurazepam | $ 58.32 |
| 82746 | | Assay of folic acid serum | $ 43.33 |
| 82747 | | Assay of folic acid rbc | $ 50.72 |
| 82757 | | Assay of semen fructose | $ 22.98 |
| 82759 | | Assay of rbc galactokinase | $ 45.90 |
| 82760 | | Assay of galactose | $ 32.98 |
| 82775 | | Assay galactose transferase | $ 62.08 |
| 82776 | | Galactose transferase test | $ 16.80 |
| 82777 | | Galectin-3 | $ 64.82 |
| 82784 | | Assay iga/igd/igg/igm each | $ 16.80 |
| 82785 | | Assay of ige | $ 48.54 |
| 82787 | | Igg 1 2 3 or 4 each | $ 13.54 |
| 82800 | | Blood pH | $ 24.93 |
| 82803 | | Blood gases any combination | $ 57.02 |
| 82805 | | Blood gases w/o2 saturation | $ 83.61 |
| 82810 | | Blood gases o2 sat only | $ 25.73 |
| 82820 | | Hemoglobin-oxygen affinity | $ 28.56 |

## Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 82930 | | Gastric analy w/ph ea spec | $ 16.07 |
| 82938 | | Gastrin test | $ 52.14 |
| 82941 | | Assay of gastrin | $ 51.97 |
| 82943 | | Assay of glucagon | $ 42.10 |
| 82945 | | Glucose other fluid | $ 11.58 |
| 82946 | | Glucagon tolerance test | $ 39.29 |
| 82947 | QW | Assay glucose blood quant | $ 11.58 |
| 82947 | | Assay glucose blood quant | $ 11.58 |
| 82948 | | Reagent strip/blood glucose | $ 9.33 |
| 82950 | QW | Glucose test | $ 14.00 |
| 82950 | | Glucose test | $ 14.00 |
| 82951 | QW | Glucose tolerance test (GTT) | $ 18.90 |
| 82951 | | Glucose tolerance test (GTT) | $ 18.90 |
| 82952 | QW | GTT-added samples | $ 11.56 |
| 82952 | | GTT-added samples | $ 11.56 |
| 82953 | | Glucose-tolbutamide test | $ 44.65 |
| 82955 | | Assay of g6pd enzyme | $ 28.56 |
| 82960 | | Test for G6PD enzyme | $ 17.84 |
| 82962 | | Glucose blood test | $ 5.31 |
| 82963 | | Assay of glucosidase | $ 63.31 |
| 82965 | | Assay of gdh enzyme | $ 22.79 |
| 82975 | | Assay of glutamine | $ 35.58 |
| 82977 | QW | Assay of GGT | $ 21.21 |

## Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 82977 | | Assay of GGT | $ 21.21 |
| 82978 | | Assay of glutathione | $ 31.38 |
| 82979 | | Assay rbc glutathione | $ 20.30 |
| 82980 | | Assay of glutethimide | $ 54.00 |
| 82985 | QW | Assay of glycated protein | $ 44.41 |
| 82985 | | Assay of glycated protein | $ 44.41 |
| 83001 | QW | Assay of gonadotropin (fsh) | $ 54.76 |
| 83001 | | Assay of gonadotropin (fsh) | $ 54.76 |
| 83002 | QW | Assay of gonadotropin (lh) | $ 54.56 |
| 83002 | | Assay of gonadotropin (lh) | $ 54.56 |
| 83003 | | Assay growth hormone (hgh) | $ 49.16 |
| 83008 | | Assay of guanosine | $ 49.46 |
| 83009 | | H pylori (c-13) blood | $ 198.48 |
| 83010 | | Assay of haptoglobin quant | $ 19.53 |
| 83012 | | Assay of haptoglobins | $ 50.67 |
| 83013 | | H pylori (c-13) breath | $ 198.48 |
| 83014 | | H pylori drug admin | $ 23.18 |
| 83015 | | Heavy metal screen | $ 55.49 |
| 83018 | | Quantitative screen metals | $ 64.71 |
| 83020 | | Hemoglobin electrophoresis | $ 34.24 |
| 83021 | | Hemoglobin chromotography | $ 53.20 |
| 83026 | | Hemoglobin copper sulfate | $ 6.98 |
| 83030 | | Fetal hemoglobin chemical | $ 24.36 |

| Exhibit #8, Pathology Laboratory Maximum Fees | | | |
|---|---|---|---|
| For Dates of Service on and After 1/1/2015 | | | |
| **HCPCS** | **Modifier** | **SHORTDESC** | **216%** |
| 83033 | | Fetal hemoglobin assay qual | $ 17.56 |
| 83036 | QW | Glycosylated hemoglobin test | $ 28.60 |
| 83036 | | Glycosylated hemoglobin test | $ 28.60 |
| 83037 | QW | Glycosylated hb home device | $ 28.60 |
| 83037 | | Glycosylated hb home device | $ 28.60 |
| 83045 | | Blood methemoglobin test | $ 14.60 |
| 83050 | | Blood methemoglobin assay | $ 21.60 |
| 83051 | | Assay of plasma hemoglobin | $ 10.32 |
| 83055 | | Blood sulfhemoglobin test | $ 14.49 |
| 83060 | | Blood sulfhemoglobin assay | $ 24.36 |
| 83065 | | Assay of hemoglobin heat | $ 20.30 |
| 83068 | | Hemoglobin stability screen | $ 24.93 |
| 83069 | | Assay of urine hemoglobin | $ 11.64 |
| 83070 | | Assay of hemosiderin qual | $ 14.00 |
| 83071 | | Assay of hemosiderin quant | $ 20.24 |
| 83080 | | Assay of b hexosaminidase | $ 7.78 |
| 83088 | | Assay of histamine | $ 87.03 |
| 83090 | | Assay of homocystine | $ 49.70 |
| 83150 | | Assay of homovanillic acid | $ 57.02 |
| 83491 | | Assay of corticosteroids 17 | $ 51.62 |
| 83497 | | Assay of 5-hiaa | $ 37.99 |
| 83498 | | Assay of progesterone 17-d | $ 80.07 |
| 83499 | | Assay of progesterone 20- | $ 74.30 |

## Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 83500 | | Assay free hydroxyproline | $ 66.74 |
| 83505 | | Assay total hydroxyproline | $ 71.65 |
| 83516 | | Immunoassay nonantibody | $ 34.00 |
| 83518 | QW | Immunoassay dipstick | $ 24.97 |
| 83518 | | Immunoassay dipstick | $ 24.97 |
| 83519 | | Ria nonantibody | $ 39.81 |
| 83520 | QW | Immunoassay quant nos nonab | $ 38.15 |
| 83520 | | Immunoassay quant nos nonab | $ 38.15 |
| 83525 | | Assay of insulin | $ 33.67 |
| 83527 | | Assay of insulin | $ 37.30 |
| 83528 | | Assay of intrinsic factor | $ 46.87 |
| 83540 | | Assay of iron | $ 19.07 |
| 83550 | | Iron binding test | $ 25.77 |
| 83570 | | Assay of idh enzyme | $ 26.07 |
| 83582 | | Assay of ketogenic steroids | $ 41.77 |
| 83586 | | Assay 17- ketosteroids | $ 37.74 |
| 83593 | | Fractionation ketosteroids | $ 77.50 |
| 83605 | QW | Assay of lactic acid | $ 4.13 |
| 83605 | | Assay of lactic acid | $ 4.13 |
| 83615 | | Lactate (LD) (LDH) enzyme | $ 17.78 |
| 83625 | | Assay of ldh enzymes | $ 17.50 |
| 83630 | | Lactoferrin fecal (qual) | $ 57.84 |

## Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 83631 | | Lactoferrin fecal (quant) | $ 57.84 |
| 83632 | | Placental lactogen | $ 59.57 |
| 83633 | | Test urine for lactose | $ 16.20 |
| 83634 | | Assay of urine for lactose | $ 33.98 |
| 83655 | QW | Assay of lead | $ 35.68 |
| 83655 | | Assay of lead | $ 35.68 |
| 83661 | | L/s ratio fetal lung | $ 29.29 |
| 83662 | | Foam stability fetal lung | $ 55.75 |
| 83663 | | Fluoro polarize fetal lung | $ 55.75 |
| 83664 | | Lamellar bdy fetal lung | $ 55.75 |
| 83670 | | Assay of lap enzyme | $ 26.98 |
| 83690 | | Assay of lipase | $ 20.30 |
| 83695 | | Assay of lipoprotein(a) | $ 38.15 |
| 83698 | | Assay lipoprotein pla2 | $ 96.10 |
| 83700 | | Lipopro bld electrophoretic | $ 29.12 |
| 83701 | | Lipoprotein bld hr fraction | $ 73.14 |
| 83704 | | Lipoprotein bld by nmr | $ 92.97 |
| 83718 | QW | Assay of lipoprotein | $ 24.13 |
| 83718 | | Assay of lipoprotein | $ 24.13 |
| 83719 | | Assay of blood lipoprotein | $ 34.28 |
| 83721 | QW | Assay of blood lipoprotein | $ 28.12 |
| 83721 | | Assay of blood lipoprotein | $ 28.12 |
| 83727 | | Assay of lrh hormone | $ 50.67 |

| Exhibit #8, Pathology Laboratory Maximum Fees | | | |
|---|---|---|---|
| For Dates of Service on and After 1/1/2015 | | | |
| HCPCS | Modifier | SHORTDESC | 216% |
| 83735 | | Assay of magnesium | $ 19.74 |
| 83775 | | Assay malate dehydrogenase | $ 21.73 |
| 83785 | | Assay of manganese | $ 72.47 |
| 83788 | | Mass spectrometry qual | $ 53.20 |
| 83789 | | Mass spectrometry quant | $ 53.20 |
| 83805 | | Assay of meprobamate | $ 51.93 |
| 83825 | | Assay of mercury | $ 47.91 |
| 83835 | | Assay of metanephrines | $ 49.92 |
| 83840 | | Assay of methadone | $ 48.12 |
| 83857 | | Assay of methemalbumin | $ 31.64 |
| 83858 | | Assay of methsuximide | $ 43.65 |
| 83861 | QW | Microfluid analy tears | $ 48.69 |
| 83861 | | Microfluid analy tears | $ 48.69 |
| 83864 | | Mucopolysaccharides | $ 58.69 |
| 83866 | | Mucopolysaccharides screen | $ 29.03 |
| 83872 | | Assay synovial fluid mucin | $ 17.28 |
| 83873 | | Assay of csf protein | $ 50.70 |
| 83874 | | Assay of myoglobin | $ 38.06 |
| 83876 | | Assay myeloperoxidase | $ 96.10 |
| 83880 | QW | Assay of natriuretic peptide | $ 96.10 |
| 83880 | | Assay of natriuretic peptide | $ 96.10 |
| 83883 | | Assay nephelometry not spec | $ 16.70 |
| 83885 | | Assay of nickel | $ 72.21 |

## Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 83887 | | Assay of nicotine | $ 69.79 |
| 83915 | | Assay of nucleotidase | $ 32.85 |
| 83916 | | Oligoclonal bands | $ 59.25 |
| 83918 | | Organic acids total quant | $ 48.49 |
| 83919 | | Organic acids qual each | $ 48.49 |
| 83921 | | Organic acid single quant | $ 48.49 |
| 83925 | | Assay of opiates | $ 57.33 |
| 83930 | | Assay of blood osmolality | $ 19.48 |
| 83935 | | Assay of urine osmolality | $ 20.09 |
| 83937 | | Assay of osteocalcin | $ 43.98 |
| 83945 | | Assay of oxalate | $ 37.93 |
| 83950 | | Oncoprotein her-2/neu | $ 189.82 |
| 83951 | | Oncoprotein dcp | $ 189.82 |
| 83970 | | Assay of parathormone | $ 121.63 |
| 83986 | QW | Assay ph body fluid nos | $ 10.54 |
| 83986 | | Assay ph body fluid nos | $ 10.54 |
| 83987 | | Exhaled breath condensate | $ 46.79 |
| 83992 | | Assay for phencyclidine | $ 43.31 |
| 83993 | | Assay for calprotectin fecal | $ 57.84 |
| 84022 | | Assay of phenothiazine | $ 45.90 |
| 84030 | | Assay of blood pku | $ 16.20 |
| 84035 | | Assay of phenylketones | $ 9.03 |
| 84060 | | Assay acid phosphatase | $ 21.77 |

| Exhibit #8, Pathology Laboratory Maximum Fees | | | |
|---|---|---|---|
| For Dates of Service on and After 1/1/2015 | | | |
| **HCPCS** | **Modifier** | **SHORTDESC** | **216%** |
| 84061 | | Phosphatase forensic exam | $ 23.31 |
| 84066 | | Assay prostate phosphatase | $ 28.47 |
| 84075 | QW | Assay alkaline phosphatase | $ 15.25 |
| 84075 | | Assay alkaline phosphatase | $ 15.25 |
| 84078 | | Assay alkaline phosphatase | $ 21.51 |
| 84080 | | Assay alkaline phosphatases | $ 43.57 |
| 84081 | | Assay phosphatidylglycerol | $ 48.69 |
| 84085 | | Assay of rbc pg6d enzyme | $ 19.87 |
| 84087 | | Assay phosphohexose enzymes | $ 30.43 |
| 84100 | | Assay of phosphorus | $ 13.95 |
| 84105 | | Assay of urine phosphorus | $ 15.25 |
| 84106 | | Test for porphobilinogen | $ 12.51 |
| 84110 | | Assay of porphobilinogen | $ 24.86 |
| 84112 | | Placenta alpha micro ig c/v | $ 189.82 |
| 84119 | | Test urine for porphyrins | $ 25.38 |
| 84120 | | Assay of urine porphyrins | $ 43.35 |
| 84126 | | Assay of feces porphyrins | $ 75.06 |
| 84127 | | Assay of feces porphyrins | $ 29.40 |
| 84132 | QW | Assay of serum potassium | $ 13.54 |
| 84132 | | Assay of serum potassium | $ 13.54 |
| 84133 | | Assay of urine potassium | $ 12.68 |
| 84134 | | Assay of prealbumin | $ 16.70 |

# Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 84135 | | Assay of pregnanediol | $ 56.38 |
| 84138 | | Assay of pregnanetriol | $ 55.79 |
| 84140 | | Assay of pregnenolone | $ 43.98 |
| 84143 | | Assay of 17-hydroxypregneno | $ 43.98 |
| 84144 | | Assay of progesterone | $ 45.90 |
| 84145 | | Procalcitonin (pct) | $ 78.93 |
| 84146 | | Assay of prolactin | $ 57.11 |
| 84150 | | Assay of prostaglandin | $ 73.55 |
| 84152 | | Assay of psa complexed | $ 54.19 |
| 84153 | | Assay of psa total | $ 54.19 |
| 84154 | | Assay of psa free | $ 54.19 |
| 84155 | QW | Assay of protein serum | $ 10.80 |
| 84155 | | Assay of protein serum | $ 10.80 |
| 84156 | | Assay of protein urine | $ 10.80 |
| 84157 | QW | Assay of protein other | $ 10.80 |
| 84157 | | Assay of protein other | $ 10.80 |
| 84160 | | Assay of protein any source | $ 15.25 |
| 84163 | | Pappa serum | $ 44.37 |
| 84165 | | Protein e-phoresis serum | $ 31.64 |
| 84166 | | Protein e-phoresis/urine/csf | $ 52.55 |
| 84181 | | Western blot test | $ 50.20 |
| 84182 | | Protein western blot test | $ 53.03 |
| 84202 | | Assay RBC protoporphyrin | $ 42.27 |

| Exhibit #8, Pathology Laboratory Maximum Fees | | | |
|---|---|---|---|
| For Dates of Service on and After 1/1/2015 | | | |
| **HCPCS** | **Modifier** | **SHORTDESC** | **216%** |
| 84203 | | Test RBC protoporphyrin | $ 25.36 |
| 84206 | | Assay of proinsulin | $ 52.34 |
| 84207 | | Assay of vitamin b-6 | $ 82.79 |
| 84210 | | Assay of pyruvate | $ 31.99 |
| 84220 | | Assay of pyruvate kinase | $ 27.82 |
| 84228 | | Assay of quinine | $ 34.28 |
| 84233 | | Assay of estrogen | $ 189.82 |
| 84234 | | Assay of progesterone | $ 191.18 |
| 84235 | | Assay of endocrine hormone | $ 154.22 |
| 84238 | | Assay nonendocrine receptor | $ 107.76 |
| 84244 | | Assay of renin | $ 64.82 |
| 84252 | | Assay of vitamin b-2 | $ 59.64 |
| 84255 | | Assay of selenium | $ 75.23 |
| 84260 | | Assay of serotonin | $ 54.78 |
| 84270 | | Assay of sex hormone globul | $ 64.04 |
| 84275 | | Assay of sialic acid | $ 39.59 |
| 84285 | | Assay of silica | $ 69.38 |
| 84295 | QW | Assay of serum sodium | $ 14.17 |
| 84295 | | Assay of serum sodium | $ 14.17 |
| 84300 | | Assay of urine sodium | $ 14.34 |
| 84302 | | Assay of sweat sodium | $ 14.34 |
| 84305 | | Assay of somatomedin | $ 57.87 |
| 84307 | | Assay of somatostatin | $ 53.87 |

| Exhibit #8, Pathology Laboratory Maximum Fees | | | |
|---|---|---|---|
| For Dates of Service on and After 1/1/2015 | | | |
| **HCPCS** | **Modifier** | **SHORTDESC** | **216%** |
| 84311 | | Spectrophotometry | $ 20.61 |
| 84315 | | Body fluid specific gravity | $ 7.41 |
| 84375 | | Chromatogram assay sugars | $ 7.06 |
| 84376 | | Sugars single qual | $ 16.20 |
| 84377 | | Sugars multiple qual | $ 16.20 |
| 84378 | | Sugars single quant | $ 33.98 |
| 84379 | | Sugars multiple quant | $ 33.98 |
| 84392 | | Assay of urine sulfate | $ 14.00 |
| 84402 | | Assay of free testosterone | $ 75.04 |
| 84403 | | Assay of total testosterone | $ 76.08 |
| 84425 | | Assay of vitamin b-1 | $ 62.55 |
| 84430 | | Assay of thiocyanate | $ 34.28 |
| 84431 | | Thromboxane urine | $ 49.53 |
| 84432 | | Assay of thyroglobulin | $ 45.04 |
| 84436 | | Assay of total thyroxine | $ 20.24 |
| 84437 | | Assay of neonatal thyroxine | $ 19.07 |
| 84439 | | Assay of free thyroxine | $ 24.02 |
| 84442 | | Assay of thyroid activity | $ 34.24 |
| 84443 | QW | Assay thyroid stim hormone | $ 49.53 |
| 84443 | | Assay thyroid stim hormone | $ 49.53 |
| 84445 | | Assay of tsi globulin | $ 149.86 |
| 84446 | | Assay of vitamin e | $ 41.77 |
| 84449 | | Assay of transcortin | $ 43.98 |

## Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 84450 | QW | Transferase (AST) (SGOT) | $ 15.25 |
| 84450 | | Transferase (AST) (SGOT) | $ 15.25 |
| 84460 | QW | Alanine amino (ALT) (SGPT) | $ 15.60 |
| 84460 | | Alanine amino (ALT) (SGPT) | $ 15.60 |
| 84466 | | Assay of transferrin | $ 37.63 |
| 84478 | QW | Assay of triglycerides | $ 16.93 |
| 84478 | | Assay of triglycerides | $ 16.93 |
| 84479 | | Assay of thyroid (t3 or t4) | $ 19.07 |
| 84480 | | Assay triiodothyronine (t3) | $ 41.77 |
| 84481 | | Free assay (FT-3) | $ 49.92 |
| 84482 | | T3 reverse | $ 46.44 |
| 84484 | | Assay of troponin quant | $ 19.70 |
| 84485 | | Assay duodenal fluid trypsin | $ 12.51 |
| 84488 | | Test feces for trypsin | $ 12.51 |
| 84490 | | Assay of feces for trypsin | $ 16.80 |
| 84510 | | Assay of tyrosine | $ 30.65 |
| 84512 | | Assay of troponin qual | $ 22.70 |
| 84520 | QW | Assay of urea nitrogen | $ 11.64 |
| 84520 | | Assay of urea nitrogen | $ 11.64 |
| 84525 | | Urea nitrogen semi-quant | $ 5.10 |
| 84540 | | Assay of urine/urea-n | $ 14.00 |
| 84545 | | Urea-N clearance test | $ 19.46 |
| 84550 | QW | Assay of blood/uric acid | $ 13.31 |

## Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 84550 | | Assay of blood/uric acid | $ 13.31 |
| 84560 | | Assay of urine/uric acid | $ 14.00 |
| 84577 | | Assay of feces/urobilinogen | $ 36.78 |
| 84578 | | Test urine urobilinogen | $ 4.13 |
| 84580 | | Assay of urine urobilinogen | $ 20.91 |
| 84583 | | Assay of urine urobilinogen | $ 14.82 |
| 84585 | | Assay of urine vma | $ 45.66 |
| 84586 | | Assay of vip | $ 43.98 |
| 84588 | | Assay of vasopressin | $ 96.10 |
| 84590 | | Assay of vitamin a | $ 34.19 |
| 84591 | | Assay of nos vitamin | $ 34.19 |
| 84597 | | Assay of vitamin k | $ 40.41 |
| 84600 | | Assay of volatiles | $ 47.37 |
| 84620 | | Xylose tolerance test | $ 34.91 |
| 84630 | | Assay of zinc | $ 33.54 |
| 84681 | | Assay of c-peptide | $ 51.21 |
| 84702 | | Chorionic gonadotropin test | $ 44.37 |
| 84703 | QW | Chorionic gonadotropin assay | $ 20.58 |
| 84703 | | Chorionic gonadotropin assay | $ 20.58 |
| 84704 | | Hcg free betachain test | $ 44.37 |
| 84830 | | Ovulation tests | $ 29.55 |
| 85002 | | Bleeding time test | $ 13.28 |
| 85004 | | Automated diff wbc count | $ 14.69 |

| Exhibit #8, Pathology Laboratory Maximum Fees | | | |
|---|---|---|---|
| For Dates of Service on and After 1/1/2015 | | | |
| **HCPCS** | **Modifier** | **SHORTDESC** | **216%** |
| 85007 | | Bl smear w/diff wbc count | $ 10.13 |
| 85008 | | Bl smear w/o diff wbc count | $ 10.13 |
| 85009 | | Manual diff wbc count b-coat | $ 10.97 |
| 85013 | | Spun microhematocrit | $ 6.98 |
| 85014 | QW | Hematocrit | $ 6.98 |
| 85014 | | Hematocrit | $ 6.98 |
| 85018 | QW | Hemoglobin | $ 6.98 |
| 85018 | | Hemoglobin | $ 6.98 |
| 85025 | | Complete cbc w/auto diff wbc | $ 20.82 |
| 85027 | | Complete cbc automated | $ 14.69 |
| 85032 | | Manual cell count each | $ 12.68 |
| 85041 | | Automated rbc count | $ 8.88 |
| 85044 | | Manual reticulocyte count | $ 12.68 |
| 85045 | | Automated reticulocyte count | $ 11.77 |
| 85046 | | Reticyte/hgb concentrate | $ 16.44 |
| 85048 | | Automated leukocyte count | $ 7.47 |
| 85049 | | Automated platelet count | $ 13.20 |
| 85055 | | Reticulated platelet assay | $ 53.33 |
| 85130 | | Chromogenic substrate assay | $ 20.82 |
| 85170 | | Blood clot retraction | $ 10.67 |
| 85175 | | Blood clot lysis time | $ 13.41 |
| 85210 | | Clot factor ii prothrom spec | $ 38.28 |
| 85220 | | Blooc clot factor v test | $ 51.99 |

# Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 85230 | | Clot factor vii proconvertin | $ 52.77 |
| 85240 | | Clot factor viii ahg 1 stage | $ 52.77 |
| 85244 | | Clot factor viii reltd antgn | $ 60.16 |
| 85245 | | Clot factor viii vw ristoctn | $ 67.61 |
| 85246 | | Clot factor viii vw antigen | $ 67.61 |
| 85247 | | Clot factor viii multimetric | $ 67.61 |
| 85250 | | Clot factor ix ptc/chrstmas | $ 56.10 |
| 85260 | | Clot factor x stuart-power | $ 52.77 |
| 85270 | | Clot factor xi pta | $ 52.77 |
| 85280 | | Clot factor xii hageman | $ 57.02 |
| 85290 | | Clot factor xiii fibrin stab | $ 48.17 |
| 85291 | | Clot factor xiii fibrin scrn | $ 26.22 |
| 85292 | | Clot factor fletcher fact | $ 55.81 |
| 85293 | | Clot factor wght kininogen | $ 55.81 |
| 85300 | | Antithrombin iii activity | $ 34.93 |
| 85301 | | Antithrombin iii antigen | $ 31.86 |
| 85302 | | Clot inhibit prot c antigen | $ 35.42 |
| 85303 | | Clot inhibit prot c activity | $ 40.76 |
| 85305 | | Clot inhibit prot s total | $ 34.19 |
| 85306 | | Clot inhibit prot s free | $ 45.17 |
| 85307 | | Assay activated protein c | $ 45.17 |
| 85335 | | Factor inhibitor test | $ 27.15 |
| 85337 | | Thrombomodulin | $ 30.72 |

## Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 85345 | | Coagulation time lee & white | $ 12.68 |
| 85347 | | Coagulation time activated | $ 12.55 |
| 85348 | | Coagulation time otr method | $ 10.97 |
| 85360 | | Euglobulin lysis | $ 13.65 |
| 85362 | | Fibrin degradation products | $ 20.30 |
| 85366 | | Fibrinogen test | $ 25.38 |
| 85370 | | Fibrinogen test | $ 33.46 |
| 85378 | | Fibrin degrade semiquant | $ 21.02 |
| 85379 | | Fibrin degradation quant | $ 23.87 |
| 85380 | | Fibrin degradj d-dimer | $ 23.87 |
| 85384 | | Fibrinogen activity | $ 25.01 |
| 85385 | | Fibrinogen antigen | $ 25.01 |
| 85390 | | Fibrinolysins screen i&r | $ 12.51 |
| 85397 | | Clotting funct activity | $ 67.61 |
| 85400 | | Fibrinolytic plasmin | $ 26.07 |
| 85410 | | Fibrinolytic antiplasmin | $ 20.87 |
| 85415 | | Fibrinolytic plasminogen | $ 50.67 |
| 85420 | | Fibrinolytic plasminogen | $ 19.27 |
| 85421 | | Fibrinolytic plasminogen | $ 30.02 |
| 85441 | | Heinz bodies direct | $ 12.40 |
| 85445 | | Heinz bodies induced | $ 20.09 |
| 85460 | | Hemoglobin fetal | $ 22.81 |
| 85461 | | Hemoglobin fetal | $ 19.55 |

## Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 85475 | | Hemolysin acid | $ 26.16 |
| 85520 | | Heparin assay | $ 31.38 |
| 85525 | | Heparin neutralization | $ 34.91 |
| 85530 | | Heparin-protamine tolerance | $ 41.77 |
| 85536 | | Iron stain peripheral blood | $ 19.07 |
| 85540 | | Wbc alkaline phosphatase | $ 25.36 |
| 85547 | | RBC mechanical fragility | $ 25.36 |
| 85549 | | Muramidase | $ 55.27 |
| 85555 | | RBC osmotic fragility | $ 19.70 |
| 85557 | | RBC osmotic fragility | $ 39.38 |
| 85576 | QW | Blood platelet aggregation | $ 63.31 |
| 85576 | | Blood platelet aggregation | $ 63.31 |
| 85597 | | Phospholipid pltlt neutraliz | $ 45.27 |
| 85598 | | Hexagnal phosph pltlt neutrl | $ 45.27 |
| 85610 | QW | Prothrombin time | $ 11.60 |
| 85610 | | Prothrombin time | $ 11.60 |
| 85611 | | Prothrombin test | $ 11.62 |
| 85612 | | Viper venom prothrombin time | $ 28.21 |
| 85613 | | Russell viper venom diluted | $ 28.21 |
| 85635 | | Reptilase test | $ 29.01 |
| 85651 | | Rbc sed rate nonautomated | $ 10.45 |
| 85652 | | Rbc sed rate automated | $ 7.97 |
| 85660 | | RBC sickle cell test | $ 16.26 |

## Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 85670 | | Thrombin time plasma | $ 17.00 |
| 85675 | | Thrombin time titer | $ 20.17 |
| 85705 | | Thromboplastin inhibition | $ 20.58 |
| 85730 | | Thromboplastin time partial | $ 17.69 |
| 85732 | | Thromboplastin time partial | $ 19.07 |
| 85810 | | Blood viscosity examination | $ 34.39 |
| 86000 | | Agglutinins febrile antigen | $ 20.56 |
| 86001 | | Allergen specific igg | $ 14.10 |
| 86003 | | Allergen specific IgE | $ 14.10 |
| 86005 | | Allergen specific IgE | $ 20.63 |
| 86021 | | WBC antibody identification | $ 44.37 |
| 86022 | | Platelet antibodies | $ 54.13 |
| 86023 | | Immunoglobulin assay | $ 36.72 |
| 86038 | | Antinuclear antibodies | $ 35.62 |
| 86039 | | Antinuclear antibodies (ANA) | $ 32.90 |
| 86060 | | Antistreptolysin o titer | $ 16.59 |
| 86063 | | Antistreptolysin o screen | $ 10.50 |
| 86140 | | C-reactive protein | $ 15.25 |
| 86141 | | C-reactive protein hs | $ 38.15 |
| 86146 | | Beta-2 glycoprotein antibody | $ 45.04 |
| 86147 | | Cardiolipin antibody ea ig | $ 45.04 |
| 86148 | | Anti-phospholipid antibody | $ 47.35 |
| 86152 | | Cell enumeration & id | $ 724.05 |

| Exhibit #8, Pathology Laboratory Maximum Fees | | | |
|---|---|---|---|
| For Dates of Service on and After 1/1/2015 | | | |
| HCPCS | Modifier | SHORTDESC | 216% |
| 86155 | | Chemotaxis assay | $ 45.90 |
| 86156 | | Cold agglutinin screen | $ 19.74 |
| 86157 | | Cold agglutinin titer | $ 23.76 |
| 86160 | | Complement antigen | $ 35.38 |
| 86161 | | Complement/function activity | $ 35.38 |
| 86162 | | Complement total (ch50) | $ 59.88 |
| 86171 | | Complement fixation each | $ 29.51 |
| 86185 | | Counterimmunoelectrophoresis | $ 26.35 |
| 86200 | | Ccp antibody | $ 38.15 |
| 86215 | | Deoxyribonuclease antibody | $ 39.05 |
| 86225 | | Dna antibody native | $ 40.48 |
| 86226 | | Dna antibody single strand | $ 35.68 |
| 86235 | | Nuclear antigen antibody | $ 44.02 |
| 86243 | | Fc receptor | $ 60.46 |
| 86255 | | Fluorescent antibody screen | $ 35.51 |
| 86256 | | Fluorescent antibody titer | $ 35.51 |
| 86277 | | Growth hormone antibody | $ 46.38 |
| 86280 | | Hemagglutination inhibition | $ 24.13 |
| 86294 | QW | Immunoassay tumor qual | $ 57.82 |
| 86294 | | Immunoassay tumor qual | $ 57.82 |
| 86300 | | Immunoassay tumor ca 15-3 | $ 61.32 |
| 86301 | | Immunoassay tumor ca 19-9 | $ 61.32 |
| 86304 | | Immunoassay tumor ca 125 | $ 61.32 |

## Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 86305 | | Human epididymis protein 4 | $ 61.32 |
| 86308 | QW | Heterophile antibody screen | $ 15.25 |
| 86308 | | Heterophile antibody screen | $ 15.25 |
| 86309 | | Heterophile antibody titer | $ 19.07 |
| 86310 | | Heterophile antibody absrbj | $ 21.73 |
| 86316 | | Immunoassay tumor other | $ 61.32 |
| 86317 | | Immunoassay infectious agent | $ 44.17 |
| 86318 | QW | Immunoassay infectious agent | $ 38.15 |
| 86318 | | Immunoassay infectious agent | $ 38.15 |
| 86320 | | Serum immunoelectrophoresis | $ 66.05 |
| 86325 | | Other immunoelectrophoresis | $ 65.90 |
| 86327 | | Immunoelectrophoresis assay | $ 66.85 |
| 86329 | | Immunodiffusion nes | $ 41.36 |
| 86331 | | Immunodiffusion ouchterlony | $ 35.32 |
| 86332 | | Immune complex assay | $ 50.76 |
| 86334 | | Immunofix e-phoresis serum | $ 65.84 |
| 86335 | | Immunfix e-phorsis/urine/csf | $ 86.49 |
| 86336 | | Inhibin A | $ 38.17 |
| 86337 | | Insulin antibodies | $ 63.09 |
| 86340 | | Intrinsic factor antibody | $ 44.41 |
| 86341 | | Islet cell antibody | $ 39.57 |
| 86343 | | Leukocyte histamine release | $ 36.74 |
| 86344 | | Leukocyte phagocytosis | $ 23.54 |

| Exhibit #8, Pathology Laboratory Maximum Fees | | | |
|---|---|---|---|
| For Dates of Service on and After 1/1/2015 | | | |
| **HCPCS** | **Modifier** | **SHORTDESC** | **216%** |
| 86352 | | Cell function assay w/stim | $ 400.38 |
| 86353 | | Lymphocyte transformation | $ 144.48 |
| 86355 | | B cells total count | $ 52.34 |
| 86356 | | Mononuclear cell antigen | $ 53.33 |
| 86357 | | Nk cells total count | $ 52.34 |
| 86359 | | T cells total count | $ 52.34 |
| 86360 | | T cell absolute count/ratio | $ 104.63 |
| 86361 | | T cell absolute count | $ 53.33 |
| 86367 | | Stem cells total count | $ 52.34 |
| 86376 | | Microsomal antibody each | $ 42.88 |
| 86378 | | Migration inhibitory factor | $ 58.02 |
| 86382 | | Neutralization test viral | $ 49.83 |
| 86384 | | Nitroblue tetrazolium dye | $ 33.54 |
| 86386 | QW | Nuclear matrix protein 22 | $ 47.07 |
| 86386 | | Nuclear matrix protein 22 | $ 47.07 |
| 86403 | | Particle agglut antbdy scrn | $ 20.58 |
| 86406 | | Particle agglut antbdy titr | $ 31.34 |
| 86430 | | Rheumatoid factor test qual | $ 16.72 |
| 86431 | | Rheumatoid factor quant | $ 16.72 |
| 86480 | | Tb test cell immun measure | $ 182.65 |
| 86481 | | Tb ag response t-cell susp | $ 220.80 |
| 86590 | | Streptokinase antibody | $ 31.38 |
| 86592 | | Syphilis test non-trep qual | $ 12.57 |

| Exhibit #8, Pathology Laboratory Maximum Fees | | | |
|---|---|---|---|
| For Dates of Service on and After 1/1/2015 | | | |
| **HCPCS** | **Modifier** | **SHORTDESC** | **216%** |
| 86593 | | Syphilis test non-trep quant | $ 12.96 |
| 86602 | | Antinomyces antibody | $ 30.00 |
| 86603 | | Adenovirus antibody | $ 33.05 |
| 86606 | | Aspergillus antibody | $ 41.45 |
| 86609 | | Bacterium antibody | $ 37.97 |
| 86611 | | Bartonella antibody | $ 30.00 |
| 86612 | | Blastomyces antibody | $ 33.05 |
| 86615 | | Bordetella antibody | $ 38.88 |
| 86617 | | Lyme disease antibody | $ 45.64 |
| 86618 | QW | Lyme disease antibody | $ 50.20 |
| 86618 | | Lyme disease antibody | $ 50.20 |
| 86619 | | Borrelia antibody | $ 39.42 |
| 86622 | | Brucella antibody | $ 24.11 |
| 86625 | | Campylobacter antibody | $ 38.66 |
| 86628 | | Candida antibody | $ 35.38 |
| 86631 | | Chlamydia antibody | $ 34.84 |
| 86632 | | Chlamydia igm antibody | $ 37.39 |
| 86635 | | Coccidioides antibody | $ 33.05 |
| 86638 | | Q fever antibody | $ 33.05 |
| 86641 | | Cryptococcus antibody | $ 20.58 |
| 86644 | | CMV antibody | $ 42.42 |
| 86645 | | Cmv antibody igm | $ 42.08 |
| 86648 | | Diphtheria antibody | $ 44.82 |

| Exhibit #8, Pathology Laboratory Maximum Fees | | | |
|---|---|---|---|
| For Dates of Service on and After 1/1/2015 | | | |
| **HCPCS** | **Modifier** | **SHORTDESC** | **216%** |
| 86651 | | Encephalitis californ antbdy | $ 38.88 |
| 86652 | | Encephaltis east eqne anbdy | $ 38.88 |
| 86653 | | Encephaltis st louis antbody | $ 38.88 |
| 86654 | | Encephaltis west eqne antbdy | $ 38.88 |
| 86658 | | Enterovirus antibody | $ 33.05 |
| 86663 | | Epstein-barr antibody | $ 38.66 |
| 86664 | | Epstein-barr nuclear antigen | $ 42.08 |
| 86665 | | Epstein-barr capsid vca | $ 42.08 |
| 86666 | | Ehrlichia antibody | $ 30.00 |
| 86668 | | Francisella tularensis | $ 22.98 |
| 86671 | | Fungus nes antibody | $ 33.05 |
| 86674 | | Giardia lamblia antibody | $ 42.08 |
| 86677 | | Helicobacter pylori antibody | $ 42.77 |
| 86682 | | Helminth antibody | $ 30.50 |
| 86684 | | Hemophilus influenza antibdy | $ 20.58 |
| 86687 | | Htlv-i antibody | $ 24.73 |
| 86688 | | Htlv-ii antibody | $ 29.40 |
| 86689 | | Htlv/hiv confirmj antibody | $ 57.02 |
| 86692 | | Hepatitis delta agent antbdy | $ 50.57 |
| 86694 | | Herpes simplex nes antbdy | $ 42.42 |
| 86695 | | Herpes simplex type 1 test | $ 38.88 |
| 86696 | | Herpes simplex type 2 test | $ 57.02 |
| 86698 | | Histoplasma antibody | $ 33.05 |

# Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 86701 | QW | Hiv-1antibody | $ 26.18 |
| 86701 | | Hiv-1antibody | $ 26.18 |
| 86702 | | Hiv-2 antibody | $ 29.40 |
| 86703 | | Hiv-1/hiv-2 1 result antbdy | $ 29.40 |
| 86704 | | Hep b core antibody total | $ 35.51 |
| 86705 | | Hep b core antibody igm | $ 34.71 |
| 86706 | | Hep b surface antibody | $ 31.64 |
| 86707 | | Hepatitis be antibody | $ 34.08 |
| 86708 | | Hepatitis a total antibody | $ 36.50 |
| 86709 | | Hepatitis a igm antibody | $ 33.18 |
| 86710 | | Influenza virus antibody | $ 39.94 |
| 86711 | | John cunningham antibody | $ 42.42 |
| 86713 | | Legionella antibody | $ 42.08 |
| 86717 | | Leishmania antibody | $ 36.09 |
| 86720 | | Leptospira antibody | $ 38.88 |
| 86723 | | Listeria monocytogenes | $ 38.88 |
| 86727 | | Lymph choriomeningitis ab | $ 33.05 |
| 86729 | | Lympho venereum antibody | $ 35.21 |
| 86732 | | Mucormycosis antibody | $ 38.88 |
| 86735 | | Mumps antibody | $ 38.45 |
| 86738 | | Mycoplasma antibody | $ 39.03 |
| 86741 | | Neisseria meningitidis | $ 38.88 |
| 86744 | | Nocardia antibody | $ 38.88 |

| Exhibit #8, Pathology Laboratory Maximum Fees | | | |
|---|---|---|---|
| For Dates of Service on and After 1/1/2015 | | | |
| **HCPCS** | **Modifier** | **SHORTDESC** | **216%** |
| 86747 | | Parvovirus antibody | $ 44.30 |
| 86750 | | Malaria antibody | $ 38.88 |
| 86753 | | Protozoa antibody nos | $ 30.50 |
| 86756 | | Respiratory virus antibody | $ 37.97 |
| 86757 | | Rickettsia antibody | $ 57.02 |
| 86759 | | Rotavirus antibody | $ 38.88 |
| 86762 | | Rubella antibody | $ 42.42 |
| 86765 | | Rubeola antibody | $ 37.97 |
| 86768 | | Salmonella antibody | $ 38.88 |
| 86771 | | Shigella antibody | $ 38.88 |
| 86774 | | Tetanus antibody | $ 43.61 |
| 86777 | | Toxoplasma antibody | $ 42.42 |
| 86778 | | Toxoplasma antibody igm | $ 42.08 |
| 86780 | | Treponema pallidum | $ 39.01 |
| 86784 | | Trichinella antibody | $ 18.73 |
| 86787 | | Varicella-zoster antibody | $ 37.97 |
| 86788 | | West nile virus ab igm | $ 42.08 |
| 86789 | | West nile virus antibody | $ 42.42 |
| 86790 | | Virus antibody nos | $ 37.97 |
| 86793 | | Yersinia antibody | $ 38.88 |
| 86800 | | Thyroglobulin antibody | $ 46.87 |
| 86803 | QW | Hepatitis c ab test | $ 42.06 |
| 86803 | | Hepatitis c ab test | $ 42.06 |

| Exhibit #8, Pathology Laboratory Maximum Fees | | | |
|---|---|---|---|
| For Dates of Service on and After 1/1/2015 | | | |
| **HCPCS** | **Modifier** | **SHORTDESC** | **216%** |
| 86804 | | Hep c ab test confirm | $ 45.64 |
| 86805 | | Lymphocytotoxicity assay | $ 154.09 |
| 86806 | | Lymphocytotoxicity assay | $ 140.25 |
| 86807 | | Cytotoxic antibody screening | $ 116.62 |
| 86808 | | Cytotoxic antibody screening | $ 87.46 |
| 86812 | | Hla typing a b or c | $ 76.05 |
| 86813 | | Hla typing a b or c | $ 94.11 |
| 86816 | | Hla typing dr/dq | $ 82.10 |
| 86817 | | Hla typing dr/dq | $ 189.73 |
| 86821 | | Lymphocyte culture mixed | $ 166.38 |
| 86822 | | Lymphocyte culture primed | $ 107.74 |
| 86825 | | Hla x-math non-cytotoxic | $ 159.99 |
| 86826 | | Hla x-match noncytotoxc addl | $ 53.33 |
| 86828 | | Hla class i&ii antibody qual | $ 116.62 |
| 86829 | | Hla class i/ii antibody qual | $ 87.46 |
| 86830 | | Hla class i phenotype qual | $ 237.92 |
| 86831 | | Hla class ii phenotype qual | $ 203.93 |
| 86832 | | Hla class i high defin qual | $ 373.87 |
| 86833 | | Hla class ii high defin qual | $ 339.90 |
| 86834 | | Hla class i semiquant panel | $ 1,053.65 |
| 86835 | | Hla class ii semiquant panel | $ 951.70 |
| 86880 | | Coombs test direct | $ 15.85 |
| 86885 | | Coombs test indirect qual | $ 16.87 |

## Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 86886 | | Coombs test indirect titer | $ 15.25 |
| 86900 | | Blood typing abo | $ 8.79 |
| 86901 | | Blood typing rh (d) | $ 8.79 |
| 86902 | | Blood type antigen donor ea | $ 11.28 |
| 86904 | | Blood typing patient serum | $ 28.02 |
| 86905 | | Blood typing rbc antigens | $ 11.28 |
| 86906 | | Blood typing rh phenotype | $ 18.90 |
| 86940 | | Hemolysins/agglutinins auto | $ 24.17 |
| 86941 | | Hemolysins/agglutinins | $ 35.68 |
| 87001 | | Small animal inoculation | $ 38.94 |
| 87003 | | Small animal inoculation | $ 49.62 |
| 87015 | | Specimen infect agnt concntj | $ 19.68 |
| 87040 | | Blood culture for bacteria | $ 30.43 |
| 87045 | | Feces culture aerobic bact | $ 27.82 |
| 87046 | | Stool cultr aerobic bact ea | $ 27.82 |
| 87070 | | Culture othr specimn aerobic | $ 25.38 |
| 87071 | | Culture aerobic quant other | $ 27.82 |
| 87073 | | Culture bacteria anaerobic | $ 27.82 |
| 87075 | | Cultr bacteria except blood | $ 27.89 |
| 87076 | | Culture anaerobe ident each | $ 20.87 |
| 87077 | QW | Culture aerobic identify | $ 20.87 |
| 87077 | | Culture aerobic identify | $ 20.87 |
| 87081 | | Culture screen only | $ 19.55 |

## Exhibit #8, Pathology Laboratory Maximum Fees

| For Dates of Service on and After 1/1/2015 | | | |
|---|---|---|---|
| **HCPCS** | **Modifier** | **SHORTDESC** | **216%** |
| 87084 | | Culture of specimen by kit | $ 25.38 |
| 87086 | | Urine culture/colony count | $ 23.78 |
| 87088 | | Urine bacteria culture | $ 23.87 |
| 87101 | | Skin fungi culture | $ 22.72 |
| 87102 | | Fungus isolation culture | $ 24.75 |
| 87103 | | Blood fungus culture | $ 26.57 |
| 87106 | | Fungi identification yeast | $ 30.43 |
| 87107 | | Fungi identification mold | $ 30.43 |
| 87109 | | Mycoplasma | $ 45.34 |
| 87110 | | Chlamydia culture | $ 57.74 |
| 87116 | | Mycobacteria culture | $ 31.84 |
| 87118 | | Mycobacteric identification | $ 32.25 |
| 87140 | | Culture type immunofluoresc | $ 16.44 |
| 87143 | | Culture typing glc/hplc | $ 36.91 |
| 87147 | | Culture type immunologic | $ 15.25 |
| 87149 | | Dna/rna direct probe | $ 59.10 |
| 87150 | | Dna/rna amplified probe | $ 103.40 |
| 87152 | | Culture type pulse field gel | $ 15.40 |
| 87153 | | Dna/rna sequencing | $ 339.94 |
| 87158 | | Culture typing added method | $ 15.40 |
| 87164 | | Dark field examination | $ 31.64 |
| 87166 | | Dark field examination | $ 33.29 |
| 87168 | | Macroscopic exam arthropod | $ 12.57 |

## Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 87169 | | Macroscopic exam parasite | $ 12.57 |
| 87172 | | Pinworm exam | $ 12.57 |
| 87176 | | Tissue homogenization cultr | $ 17.34 |
| 87177 | | Ova and parasites smears | $ 26.22 |
| 87181 | | Microbe susceptible diffuse | $ 14.00 |
| 87184 | | Microbe susceptible disk | $ 20.33 |
| 87185 | | Microbe susceptible enzyme | $ 14.00 |
| 87186 | | Microbe susceptible mic | $ 25.49 |
| 87187 | | Microbe susceptible mlc | $ 30.54 |
| 87188 | | Microbe suscept macrobroth | $ 19.57 |
| 87190 | | Microbe suscept mycobacteri | $ 12.51 |
| 87197 | | Bactericidal level serum | $ 44.28 |
| 87205 | | Smear gram stain | $ 12.57 |
| 87206 | | Smear fluorescent/acid stai | $ 15.85 |
| 87207 | | Smear special stain | $ 16.80 |
| 87209 | | Smear complex stain | $ 50.44 |
| 87210 | QW | Smear wet mount saline/ink | $ 12.57 |
| 87210 | | Smear wet mount saline/ink | $ 12.57 |
| 87220 | | Tissue exam for fungi | $ 12.57 |
| 87230 | | Assay toxin or antitoxin | $ 58.19 |
| 87250 | | Virus inoculate eggs/animal | $ 57.63 |
| 87252 | | Virus inoculation tissue | $ 76.81 |
| 87253 | | Virus inoculate tissue addl | $ 59.53 |

| Exhibit #8, Pathology Laboratory Maximum Fees | | | |
|---|---|---|---|
| For Dates of Service on and After 1/1/2015 | | | |
| **HCPCS** | **Modifier** | **SHORTDESC** | **216%** |
| 87254 | | Virus inoculation shell via | $ 57.63 |
| 87255 | | Genet virus isolate hsv | $ 99.79 |
| 87260 | | Adenovirus ag if | $ 35.34 |
| 87265 | | Pertussis ag if | $ 35.34 |
| 87267 | | Enterovirus antibody dfa | $ 35.34 |
| 87269 | | Giardia ag if | $ 35.34 |
| 87270 | | Chlamydia trachomatis ag if | $ 35.34 |
| 87271 | | Cytomegalovirus dfa | $ 35.34 |
| 87272 | | Cryptosporidium ag if | $ 35.34 |
| 87273 | | Herpes simplex 2 ag if | $ 35.34 |
| 87274 | | Herpes simplex 1 ag if | $ 35.34 |
| 87275 | | Influenza b ag if | $ 35.34 |
| 87276 | | Influenza a ag if | $ 35.34 |
| 87277 | | Legionella micdadei ag if | $ 35.34 |
| 87278 | | Legion pneumophilia ag if | $ 35.34 |
| 87279 | | Parainfluenza ag if | $ 35.34 |
| 87280 | | Respiratory syncytial ag if | $ 35.34 |
| 87281 | | Pneumocystis carinii ag if | $ 35.34 |
| 87283 | | Rubeola ag if | $ 35.34 |
| 87285 | | Treponema pallidum ag if | $ 35.34 |
| 87290 | | Varicella zoster ag if | $ 35.34 |
| 87299 | | Antibody detection nos if | $ 35.34 |
| 87300 | | Ag detection polyval if | $ 35.34 |

## Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 87301 | | Adenovirus ag eia | $ 35.34 |
| 87305 | | Aspergillus ag eia | $ 35.34 |
| 87320 | | Chylmd trach ag eia | $ 35.34 |
| 87324 | | Clostridium ag eia | $ 35.34 |
| 87327 | | Cryptococcus neoform ag eia | $ 35.34 |
| 87328 | | Cryptosporidium ag eia | $ 35.34 |
| 87329 | | Giardia ag eia | $ 35.34 |
| 87332 | | Cytomegalovirus ag eia | $ 35.34 |
| 87335 | | E coli 0157 ag eia | $ 35.34 |
| 87336 | | Entamoeb hist dispr ag eia | $ 35.34 |
| 87337 | | Entamoeb hist group ag eia | $ 35.34 |
| 87338 | | Hpylori stool eia | $ 35.36 |
| 87339 | | H pylori ag eia | $ 35.34 |
| 87340 | | Hepatitis b surface ag eia | $ 30.46 |
| 87341 | | Hepatitis b surface ag eia | $ 30.46 |
| 87350 | | Hepatitis be ag eia | $ 33.98 |
| 87380 | | Hepatitis delta ag eia | $ 48.36 |
| 87385 | | Histoplasma capsul ag eia | $ 35.34 |
| 87389 | | Hiv-1 ag w/hiv-1 & hiv-2 ab | $ 70.98 |
| 87390 | | Hiv-1 ag eia | $ 51.97 |
| 87391 | | Hiv-2 ag eia | $ 51.97 |
| 87400 | | Influenza a/b ag eia | $ 35.34 |
| 87420 | | Resp syncytial ag eia | $ 35.34 |

| Exhibit #8, Pathology Laboratory Maximum Fees | | | |
|---|---|---|---|
| For Dates of Service on and After 1/1/2015 | | | |
| **HCPCS** | **Modifier** | **SHORTDESC** | **216%** |
| 87425 | | Rotavirus ag eia | $ 35.34 |
| 87427 | | Shiga-like toxin ag eia | $ 35.34 |
| 87430 | | Strep a ag eia | $ 35.34 |
| 87449 | QW | Ag detect nos eia mult | $ 35.34 |
| 87449 | | Ag detect nos eia mult | $ 35.34 |
| 87450 | | Ag detect nos eia single | $ 28.25 |
| 87451 | | Ag detect polyval eia mult | $ 28.25 |
| 87470 | | Bartonella dna dir probe | $ 59.10 |
| 87471 | | Bartonella dna amp probe | $ 103.40 |
| 87472 | | Bartonella dna quant | $ 126.23 |
| 87475 | | Lyme dis dna dir probe | $ 59.10 |
| 87476 | | Lyme dis dna amp probe | $ 103.40 |
| 87477 | | Lyme dis dna quant | $ 126.23 |
| 87480 | | Candida dna dir probe | $ 59.10 |
| 87481 | | Candida dna amp probe | $ 103.40 |
| 87482 | | Candida dna quant | $ 123.03 |
| 87485 | | Chylmd pneum dna dir probe | $ 59.10 |
| 87486 | | Chylmd pneum dna amp probe | $ 103.40 |
| 87487 | | Chylmd pneum dna quant | $ 126.23 |
| 87490 | | Chylmd trach dna dir probe | $ 59.10 |
| 87491 | | Chylmd trach dna amp probe | $ 103.40 |
| 87492 | | Chylmd trach dna quant | $ 103.01 |
| 87493 | | C diff amplified probe | $ 103.40 |

## Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 87495 | | Cytomeg dna dir probe | $ 59.10 |
| 87496 | | Cytomeg dna amp probe | $ 103.40 |
| 87497 | | Cytomeg dna quant | $ 126.23 |
| 87498 | | Enterovirus probe&revrs trns | $ 103.40 |
| 87500 | | Vanomycin dna amp probe | $ 103.40 |
| 87501 | | Influenza dna amp prob 1+ | $ 151.22 |
| 87502 | | Influenza dna amp probe | $ 250.75 |
| 87503 | | Influenza dna amp prob addl | $ 61.19 |
| 87510 | | Gardner vag dna dir probe | $ 59.10 |
| 87511 | | Gardner vag dna amp probe | $ 103.40 |
| 87512 | | Gardner vag dna quant | $ 123.03 |
| 87515 | | Hepatitis b dna dir probe | $ 59.10 |
| 87516 | | Hepatitis b dna amp probe | $ 103.40 |
| 87517 | | Hepatitis b dna quant | $ 126.23 |
| 87520 | | Hepatitis c rna dir probe | $ 59.10 |
| 87521 | | Hepatitis c probe&rvrs trnsc | $ 103.40 |
| 87522 | | Hepatitis c revrs trnscrpj | $ 126.23 |
| 87525 | | Hepatitis g dna dir probe | $ 59.10 |
| 87526 | | Hepatitis g dna amp probe | $ 103.40 |
| 87527 | | Hepatitis g dna quant | $ 123.03 |
| 87528 | | Hsv dna dir probe | $ 59.10 |
| 87529 | | Hsv dna amp probe | $ 103.40 |
| 87530 | | Hsv dna quant | $ 126.23 |

| Exhibit #8, Pathology Laboratory Maximum Fees | | | |
|---|---|---|---|
| For Dates of Service on and After 1/1/2015 | | | |
| **HCPCS** | **Modifier** | **SHORTDESC** | **216%** |
| 87531 | | Hhv-6 dna dir probe | $ 59.10 |
| 87532 | | Hhv-6 dna amp probe | $ 103.40 |
| 87533 | | Hhv-6 dna quant | $ 123.03 |
| 87534 | | Hiv-1 dna dir probe | $ 59.10 |
| 87535 | | Hiv-1 probe&reverse trnscrpj | $ 103.40 |
| 87536 | | Hiv-1 quant&revrse trnscrpj | $ 250.75 |
| 87537 | | Hiv-2 dna dir probe | $ 59.10 |
| 87538 | | Hiv-2 probe&revrse trnscripj | $ 103.40 |
| 87539 | | Hiv-2 quant&revrse trnscripj | $ 126.23 |
| 87540 | | Legion pneumo dna dir prob | $ 59.10 |
| 87541 | | Legion pneumo dna amp prob | $ 103.40 |
| 87542 | | Legion pneumo dna quant | $ 123.03 |
| 87550 | | Mycobacteria dna dir probe | $ 59.10 |
| 87551 | | Mycobacteria dna amp probe | $ 103.40 |
| 87552 | | Mycobacteria dna quant | $ 126.23 |
| 87555 | | M.tuberculo dna dir probe | $ 59.10 |
| 87556 | | M.tuberculo dna amp probe | $ 103.40 |
| 87557 | | M.tuberculo dna quant | $ 126.23 |
| 87560 | | M.avium-intra dna dir prob | $ 59.10 |
| 87561 | | M.avium-intra dna amp prob | $ 103.40 |
| 87562 | | M.avium-intra dna quant | $ 126.23 |
| 87580 | | M.pneumon dna dir probe | $ 59.10 |
| 87581 | | M.pneumon dna amp probe | $ 103.40 |

# Exhibit #8, Pathology Laboratory Maximum Fees

| For Dates of Service on and After 1/1/2015 | | | |
|---|---|---|---|
| HCPCS | Modifier | SHORTDESC | 216% |
| 87582 | | M.pneumon dna quant | $ 123.03 |
| 87590 | | N.gonorrhoeae dna dir prob | $ 59.10 |
| 87591 | | N.gonorrhoeae dna amp prob | $ 103.40 |
| 87592 | | N.gonorrhoeae dna quant | $ 126.23 |
| 87620 | | Hpv dna dir probe | $ 59.10 |
| 87621 | | Hpv dna amp probe | $ 103.40 |
| 87622 | | Hpv dna quant | $ 123.03 |
| 87631 | | Resp virus 3-11 targets | $ 378.04 |
| 87632 | | Resp virus 6-11 targets | $ 628.95 |
| 87633 | | Resp virus 12-25 targets | $ 1,228.18 |
| 87640 | | Staph a dna amp probe | $ 103.40 |
| 87641 | | Mr-staph dna amp probe | $ 103.40 |
| 87650 | | Strep a dna dir probe | $ 59.10 |
| 87651 | | Strep a dna amp probe | $ 103.40 |
| 87652 | | Strep a dna quant | $ 123.03 |
| 87653 | | Strep b dna amp probe | $ 103.40 |
| 87660 | | Trichomonas vagin dir probe | $ 59.10 |
| 87661 | | Trichomonas vaginalis amplif | $ 103.40 |
| 87797 | | Detect agent nos dna dir | $ 59.10 |
| 87798 | | Detect agent nos dna amp | $ 103.40 |
| 87799 | | Detect agent nos dna quant | $ 126.23 |
| 87800 | | Detect agnt mult dna direc | $ 118.20 |
| 87801 | | Detect agnt mult dna ampli | $ 206.84 |

## Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 87802 | | Strep b assay w/optic | $ 35.34 |
| 87803 | | Clostridium toxin a w/optic | $ 35.34 |
| 87804 | QW | Influenza assay w/optic | $ 35.34 |
| 87804 | | Influenza assay w/optic | $ 35.34 |
| 87807 | QW | Rsv assay w/optic | $ 35.34 |
| 87807 | | Rsv assay w/optic | $ 35.34 |
| 87808 | QW | Trichomonas assay w/optic | $ 35.34 |
| 87808 | | Trichomonas assay w/optic | $ 35.34 |
| 87809 | QW | Adenovirus assay w/optic | $ 35.34 |
| 87809 | | Adenovirus assay w/optic | $ 35.34 |
| 87810 | | Chylmd trach assay w/optic | $ 35.34 |
| 87850 | | N. gonorrhoeae assay w/optic | $ 35.34 |
| 87880 | QW | Strep a assay w/optic | $ 35.34 |
| 87880 | | Strep a assay w/optic | $ 35.34 |
| 87899 | QW | Agent nos assay w/optic | $ 35.34 |
| 87899 | | Agent nos assay w/optic | $ 35.34 |
| 87900 | | Phenotype infect agent drug | $ 384.09 |
| 87901 | | Genotype dna hiv reverse t | $ 758.64 |
| 87902 | | Genotype dna/rna hep c | $ 758.64 |
| 87903 | | Phenotype dna hiv w/culture | $ 1,439.94 |
| 87904 | | Phenotype dna hiv w/clt add | $ 76.81 |
| 87905 | QW | Sialidase enzyme assay | $ 15.44 |
| 87905 | | Sialidase enzyme assay | $ 15.44 |

# Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 87906 | | Genotype dna/rna hiv | $ 379.34 |
| 87910 | | Genotype cytomegalovirus | $ 758.64 |
| 87912 | | Genotype dna hepatitis b | $ 758.64 |
| 88130 | | Sex chromatin identification | $ 44.37 |
| 88140 | | Sex chromatin identification | $ 8.55 |
| 88142 | | Cytopath c/v thin layer | $ 59.70 |
| 88143 | | Cytopath c/v thin layer redo | $ 59.70 |
| 88147 | | Cytopath c/v automated | $ 33.54 |
| 88148 | | Cytopath c/v auto rescreen | $ 44.78 |
| 88150 | | Cytopath c/v manual | $ 31.15 |
| 88152 | | Cytopath c/v auto redo | $ 31.15 |
| 88153 | | Cytopath c/v redo | $ 31.15 |
| 88154 | | Cytopath c/v select | $ 31.15 |
| 88155 | | Cytopath c/v index add-on | $ 17.67 |
| 88164 | | Cytopath tbs c/v manual | $ 31.15 |
| 88165 | | Cytopath tbs c/v redo | $ 31.15 |
| 88166 | | Cytopath tbs c/v auto redo | $ 31.15 |
| 88167 | | Cytopath tbs c/v select | $ 31.15 |
| 88174 | | Cytopath c/v auto in fluid | $ 62.96 |
| 88175 | | Cytopath c/v auto fluid redo | $ 78.06 |
| 88230 | | Tissue culture lymphocyte | $ 108.67 |
| 88233 | | Tissue culture skin/biopsy | $ 217.27 |
| 88235 | | Tissue culture placenta | $ 217.27 |

# Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 88237 | | Tissue culture bone marrow | $ 372.21 |
| 88239 | | Tissue culture tumor | $ 434.72 |
| 88240 | | Cell cryopreserve/storage | $ 29.76 |
| 88241 | | Frozen cell preparation | $ 29.76 |
| 88245 | | Chromosome analysis 20-25 | $ 438.67 |
| 88248 | | Chromosome analysis 50-100 | $ 510.32 |
| 88249 | | Chromosome analysis 100 | $ 510.32 |
| 88261 | | Chromosome analysis 5 | $ 520.80 |
| 88262 | | Chromosome analysis 15-20 | $ 367.29 |
| 88263 | | Chromosome analysis 45 | $ 442.86 |
| 88264 | | Chromosome analysis 20-25 | $ 367.29 |
| 88267 | | Chromosome analys placenta | $ 529.76 |
| 88269 | | Chromosome analys amniotic | $ 490.13 |
| 88271 | | Cytogenetics dna probe | $ 63.12 |
| 88272 | | Cytogenetics 3-5 | $ 78.90 |
| 88273 | | Cytogenetics 10-30 | $ 94.69 |
| 88274 | | Cytogenetics 25-99 | $ 102.58 |
| 88275 | | Cytogenetics 100-300 | $ 118.35 |
| 88280 | | Chromosome karyotype study | $ 73.96 |
| 88283 | | Chromosome banding study | $ 202.15 |
| 88285 | | Chromosome count additional | $ 55.99 |
| 88289 | | Chromosome study additional | $ 101.48 |
| 88371 | | Protein western blot tissue | $ 65.45 |

## Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| 88372 | | Protein analysis w/probe | $ 58.21 |
| 88720 | | Bilirubin total transcut | $ 14.77 |
| 88738 | | Hgb quant transcutaneous | $ 14.77 |
| 88740 | | Transcutaneous carboxyhb | $ 14.77 |
| 88741 | | Transcutaneous methb | $ 14.77 |
| 89050 | | Body fluid cell count | $ 12.51 |
| 89051 | | Body fluid cell count | $ 16.22 |
| 89055 | | Leukocyte assessment fecal | $ 12.57 |
| 89060 | | Exam synovial fluid crystals | $ 21.08 |
| 89125 | | Specimen fat stain | $ 12.72 |
| 89160 | | Exam feces for meat fibers | $ 10.50 |
| 89190 | | Nasal smear for eosinophils | $ 10.50 |
| 89300 | QW | Semen analysis w/huhner | $ 26.29 |
| 89300 | | Semen analysis w/huhner | $ 26.29 |
| 89310 | | Semen analysis w/count | $ 18.73 |
| 89320 | | Semen anal vol/count/mot | $ 35.51 |
| 89321 | QW | Semen anal sperm detection | $ 35.51 |
| 89321 | | Semen anal sperm detection | $ 35.51 |
| 89322 | | Semen anal strict criteria | $ 45.66 |
| 89325 | | Sperm antibody test | $ 22.98 |
| 89329 | | Sperm evaluation test | $ 61.80 |
| 89330 | | Evaluation cervical mucus | $ 29.16 |
| 89331 | | Retrograde ejaculation anal | $ 57.74 |

| Exhibit #8, Pathology Laboratory Maximum Fees | | | |
|---|---|---|---|
| For Dates of Service on and After 1/1/2015 | | | |
| **HCPCS** | **Modifier** | **SHORTDESC** | **216%** |
| ATP02 | | Auto.Test Pane Pricing Code, 1-2 Tests | $ 15.34 |
| ATP03 | | Auto.Test Pane Pricing Code, 3 Tests | $ 19.59 |
| ATP04 | | Auto.Test Pane Pricing Code, 4 Tests | $ 20.67 |
| ATP05 | | Auto.Test Pane Pricing Code, 5 Tests | $ 23.07 |
| ATP06 | | Auto.Test Pane Pricing Code, 6 Tests | $ 23.11 |
| ATP07 | | Auto.Test Pane Pricing Code, 7 Tests | $ 24.06 |
| ATP08 | | Auto.Test Pane Pricing Code, 8 Tests | $ 24.93 |
| ATP09 | | Auto.Test Pane Pricing Code, 9 Tests | $ 25.60 |
| ATP10 | | Auto.Test Pane Pricing Code, 10 Tests | $ 25.60 |
| ATP11 | | Auto.Test Pane Pricing Code, 11 Tests | $ 26.03 |
| ATP12 | | Auto.Test Pane Pricing Code, 12 Tests | $ 26.59 |
| ATP16 | | Auto Test Panel Pricing Code 13-16 Test | $ 31.13 |
| ATP18 | | Auto Test Panel Pricing Code, 17-18 Test | $ 31.36 |
| ATP19 | | Auto Test Panel Pricing Code, 19 Tests | $ 32.62 |
| ATP20 | | Auto Test Panel Pricing Code, 20 Tests | $ 33.63 |
| ATP21 | | Auto Test Panel Pricing Code, | $ 34.71 |

## Exhibit #8, Pathology Laboratory Maximum Fees

**For Dates of Service on and After 1/1/2015**

| HCPCS | Modifier | SHORTDESC | 216% |
|---|---|---|---|
| | | 21 Tests | |
| ATP22 | | Auto.Test Panel Pricing Code, 22+ Tests | $ 35.75 |
| ATP23 | | Auto.Test Panel Pricing Code, 23+ Tests | $ 35.75 |
| G0027 | | Semen analysis | $ 19.16 |
| G0103 | | PSA screening | $ 54.19 |
| G0123 | | Screen cerv/vag thin layer | $ 59.70 |
| G0143 | | Scr c/v cyto,thinlayer,rescr | $ 59.70 |
| G0144 | | Scr c/v cyto,thinlayer,rescr | $ 62.96 |
| G0145 | | Scr c/v cyto,thinlayer,rescr | $ 78.06 |
| G0147 | | Scr c/v cyto, automated sys | $ 33.54 |
| G0148 | | Scr c/v cyto, autosys, rescr | $ 44.78 |
| G0306 | | CBC/diffwbc w/o platelet | $ 20.82 |
| G0307 | | CBC without platelet | $ 14.69 |
| G0328 | QW | Fecal blood scrn immunoassay | $ 46.87 |
| G0328 | | Fecal blood scrn immunoassay | $ 46.87 |
| G0431 | | Drug screen multiple class | $ 214.27 |
| G0432 | | EIA HIV-1/HIV-2 screen | $ 29.40 |
| G0433 | QW | ELISA HIV-1/HIV-2 screen | $ 29.40 |
| G0433 | | ELISA HIV-1/HIV-2 screen | $ 29.40 |
| G0434 | QW | Drug screen multi drug class | $ 42.85 |
| G0434 | | Drug screen multi drug class | $ 42.85 |
| G0435 | | Oral HIV-1/HIV-2 screen | $ 35.34 |

| Exhibit #8, Pathology Laboratory Maximum Fees | | | |
|---|---|---|---|
| For Dates of Service on and After 1/1/2015 | | | |
| **HCPCS** | **Modifier** | **SHORTDESC** | **216%** |
| G9143 | | Warfarin respon genetic test | $ 355.73 |
| P2038 | | Blood mucoprotein | $ 14.82 |
| P3000 | | Screen pap by tech w md supv | $ 31.15 |
| P9612 | | Catheterize for urine spec | $ 6.48 |
| P9615 | | Urine specimen collect mult | $ 6.48 |
| Q0111 | | Wet mounts/ w preparations | $ 12.57 |
| Q0112 | | Potassium hydroxide preps | $ 12.57 |
| Q0113 | | Pinworm examinations | $ 15.94 |
| Q0114 | | Fern test | $ 21.08 |
| Q0115 | | Post-coital mucous exam | $ 29.16 |