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 Section 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 2011 edition of the Relative Values for Physicians (RVP©), developed by Relative Value Studies, Inc., published by Ingenix® St. Anthony Publishing, the Current Procedural Terminology CPT® 2011, Professional Edition, published by the American Medical Association (AMA) and Medicare Severity Diagnosis Related Groups (MS-DRGs) Definitions Manual, Version 29.0 developed and published by 3M Health Information Systems using MS-DRGs effective after October 1, 2011. 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 Fee Schedule Administrator, 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, unless otherwise specified in this rule.

This rule applies to all services rendered on or after January 1, 2012. 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© 2011, copyrighted and distributed by the AMA and incorporated by reference in Rule 18-1.

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

(C) MS-DRGs – version 29.0 incorporated by reference in Rule 18-1.

(D) RVP© – the 2011 edition incorporated by reference in Rule 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® St. Anthony Publishing, the Current Procedural Terminology, 2011 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	$ 51.89/RVU
Surgery	$ 96.53/RVU
Surgery X Procedures (See Rule 18-5(D) (1) (d))	$ 38.83/RVU
Radiology	$ 17.78/RVU
Pathology	$ 13.25/RVU
Medicine	$ 7.71/RVU
Physical Medicine (Physical Medicine and Rehabilitation, Medical Nutrition Therapy and Acupuncture)	$ 6.02/RVU
Evaluation & Management (E&M)	$ 9.81/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 18.

(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. Those codes listed with RVUs of "BR" (by report) and "RNE" (relativity not established) require prior authorization as explained in Rule 16. The CPT® 2011 is adopted for codes, descriptions, parenthetical notes and coding guidelines, unless modified in this rule.

(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 or Certified Registered Nurse Anesthetist (CRNA) who remains in constant attendance during the procedure for the sole purpose of rendering anesthesia.

When anesthesia is administered by a CRNA:

(1) Not under the medical direction of an anesthesiologist, reimbursement shall be 90% of the maximum anesthesia value,

(2) Under the medical direction of an anesthesiologist, reimbursement shall be 50% of the maximum anesthesia value. The other 50% is payable to the anesthesiologist providing the medical direction to the CRNA,

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

- Performs a pre-anesthesia examination and evaluation,
- Prescribes the anesthesia plan,
- Personally participates in the most demanding procedures in the anesthesia plan including induction and emergence,
- Ensures that any procedure in the anesthesia plan that s/he does not perform is performed by a qualified anesthetist,
- Monitors the course of anesthesia administration at frequent intervals,
- Remains physically present and available for immediate diagnosis and treatment of emergencies, and
- 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

QX – CRNA service; with medical direction by a physician

QZ – CRNA service; without medical direction by a physician

QY – Medical direction of one CRNA by an anesthesiologist

(d) Surgery X Procedures

(1) The surgery X procedures are limited to those listed below and found in the table under the RVP©, Anesthesia section's Guidelines XIII, "Anesthesia Services Where Time Units Are Not Allowed":

- Providing local anesthetic or other medications through a regional IV
- Daily drug management
- Endotracheal intubation
- Venipuncture, including cutdowns
- Arterial punctures
- Epidural or subarachnoid spine injections
- Somatic and Sympathetic Nerve Injections
- Paravertebral facet joint injections and rhizotomies

In addition, lumbar plexus spine anesthetic injection, posterior approach with daily administration = 7 RVUs; paravertebral facet, zygapophyseal joint or nerves with guidance are reimbursed at 10 RVUs for a single level of the cervical or thoracic, 5 RVUs for second level or more, and 8 RVUs for the lumbar or sacral single level, 4 RVUs for the second level or more.

(2) The maximum reimbursement for these procedures shall be based upon the anesthesia value listed in the table in the RVP©, Anesthesia section's Guideline XIII multiplied by $38.83 CF. No additional unit values are added for time when calculating the maximum values for reimbursement.

(3) When performing more than one surgery X procedure in a single surgical setting, multiple surgery guidelines shall apply (100% of the listed value for the primary procedure and 50% of the listed value for additional procedures). Use modifier -51 to indicate multiple surgery X procedures performed on the same day during a single operative setting. The 50% reduction does not apply to procedures that are identified in the RVP© as "Add-on" procedures.

(4) Bilateral injections: see 18-5(D) (2) (g).

(5) Other procedures from Table XIII not described above may be found in another section of the RVP© (e.g., surgery). Any procedures found in the table under the RVP©, Anesthesia section's Guidelines XIII, "Anesthesia Services Where Time Units Are Not Allowed" but not contained in this list (Rule 18-5(D) (1) (d) (1)) are reimbursed in accordance with the assigned units from their respective sections multiplied by their respective CF.

(2) Surgical Section:

(a) The use of assistant surgeons shall be limited according to the American College Of Surgeons' *Physicians as Assistants at Surgery: 2011 Study* (January 2011), 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 Fee Schedule Administrator, 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 and 16-10) 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 assistant surgeon or minimum assistant surgeon without prior authorization for payment (see Rule 16-9 and 16-10) 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) Non-physician, minimum assistant surgeons used as surgical assistants shall be reimbursed at 10 % of the listed value.

(f) Global Period

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

- E&M services unrelated to the primary surgical procedure,
- Services necessary to stabilize the patient for the primary surgical procedure,
- Services not usually part of the surgical procedure, including an E&M visit by an authorized treating physician for disability management,
- Unusual circumstances, complications, exacerbations, or recurrences, or
- Unrelated diseases or injuries.
- 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.

(2) Separate identifiable services shall use an appropriate RVP© modifier in conjunction with the billed service.

(g) Bilateral procedures are reimbursed the same as all multiple procedures: 100% for the first primary procedure and then 50% for all other procedures, including the 2nd "primary" procedure.

(h) The “Services with Significant Direct Costs” section of the RVP© is not adopted. Supplies shall be reimbursed as set out in Rule 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 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 11.2 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.

(E) Radiology Section:

(1) General

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

(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 may be billed using the total component or the appropriate modifier to bill either the professional component or the technical component. 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 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 physician supervising and interpreting the thermographic evaluation shall be board certified by the examining board of one 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 of the following:

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

Sympathetically Maintained Pain (SMP);

Autonomic neuropathy;

(c) Protocol for stress testing is outlined in the Medical Treatment Guidelines found in Rule 17.

(d) Thermography Billing Codes:

DoWC Z200	Upper body w/ Autonomic Stress Testing	$865.37
DoWC Z201	Lower body w/Autonomic Stress Testing	$865.37

(e) Prior authorization for payment (see Rule 16-9 and 16-10) is required for thermography services only if the requested study does not meet the indicators for thermography as outlined in this radiology section. The billing shall include a report supplying the thermographic evaluation and reflecting compliance with Rule 18-5(E)(2).

(F) Pathology Section:

(1) Reimbursement for billed pathology procedures includes either a technical and professional component, or a total component. If an automated clinical lab procedure does not have a separate written interpretive report beyond the computer generated values, the biller may receive the total component value as long as no other provider seeks reimbursement for the professional component. The physician ordering the automated laboratory tests 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 Z755.

(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) 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.

Only one 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. Note that the descriptor has been revised for CY 2011. 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.

Reimbursement:

G0431	$138.28
G0434	$ 27.66

(G) Medicine Section:

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

(2) Anesthesia qualifying circumstance values are reimbursed in accordance with the anesthesia section of Rule 18.

(3) Biofeedback

Prior authorization for payment (see Rule 16-9 and 16-10) 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 an applicable Rule 17 medical treatment guidelines. Persons providing biofeedback shall be certified by the Biofeedback Certification Institution of America, or be a licensed physician or psychologist, as listed under Rule 16-5(A)(1)(a) and (b) with evidence of equivalent biofeedback training.

(4) Appendix J of the 2010 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 and 16-10) shall be obtained before billing for more than four body regions in one visit. Manipulative therapy is limited to the maximum allowed in the relevant Rule 17 medical treatment guidelines. The provider's medical records shall reflect medical necessity and prior authorization for payment (see Rule 16-9 and 16-10) if treatment exceeds these limitations.

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

(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 and 16-10) is required any time the following limitations are exceeded on a single day:

Evaluation Procedures	limit: 4 hours
Testing Procedures	limit: 6 hours

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

(c) Psychotherapy services limit: 50 mins per visit

Prior authorization for payment (see Rule 16-9 and 16-10) is required any time the 50 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 and 16-10) except where specifically addressed in the treatment guidelines.

(7) Hyperbaric Oxygen Therapy Services

The maximum unit value shall be 24 units, 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 CRPS. This test is performed on a minimum of two 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 Z401	QSART	$1,007.00

Z401 is to 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 Electro diagnostic Technologists

(2) Professional /Supervisory /Interpretive

A specifically neurophysiology trained Colorado licensed physician shall monitor the patient's nervous system through out the surgical procedure. The monitoring physician's time is billed based upon the actual time the physician devotes to the individual patient, even if the monitoring physician is monitoring more than one patient. The monitoring physician's time does not have to be continuous for each patient and maybe cumulative. The monitoring physician shall not monitor more than three 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) Central Nervous System (CNS) Testing and Assessment

CNS tests and assessment services shall be billed using the appropriate code from the RVP©. All CNS tests and assessments requiring more than six hours require prior authorization.

(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 and 16-10) is required for medical nutrition therapy. See Rule 18-6(O)(10).

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

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

Prior authorization for payment (see Rule 16-9 and 16-10) shall be obtained from the payer for any physical medicine treatment exceeding the recommendations of the Medical Treatment Guidelines as set forth in Rule 17.

The injured worker shall be re-evaluated by the prescribing physician within thirty (30) calendar days from the initiation of the prescribed treatment and at least once every month while that treatment continues. Prior authorization for payment (see Rule 16-9 and 16-10) shall be required for treatment of a condition not covered under the medical treatment guidelines and exceeding sixty (60) calendar days from the initiation of treatment.

(4) Interdisciplinary Rehabilitation Programs – (Requires Prior Authorization for Payment (see Rule 16-9 and 16-10).

An interdisciplinary rehabilitation program is one that provides focused, coordinated, and goal-oriented services using a team of professionals from varying disciplines to deliver care. These programs can benefit persons who have limitations that interfere with their physical, psychological, social, and/or vocational functioning. As defined in Rule 17 Medical Treatment Guidelines, interdisciplinary rehabilitation programs may include, but are not limited to: chronic pain, spinal cord, or brain injury programs.

Billing Restrictions: All billing providers shall detail to the payer the services, frequency of services, duration of the program and their proposed fees for the entire program, inclusive for 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 Z500.

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 guidelines recommendations.

(5) Procedures (therapeutic exercises, neuromuscular re-education, aquatic therapy, gait training, massage, acupuncture, manual therapy techniques, therapeutic activities, cognitive development, sensory integrative techniques and any unlisted physical medicine procedures)

Unless the provider's medical records reflect medical necessity and the provider obtains prior authorization for payment (see Rule 16-9 and 16-10), the maximum amount of time allowed is one hour of procedures per day, per discipline.

(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 and 16-10). For maximum fee allowance, see Rule 18-6(H).

Dry Needling of Trigger Points

Bill only one of the dry needling modality codes. See relevant treatment guidelines for limitations on frequencies.

DoWC Z501	Single or multiple needles, one or two muscles,	5.4 RVUs
DoWC Z502	three or more muscles,	5.8 RVUs

(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 or OT. 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 health care professional on the same day. An evaluation service with appropriate documentation may be charged for 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 Rule 18-5(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 Z503)
- Work Tolerance Screening (DoWC Z504)

(a) Billing Restrictions:

(1) Job Site Evaluations require prior authorization for payment (see Rule 16-9 and 16-10) if exceeding 2 hours. Computer-Enhanced Evaluations, and Work Tolerance Screenings require prior authorization for payment for more than 4 hours per test or more than 6 tests per claim. Functional Capacity Evaluations require

prior authorization for payment for more than 4 hours per test or 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, a PT, an OT, a speech language pathologist/therapist or audiologist. Final reports must be written and signed by the physician, the PT, the OT, the speech language pathologist/therapist or the audiologist.

(9) 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.

(10) Supplies

Physical medicine supplies are reimbursed in accordance with Rule 18-6(H).

(11) Unattended Treatment

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

DoWC Z505	fixed fee per day	1.5 RVU

(12) Non-Medical Facility

Fees, such as gyms, pools, etc., and training or supervision by non-medical providers require prior authorization for payment (see Rule 16-9 and 16-10) and a written negotiated fee.

(13) Unlisted Service Physical Medicine

All unlisted services or procedures require a report.

(14) Work Conditioning, Work Hardening, Work Simulation

(a) Work conditioning is a non-interdisciplinary program that is focused on the individual needs of the patient to return to work.

Usually one 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 and 16-10).

(b) Work Hardening is an interdisciplinary program that uses a team of disciplines to meet the goal of employability and return to work. This type of program entails a progressive increase in the number of hours a day that an individual completes work tasks until they can tolerate a full workday. In order to do this, the program must address the medical, psychological, behavioral, physical, functional and vocational components of employability and return to work. Refer to Rule 17, Medical Treatment Guidelines.

Restriction: Maximum daily time is six (6) hours per day without additional prior authorization for payment (see Rule 16-9 and 16-10).

(c) Work Simulation is a program where an individual completes specific work-related tasks for a particular job and return to work. Use of this program is appropriate when modified duty can only be partially accommodated in the work place, when modified duty in the work place is unavailable, or when the patient requires more structured supervision. The need for work simulation should be based upon the results of a functional capacity evaluation and/or job analysis. Refer to Rule 17, Medical Treatment Guidelines.

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

(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 (see Rule 16-9 and 16-10) is required.

(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) Medical record documentation shall encompass the "E&M Documentation Guidelines" criteria as adopted in Exhibit #7 to this Rule 18 to justify the billed

level of E&M service. If 50% of the time spent for an E&M visit is 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 day prior or seven 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 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, as defined in Rule 16-5 (A-B), are limited to one office visit per patient, per day, per workers' compensation claim unless prior authorization for payment (see Rule 16-9 and 16-10) is obtained. 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 day prior to a related E&M office visit, or

(b) the service is performed more than 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 Z601: $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 (Rule 18-6(G)(4)).

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 and 16-10).

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)

(e) Billing code DoWC Z701

$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 Z720

(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 this Rule 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 $14.00 for the first 10 or fewer pages, $0.50 per page for pages 11-40, and $0.33 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/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 Z721

(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 fee schedule, that ALJ may allow a greater fee than listed in Rule 18-6(D) in 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 Z730 $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 Z731.

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 he or she has reasonably spent in preparation and one-half the time scheduled for the deposition. Bill using code DoWC Z732.

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 he or she has reasonably spent in preparation and has scheduled for the deposition. Bill using code DoWC Z733.

Deposition:

Treating or Non-treating provider: DoWC Z734 $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 Z735.

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 he or she has

reasonably spent in preparation and one-half the time scheduled for the testimony. Bill using code DoWC Z736.

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 Z737.

Testimony:

Treating or Non-treating provider: DoWC Z738

Maximum Rate of $450.00 per hour

(E) Mileage Expenses

The payer shall reimburse an injured worker for reasonable and necessary mileage expenses for travel to and from medical appointments and reasonable mileage to obtain prescribed medications. The reimbursement rate shall be 47 cents per mile. The injured worker shall submit a statement to the payer showing the date(s) of travel and number of miles traveled, with receipts for any other reasonable and necessary travel expenses incurred.

Mileage Expense Billing Code: DoWC Z723

(F) Permanent Impairment Rating

(1) The payer is only required to pay for one, 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 authorized Level II accredited 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 Rule 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 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 report only and require 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 Z759 $355.00.

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

Bill DoWC Z760 $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 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

Routine reports or records are incorporated in all fees for service. They include:

Diagnostic testing

Procedure reports

Progress notes

Office notes

Operative reports

Supply invoices, if requested by the payer

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 Rule 18.

(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 WC 164 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 WC 164 initial report. Unless requested or prior authorized by the payer in a specific workers' compensation claim, no other authorized physician should complete and bill for the initial WC 164 form. This form shall include completion of items 1-7 and 10. Note that certain information in Item 2 (such as Insurer Claim #) may be omitted if not known by the provider.

(b) 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 Rule 18-6(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 Z750	$42.00	Initial Report
DoWC Z751	$42.00	Progress Report (Payer Requested or Provider Initiated)
DoWC Z752	$42.00	Closing Report
DoWC Z753	$42.00	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 & b below. Forms requiring more than 15 minutes shall be paid as a special report.

(a) Billing Code Z754

(b) Maximum fee is $42.00 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 or reviews 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 Rule 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 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 code DoWC Z761.

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 code DoWC Z762.

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 code DoWC Z763.

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 code DoWC Z764.

Billing Codes:

Written Report Only	DoWC Code:	Z755
IME/Report with patient exam	DoWC Code:	Z756
Lengthy Form Completion	DoWC Code:	Z757
18-5(I)(7) meeting and report with Non-treating Physician	DoWC Code:	Z758

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

CRS 8-43-404 IME Audio Recording	DoWC Code:	Z766 $30.00 per exam
CRS 8-43-404 IME Audio copying fee	DoWC Code:	Z767 $20.00 per copy

(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:

(i) Concern regarding the functional status of the patient

(ii) Abnormal results on previous testing

(iii) Change in management of dosage or pain

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

(4) The opioids prescribed for long-term treatment 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 (ICD).

Bill using code DoWC Z765 $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.

(H) Supplies, Durable Medical Equipment (DME), Orthotics and Prostheses

(1) Unless otherwise indicated in this rule, minimum payment for supplies shall reflect the provider's actual cost with a 20% markup and shipping charges.

(2) Providers may bill supplies, including "Supply et al.," orthotics, prostheses, DMEs or drugs, including injectables, using Medicare's HCPCS Level II codes at the Colorado rate. The billing provider is responsible for identifying their cost for the items they wish to be paid at their cost plus 20% instead of Medicare's Colorado HCPCS Level II maximum fee. This may be done using an advance agreement between the payer and provider or may be done by furnishing an invoice with their bill.

(3) Payers may pay using Medicare's Colorado HCPCS Level II maximum fee values for the codes billed unless the provider has indicated that the item(s) is to be paid at cost plus 20%. The payer may request an invoice for any items to be paid at cost plus 20%.

(4) If the provider failed to indicate that an item was to be paid at cost plus 20%, and their cost plus 20% is more than the Medicare Colorado HCPCS Level II value, the provider may submit cost information within 60 days following receipt of the Explanation of Benefits (EOB) and is entitled to at least their cost plus 20%.

(5) 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.

(I) Inpatient Hospital Facility Fees

(1) Provider Restrictions

All non-emergency, inpatient admissions require prior authorization for payment (see Rule 16-9 and 16-10).

(2) Bills for Services

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

(b) The maximum inpatient facility fee is determined by applying the Center for Medicare and Medicaid Services (CMS) "Medicare Severity Diagnosis Related Groups" (MS-DRGs) classification system. Exhibit 1 to Rule 18 shows the relative weights per MS-DRGs that are used in calculating the maximum allowance.

The hospital shall indicate the MS-DRG code number in the remarks section (form locator 80) 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. 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 to Rule 18 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 Rule 18-6(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 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 hospital

(2) Veterans' Administration hospital

(3) State psychiatric hospital

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

(1) Medicare certified Critical Access Hospital (CAH) (listed in Exhibit 3 of Rule 18)

(2) Medicare certified long-term care hospital

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

(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 Exhibit 1 to Rule 18 and locate the hospital's base rate in Exhibit 2 to Rule 18.

The "Maximum Fee Allowance" is determined by calculating:

(1) (MS-DRG Relative Wt x Specific hospital base rate x 155%) + (reimbursement for all "Supply et al.") + (trauma center activation allowance).

(2) "Supply et al." is defined in Rule 16-2. Reimbursement shall be consistent with Rule 18-6(H). The billing provider is responsible for identifying and itemizing all "Supply et al." items.

(3) For trauma center activation allowance, (revenue codes 680-685) see Rule 18-6(M)(3)(g).

(d) Outliers are admissions with extraordinary cost warranting additional reimbursement beyond the maximum allowance under (3) (c) of Rule 18-6(I). To calculate the additional reimbursement, if any:

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

Total billed charges (excluding any "Supply et al." billed charges and trauma center activation 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 Rule 18.

(3) The "Difference" = "Hospital's Cost" – "Maximum Fee Allowance" excluding any "Supply et al." allowance and trauma center activation allowance (see (c) above)

(4) If the "Difference" is greater than $23,375.00, additional reimbursement is warranted. The additional reimbursement is determined by the following equation:

"Difference" x .80 = additional fee allowance

(e) Inpatient combined with ERD or Trauma Center reimbursement

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

(2) Except, Trauma Center activation fees (see 18-6(M)(3)(g)) are paid in addition to inpatient fees (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 to Rule 18) divided by the MS-DRG geometric mean length of stay (Exhibit 1 to Rule 18). 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), and
- "Supply et al." billed charges to the "Supply et al." allowance [cost + 20%], and
- The trauma center activation billed charge to the trauma center activation allowance.

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

(J) Scheduled Outpatient Surgery Facility Fees

(1) Provider Restrictions

(a) All non-emergency outpatient surgeries require prior authorization for payment (see Rule 16-9 and 16-10).

(b) A separate facility fee is only payable if the facility is licensed by the Colorado Department of Public Health and Environment (CDPHE) as:

(1) a hospital; or

(2) an Ambulatory Surgery Center (ASC).

(2) Bills for Services

(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 are subject to the RVP© and Dental Fee Schedules as incorporated by Rule 18.

(c) ASCs and hospitals shall bill using the surgical RVP© code(s) as indicated by the surgeon's operative note up to a maximum of four surgery codes per surgical episode.

(3) Outpatient Surgery Facility Reimbursement:

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

(1) Children's hospital

(2) Veterans' Administration hospital

(3) State psychiatric hospital

(b) CAHs, listed in Exhibit 3 of Rule 18, are to be reimbursed at 80% of billed charges.

(c) All other outpatient surgery facilities are reimbursed based on Exhibit 4 of this Rule 18. Exhibit 4 lists Medicare's Outpatient Hospital Ambulatory Prospective Payment Codes (APC) and the Division's rates for both hospitals and ASCs. The Division's hospital rate is listed in Column #4 of Exhibit 4. The Division's ASC rate is listed in Column #5 of Exhibit #4. Grouper code 210, found in Exhibit 4, was DoWC created to reimburse RVP© spinal fusion codes not listed in https://www.cms.gov/HospitalOutpatientPPS/AU/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1243097&intNumPerPage=10 (Revised Addendum B).

The APC Exhibit #4 values include the following revenue codes, except as allowed by the applicable CPT© code that identifies the APC grouper code and may be aligned on the UB-04 with one of these revenue codes and any "Supply et al." criteria that is met or agreed to by the parties:

25X-29X	drugs, biologicals and other pharmaceuticals;
61X-63X	pharmaceuticals; medical surgical supplies and
67X	surgical supplies and equipment; surgical dressings, splints, casts and other devices used for reduction of fractures or dislocations supplies, intravenous liquids and supplies, drugs, sterile supplies, except when Medicare allows for a separate payment buy using an appropriate Medicare HCPCS Level II pass- through code
31X	pathology, except for surgical pathology
32X-35X	radiology except as allowed by a separate APC value for the given CPT© code
36X-37X	operating room (or) and anesthesia supplies and equipment used for administering and monitoring anesthesia or sedation, except as allowed by a separate APC value for the given CPT© code
46X	all pulse ox readings and equipment
49X	use of ASC for surgical procedures allowed, except as allowed by a separate APC value for the given CPT© code
51X-52X	all clinics
71X	recovery room (rr)
72X	labor and delivery room
73X	routine EKG, telemetry

76X all specialty and preventative care services treatment rooms, except observation (761 revenue code), except as allowed by a separate APC value for the given CPT© code. (See 18-6(3)(c)(1).

The surgical procedure codes are classified by APC code in Medicare's Revised Addendum B. This Addendum B should be used to determine the APC code payable under the Division's Exhibit 4. However, not every surgical code listed under Revised Addendum B warrants a separate facility fee.

The Revised Addendum B can be accessed at Medicare's Hospital Outpatient PPS website.

Total maximum facility value for an outpatient surgical episode of care includes the sum of:

(1) The highest valued APC code per Exhibit 4 plus 50% of any lesser-valued APC code values.

Multiple procedures and bilateral procedures 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.

The surgery discogram procedure (APC 388) value is for all levels and includes conscious sedation and the technical component of the radiological procedure.

Facility fee reimbursement is limited to a maximum of four surgical procedures per surgical episode with a maximum of only one procedure reimbursed at 100% of the allowed value.

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 procedures may be separately payable with anatomic modifiers.

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; and

(2) "Supply et al." is defined in Rule 16-2. Reimbursement shall be consistent with Rule 18-6(H). The billing provider is responsible for identifying and itemizing all "Supply et al." items; and

(3) Diagnostic testing and preoperative labs may be reimbursed by applying the appropriate CF to the unit values for the specific CPT® code as listed in the RVP.

However, diagnostic testing and preoperative labs shall be reimbursed according to Exhibit #4 when it lists a dollar value greater than zero. Other services with non-zero Exhibit #4 values, such as cardiac and dialysis procedures, shall also be reimbursed according to Exhibit #4. Use Medicare's Revised Addendum B to link Exhibit #4 APC Grouper numbers to CPT® codes.

CPT® radiological procedure codes (not the injection codes) are to be used for all venograms, arthrograms and myelograms; and

(4) Observation room maximum allowance is limited to 6 hours without prior authorization for payment (see Rule 16-9 and 16-10). Documentation should support the medical necessity for observation or convalescent care. Observation time begins when the patient is placed in a bed for the purpose of initiating observation care in accordance with the physician's order. Observation or daily outpatient convalescence time ends when the patient is actually discharged from the hospital or ASC or admitted into a licensed facility for an inpatient stay. Observation time would not include the time patients remain in the observation area after treatment is finished for reasons such as waiting for transportation home. Hospital or convalescence licensure is required for billing observation or convalescence time beyond 23 hours.

Billing Codes:

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

(5) Additional reimbursement is payable for the following services not included in the values found in Exhibit 4 of Rule 18:

- ambulance services (Revenue Code 540)
- 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.

(d) In rare cases, a reasonable facility fee may be paid when an outpatient surgical procedure poses a significant risk to the injured worker if performed in a lesser facility, even if the procedure:

- Has a zero dollar value in Exhibit 4, and/or
- Cannot be assigned to an APC Grouper based on Medicare's Revised Addendum B.

Once the risk to the injured worker has been provided in writing and the payer has agreed or it is ordered that this procedure may occur in the facility, a reasonable dollar value shall be determined by using a similar procedure code (if the exact code cannot be used) that can be assigned under Exhibit 4 or under Medicare's Revised Addendum B. If a value does not exist in Exhibit 4, then the APC dollar value from Medicare's Revised Addendum B with reductions for "Supply et al." is multiplied by 160%. The services normally included in Exhibit 4 values shall be included in this reimbursement value, and the services allowed as additional reimbursement under Rule 18-6 (J)(3)(c)(2)-(5) would be allowed.

(e) 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.

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

(g) In compliance with Rule 16-6(B), the sum of Rule 18-6(J)(3)(c)(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 18-6(J)(3)(c) is not appropriate.

(K) Outpatient Diagnostic Testing or Treatments Done at a Hospital and Clinic Facility Fees

(1) Bills for Services

All providers shall indicate whether they are billing for the total, professional only or technical only component of a diagnostic test by listing the appropriate RVP© modifier on the required billing form, either the UB-04 or CMS 1500 (08-05).

(2) Reimbursement

(a) The following types of outpatient diagnostic testing and clinic facilities are reimbursed at 100% of billed charges:

(1) Children's hospitals,

(2) Veterans' Administration hospitals

(3) State psychiatric hospitals

(b) Rural health facilities listed in Exhibit 5 are reimbursed at 80% of billed charges for clinic visits, diagnostic testing, and supplies and drugs that do not meet the "Supply et al." threshold.

"Supply et al." is defined in Rule 16-2 and reimbursement shall be consistent with Rule 18-6(H). The billing provider is responsible for identifying and itemizing all "Supply et al." items.

(c) All other facilities:

(1) No separate allowance for clinic visit fees unless the facility is considered a rural health clinic as listed in Exhibit #5. Supplies are reimbursed in accordance with Rule 18-6(H).

(2) The technical facility fee component of an outpatient diagnostic testing done at a free-standing facility or hospital is based upon the appropriate Exhibit #4 Total Hospital APC Outpatient Payment rate listed in Column #4. The fees listed in Exhibit #4, Column #5, are the maximum facility fees for any diagnostic tests done in an ASC. The limitations as listed under Rule 18-6(J)(3)(c) are effective for any multiple diagnostic testing performed on the same day unless a Medicare composite dollar value is agreed to in writing by the provider and the payer.

The billing free-standing facility, hospital or ASC may bill the professional component of the diagnostic testing or treatment and the payer shall pay the billing provider the professional component at the RVP© relative value multiplied by the applicable Rule 18-4 conversion factor. However, only one professional fee is payable for a single diagnostic test.

The maximum allowance for all diagnostic testing and treatments/services done in a physician's office shall be based upon the appropriate RVP© unit value multiplied by the applicable Rule 18-4 conversion factor.

At no time shall any provider be paid under the RVP© technical component and Exhibit #4 APC dollar value for the same service. Nor shall any tests or treatments/services be paid more than once for either the professional or technical components.

Hospitals that perform treatments in their facility may bill for their services and the maximum fee shall be determined by Exhibit #4 listed in Column #4.

ASCs that perform treatment in their facility may bill for their services, and the maximum fee shall be determined by Exhibit #4 in Column #5.

Dyes and contrasts may be reimbursed according to Rule 18-6(H).

(3) "Supply et al." is defined in Rule 16-2 and reimbursement shall be consistent with Rule 18-6(H). The billing provider is responsible for identifying and itemizing all "Supply et al." items.

(d) 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 Rule 18-6(O).

(L) Outpatient Urgent Care Facility Fees

(1) Provider Restrictions:

(a) 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 if requested by the payer.

(b) 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;

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

(c) 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.

(d) 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.

(2) Bills for Services

(a) Urgent care facility fees may be billed on a CMS 1500 (08-05).

(b) Urgent care facility fees shall be billed using HCPCS Level II code: S9088 – "Services provided in an Urgent care facility."

(3) Urgent Care Reimbursement

The total maximum value for an urgent care episode of care includes the sum of:

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

(b) "Supply et al." is defined in Rule 16-2 and reimbursement shall be consistent with Rule 18-6(H). The billing provider is responsible for identifying and itemizing all "Supply et al." items.

Supplies and drugs that do not meet the "Supply et al." threshold and treatment rooms are included in the Urgent Care facility maximum fees; and

(c) All diagnostic testing, laboratory services and therapeutic services (including, but not limited to, radiology, pathology, respiratory therapy, physical therapy or occupational therapy) shall be reimbursed by multiplying the appropriate CF by the unit value for the specific CPT® code as listed in the RVP© and Rule 18; and

(d) The Observation Room allowance shall not exceed a rate of $45.00 per hour and is limited to a maximum of 3 hours without prior authorization for payment (see Rule 16-9 and 16-10).

(e) In compliance with Rule 16-6 (B), the sum of all Urgent Care fees charged, less any amounts charged for professional fees or dispensed prescriptions per Rule 18-6(L)(4) found on the same bill, is to be compared to the maximum reimbursement allowed by the calculated value of Rule 18-6(L)(3)(a-d). The lesser of the two amounts shall be the maximum facility allowance for the episode of urgent care. A line by line comparison is not appropriate.

(4) Any prescription for a drug supply to be used longer than a 24 hour period, filled at any Urgent Care facility, shall fall under the requirements of, and be reimbursed as, a pharmacy fee. See Rule 18-6(O).

(M) Outpatient Emergency Room Department (ERD) Facility Fees

(1) Provider Restrictions

To be reimbursed under this section (M), all outpatient ERDs within Colorado must be physically located within a hospital licensed by the CDPHE as a general hospital, or if free-standing ERD, must have equivalent operations as a licensed

ERD. To be paid as an ERD, out-of-state facilities shall meet that state's licensure requirements.

(2) Bills for Services

(a) ERD 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) Documentation should support the "Level of Care" being billed.

(3) ERD Reimbursement

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

(1) Children's hospitals

(2) Veterans' Administration hospitals

(3) State psychiatric hospitals

(b) Medicare certified Critical Access Hospitals (CAH) (listed in Exhibit 3 of Rule 18) are reimbursed at 80% of billed charges.

(c) The ERD "Level of Care" is identified based upon one of five 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.

(d) Total maximum value for an ERD episode of care includes the sum of the following:

(1) All hospital outpatient emergency room facility fees, including the ERD level, are reimbursed based on Exhibit 4 of this Rule 18. Exhibit 4 lists Medicare's outpatient hospital ambulatory prospective payment codes (APC) and rates. The Division's "Outpatient Hospital ERD Rate" is equal to Medicare's APC payment rate, as listed in Column #3 in Exhibit #4. See Medicare's January 2010 revision of Addendum B to reflect the Affordable Care Act 05/18/2010: https://www.cms.gov/HospitalOutpatientPPS/AU/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1243097&intNumPerPage=10

(Only the higher one of any ERD Levels or critical care codes shall be paid) and

(2) All diagnostic testing, laboratory services and therapeutic services not included in the hospital's point system and not included in Exhibit #4 of this Rule 18 (including, but not limited

to, radiology, pathology, any respiratory therapy, PT or OT) shall be reimbursed by the appropriate CF multiplied by the unit value for the specific code as listed in the RVP© and Rule 18; and

(3) All surgical procedures are paid according to Exhibit #4 as indicated in Rule 18-6(J); except the surgical code maximum allowances are using the Outpatient Hospital ERD column #3. No supply et al. items are separately payable.

(4) The observation room allowance shall not exceed a rate of $45.00 per hour and is limited to a maximum of 3 hours without prior authorization for payment (see Rule 16-9 and 16-10). The documentation should support the medical necessity for observation; and

(5) All "Supply et al." items are included in the values of the APCs.

(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 18 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.

(e) 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 Rule 18-6(M)(3)(d). The lesser of the two amounts shall be the maximum facility allowance for the ERD episode of care. A line by line comparison is not appropriate.

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

(g) Trauma Center fees are not paid for alerts. 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	$00.00

(1) These fees are in addition to ERD and inpatient fees.

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

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

(N) Home Therapy

Prior authorization for payment (see Rule 16-9 and 16-10) is required for all home therapy. The payer and the home health entity should agree in writing on the type of care, 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 diem rates for home infusion therapy shall include the initial patient evaluation, education, coordination of care, products, equipment, IV administration sets, supplies, supply management, and delivery services. Nursing fees should be billed as indicated in Rule 18-6(N)(2).

(a) Parenteral Nutrition:

0 -1 liter	$140.00/day
1.1 - 2.0 liter	$200.00/day
2.1 - 3.0 liter	$260.00/day

(b) Antibiotic Therapy:

$105.00/day + Average Wholesale Price (AWP) (See Rule 18-6(O)(14))

(c) Chemotherapy:

$ 85.00/day + AWP (See Rule 18-6(O)(14))

(d) Enteral nutrition:

Category I	$ 43.00/day
Category II	$ 41.00/day
Category III	$ 52.00/day

(e) Pain Management: $ 95.00/day + AWP (See Rule 18-6(O)(14))

(f) Fluid Replacement: $ 70.00/day + AWP (See Rule 18-6(O)(14))

(g) Multiple Therapies:

Rate per day for highest cost therapy only + AWP (See Rule 18-6(O)(14)) for all drugs

Medication/Drug Restrictions - the payment for drugs may be based upon the AWP (See Rule 18-6(O)(14)) of the drug as determined through the use of industry publications such as the monthly Price Alert, First Databank, Inc.

(2) Nursing Services

(a) Skilled Nursing (LPN & RN)

DoWC Z770 $95.79 per hour

There is a limit of 2 hours without prior authorization for payment (see Rule 16-9 and 16-10).

(b) Certified Nurse Assistant (CNA):

DoWC Z771 $31.67 per hour for the first hour per trip to injured worker;

DoWC Z774 $ 9.46 for each additional half hour. Service must be at least 15 minutes to bill an additional half hour charge.

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 the physical medicine and rehabilitation services section of Rule 18.

(4) Mileage

Travel allowances should be agreed upon with the payer and the mileage rate should not exceed $0.47 per mile, portal to portal.

DoWC code: Z772

(5) Travel Time

Travel is typically included in the fees listed. Travel time greater than 1 hr. one-way shall be reimbursed. The fee shall be agreed upon at the time of prior authorization for payment (see Rule 16-9 and 16-10) and shall not exceed $30.00 per hour.

DoWC code: Z773

(O) 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 (Except Compounded Drugs)

(a) For prescriptions written within 30 days from the date of injury, reimbursement shall be AWP + $4.00

(b) For 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 the source of the repackaged drugs to determine reimbursement.

(c) Drugs administered in the course of the provider's direct care shall be reimbursed at the provider's actual cost incurred.

(4) Compounded Drugs

All compounds shall be billed using the DoWC Z code corresponding with the applicable category for topical products as follows:

Category I Z790 Fee $ 75.00 per 30 day supply

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

Category II Z791 Fee $150.00 per 30 day supply

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

Category III Z792 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 Z793 Fee $350.00 per 30 day supply

Two 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. 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.

(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 within thirty (30) days after receipt 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.

(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 of the following forms:

(1) CMS 1500 (08-05) (formerly CMS 1500) – the dispensing provider shall bill by using the RVP© supply code and shall include the metric quantity and NDC number of the drug being dispensed; 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.

(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 Rule 18-6(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.

(P) Complementary Alternative Medicine (CAM) (Requires prior authorization for payment (see Rule 16-9 and 16-10)

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. Providers of CAM may be both licensed and non-licensed health practitioners with training in one or more forms of therapy. Refer to Rule 17, Medical Treatment Guidelines for the specific types of CAM modalities.

(Q) 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 providers must be Registered Acupuncturists (LAc) or certified by an existing licensing board as provided in Rule 16, Utilization Standards, and must provide evidence of training, registration and/or certification 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 and 16-10).

(b) Unless the provider's medical records reflect medical necessity and the provider obtains prior authorization for payment (see Rule 16-9 and 16-10), the maximum amount of time allowed for acupuncture and procedures is one 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 Z800
Maximum value $96.32

(3) LAc established patient visit: DOWC Z801
Maximum value $65.02

(c) Herbs require prior authorization for payment (see Rule 16-9 and 16-10) and fee agreements as in this Rule 18-6(O)(10);

(d) See the appropriate physical medicine and rehabilitation section of the RVP© for other billing codes and limitations (see also Rule 18-5(H)).

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

(R) Use of an Interpreter

Rates and terms shall be negotiated. Prior authorization for payment (see Rule 16-9 and 16-10) is required except for emergency treatment. Use DoWC Z722 to bill.

18-7 DENTAL FEE SCHEDULE

The dental schedule is adopted using the American Dental Association's Current Dental Terminology, 2009-2010 (CDT-2009-2010). 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 for the listing and maximum allowance for CDT-2009-2010 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						
Effective for Dates of Service on and After 1/1/2012						
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	24.2794	28.6	37.4
2	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W/O MCC	13.97	16.7	21.3
3	PRE	SURG	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	17.9927	29.1	35.3
4	PRE	SURG	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	10.9251	21.4	26.0
5	PRE	SURG	LIVER TRANSPLANT W MCC OR INTESTINAL TRANSPLANT	10.4814	15.9	20.9
6	PRE	SURG	LIVER TRANSPLANT W/O MCC	5.1059	8.2	9.4
7	PRE	SURG	LUNG TRANSPLANT	9.871	15.4	18.9
8	PRE	SURG	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	5.1176	10.1	12.0
10	PRE	SURG	PANCREAS TRANSPLANT	3.89	8.5	9.9
11	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W MCC	4.9967	12.1	15.2
12	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W CC	3.0957	8.5	10.0
13	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W/O CC/MCC	1.8983	5.6	6.4
14	PRE	SURG	ALLOGENEIC BONE MARROW TRANSPLANT	10.2792	18.0	24.8
16	PRE	SURG	AUTOLOGOUS BONE MARROW TRANSPLANT W CC/MCC	6.3127	18.1	19.8
17	PRE	SURG	AUTOLOGOUS BONE MARROW TRANSPLANT W/O CC/MCC	4.3224	11.6	14.6
20	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W MCC	8.5033	13.4	16.8
21	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W CC	6.4369	12.6	14.3
22	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W/O CC/MCC	4.15	5.6	7.6
23	01	SURG	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W MCC OR CHEMO IMPLANT	5.3625	8.4	11.7
24	01	SURG	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W/O MCC	3.6327	5.4	7.5
25	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W MCC	4.6927	8.5	10.9

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
26	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W CC	2.977	5.5	7.0
27	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W/O CC/MCC	2.1317	2.9	3.7
28	01	SURG	SPINAL PROCEDURES W MCC	5.6476	10.1	13.0
29	01	SURG	SPINAL PROCEDURES W CC OR SPINAL NEUROSTIMULATORS	2.8308	4.5	6.2
30	01	SURG	SPINAL PROCEDURES W/O CC/MCC	1.6924	2.4	3.1
31	01	SURG	VENTRICULAR SHUNT PROCEDURES W MCC	4.4529	8.7	12.5
32	01	SURG	VENTRICULAR SHUNT PROCEDURES W CC	1.9491	3.5	5.2
33	01	SURG	VENTRICULAR SHUNT PROCEDURES W/O CC/MCC	1.4085	2.0	2.6
34	01	SURG	CAROTID ARTERY STENT PROCEDURE W MCC	3.5003	4.5	6.9
35	01	SURG	CAROTID ARTERY STENT PROCEDURE W CC	2.1459	2.1	3.1
36	01	SURG	CAROTID ARTERY STENT PROCEDURE W/O CC/MCC	1.655	1.3	1.5
37	01	SURG	EXTRACRANIAL PROCEDURES W MCC	3.0845	5.6	8.0
38	01	SURG	EXTRACRANIAL PROCEDURES W CC	1.5804	2.4	3.5
39	01	SURG	EXTRACRANIAL PROCEDURES W/O CC/MCC	1.0305	1.4	1.7
40	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W MCC	4.0331	8.9	12.0
41	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W CC OR PERIPH NEUROSTIM	2.1775	5.1	6.6
42	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W/O CC/MCC	1.7442	2.5	3.3
52	01	MED	SPINAL DISORDERS & INJURIES W CC/MCC	1.539	4.3	5.7
53	01	MED	SPINAL DISORDERS & INJURIES W/O CC/MCC	0.8554	2.7	3.3
54	01	MED	NERVOUS SYSTEM NEOPLASMS W MCC	1.468	4.4	6.0
55	01	MED	NERVOUS SYSTEM NEOPLASMS W/O MCC	1.076	3.3	4.5

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
56	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS W MCC	1.7656	5.5	7.3
57	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS W/O MCC	0.9652	3.8	4.9
58	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W MCC	1.5223	5.3	6.8
59	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W CC	1.0181	4.0	4.8
60	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W/O CC/MCC	0.7618	3.1	3.7
61	01	MED	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W MCC	2.8804	6.2	8.0
62	01	MED	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W CC	1.9506	4.6	5.4
63	01	MED	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W/O CC/MCC	1.5361	3.3	3.8
64	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	1.8555	4.9	6.8
65	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC	1.1485	3.8	4.6
66	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W/O CC/MCC	0.8105	2.6	3.1
67	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W MCC	1.4475	4.2	5.4
68	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W/O MCC	0.8901	2.6	3.2
69	01	MED	TRANSIENT ISCHEMIA	0.7347	2.2	2.7
70	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W MCC	1.803	5.3	7.0
71	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.0578	3.9	4.9
72	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC/MCC	0.7237	2.4	3.0
73	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W MCC	1.2955	4.1	5.4
74	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O MCC	0.8644	3.2	4.0
75	01	MED	VIRAL MENINGITIS W CC/MCC	1.7196	5.4	6.8
76	01	MED	VIRAL MENINGITIS W/O CC/MCC	0.8751	3.2	3.8
77	01	MED	HYPERTENSIVE ENCEPHALOPATHY W MCC	1.6587	4.7	6.0

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
78	01	MED	HYPERTENSIVE ENCEPHALOPATHY W CC	1.02	3.5	4.2
79	01	MED	HYPERTENSIVE ENCEPHALOPATHY W/O CC/MCC	0.7218	2.4	2.9
80	01	MED	NONTRAUMATIC STUPOR & COMA W MCC	1.1865	3.6	4.9
81	01	MED	NONTRAUMATIC STUPOR & COMA W/O MCC	0.7374	2.6	3.3
82	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W MCC	2.0265	3.5	6.0
83	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W CC	1.3567	3.5	4.6
84	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W/O CC/MCC	0.8422	2.1	2.6
85	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W MCC	2.1483	5.2	7.2
86	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W CC	1.1759	3.5	4.4
87	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W/O CC/MCC	0.7834	2.3	2.8
88	01	MED	CONCUSSION W MCC	1.6177	4.1	5.4
89	01	MED	CONCUSSION W CC	0.9809	2.8	3.6
90	01	MED	CONCUSSION W/O CC/MCC	0.7297	1.9	2.3
91	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W MCC	1.6238	4.3	5.9
92	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.9247	3.2	4.0
93	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC/MCC	0.6751	2.2	2.8
94	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W MCC	3.4244	8.7	11.5
95	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W CC	2.3762	6.2	7.7
96	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W/O CC/MCC	1.9069	4.5	5.6
97	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W MCC	3.2139	8.7	11.1
98	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W CC	1.8279	6.0	7.6

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
99	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W/O CC/MCC	1.2299	4.0	5.1
100	01	MED	SEIZURES W MCC	1.5254	4.3	5.8
101	01	MED	SEIZURES W/O MCC	0.762	2.7	3.3
102	01	MED	HEADACHES W MCC	1.0129	3.1	4.3
103	01	MED	HEADACHES W/O MCC	0.6677	2.3	2.9
113	02	SURG	ORBITAL PROCEDURES W CC/MCC	1.8841	4.3	5.7
114	02	SURG	ORBITAL PROCEDURES W/O CC/MCC	0.9275	2.0	2.6
115	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT	1.2246	3.3	4.4
116	02	SURG	INTRAOCULAR PROCEDURES W CC/MCC	1.2982	3.0	4.5
117	02	SURG	INTRAOCULAR PROCEDURES W/O CC/MCC	0.7657	1.8	2.4
121	02	MED	ACUTE MAJOR EYE INFECTIONS W CC/MCC	1.044	4.1	5.3
122	02	MED	ACUTE MAJOR EYE INFECTIONS W/O CC/MCC	0.6304	3.1	3.7
123	02	MED	NEUROLOGICAL EYE DISORDERS	0.7135	2.1	2.6
124	02	MED	OTHER DISORDERS OF THE EYE W MCC	1.1702	3.6	5.1
125	02	MED	OTHER DISORDERS OF THE EYE W/O MCC	0.6918	2.5	3.2
129	03	SURG	MAJOR HEAD & NECK PROCEDURES W CC/MCC OR MAJOR DEVICE	2.2143	3.7	5.4
130	03	SURG	MAJOR HEAD & NECK PROCEDURES W/O CC/MCC	1.1858	2.3	2.8
131	03	SURG	CRANIAL/FACIAL PROCEDURES W CC/MCC	2.2558	4.1	5.7
132	03	SURG	CRANIAL/FACIAL PROCEDURES W/O CC/MCC	1.1974	2.1	2.7
133	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W CC/MCC	1.7241	3.7	5.4
134	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W/O CC/MCC	0.8722	1.7	2.1
135	03	SURG	SINUS & MASTOID PROCEDURES W CC/MCC	1.9963	4.3	6.5

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
136	03	SURG	SINUS & MASTOID PROCEDURES W/O CC/MCC	1.0114	1.7	2.3
137	03	SURG	MOUTH PROCEDURES W CC/MCC	1.316	3.8	5.0
138	03	SURG	MOUTH PROCEDURES W/O CC/MCC	0.7784	1.8	2.4
139	03	SURG	SALIVARY GLAND PROCEDURES	0.9009	1.4	1.7
146	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W MCC	2.0669	5.9	8.4
147	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W CC	1.2268	4.1	5.6
148	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W/O CC/MCC	0.7521	2.2	3.2
149	03	MED	DYSEQUILIBRIUM	0.635	2.1	2.5
150	03	MED	EPISTAXIS W MCC	1.3103	3.8	5.2
151	03	MED	EPISTAXIS W/O MCC	0.6601	2.3	2.8
152	03	MED	OTITIS MEDIA & URI W MCC	0.957	3.2	4.1
153	03	MED	OTITIS MEDIA & URI W/O MCC	0.6296	2.4	3.0
154	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W MCC	1.4235	4.2	5.6
155	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W CC	0.8985	3.2	4.1
156	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W/O CC/MCC	0.6192	2.3	2.8
157	03	MED	DENTAL & ORAL DISEASES W MCC	1.6092	4.9	6.7
158	03	MED	DENTAL & ORAL DISEASES W CC	0.8971	3.2	4.2
159	03	MED	DENTAL & ORAL DISEASES W/O CC/MCC	0.5801	2.1	2.6
163	04	SURG	MAJOR CHEST PROCEDURES W MCC	5.091	11.4	13.9
164	04	SURG	MAJOR CHEST PROCEDURES W CC	2.6029	5.9	7.1
165	04	SURG	MAJOR CHEST PROCEDURES W/O CC/MCC	1.7854	3.6	4.3
166	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	3.7322	9.2	11.7

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
167	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.0575	5.6	7.1
168	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC/MCC	1.2791	3.2	4.2
175	04	MED	PULMONARY EMBOLISM W MCC	1.6212	5.6	6.7
176	04	MED	PULMONARY EMBOLISM W/O MCC	1.0485	4.0	4.7
177	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	2.0653	6.7	8.3
178	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W CC	1.4653	5.4	6.5
179	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W/O CC/MCC	1.0025	4.0	4.8
180	04	MED	RESPIRATORY NEOPLASMS W MCC	1.7403	5.6	7.3
181	04	MED	RESPIRATORY NEOPLASMS W CC	1.2237	4.0	5.3
182	04	MED	RESPIRATORY NEOPLASMS W/O CC/MCC	0.8446	2.7	3.6
183	04	MED	MAJOR CHEST TRAUMA W MCC	1.4695	5.1	6.2
184	04	MED	MAJOR CHEST TRAUMA W CC	1.0086	3.5	4.3
185	04	MED	MAJOR CHEST TRAUMA W/O CC/MCC	0.7013	2.5	3.0
186	04	MED	PLEURAL EFFUSION W MCC	1.5824	5.1	6.6
187	04	MED	PLEURAL EFFUSION W CC	1.1123	3.7	4.8
188	04	MED	PLEURAL EFFUSION W/O CC/MCC	0.7699	2.7	3.4
189	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.2694	4.2	5.3
190	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1.1684	4.4	5.3
191	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	0.9628	3.7	4.5
192	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	0.7081	3.0	3.5
193	04	MED	SIMPLE PNEUMONIA & PLEURISY W MCC	1.4948	5.2	6.4
194	04	MED	SIMPLE PNEUMONIA & PLEURISY W CC	1.0026	4.0	4.8

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
195	04	MED	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	0.7037	3.0	3.6
196	04	MED	INTERSTITIAL LUNG DISEASE W MCC	1.6571	5.6	7.0
197	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.0943	4.0	4.9
198	04	MED	INTERSTITIAL LUNG DISEASE W/O CC/MCC	0.7839	2.9	3.6
199	04	MED	PNEUMOTHORAX W MCC	1.8145	6.1	7.8
200	04	MED	PNEUMOTHORAX W CC	0.9892	3.5	4.5
201	04	MED	PNEUMOTHORAX W/O CC/MCC	0.7121	2.7	3.5
202	04	MED	BRONCHITIS & ASTHMA W CC/MCC	0.8519	3.3	4.1
203	04	MED	BRONCHITIS & ASTHMA W/O CC/MCC	0.6133	2.6	3.1
204	04	MED	RESPIRATORY SIGNS & SYMPTOMS	0.6564	2.1	2.6
205	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W MCC	1.3324	3.9	5.3
206	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O MCC	0.7565	2.5	3.2
207	04	MED	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	5.2933	12.6	14.7
208	04	MED	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	2.2704	5.0	7.0
215	05	SURG	OTHER HEART ASSIST SYSTEM IMPLANT	13.7629	7.5	13.4
216	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W MCC	9.6922	14.1	16.7
217	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W CC	6.4987	9.4	10.6
218	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W/O CC/MCC	5.1734	7.0	7.8
219	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W MCC	8.0815	10.4	12.8
220	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W CC	5.2602	6.9	7.6

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
221	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W/O CC/MCC	4.3663	5.2	5.7
222	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W MCC	8.6807	9.8	12.0
223	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W/O MCC	6.3309	4.5	6.2
224	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W MCC	7.7154	8.0	9.9
225	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W/O MCC	5.9511	4.1	5.1
226	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W MCC	6.7895	6.0	8.7
227	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W/O MCC	5.15	2.1	3.1
228	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W MCC	7.3445	11.2	13.5
229	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W CC	4.6552	7.2	8.1
230	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W/O CC/MCC	3.6603	4.6	5.4
231	05	SURG	CORONARY BYPASS W PTCA W MCC	7.9084	10.8	12.8
232	05	SURG	CORONARY BYPASS W PTCA W/O MCC	5.669	8.0	8.8
233	05	SURG	CORONARY BYPASS W CARDIAC CATH W MCC	7.1418	11.8	13.3
234	05	SURG	CORONARY BYPASS W CARDIAC CATH W/O MCC	4.8314	8.2	8.8
235	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W MCC	5.9063	9.3	10.8
236	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W/O MCC	3.772	6.0	6.5
237	05	SURG	MAJOR CARDIOVASC PROCEDURES W MCC	5.1221	7.1	10.2
238	05	SURG	MAJOR CARDIOVASC PROCEDURES W/O MCC	3.0979	2.8	4.0
239	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W MCC	4.7401	11.2	14.3
240	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W CC	2.6063	7.5	9.2
241	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W/O CC/MCC	1.4939	4.8	5.8
242	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W MCC	3.6835	6.1	7.8

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
243	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W CC	2.6363	3.8	4.8
244	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W/O CC/MCC	2.0538	2.3	2.8
245	05	SURG	AICD GENERATOR PROCEDURES	4.1967	2.7	3.9
246	05	SURG	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W MCC OR 4+ VESSELS/STENTS	3.1727	3.6	5.1
247	05	SURG	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	1.9828	1.9	2.4
248	05	SURG	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W MCC OR 4+ VES/STENTS	2.9396	4.5	6.1
249	05	SURG	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MCC	1.8132	2.3	2.9
250	05	SURG	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W MCC	2.8921	5.0	6.8
251	05	SURG	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W/O MCC	1.8447	2.2	2.9
252	05	SURG	OTHER VASCULAR PROCEDURES W MCC	2.9865	5.1	7.7
253	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.4432	4.4	6.0
254	05	SURG	OTHER VASCULAR PROCEDURES W/O CC/MCC	1.6521	2.1	2.7
255	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W MCC	2.5192	6.7	9.0
256	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W CC	1.6035	5.6	6.9
257	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W/O CC/MCC	0.9071	3.1	4.1
258	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT W MCC	2.9714	5.3	7.0
259	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT W/O MCC	1.8217	2.5	3.3
260	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W MCC	3.6297	7.6	10.5
261	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W CC	1.675	3.2	4.3
262	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W/O CC/MCC	1.1756	2.1	2.6
263	05	SURG	VEIN LIGATION & STRIPPING	1.6226	3.2	4.8

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
264	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.558	5.4	8.0
265	05	SURG	AICD LEAD PROCEDURES	2.3133	2.4	3.5
280	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC	1.7901	5.0	6.3
281	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W CC	1.1478	3.4	4.2
282	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W/O CC/MCC	0.7856	2.2	2.7
283	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W MCC	1.7118	3.2	5.0
284	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W CC	0.84	2.0	2.8
285	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W/O CC/MCC	0.5401	1.4	1.7
286	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W MCC	2.036	4.9	6.5
287	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O MCC	1.0743	2.4	3.1
288	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W MCC	2.8654	8.3	10.3
289	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W CC	1.8502	6.1	7.4
290	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W/O CC/MCC	1.1141	4.1	5.0
291	05	MED	HEART FAILURE & SHOCK W MCC	1.501	4.7	6.1
292	05	MED	HEART FAILURE & SHOCK W CC	1.0214	3.9	4.7
293	05	MED	HEART FAILURE & SHOCK W/O CC/MCC	0.6756	2.7	3.2
294	05	MED	DEEP VEIN THROMBOPHLEBITIS W CC/MCC	0.9916	4.4	5.3
295	05	MED	DEEP VEIN THROMBOPHLEBITIS W/O CC/MCC	0.6992	3.5	4.1
296	05	MED	CARDIAC ARREST, UNEXPLAINED W MCC	1.2895	1.9	3.0
297	05	MED	CARDIAC ARREST, UNEXPLAINED W CC	0.6574	1.3	1.6
298	05	MED	CARDIAC ARREST, UNEXPLAINED W/O CC/MCC	0.4048	1.1	1.1
299	05	MED	PERIPHERAL VASCULAR DISORDERS W MCC	1.3719	4.6	5.8

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
300	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	0.9697	3.8	4.7
301	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC/MCC	0.6646	2.8	3.4
302	05	MED	ATHEROSCLEROSIS W MCC	1.0029	3.0	4.0
303	05	MED	ATHEROSCLEROSIS W/O MCC	0.5737	1.9	2.4
304	05	MED	HYPERTENSION W MCC	0.9797	3.2	4.2
305	05	MED	HYPERTENSION W/O MCC	0.613	2.1	2.6
306	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS W MCC	1.3321	4.0	5.3
307	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS W/O MCC	0.7732	2.6	3.2
308	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W MCC	1.2283	4.0	5.1
309	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.8155	2.9	3.6
310	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC/MCC	0.5608	2.0	2.4
311	05	MED	ANGINA PECTORIS	0.5067	1.8	2.2
312	05	MED	SYNCOPE & COLLAPSE	0.7139	2.3	2.9
313	05	MED	CHEST PAIN	0.5434	1.7	2.0
314	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W MCC	1.8386	5.0	6.8
315	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.9612	3.2	4.1
316	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC/MCC	0.6068	2.1	2.5
326	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W MCC	5.6803	12.2	15.5
327	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W CC	2.747	6.7	8.6
328	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W/O CC/MCC	1.3848	2.6	3.5
329	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W MCC	5.3215	12.3	15.1
330	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	2.5911	7.6	8.9

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
331	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1.6254	4.6	5.1
332	06	SURG	RECTAL RESECTION W MCC	4.8691	11.2	13.7
333	06	SURG	RECTAL RESECTION W CC	2.4758	6.8	7.9
334	06	SURG	RECTAL RESECTION W/O CC/MCC	1.6038	4.1	4.8
335	06	SURG	PERITONEAL ADHESIOLYSIS W MCC	4.2876	11.3	13.6
336	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.3392	7.1	8.6
337	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC/MCC	1.4956	4.0	5.0
338	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W MCC	3.2639	8.3	10.1
339	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	1.8484	5.4	6.3
340	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC/MCC	1.2308	3.2	3.7
341	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W MCC	2.357	5.0	6.8
342	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.3477	2.9	3.7
343	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC/MCC	0.9587	1.7	1.9
344	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W MCC	3.274	8.8	11.2
345	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.6986	5.7	6.7
346	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1.1679	4.0	4.5
347	06	SURG	ANAL & STOMAL PROCEDURES W MCC	2.533	6.4	8.8
348	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.4031	4.1	5.4
349	06	SURG	ANAL & STOMAL PROCEDURES W/O CC/MCC	0.8075	2.2	2.8
350	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W MCC	2.5207	5.9	7.9
351	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W CC	1.3837	3.5	4.5
352	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W/O CC/MCC	0.8625	1.9	2.3

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
353	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W MCC	2.8433	6.3	8.3
354	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W CC	1.5691	3.9	4.9
355	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W/O CC/MCC	1.0743	2.3	2.8
356	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W MCC	3.9628	9.0	12.0
357	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.1838	5.6	7.2
358	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	1.3062	3.0	3.9
368	06	MED	MAJOR ESOPHAGEAL DISORDERS W MCC	1.8526	5.1	6.6
369	06	MED	MAJOR ESOPHAGEAL DISORDERS W CC	1.0882	3.6	4.4
370	06	MED	MAJOR ESOPHAGEAL DISORDERS W/O CC/MCC	0.7469	2.5	3.1
371	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W MCC	2.0364	6.6	8.5
372	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC	1.2811	5.1	6.2
373	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W/O CC/MCC	0.8437	3.7	4.4
374	06	MED	DIGESTIVE MALIGNANCY W MCC	2.0951	6.2	8.4
375	06	MED	DIGESTIVE MALIGNANCY W CC	1.2851	4.3	5.6
376	06	MED	DIGESTIVE MALIGNANCY W/O CC/MCC	0.8715	2.8	3.6
377	06	MED	G.I. HEMORRHAGE W MCC	1.764	4.9	6.3
378	06	MED	G.I. HEMORRHAGE W CC	1.0238	3.4	4.1
379	06	MED	G.I. HEMORRHAGE W/O CC/MCC	0.7067	2.5	2.9
380	06	MED	COMPLICATED PEPTIC ULCER W MCC	1.8855	5.5	7.1
381	06	MED	COMPLICATED PEPTIC ULCER W CC	1.1311	3.8	4.6
382	06	MED	COMPLICATED PEPTIC ULCER W/O CC/MCC	0.8023	2.7	3.3
383	06	MED	UNCOMPLICATED PEPTIC ULCER W MCC	1.2509	4.2	5.2

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
384	06	MED	UNCOMPLICATED PEPTIC ULCER W/O MCC	0.8474	3.0	3.6
385	06	MED	INFLAMMATORY BOWEL DISEASE W MCC	1.8525	6.1	8.0
386	06	MED	INFLAMMATORY BOWEL DISEASE W CC	1.0598	4.1	5.2
387	06	MED	INFLAMMATORY BOWEL DISEASE W/O CC/MCC	0.7747	3.2	3.9
388	06	MED	G.I. OBSTRUCTION W MCC	1.6603	5.4	7.1
389	06	MED	G.I. OBSTRUCTION W CC	0.9345	3.8	4.7
390	06	MED	G.I. OBSTRUCTION W/O CC/MCC	0.6399	2.8	3.3
391	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W MCC	1.1844	3.9	5.1
392	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	0.7241	2.7	3.4
393	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W MCC	1.675	4.8	6.7
394	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W CC	0.9898	3.6	4.5
395	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W/O CC/MCC	0.6643	2.5	3.0
405	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W MCC	5.7167	11.6	15.5
406	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	2.6577	6.2	7.9
407	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC/MCC	1.8557	4.0	5.1
408	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W MCC	4.0197	10.5	13.1
409	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	2.312	6.8	8.2
410	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC/MCC	1.5243	4.6	5.5
411	07	SURG	CHOLECYSTECTOMY W C.D.E. W MCC	3.5821	9.7	11.7
412	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	2.3985	6.7	7.8
413	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC/MCC	1.7409	4.3	5.1
414	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W MCC	3.6689	9.1	11.0

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
415	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	2.0637	6.1	7.0
416	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC/MCC	1.3588	3.7	4.4
417	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W MCC	2.5319	6.2	7.8
418	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.6909	4.3	5.2
419	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC/MCC	1.1814	2.5	3.0
420	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W MCC	3.8108	8.6	11.7
421	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W CC	1.9081	4.9	6.6
422	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W/O CC/MCC	1.2324	2.9	3.7
423	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W MCC	4.1992	10.3	13.7
424	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W CC	2.4411	6.9	8.9
425	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W/O CC/MCC	1.7024	3.7	5.0
432	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W MCC	1.6737	4.8	6.4
433	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W CC	0.9424	3.5	4.4
434	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W/O CC/MCC	0.6084	2.4	2.9
435	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W MCC	1.795	5.5	7.1
436	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W CC	1.1965	4.1	5.2
437	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W/O CC/MCC	0.9309	2.7	3.6
438	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W MCC	1.7781	5.3	7.3
439	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W CC	0.9864	3.9	4.8
440	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W/O CC/MCC	0.6772	2.8	3.4
441	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W MCC	1.8873	5.2	7.1
442	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	0.9596	3.6	4.6

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
443	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC/MCC	0.6543	2.6	3.3
444	07	MED	DISORDERS OF THE BILIARY TRACT W MCC	1.6083	4.7	6.2
445	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.0678	3.5	4.4
446	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC/MCC	0.7222	2.4	2.9
453	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W MCC	10.9193	10.5	13.2
454	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W CC	7.3268	5.3	6.3
455	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W/O CC/MCC	5.6449	3.1	3.6
456	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W MCC	9.8152	10.6	13.3
457	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W CC	6.3425	5.8	6.7
458	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W/O CC/MCC	5.0565	3.4	3.9
459	08	SURG	SPINAL FUSION EXCEPT CERVICAL W MCC	6.492	7.2	8.9
460	08	SURG	SPINAL FUSION EXCEPT CERVICAL W/O MCC	3.858	3.2	3.8
461	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W MCC	5.3985	6.7	8.6
462	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W/O MCC	3.3359	3.6	3.9
463	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W MCC	5.0438	11.0	14.7
464	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W CC	2.9658	6.7	8.5
465	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W/O CC/MCC	1.7406	3.9	4.8
466	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W MCC	4.9812	7.2	8.8
467	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W CC	3.2437	4.2	4.8
468	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W/O CC/MCC	2.57	3.2	3.4
469	08	SURG	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W MCC	3.4418	6.5	7.7

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
470	08	SURG	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	2.0866	3.3	3.6
471	08	SURG	CERVICAL SPINAL FUSION W MCC	4.5444	6.4	8.9
472	08	SURG	CERVICAL SPINAL FUSION W CC	2.7906	2.6	3.8
473	08	SURG	CERVICAL SPINAL FUSION W/O CC/MCC	2.0812	1.5	1.8
474	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W MCC	3.6088	8.9	11.8
475	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W CC	1.9728	5.8	7.4
476	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W/O CC/MCC	1.0558	3.2	4.0
477	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	3.4596	9.0	11.2
478	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	2.2781	5.4	6.9
479	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	1.6827	2.9	3.8
480	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC	3.0557	7.4	8.8
481	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC	1.9093	5.0	5.4
482	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC	1.5498	4.0	4.4
483	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROC OF UPPER EXTREMITY W CC/MCC	2.4012	2.9	3.6
484	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROC OF UPPER EXTREMITY W/O CC/MCC	1.9939	1.9	2.1
485	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W MCC	3.1425	8.7	10.7
486	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.0641	6.0	7.0
487	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC/MCC	1.4925	4.4	5.0
488	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION W CC/MCC	1.7184	3.7	4.5
489	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION W/O CC/MCC	1.2284	2.4	2.8
490	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W CC/MCC OR DISC DEVICE/NEUROSTIM	1.7987	3.0	4.2

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
491	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC	1.0067	1.7	2.1
492	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W MCC	3.0498	6.7	8.3
493	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W CC	1.8771	4.0	4.8
494	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W/O CC/MCC	1.3518	2.6	3.1
495	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W MCC	2.8991	7.5	9.9
496	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W CC	1.6403	4.0	5.2
497	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W/O CC/MCC	1.0908	1.9	2.5
498	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W CC/MCC	2.0297	5.2	7.1
499	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W/O CC/MCC	0.9412	2.1	2.7
500	08	SURG	SOFT TISSUE PROCEDURES W MCC	3.1696	8.0	10.8
501	08	SURG	SOFT TISSUE PROCEDURES W CC	1.5704	4.5	5.8
502	08	SURG	SOFT TISSUE PROCEDURES W/O CC/MCC	1.0373	2.3	2.8
503	08	SURG	FOOT PROCEDURES W MCC	2.3022	6.5	8.4
504	08	SURG	FOOT PROCEDURES W CC	1.5457	5.0	6.1
505	08	SURG	FOOT PROCEDURES W/O CC/MCC	1.1297	2.5	3.2
506	08	SURG	MAJOR THUMB OR JOINT PROCEDURES	1.1621	2.5	3.5
507	08	SURG	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W CC/MCC	1.873	3.9	5.4
508	08	SURG	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W/O CC/MCC	1.2074	1.7	2.1
509	08	SURG	ARTHROSCOPY	1.3986	2.6	3.8
510	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W MCC	2.2506	4.9	6.4
511	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W CC	1.5009	3.1	3.8
512	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W/O CC/MCC	1.0781	1.8	2.2

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
513	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W CC/MCC	1.3276	3.6	4.8
514	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W/O CC/MCC	0.8295	2.1	2.6
515	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W MCC	3.2336	7.7	9.8
516	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.9801	4.7	5.8
517	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC/MCC	1.5556	2.7	3.4
533	08	MED	FRACTURES OF FEMUR W MCC	1.6148	4.6	6.3
534	08	MED	FRACTURES OF FEMUR W/O MCC	0.7553	3.1	3.8
535	08	MED	FRACTURES OF HIP & PELVIS W MCC	1.3267	4.3	5.5
536	08	MED	FRACTURES OF HIP & PELVIS W/O MCC	0.7256	3.1	3.6
537	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W CC/MCC	0.8422	3.4	4.0
538	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W/O CC/MCC	0.627	2.6	3.1
539	08	MED	OSTEOMYELITIS W MCC	1.9903	6.7	8.7
540	08	MED	OSTEOMYELITIS W CC	1.3373	5.2	6.4
541	08	MED	OSTEOMYELITIS W/O CC/MCC	0.8806	3.7	4.8
542	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W MCC	2.0419	6.3	8.2
543	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W CC	1.1719	4.4	5.5
544	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W/O CC/MCC	0.766	3.3	3.9
545	08	MED	CONNECTIVE TISSUE DISORDERS W MCC	2.4737	6.0	8.5
546	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.1849	4.1	5.2
547	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC/MCC	0.7435	2.9	3.5
548	08	MED	SEPTIC ARTHRITIS W MCC	1.8861	6.5	8.2

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
549	08	MED	SEPTIC ARTHRITIS W CC	1.24	4.7	5.9
550	08	MED	SEPTIC ARTHRITIS W/O CC/MCC	0.7363	3.3	4.0
551	08	MED	MEDICAL BACK PROBLEMS W MCC	1.6751	5.2	6.7
552	08	MED	MEDICAL BACK PROBLEMS W/O MCC	0.841	3.3	3.9
553	08	MED	BONE DISEASES & ARTHROPATHIES W MCC	1.1903	4.4	5.5
554	08	MED	BONE DISEASES & ARTHROPATHIES W/O MCC	0.6994	2.9	3.6
555	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W MCC	1.1824	3.6	4.9
556	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC	0.6688	2.5	3.1
557	08	MED	TENDONITIS, MYOSITIS & BURSITIS W MCC	1.5339	5.3	6.5
558	08	MED	TENDONITIS, MYOSITIS & BURSITIS W/O MCC	0.8979	3.6	4.3
559	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	1.8839	5.2	7.0
560	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	1.0234	3.5	4.5
561	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	0.6104	2.0	2.5
562	08	MED	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W MCC	1.4004	4.5	5.8
563	08	MED	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W/O MCC	0.7392	3.0	3.5
564	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W MCC	1.4803	4.8	6.3
565	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W CC	0.9498	3.8	4.7
566	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W/O CC/MCC	0.6371	2.6	3.2
570	09	SURG	SKIN DEBRIDEMENT W MCC	2.5158	7.6	10.1
571	09	SURG	SKIN DEBRIDEMENT W CC	1.5427	5.7	6.9
572	09	SURG	SKIN DEBRIDEMENT W/O CC/MCC	0.9872	3.9	4.7

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
573	09	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W MCC	3.4249	8.4	12.5
574	09	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W CC	2.6984	7.7	10.8
575	09	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	1.2271	4.0	5.2
576	09	SURG	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W MCC	3.4936	7.1	10.7
577	09	SURG	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W CC	1.8118	3.9	5.8
578	09	SURG	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	1.0684	2.3	3.1
579	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W MCC	2.6935	7.3	9.7
580	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.4801	3.6	5.1
581	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC/MCC	0.9497	1.8	2.4
582	09	SURG	MASTECTOMY FOR MALIGNANCY W CC/MCC	1.1504	2.1	2.7
583	09	SURG	MASTECTOMY FOR MALIGNANCY W/O CC/MCC	0.8762	1.5	1.7
584	09	SURG	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W CC/MCC	1.6488	3.7	5.3
585	09	SURG	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W/O CC/MCC	1.1004	1.7	2.2
592	09	MED	SKIN ULCERS W MCC	1.4753	5.4	7.0
593	09	MED	SKIN ULCERS W CC	1.0279	4.4	5.4
594	09	MED	SKIN ULCERS W/O CC/MCC	0.6981	3.3	4.1
595	09	MED	MAJOR SKIN DISORDERS W MCC	1.9636	5.7	7.9
596	09	MED	MAJOR SKIN DISORDERS W/O MCC	0.8924	3.6	4.6
597	09	MED	MALIGNANT BREAST DISORDERS W MCC	1.659	5.5	7.5
598	09	MED	MALIGNANT BREAST DISORDERS W CC	1.163	3.9	5.4
599	09	MED	MALIGNANT BREAST DISORDERS W/O CC/MCC	0.6798	2.4	3.4

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
600	09	MED	NON-MALIGNANT BREAST DISORDERS W CC/MCC	0.9788	3.9	4.9
601	09	MED	NON-MALIGNANT BREAST DISORDERS W/O CC/MCC	0.6086	2.8	3.4
602	09	MED	CELLULITIS W MCC	1.4597	5.2	6.5
603	09	MED	CELLULITIS W/O MCC	0.8444	3.7	4.4
604	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W MCC	1.3025	4.0	5.4
605	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W/O MCC	0.7388	2.6	3.2
606	09	MED	MINOR SKIN DISORDERS W MCC	1.36	4.3	5.9
607	09	MED	MINOR SKIN DISORDERS W/O MCC	0.6952	2.8	3.6
614	10	SURG	ADRENAL & PITUITARY PROCEDURES W CC/MCC	2.458	4.5	6.1
615	10	SURG	ADRENAL & PITUITARY PROCEDURES W/O CC/MCC	1.4319	2.4	2.8
616	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W MCC	4.3933	11.7	14.5
617	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W CC	2.0188	6.3	7.7
618	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W/O CC/MCC	1.1616	3.6	4.9
619	10	SURG	O.R. PROCEDURES FOR OBESITY W MCC	3.4953	4.5	7.6
620	10	SURG	O.R. PROCEDURES FOR OBESITY W CC	1.8384	2.5	3.1
621	10	SURG	O.R. PROCEDURES FOR OBESITY W/O CC/MCC	1.4835	1.6	1.9
622	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W MCC	3.8339	10.0	13.9
623	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W CC	1.8542	6.0	7.6
624	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W/O CC/MCC	0.9965	3.5	4.3
625	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W MCC	2.2587	4.4	6.5
626	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W CC	1.1682	2.0	2.9

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
627	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W/O CC/MCC	0.8008	1.2	1.4
628	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W MCC	3.2526	6.8	9.8
629	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.2077	6.3	7.8
630	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC/MCC	1.3128	3.2	4.3
637	10	MED	DIABETES W MCC	1.4398	4.4	5.8
638	10	MED	DIABETES W CC	0.8167	3.1	3.9
639	10	MED	DIABETES W/O CC/MCC	0.5503	2.2	2.7
640	10	MED	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W MCC	1.1125	3.4	4.8
641	10	MED	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W/O MCC	0.6988	2.8	3.5
642	10	MED	INBORN AND OTHER DISORDERS OF METABOLISM	1.1212	3.5	4.8
643	10	MED	ENDOCRINE DISORDERS W MCC	1.7057	5.6	7.1
644	10	MED	ENDOCRINE DISORDERS W CC	1.0583	4.0	5.0
645	10	MED	ENDOCRINE DISORDERS W/O CC/MCC	0.7252	2.8	3.5
652	11	SURG	KIDNEY TRANSPLANT	3.0507	6.0	7.1
653	11	SURG	MAJOR BLADDER PROCEDURES W MCC	5.9249	13.3	16.1
654	11	SURG	MAJOR BLADDER PROCEDURES W CC	3.0568	8.0	9.2
655	11	SURG	MAJOR BLADDER PROCEDURES W/O CC/MCC	1.9934	4.6	5.5
656	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W MCC	3.6359	7.5	9.9
657	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W CC	2.0127	4.7	5.6
658	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W/O CC/MCC	1.4698	2.9	3.3
659	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W MCC	3.4634	7.9	10.8

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
660	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W CC	1.8851	4.4	5.9
661	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W/O CC/MCC	1.302	2.3	2.8
662	11	SURG	MINOR BLADDER PROCEDURES W MCC	2.9733	7.6	10.2
663	11	SURG	MINOR BLADDER PROCEDURES W CC	1.4791	3.6	5.1
664	11	SURG	MINOR BLADDER PROCEDURES W/O CC/MCC	1.1269	1.5	1.9
665	11	SURG	PROSTATECTOMY W MCC	3.3775	9.5	12.2
666	11	SURG	PROSTATECTOMY W CC	1.5904	4.4	6.3
667	11	SURG	PROSTATECTOMY W/O CC/MCC	0.8128	1.8	2.3
668	11	SURG	TRANSURETHRAL PROCEDURES W MCC	2.5512	6.6	8.9
669	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.2702	3.1	4.2
670	11	SURG	TRANSURETHRAL PROCEDURES W/O CC/MCC	0.7806	1.8	2.2
671	11	SURG	URETHRAL PROCEDURES W CC/MCC	1.48	3.8	5.4
672	11	SURG	URETHRAL PROCEDURES W/O CC/MCC	0.8443	1.8	2.3
673	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W MCC	2.9875	6.2	9.5
674	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W CC	2.1338	4.8	6.7
675	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W/O CC/MCC	1.3425	1.7	2.4
682	11	MED	RENAL FAILURE W MCC	1.641	5.0	6.7
683	11	MED	RENAL FAILURE W CC	1.0183	3.9	4.8
684	11	MED	RENAL FAILURE W/O CC/MCC	0.6409	2.7	3.2
685	11	MED	ADMIT FOR RENAL DIALYSIS	0.8905	2.5	3.4
686	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W MCC	1.7795	5.6	7.8
687	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.0458	3.7	4.8

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
688	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC/MCC	0.6482	2.1	2.7
689	11	MED	KIDNEY & URINARY TRACT INFECTIONS W MCC	1.1997	4.5	5.6
690	11	MED	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	0.787	3.3	4.0
691	11	MED	URINARY STONES W ESW LITHOTRIPSY W CC/MCC	1.5289	3.0	4.0
692	11	MED	URINARY STONES W ESW LITHOTRIPSY W/O CC/MCC	1.0903	1.7	2.0
693	11	MED	URINARY STONES W/O ESW LITHOTRIPSY W MCC	1.3505	3.9	5.1
694	11	MED	URINARY STONES W/O ESW LITHOTRIPSY W/O MCC	0.709	2.0	2.5
695	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W MCC	1.2608	4.2	5.6
696	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W/O MCC	0.6449	2.5	3.1
697	11	MED	URETHRAL STRICTURE	0.8099	2.4	3.2
698	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W MCC	1.6066	5.2	6.6
699	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W CC	0.9998	3.6	4.5
700	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W/O CC/MCC	0.6783	2.6	3.2
707	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC/MCC	1.8249	3.2	4.3
708	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC/MCC	1.2757	1.6	1.8
709	12	SURG	PENIS PROCEDURES W CC/MCC	1.9299	3.6	5.9
710	12	SURG	PENIS PROCEDURES W/O CC/MCC	1.264	1.4	1.7
711	12	SURG	TESTES PROCEDURES W CC/MCC	1.8978	5.0	7.3
712	12	SURG	TESTES PROCEDURES W/O CC/MCC	0.7901	2.0	2.7
713	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC/MCC	1.2056	2.9	4.1
714	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC/MCC	0.671	1.6	1.8
715	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W CC/MCC	1.7556	4.0	5.9

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
716	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W/O CC/MCC	0.8704	1.2	1.4
717	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W CC/MCC	1.6348	4.4	6.1
718	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W/O CC/MCC	0.8146	2.0	2.5
722	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W MCC	1.5734	5.2	7.1
723	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W CC	1.0178	3.9	5.0
724	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.6724	2.1	2.8
725	12	MED	BENIGN PROSTATIC HYPERTROPHY W MCC	1.2457	4.6	6.0
726	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O MCC	0.7279	2.8	3.5
727	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W MCC	1.4244	5.1	6.5
728	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W/O MCC	0.7848	3.3	4.1
729	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W CC/MCC	1.0903	3.6	5.0
730	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W/O CC/MCC	0.6256	2.2	2.8
734	13	SURG	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W CC/MCC	2.4618	5.0	6.9
735	13	SURG	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W/O CC/MCC	1.2208	2.1	2.5
736	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W MCC	4.5276	10.6	13.1
737	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W CC	2.0221	5.6	6.5
738	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W/O CC/MCC	1.217	3.1	3.5
739	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W MCC	3.3672	7.3	9.9
740	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.5431	3.5	4.3
741	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC/MCC	1.1201	2.0	2.3
742	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC/MCC	1.4262	3.0	4.0

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
743	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	0.9306	1.8	2.0
744	13	SURG	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W CC/MCC	1.4785	3.9	5.5
745	13	SURG	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W/O CC/MCC	0.7956	1.9	2.3
746	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES W CC/MCC	1.2993	2.8	4.0
747	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES W/O CC/MCC	0.9038	1.5	1.7
748	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	0.9447	1.4	1.7
749	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W CC/MCC	2.5283	6.2	8.5
750	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	1.0799	2.2	2.9
754	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W MCC	2.0512	6.4	8.8
755	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.156	3.9	5.2
756	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.6202	2.2	3.0
757	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W MCC	1.5585	5.9	7.4
758	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W CC	1.0657	4.6	5.5
759	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.7324	3.2	4.0
760	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W CC/MCC	0.7892	2.8	3.6
761	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W/O CC/MCC	0.515	1.8	2.3
765	14	SURG	CESAREAN SECTION W CC/MCC	1.2255	4.0	5.2
766	14	SURG	CESAREAN SECTION W/O CC/MCC	0.8497	2.9	3.0
767	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.8547	2.3	2.6
768	14	SURG	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	1.818	4.7	5.8
769	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	1.5259	3.4	4.9

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
770	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.6353	1.5	1.9
774	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.7406	2.7	3.4
775	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.5283	2.1	2.3
776	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.6436	2.5	3.3
777	14	MED	ECTOPIC PREGNANCY	0.8133	1.7	2.0
778	14	MED	THREATENED ABORTION	0.4646	1.9	2.7
779	14	MED	ABORTION W/O D&C	0.5134	1.7	2.2
780	14	MED	FALSE LABOR	0.1947	1.2	1.3
781	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.6674	2.6	3.8
782	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.3175	1.5	1.8
789	15	MED	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.4933	1.8	1.8
790	15	MED	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	4.9243	17.9	17.9
791	15	MED	PREMATURITY W MAJOR PROBLEMS	3.3631	13.3	13.3
792	15	MED	PREMATURITY W/O MAJOR PROBLEMS	2.0293	8.6	8.6
793	15	MED	FULL TERM NEONATE W MAJOR PROBLEMS	3.4547	4.7	4.7
794	15	MED	NEONATE W OTHER SIGNIFICANT PROBLEMS	1.2227	3.4	3.4
795	15	MED	NORMAL NEWBORN	0.1656	3.1	3.1
799	16	SURG	SPLENECTOMY W MCC	5.0201	9.8	13.0
800	16	SURG	SPLENECTOMY W CC	2.5375	5.7	7.2
801	16	SURG	SPLENECTOMY W/O CC/MCC	1.5138	3.1	3.9
802	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W MCC	3.4676	8.4	11.5
803	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W CC	1.7277	4.5	5.9

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
804	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W/O CC/MCC	1.0293	2.2	2.9
808	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W MCC	2.0907	6.0	7.9
809	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W CC	1.2114	3.9	5.0
810	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W/O CC/MCC	0.8718	2.8	3.5
811	16	MED	RED BLOOD CELL DISORDERS W MCC	1.2182	3.7	5.0
812	16	MED	RED BLOOD CELL DISORDERS W/O MCC	0.792	2.7	3.5
813	16	MED	COAGULATION DISORDERS	1.5098	3.6	5.0
814	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W MCC	1.6769	5.0	6.7
815	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.9811	3.5	4.5
816	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC/MCC	0.7187	2.6	3.2
820	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W MCC	6.0717	13.1	17.2
821	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC	2.3666	5.0	7.1
822	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/O CC/MCC	1.2183	2.3	3.0
823	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W MCC	4.4598	11.9	15.5
824	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.3193	6.4	8.4
825	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC/MCC	1.2762	2.9	4.1
826	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W MCC	5.0537	11.1	14.2
827	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC	2.2658	5.5	7.2
828	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC/MCC	1.3082	2.7	3.4
829	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC W CC/MCC	2.856	6.6	9.8
830	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC W/O CC/MCC	1.1616	2.3	3.1
834	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W MCC	5.3606	10.5	17.0

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
835	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W CC	2.364	5.3	8.9
836	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W/O CC/MCC	1.0967	2.9	4.3
837	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX OR W HIGH DOSE CHEMO AGENT W MCC	6.5055	17.5	22.9
838	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX W CC OR HIGH DOSE CHEMO AGENT	3.2689	8.1	12.1
839	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX W/O CC/MCC	1.2623	4.7	5.6
840	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W MCC	3.035	7.8	10.8
841	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.6342	5.0	6.6
842	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC/MCC	1.0133	3.1	4.1
843	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W MCC	1.8899	5.8	7.8
844	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.175	4.2	5.4
845	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC/MCC	0.7966	2.8	3.6
846	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W MCC	2.2853	5.6	8.0
847	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W CC	1.0146	2.8	3.4
848	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W/O CC/MCC	0.7643	2.3	2.9
849	17	MED	RADIOTHERAPY	1.3127	4.3	5.8
853	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	5.4668	11.6	15.0
854	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W CC	2.6551	7.8	9.4
855	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W/O CC/MCC	1.6008	3.8	5.5
856	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W MCC	4.9588	10.9	14.5
857	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W CC	2.0726	6.0	7.6
858	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W/O CC/MCC	1.3212	4.1	5.0
862	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W MCC	1.9223	5.7	7.5

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
863	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W/O MCC	0.9943	3.9	4.8
864	18	MED	FEVER	0.8337	3.0	3.7
865	18	MED	VIRAL ILLNESS W MCC	1.5809	4.4	6.2
866	18	MED	VIRAL ILLNESS W/O MCC	0.7446	2.8	3.5
867	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W MCC	2.5523	6.9	9.3
868	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W CC	1.0816	4.0	5.0
869	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W/O CC/MCC	0.6724	2.8	3.4
870	18	MED	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	5.8339	12.7	14.9
871	18	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	1.909	5.3	7.0
872	18	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC	1.1339	4.3	5.2
876	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	2.8319	7.6	12.3
880	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	0.6337	2.3	3.0
881	19	MED	DEPRESSIVE NEUROSES	0.6156	3.2	4.2
882	19	MED	NEUROSES EXCEPT DEPRESSIVE	0.6566	3.3	4.6
883	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	1.1864	4.8	7.9
884	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.9529	4.0	5.3
885	19	MED	PSYCHOSES	0.9209	5.4	7.3
886	19	MED	BEHAVIORAL & DEVELOPMENTAL DISORDERS	0.7466	3.9	5.7
887	19	MED	OTHER MENTAL DISORDER DIAGNOSES	0.8189	2.9	4.5
894	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.4304	2.1	3.0
895	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY	1.0952	9.2	11.9
896	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION	1.4555	4.7	6.4

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
			THERAPY W MCC			
897	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O MCC	0.6687	3.2	4.0
901	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W MCC	4.103	9.2	14.4
902	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W CC	1.7938	5.4	7.5
903	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W/O CC/MCC	1.0562	3.1	4.1
904	21	SURG	SKIN GRAFTS FOR INJURIES W CC/MCC	3.1057	7.0	10.7
905	21	SURG	SKIN GRAFTS FOR INJURIES W/O CC/MCC	1.1702	3.4	4.5
906	21	SURG	HAND PROCEDURES FOR INJURIES	1.0566	2.3	3.3
907	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W MCC	3.9661	7.8	11.3
908	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	1.9298	4.6	6.0
909	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC/MCC	1.1612	2.5	3.3
913	21	MED	TRAUMATIC INJURY W MCC	1.2458	3.9	5.2
914	21	MED	TRAUMATIC INJURY W/O MCC	0.7097	2.5	3.2
915	21	MED	ALLERGIC REACTIONS W MCC	1.46	3.5	5.0
916	21	MED	ALLERGIC REACTIONS W/O MCC	0.4836	1.7	2.1
917	21	MED	POISONING & TOXIC EFFECTS OF DRUGS W MCC	1.4977	3.6	5.1
918	21	MED	POISONING & TOXIC EFFECTS OF DRUGS W/O MCC	0.6228	2.1	2.7
919	21	MED	COMPLICATIONS OF TREATMENT W MCC	1.6282	4.4	6.1
920	21	MED	COMPLICATIONS OF TREATMENT W CC	0.9629	3.1	4.1
921	21	MED	COMPLICATIONS OF TREATMENT W/O CC/MCC	0.6332	2.2	2.8
922	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W MCC	1.4748	3.9	5.7
923	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O MCC	0.6741	2.3	3.0

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
927	22	SURG	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W SKIN GRAFT	12.1033	20.0	27.3
928	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC/MCC	4.8909	10.9	15.3
929	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W/O CC/MCC	2.1779	4.9	7.2
933	22	MED	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W/O SKIN GRAFT	2.285	2.6	5.4
934	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ	1.3998	4.0	5.7
935	22	MED	NON-EXTENSIVE BURNS	1.2572	3.2	4.8
939	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W MCC	3.0656	6.9	10.3
940	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W CC	1.7678	3.5	5.2
941	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W/O CC/MCC	1.1492	2.0	2.6
945	23	MED	REHABILITATION W CC/MCC	1.3312	8.3	10.0
946	23	MED	REHABILITATION W/O CC/MCC	1.2889	6.8	7.6
947	23	MED	SIGNS & SYMPTOMS W MCC	1.1309	3.7	4.9
948	23	MED	SIGNS & SYMPTOMS W/O MCC	0.6923	2.7	3.4
949	23	MED	AFTERCARE W CC/MCC	0.9505	2.8	4.5
950	23	MED	AFTERCARE W/O CC/MCC	0.5175	2.3	3.3
951	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	0.7245	2.1	4.7
955	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.4529	8.2	11.7
956	24	SURG	LIMB REATTACHMENT, HIP & FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	3.6322	6.9	8.5
957	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W MCC	6.6017	10.0	14.5
958	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W CC	3.7491	7.5	9.2
959	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	2.4711	4.5	5.7

Exhibit #1						
Effective for Dates of Service on and After 1/1/2012						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
963	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W MCC	2.8294	5.9	8.5
964	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W CC	1.5165	4.4	5.5
965	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	1.0114	3.0	3.7
969	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE W MCC	5.6158	12.8	17.2
970	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE W/O MCC	2.3655	5.8	8.3
974	25	MED	HIV W MAJOR RELATED CONDITION W MCC	2.7063	6.9	9.8
975	25	MED	HIV W MAJOR RELATED CONDITION W CC	1.3455	4.9	6.4
976	25	MED	HIV W MAJOR RELATED CONDITION W/O CC/MCC	0.8649	3.4	4.3
977	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.0783	3.6	4.9
981		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	5.0673	10.8	13.9
982		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	2.9352	6.3	8.1
983		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.7404	3.0	4.1
984		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	3.5294	10.8	13.9
985		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	2.124	6.4	8.7
986		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.098	2.6	3.8
987		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	3.4039	8.9	11.7
988		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W CC	1.8567	5.3	7.0
989		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.0583	2.4	3.3
998		**	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0	0.0	0.0
999		**	UNGROUPABLE	0	0.0	0.0

Exhibit #2

Hospital Base Rates and CCRs, Effective 1/1/2012

Provider Number	Provider Name	Base Rate	Total CCR
60001	NORTH COLORADO MEDICAL CENTER	$6,520.95	0.286
60003	LONGMONT UNITED HOSPITAL	$5,873.14	0.343
60004	PLATTE VALLEY MEDICAL CENTER	$6,330.54	0.363
60006	MONTROSE MEMORIAL HOSPITAL	$5,817.10	0.430
60008	SAN LUIS VALLEY REGIONAL MEDICAL CENTER	$6,060.86	0.372
60009	EXEMPLA LUTHERAN MEDICAL CENTER	$6,030.19	0.235
60010	POUDRE VALLEY HOSPITAL	$5,974.81	0.354
60011	DENVER HEALTH MEDICAL CENTER	$9,613.30	0.349
60012	CENTURA HEALTH-ST MARY CORWIN MEDICAL CENTER	$6,116.18	0.245
60013	MERCY REGIONAL MEDICAL CENTER	$7,088.98	0.399
60014	PRESBYTERIAN/ST LUKE'S MEDICAL CENTER	$7,154.45	0.256
60015	CENTURA HEALTH-ST ANTHONY CENTRAL HOSPITAL	$6,079.18	0.196
60016	CENTURA HEALTH-ST THOMAS MORE HOSP & PROG CARE CTR	$5,975.88	0.303
60020	PARKVIEW MEDICAL CENTER INC	$6,169.66	0.210
60022	MEMORIAL HOSPITAL CENTRAL	$6,214.61	0.322
60023	ST MARY'S HOSPITAL AND MEDICAL CENTER	$6,345.66	0.361
60024	UNIVERSITY OF COLORADO HOSPITAL ANSCHUTZ INPATIENT	$8,678.69	0.238
60027	BOULDER COMMUNITY HOSPITAL	$5,664.14	0.317
60028	EXEMPLA SAINT JOSEPH HOSPITAL	$6,450.81	0.260
60030	MCKEE MEDICAL CENTER	$5,698.30	0.384
60031	CENTURA HEALTH-PENROSE ST FRANCIS HEALTH SERVICES	$5,502.64	0.248
60032	ROSE MEDICAL CENTER	$6,530.21	0.209
60034	SWEDISH MEDICAL CENTER	$6,046.09	0.204
60036	ARKANSAS VALLEY REGIONAL MEDICAL CENTER	$6,060.86	0.442
60043	KEEFE MEMORIAL HOSPITAL	$14,621.20	1.083
60044	COLORADO PLAINS MEDICAL CENTER	$6,060.86	0.320
60049	YAMPA VALLEY MEDICAL CENTER	$8,786.80	0.564
60054	COMMUNITY HOSPITAL	$5,459.79	0.518

Exhibit #2			
Hospital Base Rates and CCRs, Effective 1/1/2012			
Provider Number	Provider Name	Base Rate	Total CCR
60064	CENTURA HEALTH-PORTER ADVENTIST HOSPITAL	$5,709.30	0.242
60065	NORTH SUBURBAN MEDICAL CENTER	$6,640.82	0.214
60071	DELTA COUNTY MEMORIAL HOSPITAL	$5,717.85	0.489
60075	VALLEY VIEW HOSPITAL ASSOCIATION	$7,519.17	0.477
60076	STERLING REGIONAL MEDCENTER	$7,133.57	0.477
60096	VAIL VALLEY MEDICAL CENTER	$11,010.05	0.432
60100	MEDICAL CENTER OF AURORA, THE	$6,117.71	0.224
60103	CENTURA HEALTH-AVISTA ADVENTIST HOSPITAL	$6,523.84	0.307
60104	CENTURA HEALTH-ST ANTHONY NORTH HOSPITAL	$6,548.77	0.222
60107	NATIONAL JEWISH HEALTH	$6,330.54	0.391
60112	SKY RIDGE MEDICAL CENTER	$5,710.54	0.213
60113	CENTURA HEALTH-LITTLETON ADVENTIST HOSPITAL	$5,705.07	0.205
60114	PARKER ADVENTIST HOSPITAL	$5,698.79	0.228
60116	EXEMPLA GOOD SAMARITAN MEDICAL CENTER LLC	$5,661.62	0.280
60117	ANIMAS SURGICAL HOSPITAL, LLC	$5,455.98	0.585
60118	ST ANTHONY SUMMIT MEDICAL CENTER	$5,936.46	0.271
60119	MEDICAL CENTER OF THE ROCKIES	$5,462.84	0.418
60124	ORTHOCOLORADO HOSPITAL AT ST ANTHONY MED CAMPUS	$5,698.79	0.303
69999	ANY NEW HOSPITAL	$5,698.79	0.303

Exhibit 3

Effective January 1, 2012

Critical Access Hospitals

Name	***Location in Colorado***
Aspen Valley Hospital	Aspen
Conejos County Hospital	La Jara
East Morgan County Hospital	Brush
Estes Park Medical Center	Estes Park
Family Health West Hospital	Fruita
Grand River Medical Center	Rifle
Gunnison Valley Hospital	Gunnison
Haxtun Hospital District	Haxtun
Heart of the Rockies Regional Medical Center	Salida
Kit Carson County Memorial Hospital	Burlington
Kremmling Memorial Hospital	Kremmling
Lincoln Community Hospital	Hugo
Melissa Memorial Hospital	Holyoke
The Memorial Hospital	Craig
Middle Park Medical Center	Kremmling
Mt. San Rafael Hospital	Trinidad
Pagosa Mountain Hospital	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
Sedgwick County Memorial Hospital	Julesburg
Southeast Colorado Hospital	Springfield
Southwest Memorial Hospital	Cortez
Spanish Peaks Regional Helath Center	Walsenburg
St. Vincent General Hospital	Leadville

Name	***Location in Colorado***
Weisbrod Memorial County Hospital	Eads
Wray Community District Hospital	Wray
Yuma District Hospital	Yuma

Exhibit #4, Effective 1/1/2012

Outpatient Surgery Facilities (Hospitals & ASC), Outpatient, including Freestanding Diagnostic Testing Facilities (Hospital & Independent Radiology Facilities), Outpatient Hospital Emergency Room Department facilities

Column #1 APC	*Column #2 APC Title*	*Column #3 CY 2012 Total APC Payment Rate Outpatient Hospital ERD Facilities*275%*	*Column #4 Total Hospital APC Outpatient Payment Rate (subtract all "threshold Packaged implants, devices, biologicals, drugs and Radiopharmaceuticals and contrast agents") *160%*	*Column #5 Total ASC APC Payment Rate = 95% of Hospital Outpatient APC Payment Rate*
1	Level I Photochemotherapy	$105.00	$61.09	$58.03
2	Fine Needle Biopsy/Aspiration	$297.44	$173.06	$164.40
3	Bone Marrow Biopsy/Aspiration	$708.21	$399.77	$379.78
4	Level I Needle Biopsy/ Aspiration Except Bone Marrow	$868.31	$501.76	$476.68
5	Level II Needle Biopsy/Aspiration Except Bone Marrow	$1,541.07	$857.35	$814.48
6	Level I Incision & Drainage	$282.34	$163.53	$155.36
7	Level II Incision & Drainage	$2,464.77	$1,367.51	$1,299.13
8	Level III Incision and Drainage	$3,825.99	$2,096.03	$1,991.23
12	Level I Debridement & Destruction	$81.95	$47.68	$45.30
13	Level II Debridement & Destruction	$172.43	$99.37	$94.40
15	Level III Debridement & Destruction	$283.64	$162.63	$154.50
16	Level IV Debridement & Destruction	$517.44	$300.15	$285.15
17	Level VI Debridement & Destruction	$4,128.52	$2,288.19	$2,173.78
19	Level I Excision/ Biopsy	$963.85	$554.84	$527.10
20	Level II Excision/ Biopsy	$1,608.64	$913.85	$868.16
21	Level III Excision/ Biopsy	$3,424.22	$1,903.82	$1,808.62
22	Level IV Excision/ Biopsy	$4,526.61	$2,494.34	$2,369.63
28	Level I Breast Surgery	$4,847.18	$2,689.60	$2,555.12
29	Level II Breast Surgery	$6,425.76	$3,507.95	$3,332.55
30	Level III Breast Surgery	$8,523.93	$4,553.70	$4,326.01

Column #1 APC	*Column #2 APC Title*	*Column #3 CY 2012 Total APC Payment Rate Outpatient Hospital ERD Facilities*275%*	*Column #4 Total Hospital APC Outpatient Payment Rate (subtract all "threshold Packaged implants, devices, biologicals, drugs and Radiopharmaceuticals and contrast agents") *160%*	*Column #5 Total ASC APC Payment Rate = 95% of Hospital Outpatient APC Payment Rate*
31	Smoking Cessation Services	$57.01	$0.00	$0.00
35	Vascular Puncture and Minor Diagnostic Procedures	$50.66	$27.21	$25.85
37	Level IV Needle Biopsy/Aspiration Except Bone Marrow	$2,973.91	$1,648.60	$1,566.17
39	Level I Implantation of Neurostimulator Generator	$40,544.85	$3,208.20	$3,047.79
40	Percutaneous Implantation of Neurostimulator Electrodes	$12,520.81	$2,996.98	$2,847.13
41	Level I Arthroscopy	$5,676.06	$3,142.26	$2,985.15
42	Level II Arthroscopy	$9,175.51	$4,796.09	$4,556.29
45	Bone/Joint Manipulation Under Anesthesia	$2,945.53	$1,606.48	$1,526.15
47	Arthroplasty without Prosthesis	$7,441.03	$3,626.25	$3,444.93
48	Level I Arthroplasty or Implantation with Prosthesis	$11,356.35	$3,763.53	$3,575.36
49	Level I Musculoskeletal Procedures Except Hand and Foot	$4,351.55	$2,406.23	$2,285.92
50	Level II Musculoskeletal Procedures Except Hand and Foot	$6,107.28	$3,170.28	$3,011.77
51	Level III Musculoskeletal Procedures Except Hand and Foot	$8,963.08	$4,242.83	$4,030.69
52	Level IV Musculoskeletal Procedures Except Hand and Foot	$16,854.92	$7,167.57	$6,809.19
53	Level I Hand Musculoskeletal Procedures	$3,251.05	$1,808.67	$1,718.24
54	Level II Hand Musculoskeletal Procedures	$5,638.44	$3,003.99	$2,853.79
55	Level I Foot Musculoskeletal Procedures	$4,279.72	$2,351.57	$2,233.99
56	Level II Foot Musculoskeletal Procedures	$10,466.34	$4,169.48	$3,961.01
57	Bunion Procedures	$6,296.87	$3,160.98	$3,002.93
58	Level I Strapping and Cast Application	$212.16	$123.06	$116.90
60	Manipulation Therapy	$54.26	$0.00	$0.00

Column #1 APC	*Column #2 APC Title*	*Column #3 CY 2012 Total APC Payment Rate Outpatient Hospital ERD Facilities*275%*	*Column #4 Total Hospital APC Outpatient Payment Rate (subtract all "threshold Packaged implants, devices, biologicals, drugs and Radiopharmaceuticals and contrast agents") *160%*	*Column #5 Total ASC APC Payment Rate = 95% of Hospital Outpatient APC Payment Rate*
61	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr	$17,054.92	$3,448.20	$3,275.79
62	Level I Treatment Fracture/Dislocation	$5,029.61	$2,706.55	$2,571.23
63	Level II Treatment Fracture/Dislocation	$9,116.61	$4,139.93	$3,932.94
64	Level III Treatment Fracture/Dislocation	$12,672.55	$4,342.77	$4,125.63
65	Level I Stereotactic Radiosurgery, MRgFUS, and MEG	$2,687.08	$1,563.39	$1,485.22
66	Level II Stereotactic Radiosurgery, MRgFUS, and MEG	$6,887.84	$4,007.47	$3,807.10
67	Level III Stereotactic Radiosurgery, MRgFUS, and MEG	$9,373.90	$5,453.90	$5,181.21
69	Thoracoscopy	$6,599.42	$3,641.92	$3,459.83
70	Thoracentesis/Lavage Procedures	$1,053.69	$584.86	$555.61
71	Level I Endoscopy Upper Airway	$176.08	$102.45	$97.33
72	Level II Endoscopy Upper Airway	$380.99	$221.66	$210.58
73	Level III Endoscopy Upper Airway	$800.25	$465.60	$442.32
74	Level IV Endoscopy Upper Airway	$4,156.54	$2,260.19	$2,147.18
75	Level V Endoscopy Upper Airway	$5,861.52	$3,008.60	$2,858.17
76	Level I Endoscopy Lower Airway	$1,988.91	$1,096.89	$1,042.05
77	Level I Pulmonary Treatment	$79.01	$44.74	$42.50
78	Level III Pulmonary Treatment	$271.21	$155.77	$147.98
79	Ventilation Initiation and Management	$550.19	$317.07	$301.22
80	Diagnostic Cardiac Catheterization	$7,498.84	$3,791.85	$3,602.26
82	Coronary or Non-Coronary Atherectomy	$17,562.99	$6,749.30	$6,411.83
83	Coronary or Non-Coronary Angioplasty and Percutaneous Valvuloplasty	$10,395.50	$4,409.81	$4,189.32

Column #1 APC	*Column #2 APC Title*	*Column #3 CY 2012 Total APC Payment Rate Outpatient Hospital ERD Facilities*275%*	*Column #4 Total Hospital APC Outpatient Payment Rate (subtract all "threshold Packaged implants, devices, biologicals, drugs and Radiopharmaceuticals and contrast agents") *160%*	*Column #5 Total ASC APC Payment Rate = 95% of Hospital Outpatient APC Payment Rate*
84	Level I Electrophysiologic Procedures	$1,951.29	$1,099.53	$1,044.56
85	Level II Electrophysiologic Procedures	$10,160.43	$4,002.10	$3,801.99
86	Level III Electrophysiologic Procedures	$23,230.41	$7,597.27	$7,217.41
88	Thrombectomy	$7,902.29	$4,004.13	$3,803.93
89	Insertion/Replacement of Permanent Pacemaker and Electrodes	$21,482.37	$3,505.92	$3,330.63
90	Insertion/Replacement of Pacemaker Pulse Generator	$18,105.95	$2,654.66	$2,521.93
91	Level II Vascular Ligation	$8,332.78	$3,389.35	$3,219.88
92	Level I Vascular Ligation	$5,199.84	$2,829.32	$2,687.85
93	Vascular Reconstruction/Fistula Repair without Device	$6,910.92	$3,092.87	$2,938.23
94	Level I Resuscitation and Cardioversion	$448.36	$257.29	$244.43
95	Cardiac Rehabilitation	$189.23	$110.10	$104.59
96	Level II Noninvasive Physiologic Studies	$292.82	$170.37	$161.85
97	Level I Noninvasive Physiologic Studies	$182.19	$105.54	$100.27
99	Electrocardiograms	$74.97	$43.60	$41.42
100	Cardiac Stress Tests	$490.66	$285.47	$271.20
101	Tilt Table Evaluation	$808.23	$455.47	$432.70
102	Level II Pulmonary Treatment	$173.20	$100.77	$95.73
103	Miscellaneous Vascular Procedures	$3,624.56	$1,881.71	$1,787.63
104	Transcatheter Placement of Intracoronary Stents	$15,552.71	$4,508.14	$4,282.73
105	Repair/Revision/Removal of Pacemakers, AICDs, or Vascular Devices	$4,306.06	$2,199.19	$2,089.23

Column #1 APC	*Column #2 APC Title*	*Column #3 CY 2012 Total APC Payment Rate Outpatient Hospital ERD Facilities*275%*	*Column #4 Total Hospital APC Outpatient Payment Rate (subtract all "threshold Packaged implants, devices, biologicals, drugs and Radiopharmaceuticals and contrast agents") *160%*	*Column #5 Total ASC APC Payment Rate = 95% of Hospital Outpatient APC Payment Rate*
106	Insertion/Replacement of Pacemaker Leads and/or Electrodes	$9,889.77	$2,907.52	$2,762.14
107	Insertion of Cardioverter-Defibrillator	$64,362.68	$4,224.06	$4,012.86
108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	$73,781.43	$5,232.85	$4,971.20
110	Transfusion	$642.43	$357.59	$339.71
111	Blood Product Exchange	$2,346.25	$1,291.65	$1,227.06
112	Apheresis and Stem Cell Procedures	$5,957.41	$3,396.46	$3,226.64
113	Excision Lymphatic System	$4,746.72	$2,622.54	$2,491.41
114	Thyroid/Lymphadenectomy Procedures	$9,618.46	$5,297.36	$5,032.49
115	Cannula/Access Device Procedures	$6,645.65	$3,270.34	$3,106.82
121	Level I Tube or Catheter Changes or Repositioning	$1,198.92	$620.96	$589.91
126	Level I Urinary and Anal Procedures	$210.43	$122.43	$116.31
127	Level IV Stereotactic Radiosurgery, MRgFUS, and MEG	$21,068.16	$12,257.84	$11,644.95
128	Echocardiogram with Contrast	$1,372.33	$760.84	$722.80
129	Level I Closed Treatment Fracture Finger/Toe/Trunk	$299.01	$173.74	$165.05
130	Level I Laparoscopy	$7,320.91	$3,911.87	$3,716.28
131	Level II Laparoscopy	$9,062.32	$4,909.87	$4,664.37
132	Level III Laparoscopy	$13,466.61	$6,432.63	$6,111.00
133	Level I Skin Repair	$252.48	$146.26	$138.95
134	Level II Skin Repair	$598.87	$345.71	$328.43
135	Level III Skin Repair	$879.29	$507.39	$482.02
136	Level IV Skin Repair	$3,260.04	$1,824.68	$1,733.44
137	Level V Skin Repair	$4,220.43	$2,339.13	$2,222.17
138	Level II Closed Treatment Fracture Finger/Toe/Trunk	$1,042.69	$597.07	$567.22

Column #1 APC	*Column #2 APC Title*	*Column #3 CY 2012 Total APC Payment Rate Outpatient Hospital ERD Facilities*275%*	*Column #4 Total Hospital APC Outpatient Payment Rate (subtract all "threshold Packaged implants, devices, biologicals, drugs and Radiopharmaceuticals and contrast agents") *160%*	*Column #5 Total ASC APC Payment Rate = 95% of Hospital Outpatient APC Payment Rate*
139	Level III Closed Treatment Fracture Finger/Toe/Trunk	$3,946.44	$2,176.03	$2,067.22
140	Esophageal Dilation without Endoscopy	$1,243.22	$683.98	$649.78
141	Level I Upper GI Procedures	$1,682.26	$921.51	$875.43
142	Small Intestine Endoscopy	$1,929.26	$1,083.19	$1,029.03
143	Lower GI Endoscopy	$1,769.38	$985.70	$936.42
146	Level I Sigmoidoscopy and Anoscopy	$1,098.24	$617.12	$586.27
147	Level II Sigmoidoscopy and Anoscopy	$1,800.23	$989.17	$939.71
148	Level I Anal/Rectal Procedures	$1,139.44	$627.48	$596.10
149	Level III Anal/Rectal Procedures	$4,611.17	$2,521.62	$2,395.54
150	Level IV Anal/Rectal Procedures	$6,185.99	$3,305.43	$3,140.16
151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	$4,401.05	$2,216.97	$2,106.13
152	Level I Percutaneous Abdominal and Biliary Procedures	$6,011.01	$2,266.96	$2,153.61
153	Peritoneal and Abdominal Procedures	$5,016.11	$2,811.06	$2,670.51
154	Hernia/Hydrocele Procedures	$6,265.49	$3,102.94	$2,947.80
155	Level II Anal/Rectal Procedures	$3,051.87	$1,665.54	$1,582.27
156	Level III Urinary and Anal Procedures	$608.30	$346.28	$328.96
157	Colorectal Cancer Screening: Barium Enema	$234.93	$136.36	$129.54
158	Colorectal Cancer Screening: Colonoscopy	$1,567.20	$864.77	$821.54
159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	$1,043.35	$575.41	$546.64
160	Level I Cystourethroscopy and other Genitourinary Procedures	$1,409.32	$808.00	$767.60
161	Level II Cystourethroscopy and other Genitourinary Procedures	$3,328.63	$1,806.90	$1,716.56

Column #1 APC	*Column #2 APC Title*	*Column #3 CY 2012 Total APC Payment Rate Outpatient Hospital ERD Facilities*275%*	*Column #4 Total Hospital APC Outpatient Payment Rate (subtract all "threshold Packaged implants, devices, biologicals, drugs and Radiopharmaceuticals and contrast agents") *160%*	*Column #5 Total ASC APC Payment Rate = 95% of Hospital Outpatient APC Payment Rate*
162	Level III Cystourethroscopy and other Genitourinary Procedures	$4,987.79	$2,650.38	$2,517.86
163	Level IV Cystourethroscopy and other Genitourinary Procedures	$7,075.97	$3,810.63	$3,620.10
164	Level II Urinary and Anal Procedures	$385.80	$217.73	$206.84
165	Level IV Urinary and Anal Procedures	$3,804.96	$2,015.88	$1,915.09
166	Level I Urethral Procedures	$4,108.72	$2,265.98	$2,152.68
168	Level II Urethral Procedures	$6,186.18	$2,098.35	$1,993.43
169	Lithotripsy	$7,951.32	$4,495.30	$4,270.54
170	Dialysis	$1,312.93	$751.59	$714.01
174	Level IV Laparoscopy	$21,588.02	$9,564.67	$9,086.44
181	Level II Male Genital Procedures	$6,808.56	$3,607.20	$3,426.84
183	Level I Male Genital Procedures	$4,495.78	$2,486.77	$2,362.43
184	Prostate Biopsy	$2,467.74	$1,379.92	$1,310.93
188	Level II Female Reproductive Proc	$309.68	$179.71	$170.72
189	Level III Female Reproductive Proc	$685.74	$398.98	$379.03
190	Level I Hysteroscopy	$4,372.12	$2,434.39	$2,312.67
191	Level I Female Reproductive Proc	$27.39	$15.94	$15.14
192	Level IV Female Reproductive Proc	$1,243.66	$723.58	$687.40
193	Level V Female Reproductive Proc	$3,916.58	$2,165.94	$2,057.64
195	Level VI Female Reproductive Procedures	$6,756.97	$3,485.91	$3,311.61
202	Level VII Female Reproductive Procedures	$8,597.99	$3,038.50	$2,886.57
203	Level IV Nerve Injections	$2,423.52	$1,296.54	$1,231.71
204	Level I Nerve Injections	$505.40	$276.79	$262.95
206	Level II Nerve Injections	$735.35	$414.06	$393.36
207	Level III Nerve Injections	$1,437.34	$774.81	$736.07
208	Laminotomies and Laminectomies	$9,723.78	$5,159.05	$4,901.10

Column #1 APC	*Column #2 APC Title*	*Column #3 CY 2012 Total APC Payment Rate Outpatient Hospital ERD Facilities*275%*	*Column #4 Total Hospital APC Outpatient Payment Rate (subtract all "threshold Packaged implants, devices, biologicals, drugs and Radiopharmaceuticals and contrast agents") *160%*	*Column #5 Total ASC APC Payment Rate = 95% of Hospital Outpatient APC Payment Rate*
209	Level II Extended EEG, Sleep, and Cardiovascular Studies	$2,147.12	$1,249.11	$1,186.65
210	Spinal Fusions	$9,723.78	$5,159.05	$4,901.10
213	Level I Extended EEG, Sleep, and Cardiovascular Studies	$458.26	$266.49	$253.17
215	Level I Nerve and Muscle Tests	$123.45	$71.82	$68.23
216	Level III Nerve and Muscle Tests	$511.97	$297.87	$282.98
218	Level II Nerve and Muscle Tests	$222.15	$129.25	$122.79
220	Level I Nerve Procedures	$3,623.87	$2,012.71	$1,912.07
221	Level II Nerve Procedures	$7,060.16	$3,121.46	$2,965.39
224	Implantation of Catheter/Reservoir/Shunt	$7,939.39	$3,633.99	$3,452.29
227	Implantation of Drug Infusion Device	$36,589.14	$3,653.06	$3,470.41
229	Transcatherter Placement of Intravascular Shunts	$22,069.44	$6,847.79	$6,505.40
230	Level I Eye Tests & Treatments	$114.65	$66.70	$63.37
231	Level III Eye Tests & Treatments	$437.11	$254.32	$241.60
232	Level I Anterior Segment Eye Procedures	$482.63	$280.80	$266.76
233	Level II Anterior Segment Eye Procedures	$3,390.83	$1,806.14	$1,715.84
234	Level III Anterior Segment Eye Procedures	$4,624.40	$2,360.16	$2,242.15
235	Level I Posterior Segment Eye Procedures	$1,107.12	$605.50	$575.22
237	Level II Posterior Segment Eye Procedures	$4,437.98	$2,295.48	$2,180.71
238	Level I Repair and Plastic Eye Procedures	$615.95	$341.78	$324.69
239	Level II Repair and Plastic Eye Procedures	$1,538.49	$886.53	$842.20
240	Level III Repair and Plastic Eye Procedures	$3,789.91	$2,091.04	$1,986.49
241	Level IV Repair and Plastic Eye Procedures	$5,037.59	$2,681.83	$2,547.74

Column #1 APC	*Column #2 APC Title*	*Column #3 CY 2012 Total APC Payment Rate Outpatient Hospital ERD Facilities*275%*	*Column #4 Total Hospital APC Outpatient Payment Rate (subtract all "threshold Packaged implants, devices, biologicals, drugs and Radiopharmaceuticals and contrast agents") *160%*	*Column #5 Total ASC APC Payment Rate = 95% of Hospital Outpatient APC Payment Rate*
242	Level V Repair and Plastic Eye Procedures	$7,356.09	$3,551.46	$3,373.89
243	Strabismus/Muscle Procedures	$4,846.88	$2,627.68	$2,496.29
244	Corneal and Amniotic Membrane Transplant	$7,373.36	$3,371.47	$3,202.90
245	Level I Cataract Procedures without IOL Insert	$2,797.25	$1,390.69	$1,321.15
246	Cataract Procedures with IOL Insert	$4,650.58	$2,106.19	$2,000.88
247	Laser Eye Procedures	$1,062.71	$597.96	$568.06
249	Level II Cataract Procedures without IOL Insert	$5,838.36	$3,023.21	$2,872.05
250	Level I ENT Procedures	$214.61	$124.30	$118.09
251	Level II ENT Procedures	$673.12	$391.63	$372.05
252	Level III ENT Procedures	$1,500.02	$847.69	$805.30
253	Level IV ENT Procedures	$3,284.13	$1,786.57	$1,697.24
254	Level V ENT Procedures	$4,857.82	$2,635.02	$2,503.27
255	Level II Anterior Segment Eye Procedures	$1,427.03	$812.34	$771.72
256	Level VI ENT Procedures	$8,464.67	$4,546.17	$4,318.86
259	Level VII ENT Procedures	$85,416.35	$7,076.82	$6,722.98
260	Level I Plain Film Except Teeth	$123.86	$72.02	$68.42
261	Level II Plain Film Except Teeth Including Bone Density Measurement	$208.62	$121.33	$115.26
262	Plain Film of Teeth	$83.82	$48.77	$46.33
263	Level I Miscellaneous Radiology Procedures	$632.39	$340.67	$323.64
265	Level I Diagnostic and Screening Ultrasound	$171.19	$99.47	$94.50
266	Level II Diagnostic and Screening Ultrasound	$264.77	$154.05	$146.35
267	Level III Diagnostic and Screening Ultrasound	$420.72	$244.54	$232.31
269	Level II Echocardiogram Without Contrast	$1,106.57	$639.45	$607.47

Column #1 APC	*Column #2 APC Title*	*Column #3 CY 2012 Total APC Payment Rate Outpatient Hospital ERD Facilities*275%*	*Column #4 Total Hospital APC Outpatient Payment Rate (subtract all "threshold Packaged implants, devices, biologicals, drugs and Radiopharmaceuticals and contrast agents") *160%*	*Column #5 Total ASC APC Payment Rate = 95% of Hospital Outpatient APC Payment Rate*
270	Level III Echocardiogram Without Contrast	$1,545.91	$867.15	$823.79
272	Fluoroscopy	$229.63	$131.05	$124.50
274	Myelography	$1,372.53	$764.54	$726.31
275	Arthrography	$756.36	$403.10	$382.94
276	Level I Digestive Radiology	$238.48	$137.81	$130.92
277	Level II Digestive Radiology	$390.45	$225.10	$213.85
278	Diagnostic Urography	$484.33	$237.30	$225.43
279	Level II Angiography and Venography	$5,573.12	$2,576.20	$2,447.39
280	Level III Angiography and Venography	$9,046.87	$4,510.41	$4,284.89
282	Miscellaneous Computed Axial Tomography	$312.10	$181.06	$172.00
283	Computed Tomography with Contrast	$824.48	$411.20	$390.64
284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast	$1,201.70	$615.41	$584.64
288	Bone Density:Axial Skeleton	$193.93	$112.83	$107.19
293	Level VI Anterior Segment Eye Procedures	$20,785.82	$5,101.07	$4,846.01
299	Hyperthermia and Radiation Treatment Procedures	$1,068.60	$621.04	$589.99
300	Level I Radiation Therapy	$269.01	$156.51	$148.69
301	Level II Radiation Therapy	$441.49	$256.86	$244.02
303	Treatment Device Construction	$549.20	$318.07	$302.16
304	Level I Therapeutic Radiation Treatment Preparation	$287.32	$167.17	$158.81
305	Level II Therapeutic Radiation Treatment Preparation	$746.93	$433.88	$412.19
307	Myocardial Positron Emission Tomography (PET) imaging	$3,045.24	$1,176.28	$1,117.47
308	Non-Myocardial Positron Emission Tomography (PET) imaging	$2,865.47	$1,327.75	$1,261.36

Column #1 APC	*Column #2 APC Title*	*Column #3 CY 2012 Total APC Payment Rate Outpatient Hospital ERD Facilities*275%*	*Column #4 Total Hospital APC Outpatient Payment Rate (subtract all "threshold Packaged implants, devices, biologicals, drugs and Radiopharmaceuticals and contrast agents") *160%*	*Column #5 Total ASC APC Payment Rate = 95% of Hospital Outpatient APC Payment Rate*
310	Level III Therapeutic Radiation Treatment Preparation	$2,548.54	$1,479.67	$1,405.69
312	Radioelement Applications	$976.11	$556.45	$528.63
313	Brachytherapy	$1,925.28	$1,120.16	$1,064.15
315	Level II Implantation of Neurostimulator Generator	$51,839.62	$3,462.51	$3,289.38
317	Level II Miscellaneous Radiology Procedures	$1,119.55	$625.52	$594.24
318	Implantation of Cranial Neurostimulator Pulse Generator and Electrode	$62,712.16	$5,027.92	$4,776.52
319	Endovascular Revascularization of the Lower Extremity	$38,221.45	$10,747.59	$10,210.21
320	Electroconvulsive Therapy	$1,113.72	$584.87	$555.63
322	Brief Individual Psychotherapy	$227.51	$132.37	$125.75
323	Extended Individual Psychotherapy	$310.89	$180.88	$171.84
324	Family Psychotherapy	$354.26	$206.11	$195.81
325	Group Psychotherapy	$150.89	$87.79	$83.40
330	Dental Procedures	$1,551.80	$901.87	$856.78
332	Computed Tomography without Contrast	$533.09	$309.76	$294.27
333	Computed Tomography without Contrast followed by Contrast	$919.16	$465.05	$441.80
336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast	$943.06	$548.41	$520.99
337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast	$1,467.40	$787.94	$748.54
340	Minor Ancillary Procedures	$127.13	$73.84	$70.15
341	Skin Tests	$15.32	$8.52	$8.10
342	Level I Pathology	$30.36	$17.66	$16.78
343	Level III Pathology	$100.32	$58.37	$55.45
344	Level IV Pathology	$155.16	$90.27	$85.76

Column #1 APC	*Column #2 APC Title*	*Column #3 CY 2012 Total APC Payment Rate Outpatient Hospital ERD Facilities*275%*	*Column #4 Total Hospital APC Outpatient Payment Rate (subtract all "threshold Packaged implants, devices, biologicals, drugs and Radiopharmaceuticals and contrast agents") *160%*	*Column #5 Total ASC APC Payment Rate = 95% of Hospital Outpatient APC Payment Rate*
345	Level I Transfusion Laboratory Procedures	$41.06	$23.89	$22.69
346	Level II Transfusion Laboratory Procedures	$68.97	$40.11	$38.11
347	Level III Transfusion Laboratory Procedures	$133.71	$77.79	$73.90
360	Level I Alimentary Tests	$330.36	$192.21	$182.60
361	Level II Alimentary Tests	$776.82	$449.57	$427.09
363	Level I Otorhinolaryngologic Function Tests	$173.91	$101.18	$96.12
364	Level I Audiometry	$89.93	$52.30	$49.69
365	Level II Audiometry	$240.54	$139.95	$132.95
366	Level III Audiometry	$342.40	$199.22	$189.26
367	Level I Pulmonary Test	$111.60	$64.54	$61.31
368	Level II Pulmonary Tests	$163.98	$95.41	$90.64
369	Level III Pulmonary Tests	$570.96	$312.89	$297.25
370	Allergy Tests	$248.77	$144.74	$137.50
373	Level I Neuropsychological Testing	$252.70	$147.02	$139.67
375	Ancillary Outpatient Services When Patient Expires	$17,523.28	$7,339.64	$6,972.66
377	Level II Cardiac Imaging	$2,089.73	$975.47	$926.70
378	Level II Pulmonary Imaging	$879.78	$415.13	$394.37
381	Single Allergy Tests	$91.27	$53.10	$50.45
382	Level II Neuropsychological Testing	$510.87	$297.23	$282.37
383	Cardiac Computed Tomographic Imaging	$706.37	$328.62	$312.19
384	GI Procedures with Stents	$5,267.43	$2,154.78	$2,047.04
385	Level I Prosthetic Urological Procedures	$19,403.81	$4,185.01	$3,975.76
386	Level II Prosthetic Urological Procedures	$31,969.03	$4,895.56	$4,650.78
387	Level II Hysteroscopy	$7,291.13	$3,904.44	$3,709.22
388	Discography	$4,598.74	$2,560.04	$2,432.04

Column #1 APC	*Column #2 APC Title*	*Column #3 CY 2012 Total APC Payment Rate Outpatient Hospital ERD Facilities*275%*	*Column #4 Total Hospital APC Outpatient Payment Rate (subtract all "threshold Packaged implants, devices, biologicals, drugs and Radiopharmaceuticals and contrast agents") *160%*	*Column #5 Total ASC APC Payment Rate = 95% of Hospital Outpatient APC Payment Rate*
389	Level I Non-imaging Nuclear Medicine	$277.12	$112.62	$106.99
390	Level I Endocrine Imaging	$365.17	$160.86	$152.81
391	Level II Endocrine Imaging	$603.60	$247.20	$234.84
392	Level II Non-imaging Nuclear Medicine	$478.23	$202.09	$191.98
393	Hematologic Processing & Studies	$1,150.57	$386.99	$367.64
394	Hepatobiliary Imaging	$729.11	$319.77	$303.78
395	GI Tract Imaging	$658.08	$324.49	$308.27
396	Bone Imaging	$672.93	$355.23	$337.46
397	Vascular Imaging	$550.96	$203.84	$193.65
398	Level I Cardiac Imaging	$801.32	$367.43	$349.06
400	Hematopoietic Imaging	$706.81	$338.53	$321.60
401	Level I Pulmonary Imaging	$541.28	$257.52	$244.64
402	Level II Nervous System Imaging	$1,639.74	$414.72	$393.98
403	Level I Nervous System Imaging	$660.63	$264.83	$251.59
404	Renal and Genitourinary Studies	$884.02	$341.26	$324.20
406	Level I Tumor/Infection Imaging	$797.80	$377.84	$358.95
407	Level I Radionuclide Therapy	$616.33	$343.50	$326.32
408	Level III Tumor/Infection Imaging	$2,269.49	$543.49	$516.32
409	Red Blood Cell Tests	$21.40	$12.45	$11.83
412	IMRT Treatment Delivery	$1,205.11	$701.15	$666.09
413	Level II Radionuclide Therapy	$899.20	$462.27	$439.16
414	Level II Tumor/Infection Imaging	$1,306.20	$392.52	$372.90
415	Level II Endoscopy Lower Airway	$5,422.37	$2,670.57	$2,537.04
418	Insertion of Left Ventricular Pacing Elect.	$29,232.94	$4,451.06	$4,228.51
422	Level II Upper GI Procedures	$3,159.06	$1,673.68	$1,590.00
423	Level II Percutaneous Abdominal and Biliary Procedures	$10,714.19	$4,857.31	$4,614.44
425	Level II Arthroplasty or Implantation with Prosthesis	$23,639.66	$5,335.17	$5,068.41
426	Level II Strapping and Cast Application	$482.32	$280.62	$266.59

Column #1 APC	*Column #2 APC Title*	*Column #3 CY 2012 Total APC Payment Rate Outpatient Hospital ERD Facilities*275%*	*Column #4 Total Hospital APC Outpatient Payment Rate (subtract all "threshold Packaged implants, devices, biologicals, drugs and Radiopharmaceuticals and contrast agents") *160%*	*Column #5 Total ASC APC Payment Rate = 95% of Hospital Outpatient APC Payment Rate*
427	Level II Tube or Catheter Changes or Repositioning	$3,090.62	$1,308.17	$1,242.76
428	Level III Sigmoidoscopy and Anoscopy	$4,622.37	$2,583.41	$2,454.24
429	Level V Cystourethroscopy and other Genitourinary Procedures	$8,802.01	$4,877.91	$4,634.02
432	Health and Behavior Services	$90.83	$52.85	$50.21
433	Level II Pathology	$46.94	$27.31	$25.95
434	Cardiac Defect Repair	$29,740.37	$5,663.43	$5,380.26
436	Level I Drug Administration	$72.46	$41.06	$39.01
437	Level II Drug Administration	$101.42	$58.67	$55.73
438	Level III Drug Administration	$207.85	$117.77	$111.88
439	Level IV Drug Administration	$353.21	$153.94	$146.25
440	Level V Drug Administration	$566.12	$224.04	$212.84
442	Dosimetric Drug Administration	$6,157.88	$2,656.98	$2,524.13
604	Level 1 Hospital Clinic Visits	$0.00	$0.00	$0.00
605	Level 2 Hospital Clinic Visits	$0.00	$0.00	$0.00
606	Level 3 Hospital Clinic Visits	$0.00	$0.00	$0.00
607	Level 4 Hospital Clinic Visits	$0.00	$0.00	$0.00
608	Level 5 Hospital Clinic Visits	$0.00	$0.00	$0.00
609	Level 1 Type A Emergency Visits	$142.37	$0.00	$0.00
613	Level 2 Type A Emergency Visits	$239.94	$0.00	$0.00
614	Level 3 Type A Emergency Visits	$382.64	$0.00	$0.00
615	Level 4 Type A Emergency Visits	$612.10	$0.00	$0.00
616	Level 5 Type A Emergency Visits	$906.24	$0.00	$0.00
617	Critical Care	$1,278.06	$0.00	$0.00
618	Trauma Response with Critical Care	$0.00	$0.00	$0.00
621	Level I Vascular Access Procedures	$2,153.47	$0.00	$0.00
622	Level II Vascular Access Procedures	$4,862.47	$0.00	$0.00
623	Level III Vascular Access Procedures	$5,829.29	$0.00	$0.00

Column #1 APC	*Column #2 APC Title*	*Column #3 CY 2012 Total APC Payment Rate Outpatient Hospital ERD Facilities*275%*	*Column #4 Total Hospital APC Outpatient Payment Rate (subtract all "threshold Packaged implants, devices, biologicals, drugs and Radiopharmaceuticals and contrast agents") *160%*	*Column #5 Total ASC APC Payment Rate = 95% of Hospital Outpatient APC Payment Rate*
624	Phlebotomy and Minor Vascular Access Device Procedures	$119.85	$0.00	$0.00
626	Level 1 Type B Emergency Visits	$113.74	$0.00	$0.00
627	Level 2 Type B Emergency Visits	$162.88	$0.00	$0.00
628	Level 3 Type B Emergency Visits	$279.18	$0.00	$0.00
629	Level 4 Type B Emergency Visits	$455.07	$0.00	$0.00
630	Level 5 Type B Emergency Visits	$751.41	$0.00	$0.00
648	Level IV Breast Surgery	$12,120.49	$3,550.64	$3,373.11
651	Complex Interstitial Radiation Source Application	$3,106.02	$1,649.19	$1,566.73
652	Insertion of Intraperitoneal and Pleural Catheters	$5,871.86	$2,870.08	$2,726.57
653	Vascular Reconstruction/Fistula Repair with Device	$8,542.35	$3,761.87	$3,573.77
654	Insertion/Replacement of a permanent dual chamber pacemaker	$20,474.88	$2,956.72	$2,808.89
655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	$26,082.40	$3,827.19	$3,635.83
656	Transcatheter Placement of Intracoronary Drug-Eluting Stents	$20,016.43	$4,819.08	$4,578.13
659	Hyperbaric Oxygen	$288.72	$167.98	$159.58
660	Level II Otorhinolaryngologic Function Tests	$278.30	$161.92	$153.82
661	Level V Pathology	$414.65	$241.25	$229.19
662	CT Angiography	$930.96	$460.73	$437.69
664	Level I Proton Beam Radiation Therapy	$2,837.20	$1,650.74	$1,568.20
665	Bone Density:AppendicularSkeleton	$88.30	$51.38	$48.81
667	Level II Proton Beam Radiation Therapy	$3,711.43	$2,159.38	$2,051.41
668	Level I Angiography and Venography	$1,976.43	$988.82	$939.38

Column #1 APC	*Column #2 APC Title*	*Column #3 CY 2012 Total APC Payment Rate Outpatient Hospital ERD Facilities*275%*	*Column #4 Total Hospital APC Outpatient Payment Rate (subtract all "threshold Packaged implants, devices, biologicals, drugs and Radiopharmaceuticals and contrast agents") *160%*	*Column #5 Total ASC APC Payment Rate = 95% of Hospital Outpatient APC Payment Rate*
672	Level III Posterior Segment Eye Procedures	$7,757.56	$4,131.65	$3,925.06
673	Level IV Anterior Segment Eye Procedures	$8,189.80	$2,970.01	$2,821.51
674	Prostate Cryoablation	$22,051.32	$5,060.10	$4,807.09
676	Thrombolysis and Other Device Revisions	$444.62	$246.04	$233.74
678	External Counterpulsation	$279.46	$162.59	$154.46
679	Level II Resuscitation and Cardioversion	$1,022.92	$550.04	$522.54
680	Insertion of Patient Activated Event Recorders	$14,847.44	$2,427.42	$2,306.05
683	Level II Photochemotherapy	$551.79	$321.04	$304.99
685	Level III Needle Biopsy/Aspiration Except Bone Marrow	$1,843.96	$1,039.38	$987.41
687	Revision/Removal of Neurostimulator Electrodes	$4,114.41	$2,260.74	$2,147.71
688	Revision/Removal of Neurostimulator Pulse Generator Receiver	$5,509.16	$2,863.64	$2,720.46
690	Level I Electronic Analysis of Devices	$96.47	$56.13	$53.32
691	Level IV Electronic Analysis of Devices	$458.76	$261.23	$248.17
692	Level II Electronic Analysis of Devices	$305.11	$177.52	$168.64
694	Mohs Surgery	$1,016.46	$590.27	$560.75
697	Level I Echocardiogram Without Contrast	$583.88	$336.89	$320.05
698	Level II Eye Tests & Treatments	$183.67	$106.81	$101.47
699	Level IV Eye Tests & Treatments	$3,179.47	$1,734.26	$1,647.54
1506	New Technology - Level VI ($400 - $500)	$1,237.50	$720.00	$684.00

Column #1 APC	*Column #2 APC Title*	*Column #3 CY 2012 Total APC Payment Rate Outpatient Hospital ERD Facilities*275%*	*Column #4 Total Hospital APC Outpatient Payment Rate (subtract all "threshold Packaged implants, devices, biologicals, drugs and Radiopharmaceuticals and contrast agents") *160%*	*Column #5 Total ASC APC Payment Rate = 95% of Hospital Outpatient APC Payment Rate*
8000	Cardiac Electrophysiologic Evaluation and Ablation Composite	$0.00	$0.00	$0.00
8001	LDR Prostate Brachytherapy Composite	$0.00	$0.00	$0.00
8002	Level I Extended Assessment & Management Composite	$0.00	$0.00	$0.00
8003	Level II Extended Assessment & Management Composite	$0.00	$0.00	$0.00
8004	Ultrasound Composite	$0.00	$0.00	$0.00
8005	CT and CTA without Contrast Composite	$0.00	$0.00	$0.00
8006	CT and CTA with Contrast Composite	$0.00	$0.00	$0.00
8007	MRI and MRA without Contrast Composite	$0.00	$0.00	$0.00
8008	MRI and MRA with Contrast Composite	$0.00	$0.00	$0.00

Exhibit 5
Effective January 1, 2012
Rural Health Facilities

Akron Clinic
82 Main
Akron, CO 80720
Telephone: (970) 345-6336, Fax: (970) 345-6576

Arkansas Valley Family Practice, LLC
2317 San Juan Avenue
La Junta, CO 81050
Telephone: (719) 383-2325, Fax: (719) 383-2327

Brush Family Clinic
2400 W Edison
Brush, Co 80723 - Morgan County
Telephone: (970) 842-2833, Fax: (970) 842-6241

Buena Vista Family Practice Clinic
836 U.S. Hwy 24 So
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 Clenter
319 Main Street
Ordway, Co 81063 – Crowley County
Telephone: (719) 267-3503, Fax: (719) 267-4153

Conejos Medical Clinic
19021 State Hwy 285
La Jara, Co 81140 - Conejos County
Telephone: (719) 274-5121, Fax: (719) 274-6003

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

Exhibit 5
Effective January 1, 2012
Rural Health Facilities

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

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 Primary Care
501 Airport Road
Rifle, Co 81650 - Garfield County
Telephone: (970) 625-1100, Fax: (970) 625-0725

Grand River Primary Care - Battlement Mesa
73 Sipperelle Drive, Suite K
Parachute, Co 81635 - Garfield County
Telephone: (970) 285-7046, Fax: (970) 285-6064

Exhibit 5
Effective January 1, 2012
Rural Health Facilities

Holly Medical Clinic
410 West Colorado
Holly, CO 81047 – Prowers County
Telephone: (719) 537-6642, Fax: (719) 537-0637

Kit Carson Clinic
102 East 2nd Avenue
Kit Carson, Co 80825 - Cheyenne County
Telephone: (719) 962-3501, Fax: (719) 962-3403

La Jara Medical Clinic
509 Main Street
La Jara, CO 81140 – Conejos County
Telephone: (719) 274-6000,. Fax: (719) 274-4111

Lake City Area Medical Center
700 N Henson Street
Lake City, Co 81235 - Hinsdale County
Telephone: (970) 944-2331, Fax: (970) 944-2320

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

Meadows Family Medical Center
115 15th Ave., P.O. Box 3243
Idaho Springs, CO 80452 – Clear Creek County
Telephone: (303) 567-2668

Meeker Family Health Center
345 Cleveland Street
Meeker, Co 81641 - Rio Blanco County
Telephone: (970) 878-4014, Fax: (970) 878-3285

Mercy Health Services Clinic
1800 East 3rd Avenue
Durango, CO 81301 – La Plata County
Telephone: (970) 764-1790; Fax: (970) 375-7927

Mountain Medical Center Of Buena Vista, P.C

Exhibit 5
Effective January 1, 2012
Rural Health Facilities

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 Ste A
Trinidad, Co 81082 – Las Animas County
Telephone: (719) 846-2206, Fax: (719) 846-7823

North Park Medical Clinic
350 North 3rd Street
Walden, Co 80480 - Jackson County
Telephone: (970) 723-4255, Fax: (970) 723-4268

Olathe Medical Clinic
320 North 3rd Street
Olathe, Co 81425 - Montrose County
Telephone: (970) 323-6141, Fax: (970) 323-6117

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
Canon City, Co 81212 - Fremont County
Telephone: (719) 269-1727, Fax: (719) 269-1730

Prairie View Rural Health Clinic
560 N 6 W Street
Cheyenne Wells, Co 80810 - Cheyenne County
Telephone: (719) 767-5669, Fax: (719) 767-8042

R&D Medical Management Corp.
109 Latigo Lane, Ste C

Exhibit 5
Effective January 1, 2012
Rural Health Facilities

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

River Valley Pediatrics
1335 Phay Avenue
Canon City, Co 81212 – Fremont County
Telephone: (719) 276-2222

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

Santa Fe Trail Medical Center
111 Waverly Ave
Trinidad, Co 81082 - Las Animas County
Telephone: (719) 846-0123, Fax: (719) 846-0121

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

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

Exhibit 5
Effective January 1, 2012
Rural Health Facilities

Telephone: (970) 856-3146, Fax: (970) 856-4385
Telluride Medical Center
500 W Pacific
Telluride, Co 81435 - San Miguel County
Telephone: (970) 728-3840, Fax: (970) 728-3404

TMC – Primary Care
500 W Pacific Avenue
Telluride, CO 81435
Telephone: (970) 728-3848, Fax: (970) 728-3404

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

Wiley Medical Clinic
302 Main Street
Wiley, Co 81092 - Prowers County
Telephone: (719) 829-4627, Fax: (719) 829-4269

Yuma Rural Health Clinic
1000 W 8th Avenue
Yuma, Co 80759 - Yuma County
Telephone: (970) 848-4792, Fax: (970) 848-5405

Exhibit 6

Dental Fee Schedule

CDT-2009/2010	2012 Fees
D0120	$60.90
D0140	$101.85
D0145	$94.50
D0150	$107.10
D0160	$215.25
D0170	$71.40
D0180	$116.55
D0210	$169.79
D0220	$34.18
D0230	$30.87
D0240	$52.92
D0250	$65.05
D0260	$59.54
D0270	$35.28
D0272	$57.33
D0273	$69.46
D0274	$80.48
D0277	$121.28
D0290	$198.45
D0310	$504.95
D0320	$859.95
D0321	BR
D0322	$694.58
D0330	$150.15
D0340	$169.05
D0350	$80.85
D0360	$968.10
D0362	$773.85
D0363	$806.40
D0415	$50.40
D0416	$73.50
D0417	$68.25
D0418	$69.30
D0421	$50.40
D0425	$43.05
D0431	$69.30
D0460	$69.30
D0470	$152.25
D0472	$97.02
D0473	$201.60
D0474	$228.22
D0475	$149.94
D0476	$149.94
D0477	$180.81
D0478	$148.05
D0479	$225.75
D0480	$139.65
D0481	$778.37
D0482	$174.30
D0483	$174.30
D0484	$280.04
D0485	$360.15
D0486	$158.00
D0502	BR
D0999	BR
D1110	$109.15
D1120	$76.07
D1203	$44.10
D1204	$40.95
D1206	$66.15
D1310	$64.05
D1320	$70.35
D1330	$88.20
D1351	$71.40
D1352	$82.00

CDT-2009/2010	2012 Fees
D1510	$456.75
D1515	$639.45
D1520	$502.95
D1525	$777.00
D1550	$98.70
D1555	$94.50
D2140	$238.14
D2150	$307.60
D2160	$372.65
D2161	$454.23
D2330	$217.19
D2331	$277.83
D2332	$339.57
D2335	$402.41
D2390	$445.41
D2391	$254.68
D2392	$334.06
D2393	$414.54
D2394	$508.25
D2410	$414.75
D2420	$691.95
D2430	$1,199.10
D2510	$1,097.25
D2520	$1,245.30
D2530	$1,435.35

CDT-2009/2010	2012 Fees
D2542	$1,407.00
D2543	$1,472.10
D2544	$1,530.90
D2610	$1,291.50
D2620	$1,362.90
D2630	$1,452.15
D2642	$1,411.20
D2643	$1,521.45
D2644	$1,613.85
D2650	$848.40
D2651	$1,011.15
D2652	$1,062.60
D2662	$921.90
D2663	$1,084.65
D2664	$1,162.35
D2710	$569.99
D2712	$569.99
D2720	$1,404.59
D2721	$1,316.39
D2722	$1,345.05
D2740	$1,440.97
D2750	$1,422.23
D2751	$1,324.10
D2752	$1,356.08
D2780	$1,363.79

CDT-2009/2010	2012 Fees
D2781	$1,283.31
D2782	$1,325.21
D2783	$1,402.38
D2790	$1,371.51
D2791	$1,299.85
D2792	$1,324.10
D2794	$1,404.59
D2799	$569.99
D2910	$130.10
D2915	$130.10
D2920	$131.20
D2930	$358.31
D2931	$405.72
D2932	$432.18
D2933	$495.02
D2934	$495.02
D2940	$136.71
D2950	$341.78
D2951	$77.18
D2952	$540.23
D2953	$270.11
D2954	$432.18
D2955	$332.96
D2957	$216.09
D2960	$1,045.17

CDT-2009/2010	2012 Fees
D2961	$1,185.19
D2962	$1,287.72
D2970	$324.14
D2971	$207.27
D2975	$630.63
D2980	BR
D2999	BR
D3110	$118.65
D3120	$95.55
D3220	$243.60
D3221	$267.75
D3222	$247.80
D3230	$278.93
D3240	$343.98
D3310	$1,094.78
D3320	$1,341.74
D3330	$1,663.67
D3331	$428.87
D3332	$815.85
D3333	$375.95
D3346	$1,459.71
D3347	$1,717.70
D3348	$2,125.62
D3351	$878.69
D3352	$393.59

CDT-2009/2010	2012 Fees
D3353	$1,211.65
D3354	BR
D3410	$1,741.95
D3421	$1,939.30
D3425	$2,196.18
D3426	$741.98
D3430	$545.74
D3450	$1,135.58
D3460	$4,241.32
D3470	$2,166.41
D3910	$303.19
D3920	$863.26
D3950	$393.59
D3999	BR
D4210	$1,151.00
D4211	$511.00
D4230	$1,611.00
D4231	$994.46
D4240	$1,458.00
D4241	$844.00
D4245	$1,074.00
D4249	$1,598.00
D4260	$2,430.00
D4261	$1,304.00
D4263	$870.00

CDT-2009/2010	2012 Fees
D4264	$742.00
D4265	BR
D4266	$895.00
D4267	$1,151.00
D4268	BR
D4270	$1,726.00
D4271	$1,790.00
D4273	$2,110.00
D4274	$1,197.00
D4275	$1,586.00
D4276	$2,366.00
D4320	$567.79
D4321	$574.40
D4341	$327.44
D4342	$197.35
D4355	$223.81
D4381	BR
D4910	$201.76
D4920	$146.63
D4999	BR
D5110	$2,114.60
D5120	$2,114.60
D5130	$2,305.33
D5140	$2,305.33
D5211	$1,784.95

CDT-2009/2010	2012 Fees
D5212	$2,073.80
D5213	$2,513.70
D5214	$2,336.20
D5225	$1,784.95
D5226	$2,073.80
D5281	$1,362.69
D5410	$115.76
D5411	$115.76
D5421	$115.76
D5422	$115.76
D5510	$249.17
D5520	$192.94
D5610	$251.37
D5620	$286.65
D5630	$328.55
D5640	$212.78
D5650	$289.96
D5660	$347.29
D5670	$912.87
D5671	$912.87
D5710	$858.85
D5711	$820.26
D5720	$810.34
D5721	$810.34
D5730	$484.00

CDT-2009/2010	2012 Fees
D5731	$484.00
D5740	$444.31
D5741	$444.31
D5750	$646.07
D5751	$646.07
D5760	$637.25
D5761	$637.25
D5810	$1,023.12
D5811	$1,100.30
D5820	$791.60
D5821	$839.00
D5850	$202.86
D5851	$202.86
D5860	BR
D5861	BR
D5862	BR
D5867	BR
D5875	BR
D5899	BR
D5911	$536.92
D5912	$536.92
D5913	$11,295.11
D5914	$11,295.11
D5915	$15,286.16
D5916	$4,077.05

CDT-2009/2010	2012 Fees
D5919	BR
D5922	BR
D5923	BR
D5924	BR
D5925	BR
D5926	BR
D5927	BR
D5928	BR
D5929	BR
D5931	$6,081.39
D5932	$11,374.49
D5933	BR
D5934	$10,366.81
D5935	$9,020.66
D5936	$10,131.98
D5937	$1,273.39
D5951	$1,655.96
D5952	$5,375.79
D5953	$10,209.15
D5954	$9,460.55
D5955	$8,750.54
D5958	BR
D5959	BR
D5960	BR
D5982	$905.15

CDT-2009/2010	2012 Fees
D5983	$2,191.77
D5984	$2,191.77
D5985	$2,191.77
D5986	$192.94
D5987	$3,289.86
D5988	$562.80
D5991	$216.30
D5992	BR
D5993	BR
D5999	BR
D6010	$3,532.41
D6012	$3,338.37
D6040	$13,077.86
D6050	$9,069.17
D6053	$2,637.18
D6054	$2,637.18
D6055	$1,061.71
D6056	$733.16
D6057	$907.36
D6058	$2,034.11
D6059	$2,158.70
D6060	$2,040.73
D6061	$2,081.52
D6062	$2,073.80
D6063	$1,780.54

CDT-2009/2010	2012 Fees
D6064	$1,886.38
D6065	$2,001.04
D6066	$2,096.96
D6067	$2,034.11
D6068	$2,016.47
D6069	$2,158.70
D6070	$2,040.73
D6071	$1,934.89
D6072	$2,125.62
D6073	$1,923.86
D6074	$1,900.71
D6075	$2,001.04
D6076	$2,096.96
D6077	$2,034.11
D6078	BR
D6079	BR
D6080	$166.48
D6090	BR
D6091	$800.42
D6092	$156.56
D6093	$244.76
D6094	$1,712.18
D6095	BR
D6100	BR
D6190	$357.21

CDT-2009/2010	2012 Fees
D6194	$1,640.52
D6199	BR
D6205	$921.69
D6210	$1,409.00
D6211	$1,319.69
D6212	$1,373.72
D6214	$1,417.82
D6240	$1,391.36
D6241	$1,284.41
D6242	$1,354.97
D6245	$1,435.46
D6250	$1,373.72
D6251	$1,266.77
D6252	$1,307.57
D6253	$592.04
D6254	$686.00
D6545	$553.46
D6548	$574.40
D6600	$1,076.04
D6601	$1,148.81
D6602	$1,174.16
D6603	$1,292.13
D6604	$1,151.01
D6605	$1,219.37
D6606	$1,132.27

CDT-2009/2010	2012 Fees
D6607	$1,256.85
D6608	$1,125.65
D6609	$1,229.29
D6610	$1,266.77
D6611	$1,385.84
D6612	$1,260.16
D6613	$1,317.49
D6614	$1,232.60
D6615	$1,282.21
D6624	$1,174.16
D6634	$1,232.60
D6710	$1,186.29
D6720	$1,468.53
D6721	$1,392.46
D6722	$1,417.82
D6740	$1,455.30
D6750	$1,502.71
D6751	$1,402.38
D6752	$1,436.56
D6780	$1,417.82
D6781	$1,336.23
D6782	$1,417.82
D6783	$1,375.92
D6790	$1,450.89
D6791	$1,375.92

CDT-2009/2010	2012 Fees
D6792	$1,425.53
D6793	$561.17
D6794	$1,425.53
D6795	$662.00
D6920	$381.47
D6930	$222.71
D6940	$504.95
D6950	$974.61
D6970	$615.20
D6972	$500.54
D6973	$402.41
D6975	$1,080.45
D6976	$286.65
D6977	$254.68
D6980	BR
D6985	$847.82
D6999	BR
D7111	$208.37
D7140	$276.73
D7210	$368.24
D7220	$461.95
D7230	$615.20
D7240	$722.14
D7241	$907.36
D7250	$389.18

CDT-2009/2010	2012 Fees
D7251	$649.00
D7260	$2,886.35
D7261	$955.50
D7270	$717.15
D7272	$955.50
D7280	$668.85
D7282	$334.95
D7283	$286.65
D7285	$1,337.70
D7286	$573.30
D7287	$228.90
D7288	$228.90
D7290	$573.30
D7291	$423.36
D7292	$917.70
D7293	$573.30
D7294	$477.75
D7295	BR
D7310	$539.00
D7311	$472.00
D7320	$876.00
D7321	$742.00
D7340	$3,708.00
D7350	$10,787.00
D7410	$1,618.00

CDT-2009/2010	2012 Fees
D7411	$2,562.00
D7412	$2,832.00
D7413	$1,888.00
D7414	$2,832.00
D7415	$3,169.00
D7440	$2,562.00
D7441	$3,776.00
D7450	$1,618.00
D7451	$2,211.00
D7460	$1,618.00
D7461	$2,211.00
D7465	$876.00
D7471	$2,004.00
D7472	$2,381.00
D7473	$2,246.00
D7485	$2,004.00
D7490	$16,181.00
D7510	$580.00
D7511	$876.00
D7520	$2,762.00
D7521	$3,034.00
D7530	$995.00
D7540	$1,103.00
D7550	$688.00
D7560	$5,461.00

CDT-2009/2010	2012 Fees
D7610	$8,832.00
D7620	$6,623.00
D7630	$11,483.00
D7640	$7,287.00
D7650	$5,520.00
D7660	$3,255.00
D7670	$2,540.00
D7671	$4,787.00
D7680	$16,561.00
D7710	$10,380.00
D7720	$7,287.00
D7730	$15,016.00
D7740	$7,430.00
D7750	$9,450.00
D7760	$3,792.00
D7770	$5,137.00
D7771	$3,964.00
D7780	$22,082.00
D7810	$9,714.00
D7820	$1,591.00
D7830	$912.00
D7840	$13,241.00
D7850	$11,435.00
D7852	$13,093.00
D7854	$13,511.00

CDT-2009/2010	2012 Fees
D7856	$9,587.00
D7858	$27,327.00
D7860	$11,648.00
D7865	$18,770.00
D7870	$620.00
D7871	$1,241.00
D7872	$6,621.00
D7873	$7,972.00
D7874	$11,435.00
D7875	$12,527.00
D7876	$13,506.00
D7877	$11,920.00
D7880	$1,489.00
D7899	BR
D7910	$885.00
D7911	$2,209.00
D7912	$3,975.00
D7920	$6,513.00
D7940	BR
D7941	$16,585.00
D7943	$15,237.00
D7944	$13,578.00
D7945	$18,069.00
D7946	$22,384.00
D7947	$18,824.00

CDT-2009/2010	2012 Fees
D7948	$24,433.00
D7949	$31,822.00
D7950	BR
D7951	BR
D7953	$458.00
D7955	BR
D7960	$742.00
D7963	$1,214.00
D7970	$1,079.00
D7971	$405.00
D7972	$1,510.00
D7980	$1,699.00
D7981	BR
D7982	$4,018.00
D7983	$3,856.00
D7990	$3,317.00
D7991	$8,090.00
D7995	BR
D7996	BR
D7997	$620.00
D7998	$2,697.00
D7999	BR
D8010	BR
D8020	BR
D8030	BR

CDT-2009/2010	2012 Fees
D8040	BR
D8050	BR
D8060	BR
D8070	BR
D8080	BR
D8090	BR
D8210	BR
D8220	BR
D8660	$635.04
D8670	$476.28
D8680	$1,047.38
D8690	$495.02
D8691	$465.26
D8692	$518.18
D8693	$479.59
D8999	BR
D9110	$195.14
D9120	$220.50
D9210	$62.84
D9211	$68.36
D9212	$126.79
D9215	$54.02
D9220	$622.91
D9221	$278.93
D9230	$103.64

CDT-2009/2010	2012 Fees
D9241	$484.00
D9242	$235.94
D9248	$149.94
D9310	$442.10

Exhibit 7
(Effective January 1, 2012)
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)
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)
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 workersvisit 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 Chest x-rays EKG/EEG Urinalysis Ultrasound KOH prep	Rest Gargles Elastic bandages Superficial dressings
Low	Two or more self-limited or minor problems One stable chronic illness, e.g., well-controlled HTN, NIDDM, cataract, BPH Acute, uncomplicated illness or injury, e.g., allergic rhinitis or simple sprain cyctitis Acute laceration repair	Physiologic tests nor under stress, e.g., PFTs Non-cardiovascular imaging studies w/contrast, e.g., barium enema Superficial needle biopsies Lab tests requiring arterial puncture Skin biopsies	Over-the-counter drugs Minor surgery w/no identified risk factors PT/OT IV fluids w/o additives Simple or layered closure Vaccine injection
Moderate	One of more chronic illnesses with mild exacerabation, progression or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis, e.g., new extremity neurologic complaints Acute illness with systemic symptoms, e.g., pyelonephritis, colitis Acute complicated injury, e.g., head injury with brief loss of consciousness	Physiologic tests under stress, e.g. cardiac stress test, Discography, stress tests Diagnostic injections Deep needle or incisional biopsies Cardiovascular imaging studies with contrast and no identified risk factors e.g. arteriogram, cardiac cath Obtain fluid from body cavity, e.g. lumbar puncture, thoracentesis, culdocentesis	Minor surgery with identified risk factors Elective major surgery (open, percutaneous, or endoscopic) with no identified risk factors Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed Tx of Fx or dislocation w/o manipulation Inability to return the injured worker to work and requires detailed functional improvement plan.
High	One or more chronic illness with	Cardiovascular imaging	Elective major surgery

	severe exacerbation, progression or side effects of treatment Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g., multiple trauma, acute MI, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others; An abrupt change in neurological status, e.g., seizure, TIA, weakness, sensory loss	studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic endoscopies with identified risk factors	with identified risk factors Emergency major surgery Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis, Potential for significant permanent work restrictions or total disability Management of addiction behavior or other significant psychiatric condition Treatment plan for patients with symptoms causing severe functional deficits without supporting physiological \findings or verified related medical diagnosis.

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:

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.