DEPARTMENT OF LABOR AND EMPLOYMENT

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

Rule 16 UTILIZATION STANDARDS

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16-1 STATEMENT OF PURPOSE

In an effort to comply with its legislative charge to assure appropriate and timely medical care at a reasonable cost, the Director (Director) of the Division of Workers' Compensation (Division) has promulgated these utilization standards, effective January 1, ~~2018~~2019. This Rule defines the standard terminology, administrative procedures, and dispute resolution procedures required to implement the Division's Medical Treatment Guidelines and Medical Fee Schedule. ~~With respect to any matter arising under the Colorado Workers' Compensation Act and/or the Workers' Compensation Rules of Procedure and to the extent not otherwise precluded by the laws of this state, all providers and payers shall use and comply with the provisions of the "Medical Treatment Guidelines," Rule 17, and the "Medical Fee Schedule," Rule 18, as incorporated and defined in the Workers' Compensation Rules of Procedure, 7 CCR 1101-3.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(W) Supply – any single supply, durable medical equipment (DME), orthotic, prosthesis, biologic item, single drug dose for which the billed amount exceeds $500.00 and all implants.~~

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~~(X)~~ Telehealth – a broad term describing a mode of delivery of health care services through telecommunications systems, including information, electronic, and communication technologies, to facilitate the assessment, diagnosis, consultation, treatment, education,

~~(A)~~(V) care management, and/or self-management of an injured worker's health care while the injured worker is located at an originating site and the provider is located at a distant site. The term includes synchronous interactions and store-and-forward transfers. The term does not include the delivery of health care services via telephone with audio only function, facsimile machine, or electronic mail systems.

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

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

~~16-3~~16-4 ~~REQUIRED USE OF THE MEDICAL TREATMENT GUIDELINES~~

~~When an injury or occupational disease falls within the purview of Rule 17, Medical Treatment Guidelines and the date of injury occurs on or after July 1, 1991, providers and payers shall use the medical treatment guidelines, in effect at the time of service, to prepare or review their treatment plan(s) for the injured worker. A payer may not dictate the type or duration of medical treatment or rely on its' own internal guidelines or other standards for medical determination. When treatment exceeds or is outside of the Medical Treatment Guidelines, prior authorization is required. Requesters and reviewers should consider how their decision will affect the overall treatment plan for the individual patient.~~ In all instances of contest appropriate processes to deny are required. Refer to applicable sections of 16-10, 16-11 and/or 16-12.

16-4 ~~REQUIRED USE OF THE~~ MEDICAL FEE SCHEDULE

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

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

~~(C) The provider may be subject to penalties under the Workers' Compensation Act for inaccurate billing when the provider knew or should have known that the services billed were inaccurate, as determined by the Director or an administrative lawjudge.~~

~~16-5~~16-3 RECOGNIZED HEALTH CARE PROVIDERS

(A) Physician and Non-Physician Providers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) Any provider not listed in section 16-~~5~~3(A)(1)(a) or (b) must comply with section 16-~~10~~6, Prior Authorization when providing all services.

(4) Referrals:

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

(b) All non-physician providers must have a referral from an authorized treating physician. An authorized treating physician making the referral to any listed or unlisted non-physician provider is required to clarify any questions concerning the scope of the referral, prescription, or the reasonableness or necessity of the care.

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

~~(5) Rule 18, Medical Fee Schedule applies to authorized services provided in relation to a specific workers' compensation claim.~~

~~(6)~~(5) Use of PAs and NPs in Colorado Workers' Compensation Claims:

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

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

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

(d) For services performed by an NP or a PA, the authorized treating physician must counter-sign patient records related to the injured worker's inability to work resulting from the claimed work injury or disease, and the injured worker's ability to return to regular or modified employment, as required by §§ 8-42-105(2)(b) and (3)~~),~~

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~~C.R.S.~~). The authorized treating physician also must counter-sign Form WC 164. The signature of the physician provider shall serve as a certification that all requirements of this rule have been met.

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

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(B) Out-of-State Provider

(1) Relocated Injured Worker

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

(b) A change of provider must be made:

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

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

(2) Referred Injured Worker

In the event an injured worker has not relocated out-of-state but is referred to an out-of-state provider for treatment or services not available within Colorado, the referring provider shall obtain prior authorization from the payer as set forth in section 16-~~10, Prior Authorization.~~6. The referring provider's written request for out-of-state treatment shall include the following information:

(a) Medical justification prepared by the referring provider;

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

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

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

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

~~(3) The Colorado fee schedule should govern reimbursement for out-of-state providers, but the payer and provider may negotiate reimbursement in excess of this fee schedule when necessary to obtain reasonable and necessary care for an injured worker.~~

~~16-6 HANDLING, PROCESSING AND PAYMENT OF MEDICAL BILLS~~

~~(A) Use of agents, including but not limited to Preferred Provider Organizations (PPO) networks, bill review companies, third party administrators (TPAs) and case management companies, shall not relieve the employer or insurer from their legal responsibilities for compliance with these Rules.~~

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

(C) Payment for billed services not identified or identified but without established value in the Medical Fee Schedule shall require prior authorization from the payer as set forth in section 16-10, Prior Authorization, except when the billed non-established valued service or procedure is an emergency or a payment mechanism under Rule 18 is identifiable, but not explicit. Examples of the prior authorization request exception(s) include ambulance bills or supply bills that are covered under Rule 18 with an identified payment mechanism.

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

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

16-7 REQUIRED BILLING FORMS AND ACCOMPANYING DOCUMENTATION

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

(B) Required Billing Forms

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

16-4 REQUIRED USE OF THE MEDICAL TREATMENT GUIDELINES

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

(1) CMS (Centers for Medicare & Medicaid Services) -1500 shall be used by all providers billing for professional services, durable medical equipment (DME) and ambulance services, with the exception of those providers billing for dental services or procedures. Health care providers shall provide their name and credentials in the appropriate box of the CMS-1500.

(a)(1) Non-hospital-based ASCs may bill on the CMS-1500, however an SG modifier must be appended to the technical component of services to indicate a facility charge and to qualify for reimbursement as a facility claim.

(2)(1) UB-04 - shall be used by all hospitals, hospital-based ambulance/air services, Children's Hospitals, CAHs, Veterans' Administration Medical Facilities, home health and facilities meeting the definitions found in section 16-2, when billing for

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hospital services or any facility fees billed by any other provider, such as hospital-based ASCs.

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

- Revenue Code 042X- Physical Therapy

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

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

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

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

GF Services rendered in a CAH by a NP, clinical nurse specialist, certified registered nurse, or PA

SB Services rendered in a CAH by a nurse midwife

AH Services rendered in a CAH by a clinical psychologist

AE Services rendered in a CAH by a nutrition professional/registered dietitian

AQ Physician services in a physician scarcity area

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

(3)(1) American Dental Association's Dental Claim Form, Version 2012 shall be used by all providers billing for dental services or procedures.

(4) With the agreement of the payer, the ANSI ASC X12 (American National Standards Institute Accredited Standards Committee) or NCPDP (National

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Council For Prescription Drug Programs) electronic billing transaction containing the same information as in (1), (2) or (3) in this subsection may be used.

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

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

(C) International Classification of Diseases (ICD) Codes

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

(D) Required Billing Codes

All billed services shall be itemized on the appropriate billing form as set forth in sections 16-7(A) and (B), and shall include applicable billing codes and modifiers from the Medical Fee Schedule. National provider identification (NPI) numbers are required for workers' compensation bills; providers who cannot obtain NPI numbers are exempt from this requirement. When billing on a CMS-1500, the NPI should be that of the rendering provider and should include the correct place of service codes at the line level.

(E) Inaccurate Billing Forms or Codes

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

(F) Accompanying Documentation

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

(a) The report type as "initial" when the injured worker has his or her initial visit with the authorized treating physician managing the total workers' compensation claim of the patient. Generally, this will be the designated or selected authorized treating physician. When applicable, the emergency room or urgent care authorized treating physician for this workers' compensation injury may also create a WC 164 initial report. Unless requested or prior authorized by the payer in a specific workers' compensation claim, no other authorized physician should complete and bill for the initial WC 164 form. This form shall include completion of items 1-7 and 11. Note that certain information in item 2 (such as Insurer Claim #) may be omitted if not known by the provider.

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

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

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

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

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

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

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

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

(C)(E) Providers shall submit their bills for services rendered within 120 days of the date of service or the bill may be denied unless extenuating circumstances exist. Extenuating circumstances may include, but are not limited to, delays in compensability being decided or the provider has not been informed where to send the bill.

(H) All services provided to patients are expected to be documented in the medical record at the time they are rendered. Occasionally, certain entries related to services provided are not properly documented. In this event, the documentation will need to be amended, corrected, or entered after rendering the service. Amendments, corrections and delayed entries must comply with Medicare's widely accepted recordkeeping principles as

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(C) outlined in the June 2017 Medicare Program Integrity Manual Chapter 3, section 3.3.2.5. (This section does not apply to patients' requests to amend records as permitted by the Health Insurance Portability and Accountability Act (HIPAA)).

16-8 REQUIRED MEDICAL RECORD DOCUMENTATION

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

(B) All medical records shall contain legible documentation substantiating the services billed. The documentation shall itemize each contact with the injured worker and shall detail at least the following information per contact or, at a minimum for cases where contact occurs more than once a week, be summarized once per week:

(1) Patient's name;

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

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

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

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

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

(7)(1) Pain diagrams, where applicable;

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

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

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

16-916-5 NOTIFICATION

(A) The Notification process is for treatment consistent with the Medical Treatment Guidelines that has an established value under the Medical Fee Schedule. Providers may, but are not required to, utilize the Notification process to ensure payment for medical treatment that falls within the purview of the Medical Treatment Guidelines. Therefore, lack of response from the payer within the time requirement set forth in section 16-9 5(D) shall deem the proposed treatment/service authorized for payment.

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

(1) Providers can accept verbal confirmation; or

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

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

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

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

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

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

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

(2) If payer proposes to discontinue treatment before the maximum number of treatments/treatment duration has been reached due to lack of functional progress, payer shall support that decision with a medical review compliant with section 16-~~11~~7(B).

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

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

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

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

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

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

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

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

(G) Contests for denied Notification by a provider shall be made in accordance with the prior authorization dispute process outlined in 16-~~11~~7(C).

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

~~16-10~~16-6 PRIOR AUTHORIZATION

(A) Granting of prior authorization is a guarantee of payment ~~when~~ in accordance with Rule 18, RBRVS, and CPT® for ~~those~~the services/procedures requested by the provider ~~per~~pursuant to section 16-~~10~~6(E). Prior authorization may be requested using the "Authorized Treating Provider's Request for Prior Authorization" (Form WC 188) or, in the alternative, shall be clearly labeled as a prior authorization request.

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

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

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

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

(4) A prescribed service is not identified in the Medical Fee Schedule as referenced in section 16-~~6~~8(C).

(C) Prior authorization for a prescribed service or procedure may be granted immediately and without a medical review. However, the payer shall respond to all ~~providers requesting~~ prior authorization requests in writing within seven (7) business days from receipt of the provider's completed request, as defined in section 16-~~10~~6(E). The duty to respond to a provider's ~~written~~ request applies ~~without regard for~~regardless of who transmitted the request.

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

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

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

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

~~(b)~~(2) Identification of the appropriate Medical Treatment Guideline ~~application to the requested service~~, if applicable; and

~~(c)~~(3) Final diagnosis.

~~(2) When the service/procedure does not fall within the Medical Treatment~~

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~~Guidelines and/or past treatment failed functional goals; or if the requested procedure is not identified in the Medical Fee Schedule or does not have an~~

established value under the Medical Fee Schedule, such as any unlisted procedure/service with a By Report (BR) value or a Relativity Not Established (RNE) value listed in the RBRVS, authorization requests may be made using the "Authorized Treating Provider's Request for Prior Authorization" (Form WC 188).

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

(G) If, after the service was provided, the payer agrees the service provided was reasonable and necessary, lack of prior authorization for payment does not warrant denial of payment. However, the provider is still required to provide, with the bill, the documentation required by section 16-106(E) for any unlisted valued service or procedure for payment.

16-1116-7 CONTEST OF A REQUEST FOR PRIOR AUTHORIZATION

(A) If the payer contests a request for prior authorization for non-medical reasons as defined under section 16-12(B)(1), the payer shall notify the provider and parties, in writing, of the basis for the contest within seven (7) business days from receipt of the provider's completed request as defined in section 16-10(E). A certificate of mailing of the written contest must be sent to the provider and parties.

(A) If an ATP requests prior authorization and indicates in writing, including reasoning and relevant documentation, that he or she believes the requested treatment is related to the admitted workers' compensation claim, the insurer cannot deny solely for relatedness without a medical opinion as required by section 16-117(B)(2). The medical review, IME report, or report from an ATP that addresses the relatedness of the requested treatment to the admitted claim may precede the prior authorization request.

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

(1) Have all the submitted documentation under section 16-106(E) reviewed by a "physician or other health care professional,provider" as defined in section 16-53(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. The physicians or chiropractors performing this review shall be Level I or Level II accredited. In addition, a clinical pharmacist (Pharm.D.) as defined by section 16-3(A)(1)(b)(xvi) may review prior authorization requests for medications without having received Level I or Level II accreditation.

(2) After reviewing all the submitted documentation and other documentation referenced in the prior authorization request and available to the payer, the reviewing provider may call the requesting provider to expedite communication and processing of prior authorization requests. However, the written contest or approval still needs to be completed within the specified seven (7) business days specified under this section 16-11(B).

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

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

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(b) The specific cite from the Medical Treatment Guidelines ~~exhibits to Rule 17~~, when applicable;

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

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

(C) Prior Authorization ~~Disputes~~Appeals

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

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

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

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

(E) Failure of the payer to timely comply in full with section 16-~~11~~7(A), (B), or (C) shall be deemed authorization for payment of the requested treatment unless the payer has scheduled an independent medical examination (IME) and notified the requesting provider of the IME within the time prescribed for responding set forth in section 16-~~11~~7(B).

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

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

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

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

(5) The IME shall comply with ~~Rules~~Rule 8~~-8 to 8-13~~ as applicable.

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

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16-8 REQUIRED USE OF THE FEE SCHEDULE

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

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

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

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

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

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

16-9 REQUIRED BILLING FORMS, CODES, AND PROCEDURES

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

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

(2) UB-04 - shall be used by all hospitals, hospital-based ambulance/air services, Children's Hospitals, CAHs, Veterans' Administration Medical Facilities, home health and facilities meeting the definitions found in section 16-2, when billing for hospital services or any facility fees billed by any other provider, such as hospital-based ASCs.

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

- Revenue Code 042X Physical Therapy

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

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

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

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

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

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

(3) American Dental Association's Dental Claim Form, Version 2012 shall be used by all providers billing for dental services or procedures.

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

Dispensing pharmacies and pharmacy benefit managers shall use NCPDP Workers' Compensation/Property and Casualty (P&C) universal claim form,

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version 1.1, for prescription drugs billed on paper. Physicians may use the CMS-1500 billing form as described in section 16-9(A)(1).

(B) International Classification of Diseases (ICD) Codes

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

(C) Providers must accurately report their services using applicable billing codes, modifiers, instructions, and parenthetical notes listed in the Medical Fee Schedule; the National Relative Value File, as published by Medicare in the February 2018 Resource Based Relative Value Scale (RBRVS); and the American Medical Association's Current Procedural Terminology (CPT®) 2018 edition. The provider may be subject to penalties for inaccurate billing when the provider knew or should have known that the services billed were inaccurate, as determined by the Director or an administrative law judge.

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

(E) Providers shall submit their bills for services rendered within 120 days of the date of service or the bill may be denied unless extenuating circumstances exist. Extenuating circumstances may include, but are not limited to, delays in compensability being decided or the provider has not been informed where to send the bill.

16-10 REQUIRED MEDICAL RECORD DOCUMENTATION

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

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

(1) Patient's name;

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

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

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

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

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

(7) Pain diagrams, where applicable;

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

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

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

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

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

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

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

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

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

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

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

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

~~16-12~~16-11 PAYMENT OF MEDICAL BENEFITS

(A) Payer Requirements for Processing Medical Service Bills

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

(a) Name of the injured worker ~~or patient~~;

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

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

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

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

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

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

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

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

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

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

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

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(2) The payer shall send the billing party written notice that complies with sections 16-~~12~~11(A)(1) and (B) or (C) ~~if contesting payment for non-medical or medical reasons~~ within 30 days of receipt of the bill. Any notice that fails to include the required information ~~set forth in sections 16-12(A)(1) and (B) or (C) if contesting payment for non-medical or medical reasons~~ is defective and does not satisfy the ~~payer's~~ 30-day notice ~~requirements~~requirement set forth in this section.

~~(3)~~ Unless the payer provides timely and proper reasons ~~as~~ set forth by ~~the provisions outlined in~~ sections 16-~~12~~11(B~~) - ()-(~~D), all bills submitted by a provider are

~~(1)~~(3) due and payable in accordance with the Medical Fee Schedule within 30 days after receipt ~~of the bill~~ by the payer.

(4) If the payer discounts a bill and the provider requests clarification in writing, the payer shall furnish to the requester the specifics of the discount within 30 days including a copy of any contract relied on for the discount. If no response is forthcoming within 30 days, the payer must pay the maximum Medical Fee Schedule allowance or the billed charges, whichever is less.

~~(5)~~ Date of receipt of the bill may be established by the payer's date stamp or electronic acknowledgement date; otherwise, presumed receipt is presumed to occur three

~~(2)~~(5) (3) business days after the date the bill was mailed to the payer's correct address.

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

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

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

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

(2) If an ATP bills for medical services and indicates in writing, including reasoning and relevant documentation that he or she believes the medical services are related to the admitted WC claim, the payer cannot deny payment solely for relatedness without a medical opinion as required by section 16-~~12~~11(C). The medical review, IME report, or report from an ATP that addresses the relatedness of the requested treatment to the admitted claim may precede the received billed service.

(3) In all cases where a billed service is contested for non-medical reasons, the payer shall send the billing party written notice of the contest within 30 days of receipt of the bill. The written notice shall include all ~~of the~~ notice requirements set forth in section 16-~~12~~11(A)(1) and shall also include:

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

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

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

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

and/or documents supporting the payer's reasons for contesting payment.

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

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

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

(b) If the provider disagrees, then the payer shall proceed according to section 16-1211(B) or 16-12(C), as appropriate.

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

(6) When no established fee is given in the Medical Fee Schedule and the payer agrees the service or procedure is reasonable and necessary, the payer shall list on the written notice of contest (see section 16-12(A)(1)) one of the following payment options:

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

(b) The provider's requested payment based on an established similar code value as required by section 16-10(E).

If the payer disagrees with the provider's recommended code value, the payer's notice of contest shall include an explanation of why the requested fee is not reasonable, the code(s) used by the payer, and how the payer calculated/derived its maximum fee recommendation. If the payer is contesting the medical necessity of any non-valued procedure after a prior authorization was requested, the payer shall follow section 16-1211(C).

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

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

(1) Have the bill and all supporting medical documentation under section 16-7(F) reviewed by a "physician or other health care professionalprovider" as defined in section 16-53(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. The physicians or chiropractors performing this review shall be Level I or Level II accredited. In addition, a clinical pharmacist (Pharm.D.) as defined by section 16-3(A)(1)(b)(xvi) may review billed services for medications without having received Level I or

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Level II accreditation. After reviewing the supporting medical documentation, the reviewing provider may call the billing provider to expedite communication and timely processing of the contested or paid medical bill.

(2) In all cases where a billed service is contested for medical reasons, the payer shall send the provider and the ~~parties'~~parties written notice of the contest within 30 days of receipt of the bill. The written notice shall include all ~~of the~~ notice requirements set forth in section 16-~~12~~11(A)(1) and shall also include:

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

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

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

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

(e) The specific cite from the Medical Treatment Guidelines ~~exhibits to Rule 17~~, when applicable; and

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

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

(4) If the payer is contesting the medical necessity of any non-valued procedure provided without prior authorization, the payer shall follow the procedures given in sections 16-~~12~~11(C)(1) and (2).

(D) Process for Ongoing Contest of Billed Services

(1) The billing party shall have 60 days to respond to the payer's written notice under section 16-~~12~~11(A~~) – () –~~(C). The billing party's timely response must include:

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

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

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

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

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

(2) If the billing party responds timely and in compliance with section 16-~~12~~11(D)(1), the payer shall:

~~(a)~~ When contesting for medical reasons, have the bill and all supporting

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medical documentation and reasoning ~~under section 16-7(F) and, if~~

(a) ~~applicable, section 16-12(D)(1)~~ reviewed by a "physician ~~or other health care professional~~provider" as defined in section 16-~~5~~3(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. The physicians or chiropractors performing this review shall be Level I or Level II accredited. In addition, a clinical pharmacist (Pharm.D.) as defined by section 16-3(A)(1)(b)(xvi) may review billed services for medications without having received Level I or Level II accreditation. After reviewing the ~~provider's~~ documentation and response, the reviewing provider may call the billing provider to expedite communication and timely processing of the contested or paid medical bill.

(b) When contesting for non-medical reasons, have the bill and all supporting ~~medical~~ documentation and reasoning ~~under section 16-7(F) and, if applicable, section 16-12(D)(1)~~ reviewed by a person who has knowledge of the bill. After reviewing the provider's documentation and response, the ~~reviewing person~~reviewer may call the ~~billing~~ provider to expedite communication and timely processing of the contested or paid medical bill.

(3) If before or after conducting a review pursuant to section 16-~~12~~11(D)(2), the payer agrees with the billing party's response, the billed service is due and payable in accordance with the Medical Fee Schedule within 30 days after receipt of the billing party's response. Date of receipt may be established by the payer's date stamp or electronic acknowledgement date; otherwise, receipt is presumed to occur three (3) business days after the date the response was mailed to the payer's correct address.

(4) After conducting a review pursuant to section 16-~~12~~11(D)(2), if there is still a dispute regarding the billed services, the payer shall send the billing party written notice of contest within 30 days of receipt of the response. The written notice shall include all ~~of the~~ notice requirements set forth in section 16-~~12~~11(A)(1) and shall also include:

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

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

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

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

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

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

~~(6)~~ In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of

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~~(3)~~(6) Administrative Courts. The parties shall do so within 12 months of the date the original bill should have been processed in compliance with section 16-~~12~~11, unless extenuating circumstances exist.

(E) Retroactive review of Medical Bills

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

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

(b) A request for utilization review has been filed pursuant to §8-43-501~~, C.R.S~~.

(2) If the payer conducts a retroactive review to recover overpayments from a provider based on medical reasons, the payer shall have the bill and all supporting documentation reviewed by a "physician ~~or other health care professional~~provider" as defined in section 16-~~5~~3(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. The physicians or chiropractors performing this review shall be Level I or Level II accredited. In addition, a clinical pharmacist (Pharm.D.) as defined by section 16-3(A)(1)(b)(xvi) may review billed services for medications without having received Level I or Level II accreditation. The payer shall send the billing party written notice that shall include all ~~of the~~ notice requirements set forth in section 16-~~12~~11(A)(1) and ~~shall~~ also shall include:

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

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

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

(3) If the payer conducts a retroactive review to recover overpayments from a provider based on non-medical reasons, the payer shall send the billing party written notice that shall include all ~~of the~~ notice requirements set forth in section 16-~~12~~11(A)(1) and shall also include:

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

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

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

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

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

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

(G) To the extent not otherwise precluded by the laws of this state, contracts between providers, payers and any agents acting on behalf of providers or payers shall comply with section 16-~~12~~11.

(H) Onsite Review of Hospital or Other Medical Charges

~~16-13~~16-11 ~~DISPUTE RESOLUTION PROCESS~~

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

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

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

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

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

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

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

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~~16-14 ONSITE REVIEW OF HOSPITAL OR OTHER MEDICAL CHARGES~~

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

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

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

~~(1)~~(a) Name of the injured worker;

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

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

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

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

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

~~(2)~~ (b) Upon receipt of the patient's signed release of information form, allow the reviewer access to all items identified on the injured worker's signed release of information form;

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

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

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

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

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

~~(2)~~(b) Negotiate the starting date for the review;

~~(3)~~(c) Assign staff members who are familiar with medical terminology, general hospital or other medical facility charging and medical records documentation procedures or have a level of knowledge equivalent at least to that of an LPN;

~~(4)~~(d) Establish the schedule for the review which shall include, at a minimum, the dates for the delivery of preliminary findings to the hospital or other medical facility, a ten (10) business day response period for the hospital

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or other medical facility, and the delivery of an itemized ~~listing~~list of discrepancies at an exit conference upon the completion of the review; and

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

16-12 DISPUTE RESOLUTION PROCESS

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

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

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

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

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

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

~~(5)~~ Resolution of disputes not pertaining to Rule violations will be facilitated by the Division to the extent possible. In the event both parties cannot reach an agreement, the parties will be provided additional information on pursuing resolution and adjudication procedures available through the Office of Administrative Courts. Use of the dispute resolution process does not extend the 12 month application period for hearing.

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DEPARTMENT OF LABOR AND EMPLOYMENT

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

Rule 18 MEDICAL FEE SCHEDULE

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CONTENTS

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18-1 STATEMENT OF PURPOSE

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Pursuant to § 8-42-101(3)(a)(I), C.R.S.,) and § 8-47-107, C.R.S., the Director promulgates this Medical Fee Schedule to review and establish maximum allowable fees for health care services falling within the purview of the Workers' Compensation Act of Colorado. The Director adopts and hereby incorporates by reference, as modified and published by Medicare in February 2017,, the April 2018 National Physician Fee Schedule Relative Value file (RBRVS-Resource Based Relative Value Scale); the Current Procedural Terminology (CPT® 2017®) 2018, Professional Edition, published by the American Medical Association (AMA); and Medicare Severity Diagnosis Related Groups (MS-DRGs) Definitions Manual, Version 3536 using MS-DRGs effective after October 1, 20172018. The incorporation of all materials is limited to the specific editions named and does not include later revisions or additions. For information about inspecting or obtaining copies of the incorporated materials, contact the Medical Policy Unit Supervisor, 633 17th Street, Suite 400, Denver, Colorado 80202-3626. These materials may be examined at any state publications depository library. AllThe Director adopts all guidelines and instructions are adopted as set forth in the RBRVS, CPT®®, and MS-DRGs, andas well as all CPT® modifiers, unless otherwise specified in this Rule.

This Rule applies to all services rendered on or after January 1, 20182019. 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

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(A) CPT® - Current Procedural Terminology CPT® 20172018, copyrighted and distributed by the AMA and incorporated by reference in 18-1.

(B) DoWC Zxxxx – Colorado Division of Workers' Compensation created codes. See Exhibit #9.

(C) MS-DRGs – version 3536.0 incorporated by reference in 18-1.

(D) Medicare's February 2017April 2018 National Physician Fee Schedule Relative Value file (RBRVS) as modified by Rule 18 and its exhibits to establish the Medical Fee Schedule. For a list of Division-created and modified rates and values, see Exhibit #9.

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

18-3 HOW TO OBTAIN COPIES

~~All users are responsible for the timely purchase and use of Rule 18 and its supporting documentation as referenced herein. The Division shall make available for public review and inspection the~~ For information about inspecting or obtaining copies of ~~all materials~~ the incorporated ~~by reference in Rule 18. Copies of the~~ materials, interested parties may contact the Medical Services Manager, 633 17th Street, Suite 400, Denver, CO 80202-3626. These materials are available at any state publications depository library. The RBRVS may be obtained from ~~Medicare's website~~Medicare, www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/PhysicianFeeSched/Index.html. The ~~Current Procedural Terminology, 2017~~CPT® 2018 Edition~~,~~ may be purchased from the AMA. The MS-DRGs Definitions Manual may be purchased from 3M Health Information Systems. The ~~Colorado~~unofficial copies of the Workers' Compensation Rules of ~~Procedures with~~Procedure, the Medical Treatment Guidelines, 7 CCR 1101-3, ~~is~~and the Interpretive Bulletins are available on the Division's website, https://www.colorado.gov/pacific/cdle/dwc or they may be purchased from LexisNexis ~~Matthew Bender & Co., Inc., Albany, NY. Interpretive Bulletins and unofficial copies of all rules are available on the Colorado Department of Labor and Employment web site.~~. An official copy of the ~~rules~~rule is available on the Colorado Secretary of State's webpage, http://www.sos.state.co.us/CCR/Welcome.do.

18-4 CONVERSION FACTORS (CFs)

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

RBRVS SECTION	CF
Anesthesia	$50.00/RVU
Surgery	$~~71.17~~72.00/RVU
Radiology	$~~71.17~~72.00/RVU
Pathology	$~~68.40~~72.00/RVU
Medicine	$~~68.34~~72.00/RVU
Physical Medicine and Rehabilitation (Includes Medical Nutrition Therapy and Acupuncture)	$~~42.38~~43.75/RVU
Evaluation & Management (E&M)	$~~53.53~~54.81/RVU

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

~~Table #1~~

~~Place of Service Code~~	~~Place of Service Code Description~~
~~02~~	~~Telehealth Services~~
~~19~~	~~Off Campus – Outpatient Hospital~~
~~21~~	~~Inpatient Hospital~~
~~22~~	~~On Campus - Outpatient Hospital~~
~~23~~	~~Emergency Room-Hospital~~
~~24~~	~~Ambulatory Surgery Center (ASC)~~
~~26~~	~~Military Treatment Facility~~
~~31~~	~~Skilled Nursing Facility~~
~~34~~	~~Hospice~~
~~41~~	~~Ambulance - Land~~
~~42~~	~~Ambulance - Air or Water~~

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

(A) MAXIMUM ALLOWANCE

Maximum allowance for all providers under Rule 16-~~5~~3 is 100% of the RBRVS value or as specified in this Rule. The maximum ~~fee schedule value~~allowance for professional services of Physician Assistants (PAs) and Nurse Practitioners (NPs) shall be 85% of the Medical Fee Schedule. However, PAs and NPs ~~may be~~are allowed 100% of the Medical Fee Schedule ~~value~~ if the requirements of Rule 16-~~5~~3(A)(~~6~~5) have been met and one of the following conditions applies:

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

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

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

(2) The PA or NP has received Level I accreditation.

(B) RBRVS, CPT®~~®~~, HCPCS, NATIONAL DRUG CODE, AND Z CODES

(1) ~~Unless modified herein, the RBRVS is adopted for RVUs.~~ Division-created codes ~~(Zxxxx)~~ and values supersede ~~the~~ CPT® ~~or RBRVS~~®, Health Care Common Procedure Coding System (HCPCS), and National Drug Code (NDC) codes~~. Those codes~~ and values. Codes listed with RVUs of "BR" (by report), not listed, or listed with a zero value and not included by Medicare in another procedure(s), require prior authorization ~~pursuant to Rule 16. The CPT® 2017 is adopted for codes, descriptions, parenthetical notes and coding guidelines, unless modified in this Rule.~~(see Rule 16-6).

(2) ~~When billing for services reported with time-~~ Correct Reporting of Services/Procedures and Payment Policies:

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(a) Providers shall report codes and number of units based ~~codes, practitioners are required to~~ on all applicable code descriptions and Rule 18. In addition, providers shall document all services/procedures in the medical record ~~the duration of the encounter. The time considered is~~.

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

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

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

~~(a)~~(e) Providers shall apply modifiers to ~~face~~ clarify services rendered and/or adjust the maximum allowances as indicated in Rule 18. Prior to correcting a modifier, payers shall comply with ~~the patient, performing the billed service (e.g., 60 minutes of psychotherapy) and/or the time spent performing non-face-to-face services/procedures (e.g., prolonged record review).~~Rule 16-11(B)(4).

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

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

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

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

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

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

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

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

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

(3) The following RBRVS fields and attributes are adopted, including additional fields as defined by the Division:

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

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

(b) Modifier;

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

(d) Status Code:

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

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

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

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

~~(d)~~(h) Non-Facility ~~RVU~~(NF) Total RVUs;

~~(e)~~(i) ~~Total~~ Facility ~~RVU;~~(F) Total RVUs;

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

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

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

8	Physician Interpretation Codes – separate payments may be made only if a physician interprets an abnormal smear for a hospital inpatient.
9	Concept of PC/TC distinction does not apply.

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

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

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

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

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

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

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

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

(o) Multiple-Procedure Modifier

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

Indicator	Meaning
0	No payment adjustment for multiple procedures applies. These codes are generally identified as “add-on” codes in CPT®.
1, 2, or 3	Standard payment reduction applies (100% for the highest-valued procedure and 50% for all lesser-valued procedures performed during the same operative setting).

4, 5, 6, or 7	Not subject to the multiple procedure adjustments.
9	Multiple procedure concept does not apply.

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

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

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

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

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

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

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

(p) ~~"7" - Physical Therapy Services – these~~

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

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	is one payment per line. Indicator 3 codes are primarily diagnostic radiology and other diagnostic medicine procedures.
9	Not eligible for the bilateral payment adjustment because the concept does not apply.

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

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

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

No separate assistant surgeon or minimum assistant fees shall be paid if a co-surgeon is paid for the same operative procedure during the same surgical episode.

(r) Co-Surgeons, Modifier 62

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

(s) Team Surgeons, Modifier 66

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

~~(viii)~~ (t) Endoscopy base codes are not recognized ~~by DoWC;~~for payment adjustments except when other modifiers apply.

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

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

~~(g) Global Days;~~

~~(h) CFs as specified in Rule 18-4.~~

(u) ~~(6~~All other fields are not recognized.

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

8(C) ~~ANESTHESIA).~~

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(C) EVALUATION AND MANAGEMENT (E&M)

(1) Evaluation and management codes may be billed by physician providers as defined in Rule 16-3(A)(1)(a), nurse practitioners (NP), and physician assistants (PA). To justify the billed level of E&M service, medical record documentation shall utilize the 2018 CPT® E&M Services Guidelines and either the "E&M Documentation Guidelines" criteria adopted in Exhibit #7, or Medicare's 1997 Evaluation and Management Documentation Guidelines.

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

For adjusted RVUs and rates, see Exhibit #9.

(2) New or Established Patients

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

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

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

(3) Number of Office Visits

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) Prolonged Services:

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

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

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

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

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

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

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

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

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

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(D) ANESTHESIA

(1) All anesthesia base values ~~shall be established by the use of the codes as~~are set forth in Medicare's ~~2017~~2018 Anesthesia Base Values. For adjusted RVUs and rates, see Exhibit #9. Anesthesia services are only reimbursable if the anesthesia is administered by a physician, a Certified Registered Nurse Anesthetist (CRNA), or an anesthesiologist assistant (AA) who remains in constant attendance during the procedure for the sole purpose of rendering anesthesia.

When ~~anesthesia is administered by~~ a CRNA or AA administers anesthesia:

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

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

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

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(i) ~~Performs~~performs a pre-anesthesia examination and evaluation,
(ii) ~~Prescribes~~prescribes the anesthesia plan,
(iii) ~~Personally~~personally participates in the most demanding procedures in the anesthesia plan including induction and emergence,
(iv) ~~Ensures~~ensures that any procedure in the anesthesia plan that s/he does not perform is performed by a qualified anesthetist,
(v) ~~Monitors the course of~~monitors anesthesia administration at frequent intervals,
(vi) ~~Remains~~remains physically present and available for immediate diagnosis and treatment of emergencies, and
(vii) ~~Provides~~provides indicated post-anesthesia care.

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

(3) HCPCS Level II modifiers are ~~to be used~~required when billing for anesthesia services~~:~~

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

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

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

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

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

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

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

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

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

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

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

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

(5) Qualifying circumstance codes are reimbursed using the anesthesia CF~~:~~.

~~(a) Anesthesia complicated by extreme age; under 1 year old or > 70 years old 1 RVU~~

~~(b) Anesthesia complicated by utilization of total body hypothermia 5 RVUs~~

~~(c) Anesthesia complicated by utilization of controlled hypotension 5 RVUs~~

~~(d) Anesthesia complicated by emergency conditions (specify) 2 RVUs~~

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

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

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

(8) Calculation of Maximum Fees for Anesthesia

Base Anesthesia value from the Medicare's ~~2017~~2018 Anesthesia Base Values

+1 Unit/15 minutes of anesthesia time
+Any physical status modifier units
Total Relative Value Anesthesia Units
Multiplied by the Anesthesia CF in section 18-4
Total Maximum Anesthesia Fees

(9) Non-time based ~~Anesthesia Procedures~~

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Modifier -47anesthesia procedures shall be used by surgeons performing non-time based anesthesia.billed with modifier 47.

(DE) SURGERY

(1(1) Assistant Surgeons Payment Policies and Modifiers:

(a) The use of assistant surgeons shall be limited according to the American College Of Surgeons' Physicians as Assistants at Surgery: 20162018 Update (April 2016February 2018), available from the American College of Surgeons, Chicago, IL, or from its web page. The incorporation is limited to the edition named and does not include later revisions or additions. Copies of the material incorporated by reference may be inspected at any State publications depository library. For information about inspecting or obtaining copies of the incorporated material, contact the Medical Policy Unit Supervisor, 633 17th Street, Suite 400, Denver, Colorado, 80202-3626.

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

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

(3) No paymentProvider shall be madedocument the medical necessity for any assistant surgeon in the operative report.

(b) Payment for more than one (1) assistant surgeon or minimum assistant surgeon withoutrequires prior authorization for payment (see Rule 16-106).

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

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

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

(c) Assistant Surgeon, Maximum allowance for an assistant surgeon or minimum assistant surgeon, reported by a physician, as indicated by modifier -80 has a maximum allowance of 20 , 81 or 82 is 20% of the surgeon's fees.
Assistant Surgeon (when qualified resident surgeon is not available),

Maximum allowance for an assistant surgeon or minimum assistant surgeon, reported by a non-physician, as indicated by modifier -AS with modifier 80, 81 or 82, is also reimbursed at 2010% of the surgeon's fees.

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

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

~~(b) –81 for~~

(e) The services performed by ~~clinical nurse specialists,~~registered surgical ~~technicians, or any other non-physician providers.~~technologists are bundled fees and are not separately payable.

~~(6~~

(f) See section 18-5(B)(3)(q) for additional payment policies applicable to assistant surgeons.

(2) Global ~~Period~~Package

(a) All surgical procedures include the following:

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

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

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

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

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

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

(vii) ~~Typical postoperative~~ typical post-operative follow-up care during the global period of the surgery that is related to recovery ~~from the surgery as identified in RBRVS as global:~~, see section 18-5(B)(3)(k).

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

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

~~(ix) Miscellaneous Services – Items such as~~ (viii)supplies integral to an operative procedure. See section

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18-6(H) to determine reimbursement for unrelated supplies or Durable Medical Equipment, Orthotics or Prosthetics (DMEPOS).

Casting supplies are separately payable only if related fracture or surgical care code is not billed. The HCPCS Level II "Q" code(s) are used for reporting any associated DMEPOS fees.

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

- dressing changes;
- local incisional care;
- removal of operative pack;
- removal of cutaneous sutures and staples, lines, wires, tubes, or drains~~,~~;
- initial application of casts and splints;
- insertion, irrigation, and removal of urinary catheters~~,~~;
- routine peripheral IV lines~~,~~;
- nasogastric and rectal tubes;
- changes and removal of tracheostomy tubes;
- ~~(x) Applicable Surgical~~ post-surgical pain management by the surgeon;
- all complications leading to additional procedures performed by the surgeon, but not requiring an operating room. Complications requiring an operating room are separately payable with modifier 78.

(b) Modifiers:

- ~~22 – Increased procedural service. The payer and provider shall negotiate the value based on the fee schedule and the amount of additional work.~~
- ~~24 - Unrelated E&M service by the same physician during a postoperative period.~~

~~25 -~~

Code	Payment policy
22	The payer and provider shall negotiate the value based on the fee schedule and the amount of additional work.
54	Surgical care only. This modifier can be combined with either modifier 55 or 56, but not both. Maximum fee is the applicable percentage in the "intra-op %" RBRVS column multiplied by the fee schedule value.
55	Post-operative management only. This modifier can be combined with either modifier 54 or 56, but not both. Maximum fee is the applicable percentage in the "post-op %" RBRVS column multiplied by the fee schedule value.
56	Pre-operative management only. This modifier can be

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	combined with either modifier 54 or 55, but not both. Maximum fee is the applicable percentage in the "pre-op %" RBRVS column multiplied by the fee schedule value.
58	Maximum fee value is 100% of prospective procedures that occur on the same day or staged over a couple of days.
62	Co-Surgeon use when different surgical skills are necessary to perform a surgical procedure.
76	
78	Maximum fees for this unplanned trip is the intra-operative value of the procedure(s) performed only and the original post-operative global days continue from the initial surgical procedure(s).
79	

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

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

~~(i) E&M services unrelated to the primary surgical procedure.~~
~~(ii) Services necessary to stabilize the patient for the primary surgical procedure.~~
~~(iii) Services not considered part of the surgical procedure, including an E&M visit by an authorized treating physician for disability management.~~are separately payable. The ~~E&M service shall have an appropriate modifier appended to the E&M level of the service code when the surgeon is performing~~ services ~~during the global period. If at all possible, an appropriate identifying diagnosis code shall identify the E&M service as unrelated to the surgical global period. In addition, the reasonableness and necessity for an E&M service that is separate and identifiable from the surgical global period shall be clearly documented in the medical record.~~

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~~(iv) Disability management of an injured worker for the same diagnosis requires the managing physician to clearly identify in the medical record the specific disability management detail that was performed during that visit. The definitions of what is considered disability counseling can be located under section 18-5(I)(1) and in Exhibit #7 of this Rule.~~

~~(v)~~ ~~Unusual~~involve unusual circumstances, complications, exacerbations, or recurrences; and/or unrelated diseases or injuries.

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~~(vi) Unrelated diseases or injuries.~~

~~(vii) If a patient is seen for the first time or an established patient is seen for a new problem and the "decision for surgery" is made the day of the procedure or the day before the procedure is performed, then the surgeon can bill both the procedure code and an E&M code, using a -57 modifier or -25 modifier on the E&M code.~~

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

~~(7) Multiple Procedures (modifier -51) and~~ Modifiers 24, 25, and 57 shall be used to over-ride the global package edits/limits:

Modifier	Payment and billing policies	Applicability/Documentation
24	E&M services unrelated to the primary surgical procedure. The reasonableness and necessity for an E&M service that is separate and identifiable from the surgical global period shall be documented in the medical record. If possible, an appropriate identifying diagnosis code shall identify the E&M service as unrelated to the surgical global period. Disability management of an injured worker for the same diagnosis requires the physician to identify the specific disability management detail performed during that visit.	Services necessary to stabilize the patient for the primary surgical procedure. Services not considered part of the surgical procedure, including an E&M visit by an authorized treating physician for disability management. The definitions of disability counseling are located under section 18-5(C)(1) and in Exhibit #7.
25	Initial or follow up visit that occurred on the same day/encounter as a minor surgical procedure.	E&M documentation must support the patient's condition. The visit must be significant and

		separately identifiable from the minor surgical procedure and the usual pre- and post-operative care required.
57	The surgeon's E&M visit that resulted in the decision for major surgery performed on either the same day or the day after the visit.	The E&M documentation must identify the medical necessity of the procedure and the discussion with the patient.

(3) General Surgical Payment Policies:

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

A diagnostic arthroscopy that resulted~~Bilateral Procedures (modifier -50)~~

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

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

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

~~(8) If a surgical arthroscopic procedure is converted to the same surgical open procedure on the same joint, only the open procedure is payable. If an arthroscopic procedure and open procedure are performed on different joints, the two (2) procedures may be separately payable with anatomic modifiers or modifier -50.~~

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

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

(b) ~~G0289 shall be paid when reported~~ in ~~conjunction with other knee~~ a surgical arthroscopy ~~codes~~at the same surgical encounter is bundled into the surgical arthroscopy and is not separately payable.

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

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

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

(4) Knee Arthroscopies

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

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

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

(d) ~~(10~~Payment for a major synovectomy procedure shall require a synovial diagnosis and two or more knee compartments without any other arthroscopic surgical procedures performed in the same compartment.

(5) Shoulder Arthroscopies

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

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

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

(d) Extensive debridement is separately payable if documented in the medical record.

(6) Spine and Nervous System

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

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

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

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

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

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

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

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

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

(~~11~~8) Platelet Rich Plasma (PRP) Injections

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

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The provider performing PRP injections in an office setting shall bill DoWC Z0813~~, maximum total allowance of $744.00,~~ for professional fees.

The provider performing PRP injections in a facility setting shall bill CPT® 0232T, ~~maximum total allowance of $269.50,~~ for professional fees. For adjusted RVUs and rates, see Exhibit #9.

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

(~~E~~F) RADIOLOGY

(1) General Policies

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

~~(b)~~ ~~The~~ technical component (TC) modifiers per CPT® guidelines. The technical component represents the cost of equipment, supplies and personnel necessary to perform the procedure. ~~It is identified by appending modifier TC to the procedure code.~~

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

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

(2) Payments

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

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

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

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

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(e) The payer may use available billing information such as provider credential(s) and clinical record(s) to determine if ~~an~~ appropriate CPT®/RBRVS modifier should have been used on the bill. To modify a billed code, refer to Rule 16-~~12~~11(B)(4).

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

~~(g~~(f) Providers using film instead of digital X-rays shall append "the FX" modifier. The fee is 80% of the ~~maximum fee schedule~~Maximum Fee Schedule.

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

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

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

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

(3) Thermography

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

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

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

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

~~(c) General Protocols for Stress Testing~~

~~Cold Water Autonomic Functional Stress Testing – Baseline infrared images are obtained in a 68º F +/- 1 degree steady state environment following equilibration for 15 minutes. After the quantitative and qualitative baseline images are captured, cold water autonomic functional stress~~

testing is performed by submersing the asymptomatic extremity in 68º F +/- 1 degree cold water bath for 5 minutes while imaging and evaluating the autonomic response.

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

(d) Thermography Billing Codes:

DoWC Z0200 Upper body w/ Autonomic Stress Testing $980.00

DoWC Z0201 Lower body w/Autonomic Stress Testing $980.00

(ec) Prior authorization for payment (see Rule 16-106) is required for thermography services only if the requested study does not meet the indicators for thermography as outlined in this radiology section.the Division's Chronic Regional Pain Syndrome Medical Treatment Guideline (Rule 17, Exhibit #7). The billingbill shall include a report supplyingthat supplies the thermographic evaluation and reflecting compliancecomplies with section 18-5(EF)(2).

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

(FG) PATHOLOGY

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(1) General Policies

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

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

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

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

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(2) Clinical Laboratory Improvement Amendments (CLIA)

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

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

(3) Payments

All clinical pathology laboratory tests, except as allowed by this ~~rule~~Rule, are reimbursed at the total component ~~dollar~~ value listed under Exhibit #8 ~~of this Rule~~ or billed charges, whichever is less. ~~No separate technical~~Technical or professional component maximum ~~dollar~~ split is not separately payable ~~by the payer.~~. However ~~the technical and professional component~~ , the billing parties may agree ~~upon a dollar value~~how to split ~~of~~ the total maximum fees listed in Exhibit #8 ~~of this Rule~~.

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

(a) physician blood bank services,

(b) cytopathology and cell marker study interpretations,

(c) cytogenics or molecular cytogenics interpretation and report,

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

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

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

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

(a) Clinical drug screening/testing evaluates whether:

(i) ~~Prescribed~~prescribed medications are at or below therapeutic or toxic levels (~~Therapeutic Drug Monitoring~~therapeutic drug monitoring); or
(ii) ~~Th~~the patient is taking prescribed controlled substance medications; or
(iii) ~~Th~~the patient is taking any illicit or non-prescribed drugs.

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(b) Billing requirements for ~~Clinical Drug Testing~~clinical drug testing:

(i) ~~Th~~the ordering physician shall document the medical necessity of the clinical drug test.
(ii) ~~Th~~the ordering physician shall specify which drugs require definitive testing to meet the patient's medical needs.
(iii) ~~Quantification~~quantification of illicit or non-prescribed drugs or drug classes requires a physician order.
(iv) Medicare codes used in the ~~2017~~2018 Medicare Fee Schedule shall be billed for presumptive and definitive urine drug tests.
(v) ~~All~~all recognized codes and maximum fee values are listed in Exhibit #8 ~~to this Rule~~.

(c) Presumptive Tests

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

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

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

- Unexpected positive presumptive or qualitative test results inadequately explained by the injured worker.
- Unexpected negative presumptive or qualitative test results and suspected medication diversion.
- Differentiate drug compliance:
  - Buprenorphine vs. norbuprenorphine
  - Oxycodone vs. oxymorphone and noroxycodone
- Need for quantitative levels to compare with established benchmarks for clinical decision-making, such as tetrahydrocannabinol (THC) quantitation to document discontinuation of a drug.
- Chronic ~~Opioid Management:~~
- ~~Drug~~opioid management - drug testing shall be done prior to the implementation of the initial long-term drug prescription and randomly repeated at least annually.

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- While the injured worker ~~is receiving~~receives chronic opioid management, additional drug screens with documented justification may be conducted (see section 18-8(A) for examples). Providers may ~~ONLY~~only bill ~~for~~ one ~~of the five~~ definitive ~~codes~~HCPCS Level II code per day~~:~~.

  - ~~G0480- Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to gc/ms (any type, single or tandem) and lc/ms (any type, single or tandem and excluding immunoassays (e.g., ia, eia, elisa, emit, fpia) and enzymatic methods [e.g., alcohol dehydrogenase]), (2) Stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 1-7 drug class(es), including metabolite(s) if performed.~~
  - ~~G0481- Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to gc/ms (any type, single or tandem) and lc/ms (any type, single or tandem and excluding immunoassays (e.g., ia, eia, elisa, emit, fpia) and enzymatic methods [e.g., alcohol dehydrogenase]), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 8-14 drug class(es), including metabolite(s) if performed.~~
  - ~~G0482- Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to gc/ms (any type, single or tandem) and lc/ms (any type, single or tandem and excluding immunoassays (e.g., ia, eia, elisa, emit, fpia) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 15-21 drug class(es), including metabolite(s) if performed.~~
  - ~~G0483- Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to gc/ms (any type, single or tandem) and lc/ms (any type, single or tandem and~~

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excluding immunoassays (e.g., Ia, eia, elisa, emit, fpia) and enzymatic methods (e.g., Alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., To control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., To control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 22 or more drug class(es), including metabolite(s) if performed.

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

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

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

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

(H) MEDICINE

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

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

(3) Biofeedback

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Licensed medical and mental health professionals who provide biofeedback must practice within the scope of their training. Non-licensed biofeedback providers must hold Clinical Certification from the Biofeedback Certification International Alliance (BCIA), practice within the scope of their training, and receive ~~a~~ prior approval of their biofeedback treatment plan from the patient's authorized treating physician, psychologist, or psychiatrist. Professionals integrating biofeedback with any form of psychotherapy must be licensed as a psychologist, a social worker, a marriage or a family therapist, or a licensed professional counselor. ~~For purposes of this rule, "licensed" means holding a license issued by the Colorado Medical Board, the Colorado Board of Chiropractic Examiners, the Colorado Podiatry Board, the Colorado Dental Board, or a board of the Colorado Department of Regulatory Agencies (DORA).~~

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

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

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

~~CPT® Code 90901, Biofeedback training by any modality:~~

~~Non-facility RVU is 2.14, Facility RVU is 1.14~~

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

~~Non-facility RVU is 4.76, Facility RVU is 2.48~~

For adjusted RVUs and rates, see Exhibit #9.

(4) Appendix J of ~~the 2017~~2018 CPT® identifies mixed, motor, and sensory nerve conduction studies and applicable billing requirements. Electromyography (EMG) and nerve conduction velocity (NCV) values generally include an evaluation and management (E&M) service. However, an E&M service may be separately payable if the requirements listed in Appendix A of ~~the 2017~~2018 CPT® for billing modifier 25 have been met.

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

(a) Prior authorization ~~for payment~~ (see Rule 16-~~10~~6) shall be obtained before billing for more than four body regions in one (1) visit. Manipulative therapy is limited to the maximum allowed in ~~Rule 17,~~the Medical Treatment Guidelines. The provider's medical records shall reflect medical necessity and prior authorization ~~for payment (see Rule 16-10)~~ if treatment exceeds these limitations.

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

(c) ~~Facility RVU is 0.79~~For adjusted RVUs and ~~non-facility RVU is 1.00 for CPT® code 98940~~rates, see Exhibit #9.

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

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

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

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

~~(i) Without Evaluation & Management Service:~~

~~Non-facility is 9.91 RVUs~~
~~Facility is 9.6 RVUs~~
~~(ii) With Evaluation and Management Service~~
~~Non-facility is 11.12 RVUs~~
~~Facility is 10.8 RVUs~~

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

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

Brief psychological screens (including, but not limited to, the Distress Risk and Assessment Method (DRAM), Primary Care Evaluation of Mental Disorders (PRIME-MD), Zung Self-Rating Depression Scale, Beck Depression Inventory, and CES-D (Center for Epidemiologic Studies Depression Scale) are not equivalent to psychological testing~~, CPT®~~ codes ~~96101-96127.~~listed in the CNS section of CPT®.

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

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

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

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

Prior authorization ~~for payment (see Rule 16-10)~~ is required any time the 60 minutes per visit limitation is exceeded. The time for internal record review/documentation is included in this limit.

Psychotherapy for work-related conditions requiring more than 20 visits or continuing for more than three (3) months after the initiation of therapy, whichever comes first, requires prior authorization ~~for payment (see Rule 16-10) except where~~unless specifically addressed in ~~Rule 17,~~the Medical Treatment Guidelines.

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

(i) ~~Both~~both services must be separately identifiable;

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

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

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

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

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

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

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

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

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

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

(i) Resting Sweat Test;

(ii) Stimulated Sweat Test;

(iii) Resting Skin Temperature Test; and

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

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(b) ~~Maximum fee~~Bill DoWC Z0401 QSART, when all of the services outlined ~~in 18-5(G)(8)(a)~~above are completed and documented~~:~~

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

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

(9) Intra-Operative Monitoring (IOM)

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

(a) Clinical Services for IOM: Technical and Professional

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

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

(ii) Professional/Supervisory /Interpretive

A Colorado-licensed physician trained in neurophysiology shall monitor the patient's nervous system throughout the surgical procedure. The monitoring physician's time is billed based upon the actual time the physician devotes to the individual patient, even if the monitoring physician is monitoring more than one ~~(1)~~ patient. The monitoring physician's time does not have to be continuous for each patient and may be cumulative. The monitoring physician shall not monitor more than three (3) surgical patients at one time. The monitoring physician shall provide constant neuromonitoring at critical points during the surgical procedure as indicated by the surgeon or any unanticipated testing responses. There must be a neurophysiology ~~-~~trained Colorado licensed physician backup available to continue monitoring the other two patients if one of the patients being monitored has complications and/or requires the monitoring physician's undivided attention for any reason. There is no additional payment for the back-up neuromonitoring physician, unless he/she is utilized in a specific case.

(iii) Technical Electronic Capacity for Real-~~time~~Time Communication ~~requirements~~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

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the monitoring modalities that may be applied with the IOM procedure code.

(b) Procedures and Time Reporting

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

(c) Billing Restrictions

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

The monitoring physician is the only ~~billing~~ party allowed to report ~~CPT® 95940 or 95941~~these codes.

~~(10) Speech Therapy/Evaluation and Treatment~~

For adjusted RVUs and rates, see Exhibit #9.

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

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

(11) Vaccine and ~~Toxoids~~

~~Shall~~toxoids shall be billed using the appropriate J code or CPT® code listed in the Medicare Part B Drug Average Sale Price (ASP), ~~or at cost to the billing provider if no dollar value is listed in ASP.~~unless the ASP value does not exist for the drug or the provider's actual cost exceeds the ASP. In these circumstances, the provider may request reimbursement based on the actual cost, after taking into account any discounts/rebates the provider may have received.

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

IV infusion therapy performed in a physician's office shall be billed under the "Therapeutic, Prophylactic, and Diagnostic Injections and Infusions" and the "Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration" in the Medicine Section of CPT®. ~~The appropriate CPT®/RBRVS code units multiplied by the Medicine CF is the Maximum Fee Schedule value for the infusion service.~~ The infused therapeutic drugs are payable at cost to the provider's office.

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

(13) Moderate (~~conscious) sedation~~Conscious) Sedation

Providers billing for moderate sedation services shall comply with all applicable ~~2017~~2018 CPT® billing instructions. The ~~maximum fee schedule~~Maximum Fee Schedule value is determined using the Medicine CF.

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

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

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

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

(d) Any stored clinical or physiological data analysis is not recognized unless the provider shows the reasonableness and necessity of these services and obtains prior authorization from the payer ~~(CPT® codes 99090 and 99091).~~

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

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

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

Restorative services are an integral part of the healing process for a variety of injured workers. For adjusted RVUs and rates, see Exhibit #9.

~~-~~(1) Billing and documentation requirements:

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

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

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

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

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plan changes. The ordering ~~PM&R~~ ATP must also agree with the PM&R continuation or changes to the treatment plan.

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

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

(4) Special Note to ~~All Physical Medicine and Rehabilitation~~all PM&R Providers:

The ATP shall obtain prior authorization ~~for payment~~ (see Rule 16-~~10~~6) from the payer for any PM&R treatment not listed in or exceeding the frequency or duration recommendations in ~~Rule 17,~~the Medical Treatment Guidelines.

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

(5) Interdisciplinary Rehabilitation Programs – ~~Requires Prior Authorization for Payment (see Rule 16-10).~~require prior authorization to determine fees.

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

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

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

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

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

The provider's medical records shall reflect the medical necessity and the provider shall obtain prior authorization ~~for payment (see Rule 16-10)~~ if the procedures are not recommended or the frequency and duration exceeds the recommendations of the ~~Rule 17, Medical Treatment Guidelines. The maximum amount of time allowed is one (1) hour of procedures per day, per discipline; unless medical necessity is documented and prior authorization is obtained from the payer.~~Medical Treatment Guidelines.

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

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

For Dry Needling of Trigger Points, ~~Single~~single or multiple needles,

use DoWC Z0501 ~~- initial 15 minutes of dry needling 1.3 non-facility RVUs .77 facility RVUs~~

~~DoWC~~or Z0502 ~~- each add'l 15 minutes of dry needling .77 non-facility RVUs~~as appropriate.
~~.72 facility RVUs~~

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(7) Modalities

~~RBRVS Timed and Non-timed Modalities~~

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

NOTE: Instruction and application of a transcutaneous electric nerve stimulation (TENS) unit for the patient's independent use at home shall be billed only once per workers' compensation claim using CPT® 64550. Rental or purchase of a TENS unit requires prior authorization ~~for payment (see Rule 16-10).~~. For Maximum Fee Schedule value, see section 18-6(H).

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

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

(a) All evaluation services must be supported by the appropriate history, physical examination documentation, treatment goals and treatment plan or re-evaluation of the treatment plan, as outlined in the ~~2017~~2018 CPT®. The provider shall clearly state the reason for the evaluation, the nature and results of the physical examination of the patient, and the reasoning for recommending the continuation or adjustment of the treatment protocol. Without appropriate supporting documentation, the payer may deny payment. The re-evaluation codes shall not be billed for routine pre-treatment patient assessment.

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

~~A reexamination, reevaluation~~A re-examination, re-evaluation, or re-assessment is different from a progress note. Therapists should not bill these codes for a progress note. Therapists may bill ~~CPT® codes 97164, 97168, or 97172 for a reevaluation only in the following cases~~a re-evaluation code only if:

(i) ~~Professional~~professional assessment indicates a significant improvement or decline or change in the patient's condition or a functional status that was not anticipated in the ~~Plan~~plan of ~~Care (POC)~~care for that time interval.
(ii) ~~New~~new clinical findings ~~come to light~~become known.
(iii) ~~The~~the patient fails to respond to the treatment outlined in the current ~~POC~~ plan of care.

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

~~97161 – PT initial evaluation, low complexity, 1.66 RVUs~~

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~~97162 – PT initial evaluation, moderate complexity, 2.48 RVUs~~

~~97163 – PT initial evaluation, high complexity, 3.71 RVUs~~

~~97164 – PT re-evaluation, 1.60 RVUs~~

~~97165 – OT initial evaluation, low complexity, 1.66 RVUs~~

~~97166 – OT initial evaluation, moderate complexity, 2.48 RVUs~~

~~97167 – OT initial evaluation, high complexity, 3.71 RVUs~~

~~97168 – OT re-evaluation, 1.60 RVUs~~

~~97169 – ATC initial evaluation, low complexity, 1.41 RVUs~~

~~97170 – ATC initial evaluation, moderate complexity, 2.10 RVUs~~

~~97171 – ATC initial evaluation, high complexity, 3.10 RVUs~~

~~97172 – ATC re-evaluation, 1.36 RVUs~~

~~The above RVUs are for both facility and non-facility providers.~~

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

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

The WC196 form must be completed and include which ~~of the approved~~validated functional ~~tools, from the Division's Quality Performance and Outcomes Payments (QPOP) list,~~tool was used for assessing the patient.

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

~~Billing code DoWC Z0817 - $15.00~~

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

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

(~~f~~e) Reimbursement to PTs and OTs for coordination of care with professionals shall be based upon the telephone codes for qualified non-physician providers found in the ~~RBRVS~~ Medicine Section~~.~~ of CPT®. Coordination of

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care reimbursement is limited to telephone calls made to outside professionals and/or to the injured worker or ~~their~~his or her family.

(~~g~~) ~~All interdisciplinary~~f) Interdisciplinary team conferences shall be billed ~~in compliance with section 18-~~per subsection (5~~(H)(5).~~) above.

(9) Special Tests

(a) The following are considered special tests:

(i) Job Site Evaluation
(ii) Functional Capacity Evaluation
(iii) Assistive Technology Assessment
(iv) Speech
(v) Computer Enhanced Evaluation (DoWC Z0503)
(vi) Work Tolerance Screening (DoWC Z0504)

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

(b) Billing Restrictions:

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

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

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

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

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

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

(10) ~~Supplies~~

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

(11) ~~Unattended Treatment~~

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

DoWC Z0505 ~~— fixed fee~~(once per day~~ 0.232 RVU~~).

(12) Non-Medical Facility

Fees~~, such as gyms~~

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

(13) Unlisted ~~Service Physical Medicine~~

~~All unlisted~~ services ~~or procedures~~ require a report.

(14) Work Conditioning, Work Hardening, Work Simulation

(a) Work ~~conditioning~~Conditioning is a non-interdisciplinary program that is focused on the individual needs of the patient to return to work. Usually one (1) discipline oversees the patient in meeting goals to return to work. ~~Refer to Rule 17, Medical Treatment Guidelines.~~

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

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

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

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~~(d)~~(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.~~

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

(d) Treatment Plan:

(i) The provider shall submit a treatment plan including expected frequency and duration of treatment. If requested by the provider, the payer will prior authorize payment for the treatment plan services or

shall identify any concerns including those based on the reasonableness or necessity of care.

(ii) If the frequency and duration is expected to exceed the Medical Treatment Guidelines' recommendation, prior authorization ~~for payment~~ is required ~~(see Rule 16-10).~~.

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

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

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

(15) Wound Care

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

~~(I) EVALUATION AND MANAGEMENT (E&M)~~

~~(1) Evaluation and management codes may be billed by medical providers as defined in Rule 16-5(A)(1)(a), nurse practitioners (NP), and physician assistants (PA). To justify the billed level of E&M service, medical record documentation shall utilize the 2017 CPT® E&M Services Guidelines and either the "E&M Documentation Guidelines" criteria adopted in Exhibit #7 of this Rule, or Medicare's 1997 Evaluation and Management Documentation Guidelines.~~

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

~~(2) New or Established Patients~~

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

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

~~(3) Number of Office Visits~~

~~All providers are limited to one (1) office visit per patient, per day, per workers' compensation claim, unless prior authorization for payment is obtained (see Rule 16-10). The E&M Guideline criteria as specified in the RBRVS E&M Section shall be used in all office visits to determine the appropriate level.~~

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

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

~~(a) The amount of time and date;~~

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

~~(c) The specifics of the discussion and/or decision made during the communication.~~

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

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

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

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

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

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

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

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

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

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

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

Outpatient Consultation RVUs:

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

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

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

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

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

Inpatient Consultation facility RVUs:

CPT® 99251 = 2.79

CPT® 99252 = 3.83

CPT® 99253 = 4.95

~~CPT® 99254 = 6.39~~

~~CPT® 99255 = 8.47~~

~~Subsequent Hospital RVU changes are as follows:~~

~~CPT® 99231 = 2.21 RVUs~~

~~CPT® 99232 = 3.15 RVUs~~

~~CPT® 99233 = 4.22 RVUs~~

~~(7) Prolonged Services:~~

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

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

~~(i) An E&M code shall accompany prolonged services codes CPT® 99354-99357.~~

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

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

~~(iv)~~(i) ~~The provider billing CPT® 99358 and 99359 for extensive record review shall document the names of providers and dates of service reviewed, as well as briefly summarize each record reviewed.~~

~~(b) Prolonged clinical staff services (RNs or LPNs) with physician or other qualified health care professional supervision:~~
~~(i) The supervising physician or other qualified health care professional may not bill CPT® 99354-99359 for the time spent supervising clinical staff.~~
~~(ii) Clinical staff services cannot be provided in an urgent care or emergency room setting.~~

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(J) TELEHEALTH

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

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

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

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

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

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

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

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

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

- The office of a physician or practitioner
- A hospital (inpatient or outpatient)
- A critical access hospital (CAH)
- A rural health clinic (RHC)
- A federally qualified health center (FQHC)
- A hospital based or critical access hospital based renal dialysis center (including satellites)
- A skilled nursing facility (SNF)
- A community mental health center (CMHC)

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

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

(c) Telehealth:

(i) Approved telehealth facilities can bill Q3014 per 15 minutes for the originating fee ~~as follows:~~.
~~Q3014 $35.00 /per 15 minutes~~

~~A~~All locations not associated with medical care, such as a private residence ~~at which~~where an injured worker is located when ~~he or she~~

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~~is~~ receiving ~~healthcare services through~~ telehealth services may not bill ~~for~~ the originating fee.

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

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

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

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

(d) Telemedicine:

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

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

18-6 DIVISION ESTABLISHED CODES AND VALUES

(A) FACE-TO-FACE OR TELEPHONIC MEETINGS

(1) Face-to-face or telephonic meeting by a treating physician ~~with the~~(as defined by Rule 16-3(A)(1)(a)) or a psychologist (PsyD, PhD, or EdD) with an employer, claim ~~representatives~~representative, or any attorney, and with or without the injured worker. Claim representatives ~~may~~ include physicians or other qualified medical personnel performing payer-initiated medical treatment reviews, but this ~~code~~Rule does not apply to ~~requests~~ provider-initiated ~~by a provider~~ requests for prior authorization ~~for payment~~ (see Rule 16-~~10).~~

~~Before~~ 6). The physician or psychologist may bill for the time spent attending the meeting and preparing the report (no travel time or mileage is separately payable). The fee includes the cost of the report for all parties, including the injured worker.

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

(a) Each meeting (including the time to document) shall be ~~at~~ a minimum ~~15~~of 8 minutes.

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

(i) Who was present at the meeting and their role at the meeting;
(ii) Purpose of the meeting;

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(iii) A brief statement of recommendations and actions at the conclusion of the meeting;
(iv) Documented time (both start and end times~~); and~~).
~~(v)~~ (c) Billing code is DoWC Z0701~~.~~

~~$85.00 per 15 minutes for time attending the meeting and preparing the report (no travel time or mileage is separately,~~ payable~~).~~ in 8-minute increments. The ~~fee includes the cost~~CPT® mid-point rule for attaining a unit of ~~the report for all parties, including the injured worker.~~time does not apply to this code. The physician or psychologist may bill multiple units of this code per date of service.

(d) For reimbursement to qualified non-physician providers for coordination of care with medical professionals, see section 18-5(H)(7).

(2) Face-to-face or telephonic meeting by a non-treating physician with the employer, claim representatives or any attorney in order to provide a medical opinion on a specific workers' compensation case, which is not accompanied by a specific report or written record.

Billing Code DoWC is Z0601~~: $74.00~~, per 15 minutes billed to the requesting party.

(3) Face-to-face or telephonic meeting by a non-treating physician with the employer, claim representatives or any attorney ~~in order~~ to provide a medical opinion on a specific workers' compensation case, which is accompanied by a report or written record, shall be billed as a special report (see section 18-6(G)(4)).

(4) Peer-to-peer review by a treating physician with a medical reviewer, following the treating physician's complete prior authorization request ~~as defined in~~pursuant to Rule 16-~~10~~6(E).

Billing Code DoWC is Z0602~~: $74.00~~, per 15 minutes billed to the requesting party.

(B) CANCELLATION FEES FOR PAYER-MADE APPOINTMENTS

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

The payer shall pay one-half of the usual fee for the scheduled services, or $180.00, whichever is less:

~~Cancellation Fee~~ Billing Code~~:~~ is DoWC Z0720 ~~or~~. The provider shall indicate the code corresponding to the service that has been cancelled ~~and append modifier 51.~~ in Box 19 of the CMS-1500 form or electronic billing equivalent.

For payer-made appointments scheduled for four (4) hours or longer, the payer shall pay one-half of the usual fee for the scheduled service.

Billing Code is DoWC Z0740. The provider shall ~~bill~~indicate the code corresponding to the service that has been cancelled ~~and append modifier 51~~in Box 19 of the CMS-1500 form or electronic billing equivalent.

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(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~~inquire if the payer wishes to reschedule the appointment for the claimant. If the claimant fails to keep the payer's rescheduled appointment, the provider may bill for a cancellation fee according to this section ~~18-6(B).~~.

(C) COPYING FEES

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The payer, payer's representative, injured worker and injured worker's representative shall pay a reasonable fee for the reproduction of the injured worker's medical record. If the requester and provider agree, the copy may be provided on a disc. If the requester and provider agree and appropriate security is in place, including, but not limited to, compatible encryption, the copies may be submitted electronically. Requester and provider should attempt to agree on a reasonable fee. Absent an agreement to the contrary, the fee shall be $0.10 per page.

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

Copying Fee Billing Codes and Maximum Fees:

DoWC Z0721 ~~- $18.53~~ for first 10 or fewer paper page(s~~)~~), including faxed documents

DoWC Z0725 ~~- $0.85~~ per paper page for the next 11-40 paper page(s~~)~~), including faxed documents

DoWC Z0726 ~~- $0.57~~ per paper page for remaining paper page(s~~)~~), including faxed documents

DoWC Z0727 ~~- $1.50~~ per microfilm page

DoWC Z0728 ~~- $14.00~~ per computer disc or as agreed

DoWC Z0729 ~~- $0.10~~ per electronic page or as agreed

DoWC Z0802~~—~~ actual postage paid

(D) DEPOSITION AND TESTIMONY FEES

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(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~~periods and/or fees, the ~~following~~ deposition and testimony rules and fees listed below shall be used.

If, in an individual case, a party can show good cause to an Administrative Law Judge (ALJ) for exceeding the Maximum Fee Schedule value, that ALJ may allow a greater fee than listed in this section.

(2) By prior agreement, the provider may charge for preparation time for a deposition or testimony, for reviewing and signing the deposition or for preparation time for testimony.

Preparation Time:

Treating or ~~Non~~non-treating ~~Physician~~physician as defined by Rule 16-~~5~~3(A)(1)(a) or ~~Psychologist~~psychologist (PsyD, PhD, or EdD):

DoWC Z0730 ~~$367.00 per hour~~, billed in half-hour increments.

Other providers shall be paid 85% of this fee.

(3) Deposition:

Payment for a treating or non-treating provider's testimony at a deposition shall not exceed ~~$367.00 per hour~~the hourly rate for DoWC Z0730 for physicians or psychologists, billed in half-hour increments. Calculation of the provider's time shall be "portal to portal." Other providers shall be paid 85% of this fee.

If requested, the provider is entitled to a full hour deposit in advance in order to schedule the deposition.

If the provider is notified of the cancellation of the deposition at least seven (7) business days prior to the scheduled deposition, the provider shall be paid the number of hours s/he has reasonably spent in preparation and shall refund to the deposing party any portion of an advance payment in excess of time actually spent preparing and/or testifying. Bill ~~using code~~ DoWC Z0731.

If the provider is notified of the cancellation of the deposition at least five (5) business days but less than seven (7) business days prior to the scheduled deposition, the provider shall be paid the number of hours s/he has reasonably spent in preparation and one-half the time scheduled for the deposition. Bill ~~using code~~ DoWC Z0732.

If the provider is notified less than five (5) business days in advance of a cancellation, or the deposition is shorter than the time scheduled, the provider shall be paid the number of hours s/he has reasonably spent in preparation and has scheduled for the deposition. Bill ~~using code~~ DoWC Z0733.

~~Deposition:~~

Treating or ~~Non~~non-treating ~~Physician~~physician as defined by Rule 16-~~5~~3(A)(1)(a) or ~~Psychologist~~psychologist (PsyD, PhD, or EdD):

DoWC Z0734 ~~$367.00 per hour~~, billed in half-hour increments.

Other providers shall be paid 85% of this fee.

(4) Testimony:

Calculation of the provider's time shall be "portal to portal" (includes travel time and mileage in both directions).

For testifying at a hearing, if requested, the provider is entitled to a four (4) hour deposit in advance in order to schedule the testimony.

If the provider is notified of the cancellation of the testimony at least seven (7) business days prior to the scheduled testimony, the provider shall be paid the number of hours s/he has reasonably spent in preparation and shall refund any portion of an advance payment in excess of time actually spent preparing and/or testifying. Bill ~~using code~~ DoWC Z0735.

If the provider is notified of the cancellation of the testimony at least five (5) business days but less than seven (7) business days prior to the scheduled testimony, the provider shall be paid the number of hours s/he has reasonably spent in preparation and one-half the time scheduled for the testimony. Bill ~~using code~~ DoWC Z0736.

If the provider is notified of a cancellation less than five (5) business days prior to the date of the testimony or the testimony is shorter than the time scheduled, the provider shall be paid the number of hours s/he has reasonably spent in preparation and has scheduled for the testimony. Bill ~~using code~~ DoWC Z0737.

~~Testimony:~~

Treating or ~~Non~~non-treating ~~Physician~~physician as defined by Rule 16-~~5~~3(A)(1)(a) or ~~Psychologist~~psychologist (PsyD, PhD, or EdD):

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

Other providers shall be paid 85% of this fee.

(E) INJURED WORKER TRAVEL EXPENSES

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

Mileage Expense Billing Code: DoWC Z0723

Other Travel Expenses Billing Code: DoWC Z0724

(F) PERMANENT IMPAIRMENT RATING

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(1) The payer is only required to pay for one (1) combined whole-person permanent impairment rating per claim, except as otherwise provided in the Workers' Compensation Rules of Procedures. Exceptions that may require payment for an additional impairment rating include, but are not limited to, reopened cases, as ordered by the Director or an Administrative Law Judge, or a subsequent request to review apportionment. The ATP is required to submit in writing all permanent restrictions and future maintenance care related to the injury or occupational disease.

(2) Provider Restrictions

The Level II accredited authorized treating physician (see Rule 5) shall determine the permanent impairment rating ~~shall be determined by the Level II Accredited Authorized Treating Physician (see Rule 5-5(D)).~~

(3) Maximum Medical Improvement (MMI) Determined Without any Permanent Impairment

If a physician determines the injured worker is at MMI and has no permanent impairment, the physician should be reimbursed for the examination at the appropriate level of E&M service~~, as defined in the RBRVS.~~. The authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient should complete the Physician's Report of Workers' Compensation Injury (Closing Report), WC164 (see section 18-6(G)(2)).

(4) MMI Determined with a Calculated Permanent Impairment Rating

(a) Calculated Impairment: The total fee includes the office visit, a complete physical examination, complete history, review of all medical records except when the amount of medical records is extensive (see below), determining MMI, completing all required measurements, referencing all tables used to determine the rating, using all report forms from the AMA's Guide to the Evaluation of Permanent Impairment, Third Edition (Revised), (AMA Guides), and completing the ~~Division form, titled~~ Physician's Report of Workers' Compensation Injury (Closing Report) WC164.

Extensive medical records take longer than one (1) hour to review and a separate report is created. The separate report must document each record reviewed, specific details of the ~~record~~records reviewed and the dates represented by the ~~record(s)~~records reviewed. The separate record review can be billed under special reports for written reports only and requires prior authorization and agreement from the payer for the separate record review fees.

(b) ~~Use~~Bill the appropriate DoWC code:

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

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

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

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

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

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(G) REPORT PREPARATION

(1) Routine Reports

Providers shall submit routine reports free of charge as directed in Rule 16-~~7(F~~10(D) and by statute. Requests for additional copies of routine reports and for reports not in Rule 16-~~7(F)~~10 or in statute are reimbursable under the copying fee section of this Rule. Routine reports include:

(a) Diagnostic testing

(b) Procedure reports

(c) Progress notes

(d) Office notes

(e) Operative reports

(f) Supply invoices, if requested by the payer

~~-~~(2) Completion of the Physician's Report of Workers' Compensation Injury (WC164)

(a) Initial Report

The authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient completes the initial WC164 and submits it to the payer and to the injured worker after the first visit with the injured worker. When applicable, the emergency department or urgent care authorized treating physician for this workers' compensation injury may also create a WC164 initial report. Unless requested or prior authorized by the payer in a specific workers' compensation claim, no other authorized physician should complete and bill for the initial WC164 form. This form shall include completion of items 1-7 and 11. 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,~~B-C, and 7-11. If the injured worker has sustained a permanent impairment, ~~then item 10 must be completed and~~ the following additional information shall be attached to the bill at the time MMI is determined:

(i) All necessary permanent impairment rating reports, medical reports and narrative relied upon by the authorized treating physician (ATP), when the ATP (generally the designated or selected physician) managing the total workers' compensation claim of the patient is Level II Accredited; or

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(ii) The name of the Level II Accredited Physician requested to perform the permanent impairment rating when a rating is necessary and the ATP (generally the designated or selected physician) managing the total workers' compensation claim of the patient is not determining the permanent impairment rating.

(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 section 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 the WC164 report:

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

DoWC Z0750 ~~$49.00~~ Initial Report

DoWC Z0751 ~~$49.00~~ Progress Report (Payer Requested or Provider Initiated)

DoWC Z0752 ~~$49.00~~ Closing Report

DoWC Z0753 ~~$49.00~~ Initial and Closing Reports are completed on the same form for the same date of service

(3) Request for physicians to complete additional forms sent to them by a payer or employer shall be paid by the requesting party. A form requiring 15 minutes or less of a physician's time shall be billed ~~pursuant to (a) and (b) below.~~using DoWC Z0754. Forms requiring more than 15 minutes shall be paid as a special report.

~~(a) Billing Code Z0754~~

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

(4) Special Reports

~~Description:~~ The term ~~"~~special reports~~"~~ includes ~~reports not otherwise addressed under Rule 16, Utilization Standards, Rule 17, Medical Treatment Guidelines and Rule 18, including~~ any form, questionnaire or letter with variable content~~.~~ not otherwise addressed in Rules. This includes, but is not limited to~~.~~: (a) independent medical evaluations ~~(Z0756, Z0770 and Z0768)~~ or reviews when the physician is requested to review files and examine the patient to provide an opinion for the requesting party, performed outside ~~C.R.S. §~~§ 8-42-107.2 (the Division IME process) and (b) 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. ~~Reimbursement for preparation of special reports or records shall require prior agreement with the requesting party.~~

Billable Hours: Because narrative reports may have variable content, the content and total payment shall be agreed upon by the provider and the report's requester before the provider begins the report.

Advance Payment: If requested, the provider is entitled to a two (2) hour deposit in advance in order to schedule ~~an~~a patient exam associated with a special report.

Cancellation:

Written Reports Only: In cases of cancellation for those special reports not requiring a scheduled patient exam, the provider shall be paid for the time s/he has reasonably spent in preparation up to the date of cancellation. Bill ~~the cancellation using~~ DoWC ~~code~~ Z0761.

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

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

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

Billing Codes:

Written Report Only	DoWC Code:	Z0755
Lengthy Form Completion	DoWC Code:	Z0757
Meeting and ~~report~~ Report with Non-treating Physician	DoWC Code:	Z0758

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

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

~~CRS~~Section 8-43-404 requires RIMEs to be recorded in audio in their entirety and retained by the examining physician ~~until requested~~for 12 months and made available by request to any party to the case.

IME Audio Recording _____ DoWC Code: Z0766 ~~$34.00 per exam~~

IME Audio ~~copying fee~~Copying Fee _____ DoWC Code: Z0767 ~~$23.00 per copy~~

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

DIME: Division Independent Medical Examination (DIME)/Report with patient exam _____ See Rule 11 ~~for billing codes and fees~~

All RIME, CIME and DIME reports must be served concurrently to all parties no later than 20 calendar days after the examination.

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

(1) Supplies necessary to perform a service or procedure are considered inclusive and not separately reimbursable. Only supplies that are not an integral part of a service or procedure are considered to be over and above those usually included in the service or procedure.

(2) Unless other limitations exist in this Rule, medical professionals shall bill supplies, including ~~"Supply et al.,"~~ orthotics, prostheses, durable medical equipment (DME~~) or~~), injectable or non-injectable drugs~~, including injectables,~~ using ~~Medicare's~~ a HCPCS Level II ~~codes~~code, when one exists, as established in the January ~~2017~~2018 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) schedule for rural (R) or non-rural (NR~~).~~) areas. Rural is identified in Medicare's DME Rural Zip and Formats file on ~~their~~its website or the January ~~2017~~2018 Medicare's Part B Drug Average Sale Price (ASP). Otherwise, the billing provider shall identify ~~their~~its cost by submitting a copy of ~~their~~its invoice with ~~their~~its bill. ~~The~~ DMEPOS schedule ~~can be found at~~ **Error! Hyperlink reference not valid.** ~~The~~and Medicare Part B Drug ~~Average Sale Price (~~ASP~~)~~ fees ~~can be found at~~are available at https://www.cms.gov. **Error! Hyperlink reference not valid.**

Maximum fees for any orthotic created using casting materials shall be billed using Medicare's Q codes and values listed under Medicare's DMEPOS fee schedule for Colorado. The therapist time necessary to create the orthotic shall be billed using CPT® 97760.

(3) ~~Payers~~Medical providers shall ~~pay medical professionals using~~be reimbursed based on Medicare's January ~~2017~~ 2018 DMEPOS Colorado HCPCS Level II maximum fee values or Medicare's Part B Drug ASP values listed for the codes billed. If no code exists, the payer shall pay 120% of the cost for the item as indicated on the provider's invoice. Payers shall not recognize the KE modifier.

(4) Unless other limitations exist in this Rule, DMEPOS suppliers shall be reimbursed using Medicare's HCPCS Level II codes, when one exists, as established in the ~~July 2017~~ January 2018 DMEPOS schedule. Otherwise, the supplier shall be

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reimbursed at 100% of Colorado Medicaid's January ~~2017~~2018 fee schedule. ~~The Colorado Medicaid Fee Schedule can be found at:~~See https://www.colorado.gov/hcpf/provider-rates-fee-schedule~~.~~ for the Colorado Medicaid Fee Schedule. If no Medicare or Medicaid fee schedule value exists, payers shall reimburse ~~Suppliers~~suppliers the published Manufactures Suggested Retail Price (MSRP), the item will be reimbursed at MSRP less 20%. If there is no established fee schedule value or MSRP, reimbursement shall be based on 120% of the cost of the item as indicated on the supplier's invoice. Shipping and handling charges are not separately payable.

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

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

(b) Capped Rental/Purchased Equipment:

(i) Rented DME items must be purchased or discontinued after 15 months of continuous use.
(ii) The monthly rental rate cannot exceed 10% of the DMEPOS fee schedule, or if not available, the cost of the item to the provider or the supplier (after taking into account any discounts/rebates the supplier or the provider may have received). The payer shall not pay for rental fees once the total fee scheduled price of the rented item has been reached. When the item is purchased, all rental fees shall be deducted from the total fee scheduled price. If necessary, the parties should use an invoice to establish the purchase price.
(iii) Items that cost $100.00 or less (according to provider's invoice) shall be purchased and reimbursed pursuant to section 18-6(H~~) of this rule.~~).
(iv) Purchased items may require maintenance/servicing agreements or fees. The fees are separately payable. Rented items typically include these fees in the monthly rental rates.

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

(i) TENS (Transcutaneous Electric Nerve Stimulator) machines/kits, IF (Interferential) machines/kits, and any other type of electrical stimulator combination kits: E0720 for a kit with 2 leads or E0730 for a kit with 4 leads;
(ii) Electrical Muscle Stimulation machines/kits: E0744 for scoliosis; or E0745 for neuromuscular stimulator, electric shock unit;
(iii) Osteogenesis electrical stimulation: E0748 or E0749 for non-invasive spinal application, or E0760 for ultrasound low intensity;

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

(v) Conductive Garments: E0731;

(d) Continuous Passive Motion Devices (CPMs):

E0935 – continuous passive motion exercise device for use on the knee only; or E0936 – continuous passive motion exercise device for use on body parts other than knee. These devices are bundled into the facility fees and not separately payable, unless the Medial Treatment Guidelines recommend their use after discharge for the particular condition.

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

E0650-E0676 – Codes based on body part(s), segmental or not, gradient pressure and cycling of pressure and purpose of use; and

A4600 – Sleeve for intermittent limb compression device, replacement only, per each limb.

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

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

(8) Payment for professional services associated with the fabrication and/or modification of orthotics, custom splints, adaptive equipment, and/or adaptation and programming of communication systems and devices shall be paid in accordance with the Colorado Medicare HCPCS Level II values.

(9) Take home exercise supplies with a total cost of $50 or less may be billed without an invoice at a maximum fee of actual billed charges; however, payers reserve the right to request an invoice, at any time, to validate the provider's cost. Home exercise supplies can include, but are not limited to the following items: therabands, theratubes, band/tube straps, theraputty, bow-tie tubing, fitness cables/trainers, overhead pulleys, exercise balls, cuff weights, dumbbells, ankle weight bands, wrist weight bands, hand squeeze balls, flexbars, digiflex hand exercisers, power webs, plyoballs, spring hand grippers, hand helper rubber band units, ankle stretchers, rocker boards, balance paws, and aqua weights.

(10) Complex Rehabilitation Technology dispensed and billed by Non-Physician DMEPOS Suppliers

(a) Complex rehabilitation technology (CRT) items, including products such as complex rehabilitation power wheelchairs, highly configurable manual wheelchairs, adaptive seating and positioning systems, and other specialized equipment, such as standing frames and gait trainers, enable individuals to maximize their function and minimize the extent and costs of their medical care.

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(b) Complex Rehabilitation Technology products must be provided by suppliers who are specifically accredited by a Center for Medicare and Medicaid Services (CMS) deemed accreditation organization as a supplier of CRT and licensed as a DMEPOS Supplier with the Colorado Secretary of State.

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

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(I) INPATIENT HOSPITAL FACILITY FEES

(1) Provider Restrictions

All non-emergency, inpatient admissions require prior authorization ~~for payment~~ (see Rule 16-~~10~~6).

(2) Bills for Services

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

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

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

(c) Exhibit #1 ~~of this Rule~~ establishes the maximum length of stay (LOS) using the "arithmetic mean LOS". However, no additional allowance for exceeding this LOS, other than through the cost outlier criteria under section 18-6(I)(3)(e) is allowed.

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

(3) Inpatient Facility Reimbursement:

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

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

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

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

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

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

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

(c) Medicare Long Term Care Hospitals (MLTCH)

MLTCHs are reimbursed at $3,~~200~~350 per day, not to exceed 75% of billed charges. If total billed charges exceed $300,000, reimbursement shall be at 75% of billed charges. All charges shall be submitted on a final bill ~~and no~~, unless the parties agree on interim ~~bills are payable.~~billing.

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

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

The "Maximum Fee Allowance" is determined by calculating:

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

(ii) For trauma center activation allowance, (revenue codes 680-685) see section18-6(J)(6)(d).

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

(e) Outliers are admissions with extraordinary cost warranting additional reimbursement beyond the maximum allowance under ~~section 18-6(I)(3)(d).~~subsection (d) above. To calculate the additional reimbursement, if any:

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

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

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

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

(iv) If the "Difference" is greater than $~~26,601~~27,545.00, additional reimbursement is warranted. The additional reimbursement is determined by the following equation:

"Difference" x .80 = additional fee allowance

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

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

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

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

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

(i) The MS-DRG adjusted billed charges to the MS-DRG allowance (including any outlier allowance);
(ii) The trauma center activation billed charge to the trauma center activation allowance; and
(iii) The organ acquisition charges to the organ acquisition maximum fees.

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

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

(J) OUTPATIENT HOSPITAL FACILITY FEES

(1) Provider Restrictions

(a) All non-emergency outpatient surgeries require prior authorization ~~for payment~~ (see Rule 16-~~10~~6).

(b) A separate facility fee is only payable if the location of where the services are provided is licensed as a hospital~~,~~ or ASC for surgical episodes, by the

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Colorado Department of Public Health and Environment (CDPHE) or applicable out of state governing agency and statute.

(2) Types of Bills for Service:

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

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

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

(3) Outpatient Facility Reimbursement:

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

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

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

~~(c) Exhibit #4 to this Rule:~~

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

Hospital reimbursement is based upon Medicare's ~~2017~~2018 Outpatient Prospective Payment System (OPPS) as modified in Exhibit #4 ~~of this Rule.~~. Exhibit #4 lists Medicare's Outpatient Hospital ~~Ambulatory Prospective Payment (APC)~~APC Codes and the Division's established rates for hospitals and other types of providers as follows:

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

To identify which APC grouper is aligned with an Exhibit #4 APC code ~~#~~number and dollar value, use Medicare's ~~2017~~2018 Addendum B. Spinal fusion CPT® codes listed with a "C" status indicator in Medicare's Addendum B, shall have an equivalent value no greater than APC ~~5123~~5115.

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

Services and Items Included in the APC Value:

(a) nursing, technician, and related services;
(b) use of the facility where the surgical procedure(s) was performed;
(c) drugs and biologicals for which separate payment is not allowed;
(d) medical and surgical supplies, durable medical equipment and orthotics not listed as a "pass through";
(e) surgical dressings;
(f) equipment;
(g) splints, casts and related devices;
(h) radiology services when not allowed under Exhibit #4;
(i) administrative, record keeping and housekeeping items and services;
(j) materials, including supplies and equipment for the administration and monitoring of anesthesia;
(k) supervision of the services of an anesthetist by the operating surgeon;
(l) post-operative pain blocks; and
(m) implanted items.

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Packaged Services

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

0343	Nuclear Medicine; Diagnostic Radiopharmaceuticals
0344	Nuclear Medicine; Therapeutic Radiopharmaceuticals
0370	Anesthesia; General Classification
0371	Anesthesia; Anesthesia Incident to Radiology
0372	Anesthesia; Anesthesia Incident to Other DX Services
0379	Anesthesia; Other Anesthesia
0390	Administration, Processing & Storage for Blood & Blood Components; General Classification
0392	Administration, Processing & Storage for Blood & Blood Components; Processing & Storage
0399	Administration, Processing & Storage for Blood & Blood Components; Other Blood Handling
0621	Medical Surgical Supplies - Extension of 027X; Supplies Incident to Radiology
0622	Medical Surgical Supplies - Extension of 027X; Supplies Incident to Other DX Services
0623	Medical Supplies - Extension of 027X, Surgical Dressings
0624	Medical Surgical Supplies - Extension of 027X; FDA Investigational Devices
0630	Pharmacy - Extension of 025X; Reserved
0631	Pharmacy - Extension of 025X; Single Source Drug
0632	Pharmacy - Extension of 025X; Multiple Source Drug
0633	Pharmacy - Extension of 025X; Restrictive Prescription
0700	Cast Room; General Classification
0710	Recovery Room; General Classification
0720	Labor Room/Delivery; General Classification
0721	Labor Room/Delivery; Labor
0732	EKG/ECG (Electrocardiogram); Telemetry
0821	Hemodialysis-Outpatient or Home; Hemodialysis Composite or Other Rate
0824	Hemodialysis-Outpatient or Home; Maintenance - 100%
0825	Hemodialysis-Outpatient or Home; Support Services
0829	Hemodialysis-Outpatient or Home; Other OP Hemodialysis
0942	Other Therapeutic Services (also see 095X, an extension of 094x); Education/Training
0943	Other Therapeutic Services (also see 095X, an extension of 094X), Cardiac Rehabilitation
0948	Other Therapeutic Services (also see 095X, an extension of 094X), Pulmonary Rehabilitation

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

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

~~(b) "B" means it is not recognized by Medicare for Outpatient Hospital services Part B bill type (12x and 130x) and therefore is not separately payable unless separate fees are applicable under another section of this Rule, such as home health.~~

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

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

(e) "E1" or "E2" means not paid by Medicare when submitted on any outpatient bill type. However, services could still be reasonable and necessary, thus requiring hospital or ASC level of care. The billing party shall submit documentation to substantiate the billed service codes and any similar established codes with fees in Exhibit #4.

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

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

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

(i) "J1" or "J2" means the services are paid through a "comprehensive APC" for Medicare. However, the DoWC has not adopted the "comprehensive APC." Therefore, an agreement between the payer and the provider is necessary to implement "comprehensive APCs."

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

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

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

(m) "M" means not separately payable.

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

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

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

(q) "S" and "T" mean there are multiple procedures, the highest valued code allowed at 100% of the Exhibit #4 value and up to three (3) additional codes allowed at 50% of the Exhibit #4 value, per episode of care.

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

(s) "V" represents a clinic or an ED visit and is separately payable for hospitals as specified in section 18-6(J).

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

Indicator	Meaning
A	Use another fee schedule instead of Exhibit #4, such as conversion factors listed in section 18-4, RBRVS RVUs, Ambulance Fee Schedule, or Exhibit #8.
B	Is not recognized by Medicare for Outpatient Hospital Services Part B bill type (12x and 130x) and therefore is not separately payable unless separate fees are applicable under another section of this Rule.
C	Recognized by Medicare as inpatient-only procedures. However, the Division recognizes these procedures on an outpatient basis with prior authorization.
D	Discontinued code.
E1 or E2	Not paid by Medicare when submitted on any outpatient bill type. However, services could still be reasonable and necessary, thus requiring hospital or ASC level of care. The billing party shall submit documentation to substantiate the billed service codes and any similar established codes with fees in Exhibit #4.
F	Corneal tissue acquisition and certain CRNA services and Hepatitis B vaccines are allowed at a reasonable cost to the facility. The facility must provide a separate invoice identifying its cost.
G	"Pass-Through Drugs and Biologicals" are separately payable under Exhibit #4 as an APC value.
H	A "Pass-Through Device" is separately payable based on cost to the facility.
J1 or J2	The services are paid through a "comprehensive APC" for Medicare. However, the DoWC has not adopted the "comprehensive APC." Therefore, an agreement between the payer and the provider is necessary.
K	A separately payable "Pass-Through Drug or Biological or Device" for therapeutic radiopharmaceuticals, brachytherapy sources, blood and blood products as listed under Exhibit #4 APC value.
L	Represents Influenza Vaccine/Pneumococcal Pneumonia Vaccine and therefore is generally considered to be unrelated to work injuries.
M	Not separately payable.
N	Service is bundled and is not separately payable.
P	Partial hospitalization paid based on observation fees outlined in

	section 18-6(J).
R	Blood and blood products
Q	Any "Packaged Codes" with Q1, Q2, Q3, Q4 or STVX combinations are not recognized unless the parties make a prior agreement.
S or T	Multiple procedures, the highest-valued code allowed at 100% of the Exhibit #4 value and up to three (3) additional codes allowed at 50% of the Exhibit #4 value, per episode of care.
U	Brachytherapy source and is separately payable under Exhibit #4 APC value.
V	Represents a clinic or an ED visit and is separately payable for hospitals as specified in section 18-6(J).
Y	Non-implantable Durable Medical Equipment paid pursuant to Medicare's Durable Medical Equipment Regional Carrier fee schedule for Colorado.

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

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

Facility fee reimbursement is limited to a maximum of four (4) CPT® procedure codes per episode, with a maximum of only one (1) procedure reimbursed at 100% of the allowed Exhibit #4 value for the type of facility:

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

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

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~~-~~(i) The EDs must be physically located within a hospital licensed by the CDPHE as a general hospital or meet the out-of-state facility's state's licensure requirements and billed using revenue code 450 ~~with level of care~~and applicable CPT® codes ~~99281-99285~~; or

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

(c) ED level of care is identified based upon one (1) of five (5) levels of care for either a type "A" ~~(CPT® 99281-99285, 99291 or 99292)~~ or type "B" ~~(G0380-G0384)~~ ED visit. The level of care is defined by CPT® E&M definitions and internal level of care guidelines developed by the hospital in compliance with Medicare regulations. The hospital's guidelines should establish an appropriate graduation of hospital resources (ED staff and

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other resources) as the level of service increases. Upon request, the provider shall supply a copy of their level of care guidelines to the payer. (Only the higher one (1) of any ED levels or critical care codes shall be paid).

(d) APC 5045, Trauma Response with Critical Care, is not recognized for separate payment. Trauma Center fees are not paid for alerts. Trauma activation ~~fees~~revenue codes are ~~as follows:~~681, 682, 683, or 684.

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~~Revenue Code 681 $3,000.00~~

~~Revenue Code 682 $2,500.00~~

~~Revenue Code 683 $1,000.00~~

~~Revenue Code 684 $0~~

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

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

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

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

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

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

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

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

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

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

Billing ~~Codes:~~

Code is G0378 ~~Observation/Convalescence rate: $45.00~~ per hour,

round to the nearest hour. For adjusted RVUs and rates, see Exhibit #9.

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

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(i) ambulance services (~~Revenue Code~~revenue rode 540), see section 18-6(R)
(ii) blood, blood plasma, platelets (~~Revenue Codes~~revenue codes 380X)
(iii) ~~Physician~~physician or physician assistant services
(iv) ~~Nurse~~nurse practitioner services
(v) ~~Licensed~~licensed clinical psychologist
(vi) ~~Licensed~~licensed social workers
(vii) ~~Rehabilitation~~rehabilitation services (PT, OT, respiratory~~Respiratory~~ or ~~Speech/Language, Revenue Codes~~speech/language, revenue codes 420, 430,440) are paid based upon the RBRVS unit value multiplied by the applicable CF. Modifiers are required to indicate the type of care plan or therapist being billed. See ~~Rule~~section 18-5(~~H) Physical Medicine & Rehabilitation~~I) for appropriate modifiers.

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

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

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

- Rural Health Clinics as identified ~~under Rule 18,~~in Exhibit #5 and/or as certified by the Colorado Department of Public Health and Environment;
- Critical Access Hospitals as identified ~~under Rule 18,~~in Exhibit #3 and/or as certified by the Colorado Department of Public Health and Environment;
- Any specialty care clinic (wound/infections) that requires expensive drugs/supplies that are not typically provided in a physician's office.

(ii) Billing and Maximum Fees

- Clinics designated as rural health facilities and listed in Exhibit #5 ~~to this Rule~~ may be reimbursed a single separate clinic fee at 80% of billed charges per date of service, regardless of whether the clinic has been designated by the employer, the urgency of the episode of care, or the time of day.
- CAHs listed in Exhibit #5 ~~of this Rule~~ may be reimbursed a single separate clinic fee at 80% of billed charges per date of service.
- Any specialty care clinic (wound/infections) that requires drugs/supplies that are typically not provided in a physician's office may be allowed a separate clinic fee with prior approval from the payer, as outlined in Exhibit #4.
- No other clinic facility fees are payable except those listed in sections 18-6(I), (J), (K) or (L).
- Maximum fees for hospital urgent care facilities or services are covered under section 18-6(L). These are identified by either place of service code 20, as billed on a CMS-1500, or by revenue code(s) ~~456,~~ 516 or 526 on a UB-04.

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

~~(l) IV Infusions Performed in Outpatient Hospital Facilities~~

(l) IV infusion therapy performed in an outpatient hospital facility is reimbursed per section 18-6(J).

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

(K) AMBULATORY SURGERY CENTERS

(1) Provider Restrictions

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

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

(2) ~~Billing Codes and Maximum Fees~~

ASCs are reimbursed in accordance with section 18-6(J) for any surgical episodes of care. Column 4 from Exhibit #4 ~~of this Rule~~ lists the ~~dollar value~~values used to determine the maximum fees.

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

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(1) Provider Restrictions

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

(2) Billing and Maximum Fees:

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

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

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

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

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

(iv) Hospital and non-hospital based urgent care facilities may bill for the facility fee, HCPCS code S9088, on the CMS-1500 with professional services. All other services and procedures provided in an urgent care facility, including a freestanding facility, are reimbursed according to the appropriate CPT® code relative weight from RBRVS multiplied by the appropriate ~~Rule 18-4~~ CF.

(c) All professional physician or non-physician fees shall be billed on a CMS-1500 with a Place of Service Code #20. The maximum fees shall be in accordance with the appropriate CPT® code relative weight from RBRVS multiplied by the appropriate ~~Rule 18-4~~ CF.

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

6). Bill G0378 ~~Observation rate: $45.00~~ per hour. For adjusted RVUs and rates, see Exhibit #9.

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

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

(M) HOME CARE SERVICES

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Prior authorization ~~for payment~~ (see Rule 16-~~10~~6) is required for all home care services. All skilled home care service providers shall be licensed by the Colorado Department of Public Health and Environment (CDPHE) as Type A or B providers. The payer and the home health entity should agree in writing on the type of care, the type and skill level of provider, frequency of care and duration of care at each visit, and any financial arrangements to prevent disputes. For adjusted RVUs and rates, see Exhibit #9.

(1) Home Infusion Therapy

The per day or refill rates for home infusion therapy shall include all reasonable and necessary products, equipment, IV administration sets, supplies, supply management, and delivery services necessary to perform the infusion therapy. Per diem rates are only payable when licensed professionals (RNs) are providing "reasonable and necessary" skilled assessment and evaluation services in the patient's home.

Skilled Nursing fees are separately payable when the nurse travels to the injured ~~workers~~worker's home to perform initial and subsequent patient evaluation(s), education, and coordination of care. Skilled nursing fees are billed and payable as indicated under section 18-6(L)(2).

~~-~~(a) Parenteral Nutrition:

~~S9364 <1 Liter $160.00/ day~~

~~S9365 1 liter $174.00/ day~~

~~S9366 1.1 - 2.0 liter $200.00/ day~~

~~S9367 2.1 - 3.0 liter $227.00/ day~~

~~S9368 > 3.0 liter $254.00/ day~~

Code	Quantity	Max Bill Frequency
S9364	<1 Liter	once per day
S9365	1 liter	once per day

S9366	1.1 - 2.0 liter	once per day
S9367	2.1 - 3.0 liter	once per day
S9368	> 3.0 liter	once per day

The ~~per day rates include~~daily rate includes the standard total parenteral nutrition (TPN) formula. Lipids, specialty amino acid formulas, and drugs other than in standard formula are separately payable under section 18-6(N).

(b) Antibiotic Therapy per day rate by professional + drug cost at Medicare's Average Sale Price (ASP). If ASP is not available, ~~bill using the drug cost at~~use Average Wholesale Price (AWP~~).~~) (see section 18-6(N)).

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~~S9494 hourly $158.00/ day~~

~~S9497 once every 3 hours $152.00/ day~~

~~S9500 every 24 hours $ 97.00/ day~~

~~S9501 once every 12 hours $110.00/ day~~

~~S9502 once every 8 hours $122.00/ day~~

~~S9503 once every 6 hours $134.00/ day~~

~~S9504 once every 4 hours $146.00/ day~~

Code	**Time**	**Max Bill Frequency**
S9494	hourly	once per day
S9497	once every 3 hours	once per day
S9500	every 24 hours	once per day
S9501	once every 12 hours	once per day
S9502	once every 8 hours	once per day
S9503	once every 6 hours	once per day
S9504	once every 4 hours	once per day

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

~~S9329 Administrative Services $ 0.00/ day~~

~~S9330 Continuous (24 hrs. or more) chemotherapy $ 91.00/ day~~

~~S9331 Intermittent (less than 24 hrs.) $103.00/ day~~

Code	Description	Max Bill Frequency
S9329	Administrative Services	once per day
S9330	Continuous (24 hrs. or more) chemotherapy	once per day
S9331	Intermittent (less than 24 hrs.)	once per day

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

~~S9341 Via Gravity $44.09/ day~~

~~S9342 Via Pump $24.23/ day~~

~~S9343 Via Bolus $24.23/ day~~

Code	Description	Max Bill Frequency
S9341	Via Gravity	once per day
S9342	Via Pump	once per day
S9343	Via Bolus	once per day

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

~~S9326 Continuous (24 hrs. or more) $ 79.00/ day~~

~~S9327 Intermittent (less than 24 hrs.) $103.00/ day~~

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

Code	Description	Max Bill Frequency
S9326	Continuous (24 hrs. or more)	once per day
S9327	Intermittent (less than 24 hrs.)	once per day
S9328	Implanted pump (no	Per refill

	separate daily rate)	

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

~~S9373 < 1 liter per day $61.00/ day~~

~~S9374 1 liter per day $85.00/ day~~

~~S9375 >1 but <2 liters per day $85.00/ day~~

~~S9376 >2 liters but <3 liters $85.00/ day~~

~~S9377 >3 liters per day $85.00/ day~~

Code	Quantity	Max Bill Frequency
S9373	< 1 liter per day	once per day
S9374	1 liter per day	once per day
S9375	>1 but <2 liters per day	once per day
S9376	>2 liters but <3 liters	once per day
S9377	>3 liters per day	once per day

(g) Multiple Therapies:

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

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

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

(2) Nursing Services

~~(a) Skilled Nursing (LPN & RN)~~

~~S9123 RN $111.00/hr.~~

~~S9124 LPN $ 89.00/hr.~~

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

~~(b) Certified Nurse Assistant (CNA):~~

~~S9122 CNA $ 45.00/hr.~~

~~The amount of time spent with the injured worker must be specified~~, unless otherwise indicated in the ~~medical records and on the bill.~~Medical Treatment Guidelines:

Code	Type of Nurse	Max Bill Frequency
S9123	RN	2 hrs
S9124	LPN	2 hrs
S9122	CNA	The amount of time spent with the injured worker must be specified in the medical records and on the bill. No prior authorization required.

(3) Physical ~~Medicine~~

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

(4) Mileage

~~Travel allowances~~ The parties should ~~be agreed~~agree upon ~~with the payer~~ travel allowances and the mileage rate should not exceed ~~$0.53~~the fee schedule rate for DoWC Z0772~~,~~ per mile, portal to portal.

~~DoWC code: Z0772~~

(5) Travel Time

Travel is typically included in the fees listed. Travel time greater than one (1) hour one-way shall be reimbursed. The fee shall be agreed upon at the time of prior authorization ~~for payment (see Rule 16-10)~~ and shall not exceed ~~$34.00 per hour~~the hourly fee schedule rate for DoWC Z0773.

~~DoWC code: Z0773~~

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

As defined in ~~Rule~~section 18-6(H), any drugs/supplies/DME/Orthotics/Prosthetics considered integral to ~~any~~ at-home professional's service are not separately payable.

The maximum fees for non-integral drugs/supplies/DME/Orthotics/Prosthetics used during a professional's home care visits are listed in ~~Rule~~section 18-6(H). All IV infusion supplies are included in the per diem or refill rates listed in this ~~rule~~Rule.

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(N) DRUGS AND MEDICATIONS

~~(1~~(1) All medications must be reasonably needed to cure and relieve the injured worker from the effects of the injury. Prior authorization is required for medications "not recommended" in the Medical Treatment Guidelines for a particular diagnosis or if Rules 16-6(B) and 17-4(A) apply.

(2) Prescription Writing

(a) This Rule applies to all pharmacies, whether located in- or out-of-state.

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

(c) All prescriptions shall be filled with bio-equivalent generic drugs unless the physician indicates "Dispense As Written" (DAW) on the prescription. In addition to the Rule 16-9(A)(2) requirements, providers prescribing a brand name with a DAW indication shall provide a written medical justification explaining the reasonableness and necessity of the brand name over the generic equivalent.

(d) The provider shall not exceed a 60-day supply per prescription.

(e) Opioids classified as Schedule II or Schedule III controlled substances that are prescribed for treatment lasting longer than 7 days shall be provided through a pharmacy.

(3) Billing

(a) Drugs (brand name or generic) shall be reported on bills using the applicable identifier from the National Drug Code (NDC) Directory as published by the Food and Drug Administration (FDA).

~~(2~~(b) All parties shall use one (1) of the following forms:

(i) CMS-1500 – dispensing provider shall bill by using the metric quantity (number of tablets, grams, or mls) in column 24.G and NDC number of the drug being dispensed or, if one does not exist, the RBRVS supply code. For repackaged drugs, dispensing provider shall list the "repackaged" and the "original" NDC numbers in field 24 of the CMS-1500. The dispensing provider shall list the "repackaged" NDC number of the actual dispensed medication first and the "original" NDC number second, with the prefix 'ORIG' appended.

(ii) With the agreement of the payer, the National Council for Prescription Drug Programs (NCPDP) or ANSI ASC 837 (American National Standards Institute Accredited Standards Committee) electronic billing transaction containing the same information as in (1) or (2) in this sub-section may be used for billing. NCPDP Workers' Compensation/Property and Casualty (P&C) Universal Claim Form, version 1.1, for prescription drugs billed on paper shall be used by dispensing pharmacies and pharmacy benefit managers.

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(c) Dispensing provider shall keep a signature on file indicating the injured worker or his/her authorized representative has received the prescription.

(4) Average Wholesale Price (AWP)

(a) AWP for brand name and generic pharmaceuticals may be determined through the use of such monthly publications as Price Alert, Red Book, or Medispan. In case of a dispute on AWP values for a specific NDC, the parties should take the lower of their referenced published values.

(b) If published AWP data becomes unavailable, substitute Wholesale Acquisition Cost (WAC) + 20% for AWP everywhere ~~it is found~~ in this Rule.

(~~3~~5) Reimbursement for Prescription Drugs & Medications

(a) For prescription medications, except topical compounds, reimbursement shall be AWP + $4.00. If drugs have been repackaged, use the original AWP and NDC that was assigned by the source of the repackaged drugs to determine reimbursement.

(b) The entity packaging two or more products together makes an implied claim that the products are safe and effective when used together and shall be billed as individual line items identified by their original AWP and NDC. This original AWP and NDC shall be used to determine reimbursement. Supplies are considered integral to the package are not separately reimbursable.

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(c) Reimbursement for an opiate antagonist prescribed or dispensed under §§ 12-36-117.7, 12-38-125.5, 12-42.5-120, 13-21-108.7, ~~C.R.S. (2015),~~ to an injured worker at risk of experiencing an opiate-related drug overdose event, or to a family member, friend, an employee or volunteer of a harm reduction organization, or other person in a position to assist the injured worker shall be AWP plus $4.00.

(d) Drugs administered in the course of the provider's direct care (injectables) shall be reimbursed at ~~the provider's actual cost incurred or~~ Medicare's Part B Drug Average Sale Price (ASP~~).~~), unless the ASP value does not exist for the drug or the provider's actual cost exceeds the ASP. In this circumstance, provider may request reimbursement based on the actual cost, after taking into account any discounts/rebates the provider may have received.

(e) The provider may bill for the discarded portion of drug from a single use vial or a single use package, appending the JW modifier to the ~~HCPC~~HCPCS Level II code. The provider shall bill for the discarded drug amount and the amount administered to the injured worker on two separate lines. The provider must document the discarded drug in the medical record.

(46) Prescription Strength Topical Compounds

In order to qualify as a compound under this section, the medication must require a prescription; the ingredients must be combined, mixed, or altered by a licensed pharmacist or a pharmacy technician being overseen by a licensed pharmacist, a licensed physician, or, in the case of an outsourcing facility, a person under the

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supervision of a licensed pharmacist; and it must create a medication tailored to the needs of an individual patient. All topical compounds shall be billed using the DoWC Z code corresponding with the applicable category as follows:

Category I Z0790 ~~Fee $ 80.00~~ per 30 day supply

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

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

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

Category III Z0792 ~~Fee $265.00~~ per 30 day supply

Any single agent other than anti-inflammatory agent or local anesthetic, either alone, or in combination with anti-inflammatory or local anesthetic agents.

Category IV Z0793 ~~Fee $370.00~~ per 30 day supply

Two (2) or more agents that are not anti-inflammatory or local anesthetic agents, either alone or in combination with other anti-inflammatory or local anesthetic agents.

All ingredient materials must be listed by quantity used per prescription. If the Medical Treatment Guidelines approve some but not all of the active ingredients for a particular diagnosis, the insurer shall count only the number of the approved ingredients to determine the applicable category. In addition, ~~the~~ initial prescription containing the approved ingredients shall be reimbursed without a medical review. Continued use (refills) may require documentation of effectiveness including functional improvement.

Category fees include materials, shipping and handling, and time. Regardless of how many ingredients or what type, compounded drugs cannot be reimbursed higher than the Category IV fee. The 30 day Maximum Fee Schedule value shall be fractioned down to the prescribed and dispensed amount given to the injured worker. Automatic refilling is not allowed.

(~~5~~7) Over-the-Counter Medications

(a) ~~Over-the-counter medications, drugs~~Medications that are ~~safe and effective~~available for ~~use~~purchase by the general public without a prescription and listed as over-the-counter in publications such as Price Alert, RedBook, or Medispan, are reimbursed at NDC/AWP and are not eligible for dispensing fees. If drugs have been repackaged, use the original AWP and NDC that was assigned by the source of the repackaged drugs to determine reimbursement.

(b) The maximum reimbursement for any topical muscle relaxant, analgesic, anti-inflammatory and/or anti-neuritic medications containing only active ingredients available without a prescription shall be reimbursed at cost to the billing provider up to $30.00 per 30 day supply for any application (excludes patches). Maximum reimbursement for a patch is cost to the billing provider up to $70.00 per 30 day supply.

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(DoWC Z0794 per 30 day supply for any application (excludes patches).

DoWC Z0795 per 30 day supply for patches.

See section 18-6(N)(5) for prescription-strength topicals and patches.

(8) Dietary Supplements, Vitamins and Herbal Medicines

Reimbursement for outpatient dietary supplements, vitamins and herbal medicines is authorized only by prior agreement of the payer or if specifically indicated in the Medical Treatment Guidelines. The reimbursement shall be at cost to the injured worker (see subsection (9) below).

(9) Injured Worker Reimbursement

In the event the injured worker has directly paid for authorized prescriptionsmedications, the payer shall reimburse the injured worker for the amounts actually paid for authorized prescriptions or authorized over-the-counter drugs within 30 days after submission of the injured worker's receipt. See Rule 16-1211(F).

~~(7) Dietary Supplements, Vitamins and Herbal Medicines~~

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

~~(8) Prescription Writing~~

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

~~(b) All prescriptions shall be filled with bio-equivalent generic drugs unless the physician indicates "Dispense As Written" (DAW) on the prescription. In addition to the requirements outlined in Rule 16-5(B)(2), providers using pharmacies and prescribing a brand name compounded topical drug with a DAW indication shall provide a written medical justification explaining the reasonableness and necessity of the brand name over the generic equivalent. This rule applies to all pharmacies, whether located in-state or out-of-state.~~

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

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

~~(9) Required Billing Forms~~

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

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

~~(ii) With the agreement of the payer, the National Council for Prescription Drug Programs (NCPDP) or ANSI ASC 837 (American National Standards Institute Accredited Standards Committee) electronic billing transaction containing the same information as in (1) or (2) in this sub-section may be used for billing. NCPDP Workers' Compensation/Property and Casualty (P&C) Universal Claim Form, version 1.1, for prescription drugs billed on paper shall be used by dispensing pharmacies and pharmacy benefit managers (PBMs). Physicians may use the CMS-1500 billing form as described in Rule 16-7(B)(1).~~

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

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

(O) ~~COMPLEMENTARY~~ ALTERNATIVE INTEGRATIVE MEDICINE ~~(CAM)~~

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~~CAM is a term used to describe~~Alternative integrative medicine describes a broad range of treatment modalities, some of which are generally accepted in the medical community and others that remain outside the accepted practice of conventional western medicine. Non-physician providers of ~~CAM~~alternative integrative medicine may be both licensed and non-licensed health practitioners with training in one (1) or more forms of therapy and certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in acupuncture and/or Chinese herbology. ~~CAM requires prior authorization for payment (see Rule 16-10). Refer to Rule 17,~~ Alternative integrative medicine services not priced in the fee schedule or not recommended in the Medical Treatment Guidelines ~~for the specific types of CAM modalities~~require prior authorization.

(P) ACUPUNCTURE

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

(1) Provider Restrictions

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

(2) Billing Restrictions

(a) For treatment frequencies exceeding the maximum allowed in ~~Rule 17,~~the Medical Treatment Guidelines, the provider must obtain prior authorization ~~for payment~~ (see Rule 16-~~10~~6).

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

(3) Billing Codes:

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

(b) Non-Physician evaluation services

(i) New or established patient services are reimbursable only if the medical record specifies the appropriate history, physical examination, treatment plan or evaluation of the treatment plan. Payers are only required to pay for evaluation services directly performed by an LAc. All evaluation notes or reports must be written and signed by the LAc. Without appropriate supporting documentation, the payer may deny payment. (See Rule 16-~~12~~11)

(ii) LAc new patient visit: DOWC Z0800 ~~Maximum value $105.10~~

(iii) LAc established patient visit: DOWC Z0801 ~~Maximum value $67.80~~

(c) Herbs require prior authorization ~~for payment (see Rule 16-10)~~ and fee agreements ~~as per~~(see section 18-6(N)(~~7~~).8)).

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

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

(Q) USE OF AN INTERPRETER

Rates and terms shall be negotiated. Prior authorization ~~for payment~~ (see Rule 16-~~10~~6) is required except for emergency treatment. ~~Use~~Bill DoWC Z0722 ~~to bill~~.

(R) ~~AMBULANCE FEE SCHEDULE~~MEDICAL TRANSPORTATION

(1) ~~Billing Requirements~~Fee Schedule:

~~Payment under the~~The fee schedule for ~~ambulance services is comprised~~medical transportation consists of a base rate ~~payment plus~~and a payment for mileage. Both the transport of the injured worker to the nearest facility and all items and services associated with such transport are ~~considered inclusive with~~included in the base rate and mileage rate. For adjusted RVUs and rates, see Exhibit #9.

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(2) General Claims Submission:

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

(b) Use the appropriate Providers shall use HCPCS code plus the HCPCS codes and origin/destination modifiermodifiers.

(c) The transporting supplier'sProviders shall list their name, complete address and providerNPI number should be listed in Item 33 (CMS-1500).

(d) The Providers shall list the zip code for the origin (point of pickup) must be in Item 23 (of the CMS-1500). If billing on or FL 39-41 of the UB-04 use FL 39-41 with an "AO" and the point of pick up zip code. If billing for multiple trips and the zip code for each origin is the same, services can be submitted on the same claim. If the zip codes are different, a separate claim must be submitted for each trip.

(3) Ground and Air Ambulance Vehicle and Crew Requirements

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

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

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

The selection of the base code is based upon the condition of the injured worker at the time of transport, not the vehicle used and includes services and supplies used during the transport.

HCPCS	Base Rate *250%	URBAN BASE RATE / URBAN MILEAGE *250%	RURAL BASE RATE / RURAL MILEAGE *250%	RURAL BASE RATE / LOWEST QUARTILE *250%	RURAL GROUND MILES 250%
A0425	$ 17.88	$18.23	$18.40	n/a	$27.60
A0426	$ 555.73	$687.35	$694.10	$850.98	n/a
A0427	$ 555.73	$1,088.30	$1,098.98	$1,347.35	n/a
A0428	$ 555.73	$572.80	$578.40	$709.13	n/a
A0429	$ 555.73	$916.48	$925.45	$1,134.60	n/a
A0432	$ 555.73	$1,002.38	$1,012.20	n/a	n/a
A0433	$ 555.73	$1,575.18	$1,590.63	$1,950.10	n/a
A0434	$ 555.73	$1,861.58	$1,879.83	$2,304.68	n/a
A0435	$ 21.40	$21.40	$32.10	n/a	$32.10
A0436	$ 57.10	$57.10	$85.65	n/a	$85.65

The "urban" base rate(s) and mileage rate(s) as indicated in section 18-6(R) shall be appliedapply to all relevant/applicable ambulance services unless the zip code range area is "Rural" or "Super Rural." Medicare MSA zip code grouping is listed on Medicare's webpage with an "R" indicator for "Rural" and "B" indicator for "Super

Rural." See Medicare's Zip Code to Carrier Locality File~~ Updated 08/27/2014~~, updated May 15, 2018, available at https://www.cms.gov.

(4) Non-Emergent Medical Transportation Billing Codes and Fees:

The payer shall reimburse for non-emergent medical transportation of the injured worker to and from reasonable and necessary medical services. The payment shall be for the least expensive means appropriate for the injured worker's condition.

Billing Code	Billing Code Description	Unit
A0130	Wheelchair Van Base Rate	One Way Trip
S0209	Wheelchair Van Mileage	Per Mile
T2005	Stretcher Van Base Rate	One Way Trip
T2049	Stretcher Van Mileage	Per Mile
A0120	Mobility Van Base Rate	One Way Trip

(5) Modifiers

Modifiers identify place of origin and destination of the ~~ambulance~~ trip. The modifier is to be placed next to the HCPCS code billed. The following is a list of current ~~ambulance~~ modifiers. Each of the modifiers may be utilized to make up the first and/or second half of a two-letter modifier. The first letter must describe the origin of the transport, and the second letter must describe the destination (Example: if a patient is picked up at his/her home and transported to the hospital, the modifier to describe the origin and destination would be ~~–~~RH).

~~Code Description~~

~~D Diagnostic or therapeutic site other than "P" or "H"~~

~~E Residential, domiciliary, custodial facility, nursing home other than SNF (other than 1819 facility)~~

~~G Hospital-based dialysis facility (hospital or hospital-related) which includes:~~

~~- Hospital administered/Hospital located~~

~~- Non-Hospital administered/Hospital located~~

~~GM Multiple patients on one ambulance trip~~

~~H Hospital~~

~~I Site of transfer (e.g., airport, ferry, or helicopter pad) between modes of ambulance transport~~

~~J Non-hospital-based dialysis facility~~

~~- Non-Hospital administered/Non-Hospital located~~

~~- Hospital administered/Non-Hospital located~~

~~N Skilled Nursing Facility (SNF) (1819 Facility)~~

~~P Physician's Office (includes HMO non-hospital facility, clinic, etc.)~~

~~QL Patient pronounced dead after ambulance called.~~

~~QM Ambulance service under arrangement by a provider of service~~

~~QN Ambulance service furnished directly by a provider of service.~~

~~R Residence~~

~~S Scene of Accident or Acute Event~~

~~X~~ Code	~~Destination Code Only (Intermediate stop at physician's office en route to the hospital, includes HMO non-hospital facility, clinic, etc.)~~ Description
D	Diagnostic or therapeutic site other than "P" or "H"
E	Residential, domiciliary, custodial facility, nursing home other than a skilled nursing facility
G	Hospital-based dialysis facility (hospital or hospital-related) which includes: - Hospital administered/Hospital located - Non-Hospital administered/Hospital located
GM	Multiple patients on one ambulance trip
H	Hospital
I	Site of transfer (i.e., airport, ferry, or helicopter pad) between modes of ambulance transport
J	Non-hospital-based dialysis facility - Hospital administered/Hospital located - Non-Hospital administered/Hospital located
N	Skilled Nursing Facility
P	Physician's Office (includes non-hospital facility, clinic, etc.)
QL	Patient pronounced dead after ambulance called.
QM	Ambulance service under arrangement by a provider of service
QN	Ambulance service furnished directly by a provider of service.
R	Residence

S	Scene of Accident or Acute Event
X	Destination Code Only (Intermediate stop at physician's office en route to the hospital, includes non-hospital facility, clinic, etc.)

(6) Mileage Charges for mileage must be based on loaded mileage only, i.e., from the pickup of a patient to his/her arrival at the destination. ~~Payment is allowed for all medically necessary mileage. If mileage is billed, the~~ The miles billed must be in whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number~~. Use code "1" as the mileage for trips of less than a mile~~.

18-7 DENTAL FEE SCHEDULE

The dental fee schedule is adopted using the American Dental Association's Current Dental Terminology, ~~2017~~2018 (CDT ~~2017~~®-2018). However, surgical treatment for dental trauma and subsequent~~,~~ related procedures ~~may~~shall be billed using medical codes from the RBRVS. If billed using ~~medical codes as listed in the~~ RBRVS, reimbursement shall be in accordance with the values listed in the Surgery/ ~~Anesthesia~~ section ~~of~~and the ~~RBRVS and its~~ corresponding CF. ~~All dental billing and reimbursement shall be in accordance with the Division's Rule 16, Utilization Standards, and Rule 17, Medical Treatment Guidelines.~~ See Exhibit #6 ~~of this Rule~~ for the listing and Maximum Fee Schedule value for CDT ~~2017~~®-2018 dental codes.

Regarding prosthetic appliances, the provider may bill and be reimbursed for 50% of the allowed fee at the time the master casts are prepared for removable prosthodontics or the final impressions are taken for fixed prosthodontics. The remaining 50% may be billed on insertion of the final prosthesis.

18-8 QUALITY INITIATIVES

(A) OPIOID MANAGEMENT

(1) Codes and maximum fees are payable to the ATP for a written report with all the following opioid review services completed and documented:

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

(b) ~~Ordering~~ordering and reviewing Colorado Prescription Drug Monitoring Program (PDMP) results;

(c) ~~Reviewing~~reviewing the medical records;

(d) ~~Reviewing~~reviewing the injured ~~workers'~~worker's current functional status;

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

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

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In determining the prescribed levels of medications, the ATP shall review and integrate the drug screening results required for subacute and chronic opioid management, as appropriate; the PDMP and its results; an evaluation of compliance with treatment and risk for addiction or misuse; as well as the injured worker's past and current functional status. A written report also must document the treating physician's assessment of the patient's past and current functional status of work, leisure, and activities of daily living.

The patient should initially and periodically be evaluated for risk of misuse or addiction. The ATP may consider whether the injured worker experienced an opiate-related drug overdose event that resulted in an opiate antagonist being prescribed or dispensed pursuant to §§ 12-36-117.7, 12-38-125.5, 12-42.5-120, or 13-21-108.7~~, C.R.S~~. If the patient is deemed to be at risk for an opiate overdose, an opioid antagonist may be prescribed (see section 18-6(N)(~~3~~5)(c)).

Opioid Management Billing Codes:

Acute Phase: DoWC Code~~:~~ Z0771 ~~$84.00~~ per 15 minutes~~—~~, maximum of 30 minutes per report

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

(2) Definitions:

(a) Acute opioid use refers to the prescription of opioid medications (single or multiple) for duration of 30 days or less for non-traumatic injuries, or 6 weeks or less for traumatic injuries or post-operatively.

(b) Subacute opioid use refers to the prescription of opioid medications for longer than 30 days for non-surgical cases and longer than 6 weeks for traumatic injuries or post-operatively.

(c) Chronic Opioid use refers to the prescription of opioid medications for longer than 90 days.

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

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(4) When the ATP prescribes long-term opioid treatment, s/he shall comply with the Division's Chronic Pain Disorder Medical Treatment Guideline (Rule 17, Exhibit ~~9)~~ ~~and other relevant Treatment Guidelines,~~#9), and review the Colorado Medical Board Policy #40-26, "Policy for Prescribing and Dispensing Opioids."

(5) Urine drug tests are required for subacute and chronic opioid management and shall employ testing methodologies that meet or exceed industry standards for sensitivity, specificity, and accuracy. The test methodology must be capable of identifying and quantifying the parent compound and relevant metabolites of the opioid prescribed. In-office screening tests designed to screen for drugs of abuse are not appropriate for subacute or chronic opioid compliance monitoring. Refer to section 18-5(~~F~~G)(4) for clinical drug screening testing codes and values.

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

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

(i) Concern regarding the functional status of the patient;
(ii) Abnormal results on previous testing;
(iii) Change in management of dosage or pain; and
(iv) Chronic daily opioid dosage above 50 ~~MME~~MMEs.

(B) FUNCTIONAL ASSESSMENTS

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

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

(b) Pre-and post-injection procedure shall have at least three (3) objective, diagnostically appropriate, functional measures identified, measured and documented. These may include spinal range of motion; tolerance and time limits for sitting, walking and lifting; straight leg raises for herniated discs; a variety of provocative SI joint maneuvers such as Patrick's sign, Gaenslen, distraction or gapping and compression tests. Objective descriptions, preferably with measurements, shall be provided initially and post procedure at the appropriate time for medication effect, usually 30 minutes post procedure.

(c) There shall be a trained physician or trained non-physician health care professional detailed report with a pre- and post-procedure pain diagram, normally using a 0-10 point scale. The patient(s) should be instructed to keep a post-injection pain diary that details the patient's pain level for all pertinent body parts, including any affected limbs. The patient pain diary should be kept for at least eight (8) hours post injection and preferably up

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to seven (7) days. The patient should be encouraged to also report any changes in activity level post injection.

(2) If all three (3) elements are documented, the billing codes and maximum fees are as follows:

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

DOWC Z0812 ~~$33.00~~ for a subsequent visit of therapeutic post-injection care (preferably done by a non-injectionist and at least seven (7) days after the injection), billed along with the appropriate E&M code, related to follow-up care of spinal or SI joint injections. The injured worker should provide post injection pain data, including a pain diary.

DOWC Z0814 ~~$33.00~~ for post-diagnostic injection care (repeat functional assessment within the time period for the effective agent given).

(C) QUALITY PERFORMANCE AND OUTCOMES PAYMENTS (QPOP)

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(1) Medical providers who are Level I or II accredited, or who have completed the Division-sponsored Level I or II accreditation program and have successfully completed the QPOP training may bill separately for documenting functional progress made by the injured worker. The medical providers must utilize both a Division-approved psychological screen and a Division-approved functional tool. The psychological screen and the functional tool are approved by the Division and are validated for the specific purpose for which they have been created. The medical provider also must document whether the injured worker's perception of function correlates with clinical findings. The documentation of functional progress should assist the provider in preparing a successful plan of care, including specific goals and expected time frames for completion, or for modifying a prior plan of care. The documentation must include:

(a) Specific testing that occurred, interpretation of testing results, and the weight given to these results in forming a reasonable and necessary plan of care;

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(b) Explanation of how the testing goes beyond the evaluation and management (E&M) services typically provided by the provider;

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(c) Meaningful discussion of actual or expected functional improvement between the provider and the injured worker.

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

DOWC Z0815 ~~$ 80.00~~ for the initial assessment during which the injured worker provides functional data and completes the validated psychological screen, which the provider considers in preparing a plan of care. This code also may be used for the final assessment that includes review of the functional gains achieved during the course of treatment and documentation of MMI.

DOWC Z0816 ~~– $ 40.00~~ for subsequent visits during which the injured worker provides follow-up functional data ~~which~~that could alter the treatment plan. The provider may use this code if the analysis of the data causes him or her to modify the treatment plan. The provider should not bill this code more than once every 2 to 4 weeks.

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

(D) PILOT PROGRAMS

Payers may submit a proposal to conduct a pilot program(s) to the Director for approval. Pilot programs authorized by this ~~rule~~Rule shall be designed to improve quality of care, determine the efficacy of clinic or payment models, and to provide a basis for future development and expansion of such models.

The proposal for a pilot program shall meet the minimum standards set forth in § 8-43-602, ~~C.R.S.,~~ and shall include:

(1) ~~Beginning~~beginning and end date for the pilot program.
(2) ~~Population~~population to be managed (e.g. size, specific diagnosis codes).
(3) ~~Provider~~provider group(s) participating in the program.
(4) ~~Proposed~~proposed codes and fees.
(5) ~~Process~~process for evaluating the program's success.

Participating payers must submit data and other information as required by the Division to examine such issues as the financial implications for providers and patients, enrollment patterns, utilization patterns, impact on health outcomes, system effects and the need for future health planning.

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18-9 INDIGENCE STANDARDS

(A) A person shall be found to be indigent only if:

(1) income is at or below eligibility guidelines with liquid assets of $1,500 or less; or

(2) income is up to 25% above the eligibility guidelines, liquid assets equal $1,500 or less, and the claimant's monthly expenses equal or exceed monthly income; or,

(3) if "extraordinary circumstances" exist which merit a determination of indigence.

(B) Income Eligibility Guidelines:

Family Size	Monthly income guidelines	Monthly income guideline plus 25%
1	$1,265	$1,581
2	$1,715	$2,143
3	$2,165	$2,706

4	$2,615	$3,268
5	$3,065	$3,831
6	$3,515	$4,393
7	$3,965	$4,956
8	$4,461	$5,577

*For family units with more than eight members, add $390 per month for “monthly income” or $4,675 per year for "yearly income" for each additional family member.

(1) Income is gross income from all members of the household who contribute monetarily to the common support of the household.

(2) Liquid assets include cash on hand or in accounts, stocks, bonds, certificates of deposit, equity and personal property or investments which could readily be converted into cash without jeopardizing the applicant’s ability to maintain home and employment. “Liquid assets” exclude any equity in any vehicle which the injured worker or his/her family must use for essential transportation unless the ALJ makes an affirmative finding of fact that the worker is credit worthy, can borrow against the equity in this vehicle, and can afford to pay back a loan without compromising food, clothing, shelter, and transportation needs.

(3) Expenses for nonessential items such as cable television, club memberships, entertainment, dining out, alcohol, cigarettes, etc. shall not be included.

18-10 LIST OF EXHIBITS

Exhibit 1 – MS-DRG Relative Weights

Exhibit 2 - Hospital Base Rates and Cost to Charge Ratios (CCRs)

Exhibit 3 - Critical Access Hospitals

Exhibit 4 - Hospital and ASC APCs

Exhibit 5 - Rural Health Clinics

Exhibit 6 - Dental Fee Schedule

Exhibit 7 - Evaluation and Management (E&M)

Exhibit 8 - Clinical Lab

Exhibit 9 - Division established RVUs and Z-Codes

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
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	26.4106	29.1	37.5
2	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W/O MCC	13.4227	15.1	18.0
3	PRE	SURG	ECMO OR TRACH W MV >96 HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	18.2974	23.4	30.1
4	PRE	SURG	TRACH W MV >96 HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	11.4192	19.5	23.6
5	PRE	SURG	LIVER TRANSPLANT W MCC OR INTESTINAL TRANSPLANT	10.2545	14.6	20.0
6	PRE	SURG	LIVER TRANSPLANT W/O MCC	4.8655	7.9	8.6
7	PRE	SURG	LUNG TRANSPLANT	10.6510	16.7	20.2
8	PRE	SURG	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	5.2490	8.9	10.1
10	PRE	SURG	PANCREAS TRANSPLANT	4.5139	7.8	8.5
11	PRE	SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES OR LARYNGECTOMY W MCC	4.9124	10.9	13.4
12	PRE	SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES OR LARYNGECTOMY W CC	3.8137	8.7	9.8
13	PRE	SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES OR LARYNGECTOMY W/O CC/MCC	2.3265	5.9	6.7
14	PRE	SURG	ALLOGENEIC BONE MARROW TRANSPLANT	11.9503	24.1	27.4
16	PRE	SURG	AUTOLOGOUS BONE MARROW TRANSPLANT W CC/MCC OR T-CELL IMMUNOTHERAPY	6.5394	17.1	18.4
17	PRE	SURG	AUTOLOGOUS BONE MARROW TRANSPLANT W/O CC/MCC	4.3811	7.9	10.7
20	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W MCC	10.4253	13.6	16.5
21	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W CC	7.9056	12.1	13.7
22	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W/O CC/MCC	5.1575	6.3	8.1

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
23	01	SURG	CRANIOTOMY W MAJOR DEVICE IMPLANT OR ACUTE COMPLEX CNS PDX W MCC OR CHEMOTHERAPY IMPLANT OR EPILEPSY W NEUROSTIMULATOR	5.4601	7.3	10.2
24	01	SURG	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W/O MCC	3.9194	4.3	5.7
25	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W MCC	4.2775	6.7	8.8
26	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W CC	3.0157	4.3	5.7
27	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W/O CC/MCC	2.4057	2.1	2.7
28	01	SURG	SPINAL PROCEDURES W MCC	5.3748	9.0	11.8
29	01	SURG	SPINAL PROCEDURES W CC OR SPINAL NEUROSTIMULATORS	3.1557	4.4	5.8
30	01	SURG	SPINAL PROCEDURES W/O CC/MCC	2.1757	2.3	3.0
31	01	SURG	VENTRICULAR SHUNT PROCEDURES W MCC	4.1829	7.2	10.1
32	01	SURG	VENTRICULAR SHUNT PROCEDURES W CC	2.3021	3.3	4.8
33	01	SURG	VENTRICULAR SHUNT PROCEDURES W/O CC/MCC	1.6877	1.8	2.3
34	01	SURG	CAROTID ARTERY STENT PROCEDURE W MCC	3.5998	4.7	6.8
35	01	SURG	CAROTID ARTERY STENT PROCEDURE W CC	2.2203	2.1	3.0
36	01	SURG	CAROTID ARTERY STENT PROCEDURE W/O CC/MCC	1.7260	1.2	1.4
37	01	SURG	EXTRACRANIAL PROCEDURES W MCC	3.2098	5.1	7.4
38	01	SURG	EXTRACRANIAL PROCEDURES W CC	1.6717	2.2	3.1
39	01	SURG	EXTRACRANIAL PROCEDURES W/O CC/MCC	1.1324	1.3	1.5
40	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W MCC	3.9282	7.6	10.7
41	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W CC OR PERIPH NEUROSTIM	2.3584	4.2	5.3
42	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W/O CC/MCC	1.8715	2.5	3.1
52	01	MED	SPINAL DISORDERS & INJURIES W CC/MCC	1.7004	4.1	5.8

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
53	01	MED	SPINAL DISORDERS & INJURIES W/O CC/MCC	0.9141	2.7	3.3
54	01	MED	NERVOUS SYSTEM NEOPLASMS W MCC	1.3166	3.8	5.1
55	01	MED	NERVOUS SYSTEM NEOPLASMS W/O MCC	1.0472	3.1	4.4
56	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS W MCC	2.1245	5.5	8.1
57	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS W/O MCC	1.2089	3.9	5.6
58	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W MCC	1.7596	5.0	6.9
59	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W CC	1.0993	3.7	4.5
60	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W/O CC/MCC	0.8327	3.0	3.5
61	01	MED	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA W THROMBOLYTIC AGENT W MCC	2.8477	5.0	6.5
62	01	MED	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA W THROMBOLYTIC AGENT W CC	1.9437	3.4	4.0
63	01	MED	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA W THROMBOLYTIC AGENT W/O CC/MCC	1.6280	2.4	2.7
64	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	1.8692	4.4	6.1
65	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	1.0315	3.1	3.8
66	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W/O CC/MCC	0.7268	2.1	2.5
67	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W MCC	1.5014	3.6	4.8
68	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W/O MCC	0.8987	2.3	2.8
69	01	MED	TRANSIENT ISCHEMIA W/O THROMBOLYTIC	0.7655	2.1	2.5

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
70	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W MCC	1.6453	4.5	6.2
71	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	0.9858	3.3	4.3
72	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC/MCC	0.7420	2.4	2.9
73	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W MCC	1.4111	3.7	5.1
74	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O MCC	0.9739	2.9	3.7
75	01	MED	VIRAL MENINGITIS W CC/MCC	1.4816	4.8	6.0
76	01	MED	VIRAL MENINGITIS W/O CC/MCC	0.8248	2.8	3.3
77	01	MED	HYPERTENSIVE ENCEPHALOPATHY W MCC	1.5520	4.1	5.2
78	01	MED	HYPERTENSIVE ENCEPHALOPATHY W CC	0.9701	3.1	3.8
79	01	MED	HYPERTENSIVE ENCEPHALOPATHY W/O CC/MCC	0.7465	2.1	2.5
80	01	MED	NONTRAUMATIC STUPOR & COMA W MCC	1.8788	4.5	6.8
81	01	MED	NONTRAUMATIC STUPOR & COMA W/O MCC	0.8546	2.7	3.7
82	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W MCC	2.1586	3.8	6.0
83	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W CC	1.2950	3.2	4.2
84	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W/O CC/MCC	0.9233	2.2	2.7
85	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W MCC	2.1800	4.7	6.5
86	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W CC	1.2431	3.2	4.1
87	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W/O CC/MCC	0.8453	2.1	2.6
88	01	MED	CONCUSSION W MCC	1.4796	3.6	4.7
89	01	MED	CONCUSSION W CC	1.0675	2.7	3.5
90	01	MED	CONCUSSION W/O CC/MCC	0.7934	1.9	2.3
91	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W MCC	1.6120	4.2	5.7

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
92	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.9433	3.0	3.8
93	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC/MCC	0.7378	2.2	2.7
94	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W MCC	3.6779	8.0	11.0
95	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W CC	2.3809	5.7	7.1
96	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W/O CC/MCC	2.1110	4.4	5.2
97	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W MCC	3.5389	8.4	11.4
98	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W CC	1.8505	5.4	6.9
99	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W/O CC/MCC	1.2729	3.7	4.7
100	01	MED	SEIZURES W MCC	1.8124	4.3	5.9
101	01	MED	SEIZURES W/O MCC	0.8693	2.7	3.4
102	01	MED	HEADACHES W MCC	1.0765	3.0	4.0
103	01	MED	HEADACHES W/O MCC	0.7814	2.3	3.0
113	02	SURG	ORBITAL PROCEDURES W CC/MCC	2.3027	4.5	6.2
114	02	SURG	ORBITAL PROCEDURES W/O CC/MCC	1.2551	2.3	2.9
115	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT	1.3621	3.5	4.5
116	02	SURG	INTRAOCULAR PROCEDURES W CC/MCC	1.7080	4.0	5.8
117	02	SURG	INTRAOCULAR PROCEDURES W/O CC/MCC	1.0025	2.3	3.1
121	02	MED	ACUTE MAJOR EYE INFECTIONS W CC/MCC	1.0593	4.0	5.2
122	02	MED	ACUTE MAJOR EYE INFECTIONS W/O CC/MCC	0.7058	3.2	4.1
123	02	MED	NEUROLOGICAL EYE DISORDERS	0.7529	2.0	2.5
124	02	MED	OTHER DISORDERS OF THE EYE W MCC	1.3313	3.6	4.9
125	02	MED	OTHER DISORDERS OF THE EYE W/O MCC	0.8102	2.6	3.3
129	03	SURG	MAJOR HEAD & NECK PROCEDURES W CC/MCC OR MAJOR DEVICE	2.4310	3.7	5.5
130	03	SURG	MAJOR HEAD & NECK PROCEDURES W/O CC/MCC	1.4912	2.3	2.9
131	03	SURG	CRANIAL/FACIAL PROCEDURES W CC/MCC	2.6284	4.2	5.7

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
132	03	SURG	CRANIAL/FACIAL PROCEDURES W/O CC/MCC	1.5286	2.0	2.5
133	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W CC/MCC	2.0986	4.0	5.8
134	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W/O CC/MCC	1.1987	2.0	2.5
135	03	SURG	SINUS & MASTOID PROCEDURES W CC/MCC	2.2982	4.4	6.4
136	03	SURG	SINUS & MASTOID PROCEDURES W/O CC/MCC	1.2125	1.8	2.8
137	03	SURG	MOUTH PROCEDURES W CC/MCC	1.3771	3.6	4.8
138	03	SURG	MOUTH PROCEDURES W/O CC/MCC	0.8452	2.0	2.4
139	03	SURG	SALIVARY GLAND PROCEDURES	1.1604	2.1	2.8
146	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W MCC	1.9231	5.3	7.4
147	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W CC	1.2505	3.7	5.2
148	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W/O CC/MCC	0.7238	2.1	2.8
149	03	MED	DYSEQUILIBRIUM	0.7111	2.0	2.5
150	03	MED	EPISTAXIS W MCC	1.3275	3.5	4.8
151	03	MED	EPISTAXIS W/O MCC	0.7038	2.2	2.8
152	03	MED	OTITIS MEDIA & URI W MCC	1.0421	3.2	4.1
153	03	MED	OTITIS MEDIA & URI W/O MCC	0.7118	2.4	2.9
154	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W MCC	1.4465	4.0	5.3
155	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W CC	0.8833	2.9	3.7
156	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W/O CC/MCC	0.6599	2.2	2.7
157	03	MED	DENTAL & ORAL DISEASES W MCC	1.6730	4.4	6.1
158	03	MED	DENTAL & ORAL DISEASES W CC	0.8903	2.8	3.6
159	03	MED	DENTAL & ORAL DISEASES W/O CC/MCC	0.6784	2.1	2.6
163	04	SURG	MAJOR CHEST PROCEDURES W MCC	4.9193	9.7	12.1
164	04	SURG	MAJOR CHEST PROCEDURES W CC	2.5689	4.8	5.9
165	04	SURG	MAJOR CHEST PROCEDURES W/O CC/MCC	1.8524	2.9	3.5

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
166	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	3.4980	7.9	10.2
167	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	1.8976	4.3	5.6
168	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC/MCC	1.3416	2.4	3.0
175	04	MED	PULMONARY EMBOLISM W MCC	1.4649	4.3	5.3
176	04	MED	PULMONARY EMBOLISM W/O MCC	0.8990	2.8	3.4
177	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	1.8408	5.5	6.8
178	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W CC	1.2744	4.3	5.3
179	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W/O CC/MCC	0.9215	3.2	4.0
180	04	MED	RESPIRATORY NEOPLASMS W MCC	1.6960	4.9	6.5
181	04	MED	RESPIRATORY NEOPLASMS W CC	1.1409	3.4	4.5
182	04	MED	RESPIRATORY NEOPLASMS W/O CC/MCC	0.7951	2.2	2.8
183	04	MED	MAJOR CHEST TRAUMA W MCC	1.4909	4.4	5.5
184	04	MED	MAJOR CHEST TRAUMA W CC	1.0044	3.2	3.8
185	04	MED	MAJOR CHEST TRAUMA W/O CC/MCC	0.7323	2.4	2.8
186	04	MED	PLEURAL EFFUSION W MCC	1.5595	4.4	5.8
187	04	MED	PLEURAL EFFUSION W CC	1.0540	3.3	4.1
188	04	MED	PLEURAL EFFUSION W/O CC/MCC	0.7672	2.4	3.0
189	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.2353	3.8	4.8
190	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1.1907	3.8	4.7
191	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	0.9139	3.1	3.7
192	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	0.7241	2.5	3.0
193	04	MED	SIMPLE PNEUMONIA & PLEURISY W MCC	1.3167	4.2	5.2
194	04	MED	SIMPLE PNEUMONIA & PLEURISY W CC	0.9002	3.3	3.9
195	04	MED	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	0.6868	2.6	3.1
196	04	MED	INTERSTITIAL LUNG DISEASE W MCC	1.6381	4.8	6.2

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
197	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.0017	3.3	4.0
198	04	MED	INTERSTITIAL LUNG DISEASE W/O CC/MCC	0.7585	2.5	3.1
199	04	MED	PNEUMOTHORAX W MCC	1.7828	5.3	6.9
200	04	MED	PNEUMOTHORAX W CC	1.0748	3.4	4.3
201	04	MED	PNEUMOTHORAX W/O CC/MCC	0.6989	2.4	3.0
202	04	MED	BRONCHITIS & ASTHMA W CC/MCC	0.9401	3.0	3.7
203	04	MED	BRONCHITIS & ASTHMA W/O CC/MCC	0.6970	2.4	2.9
204	04	MED	RESPIRATORY SIGNS & SYMPTOMS	0.7676	2.2	2.8
205	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W MCC	1.5179	4.0	5.4
206	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O MCC	0.8635	2.5	3.1
207	04	MED	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT >96 HOURS OR PERIPHERAL EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)	5.5965	12.0	13.9
208	04	MED	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <=96 HOURS	2.4374	4.9	6.7
215	05	SURG	OTHER HEART ASSIST SYSTEM IMPLANT	12.8861	5.2	8.7
216	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W MCC	9.8209	12.5	15.3
217	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W CC	6.3628	7.3	8.8
218	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W/O CC/MCC	5.9053	4.1	5.5
219	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W MCC	7.6916	9.1	11.1
220	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W CC	5.2053	6.1	6.7

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
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	4.6074	4.2	4.8
222	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W MCC	8.1372	9.2	11.1
223	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W/O MCC	6.3562	5.3	6.4
224	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W MCC	7.4247	7.7	9.6
225	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W/O MCC	5.7194	4.1	4.8
226	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W MCC	6.8182	6.5	8.4
227	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W/O MCC	5.3167	3.1	4.1
228	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W MCC	6.5762	6.7	9.7
229	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W/O MCC	4.6484	3.4	4.7
231	05	SURG	CORONARY BYPASS W PTCA W MCC	8.3989	10.3	12.0
232	05	SURG	CORONARY BYPASS W PTCA W/O MCC	6.1604	8.0	8.8
233	05	SURG	CORONARY BYPASS W CARDIAC CATH W MCC	7.6377	11.5	12.9
234	05	SURG	CORONARY BYPASS W CARDIAC CATH W/O MCC	5.1472	8.1	8.6
235	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W MCC	5.8099	8.8	10.1
236	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W/O MCC	3.9263	6.0	6.5
239	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W MCC	4.7093	10.2	13.0
240	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W CC	2.7449	7.0	8.5
241	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W/O CC/MCC	1.5960	4.4	5.2

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
242	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W MCC	3.7369	5.4	7.0
243	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W CC	2.5543	3.3	4.0
244	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W/O CC/MCC	2.1108	2.3	2.7
245	05	SURG	AICD GENERATOR PROCEDURES	5.0121	4.4	6.1
246	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W DRUG-ELUTING STENT W MCC OR 4+ ARTERIES OR STENTS	3.2388	4.1	5.4
247	05	SURG	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	2.0771	2.2	2.6
248	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W NON-DRUG-ELUTING STENT W MCC OR 4+ ARTERIES OR STENTS	3.1726	4.7	6.3
249	05	SURG	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MCC	1.9901	2.4	3.0
250	05	SURG	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W MCC	2.5868	3.9	5.3
251	05	SURG	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W/O MCC	1.6778	2.2	2.7
252	05	SURG	OTHER VASCULAR PROCEDURES W MCC	3.2598	5.3	7.6
253	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.5943	4.1	5.4
254	05	SURG	OTHER VASCULAR PROCEDURES W/O CC/MCC	1.8100	2.3	2.8
255	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W MCC	2.5403	6.5	8.1
256	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W CC	1.7487	5.2	6.2
257	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W/O CC/MCC	1.1261	3.5	4.3
258	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT W MCC	2.9888	5.0	6.4
259	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT W/O MCC	2.0970	2.7	3.4

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
260	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W MCC	3.6195	6.8	9.2
261	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W CC	1.9918	3.3	4.2
262	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W/O CC/MCC	1.6309	2.3	2.7
263	05	SURG	VEIN LIGATION & STRIPPING	2.3922	4.2	6.3
264	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	3.1586	6.5	9.2
265	05	SURG	AICD LEAD PROCEDURES	3.1167	3.7	5.1
266	05	SURG	ENDOVASCULAR CARDIAC VALVE REPLACEMENT W MCC	7.1915	4.0	6.1
267	05	SURG	ENDOVASCULAR CARDIAC VALVE REPLACEMENT W/O MCC	5.8481	2.3	2.9
268	05	SURG	AORTIC AND HEART ASSIST PROCEDURES EXCEPT PULSATION BALLOON W MCC	6.7037	6.4	9.5
269	05	SURG	AORTIC AND HEART ASSIST PROCEDURES EXCEPT PULSATION BALLOON W/O MCC	4.1509	1.7	2.4
270	05	SURG	OTHER MAJOR CARDIOVASCULAR PROCEDURES W MCC	5.0617	6.6	9.5
271	05	SURG	OTHER MAJOR CARDIOVASCULAR PROCEDURES W CC	3.4938	4.3	5.8
272	05	SURG	OTHER MAJOR CARDIOVASCULAR PROCEDURES W/O CC/MCC	2.6181	2.1	2.8
273	05	SURG	PERCUTANEOUS INTRACARDIAC PROCEDURES W MCC	3.6525	5.3	7.3
274	05	SURG	PERCUTANEOUS INTRACARDIAC PROCEDURES W/O MCC	2.9783	2.0	2.6
280	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC	1.6571	4.2	5.4
281	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W CC	0.9796	2.6	3.2
282	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W/O CC/MCC	0.7490	1.8	2.2
283	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W MCC	1.8047	3.0	4.8

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
284	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W CC	0.7666	1.7	2.3
285	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W/O CC/MCC	0.5964	1.3	1.6
286	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W MCC	2.1808	5.2	6.9
287	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O MCC	1.1389	2.4	3.0
288	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W MCC	2.6941	7.3	9.6
289	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W CC	1.7099	5.4	6.7
290	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W/O CC/MCC	1.0114	3.4	4.3
291	05	MED	HEART FAILURE & SHOCK W MCC OR PERIPHERAL EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)	1.3454	4.1	5.2
292	05	MED	HEART FAILURE & SHOCK W CC	0.9198	3.3	4.0
293	05	MED	HEART FAILURE & SHOCK W/O CC/MCC	0.6656	2.4	2.8
294	05	MED	DEEP VEIN THROMBOPHLEBITIS W CC/MCC	1.1608	3.4	4.4
295	05	MED	DEEP VEIN THROMBOPHLEBITIS W/O CC/MCC	0.5513	2.3	3.1
296	05	MED	CARDIAC ARREST, UNEXPLAINED W MCC OR PERIPHERAL EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)	1.5355	2.0	3.2
297	05	MED	CARDIAC ARREST, UNEXPLAINED W CC	0.6524	1.3	1.5
298	05	MED	CARDIAC ARREST, UNEXPLAINED W/O CC/MCC	0.4825	1.1	1.2
299	05	MED	PERIPHERAL VASCULAR DISORDERS W MCC	1.4504	3.9	5.2
300	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	1.0237	3.3	4.1
301	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC/MCC	0.7262	2.3	2.8
302	05	MED	ATHEROSCLEROSIS W MCC	1.0695	2.7	3.6
303	05	MED	ATHEROSCLEROSIS W/O MCC	0.6655	1.9	2.3
304	05	MED	HYPERTENSION W MCC	1.0811	3.0	3.9
305	05	MED	HYPERTENSION W/O MCC	0.7199	2.2	2.7
306	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS W MCC	1.4088	3.8	5.2

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
307	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS W/O MCC	0.8560	2.4	3.1
308	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W MCC	1.2036	3.6	4.6
309	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.7635	2.5	3.0
310	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC/MCC	0.5623	1.9	2.2
311	05	MED	ANGINA PECTORIS	0.6872	1.9	2.4
312	05	MED	SYNCOPE & COLLAPSE	0.8015	2.3	2.9
313	05	MED	CHEST PAIN	0.7073	1.7	2.1
314	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W MCC	2.0231	4.8	6.5
315	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.9559	2.8	3.6
316	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC/MCC	0.7513	2.0	2.4
326	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W MCC	5.2559	10.1	13.5
327	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W CC	2.4843	4.9	6.7
328	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W/O CC/MCC	1.5421	2.2	2.8
329	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W MCC	4.9927	10.8	13.4
330	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	2.5233	6.2	7.4
331	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1.6947	3.7	4.2
332	06	SURG	RECTAL RESECTION W MCC	3.3982	6.9	8.8
333	06	SURG	RECTAL RESECTION W CC	1.9278	4.4	5.4
334	06	SURG	RECTAL RESECTION W/O CC/MCC	1.3062	2.4	2.9
335	06	SURG	PERITONEAL ADHESIOLYSIS W MCC	4.0620	10.1	12.3
336	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.2982	6.3	7.7
337	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC/MCC	1.6033	3.9	4.8

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
338	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W MCC	2.8648	6.6	8.2
339	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	1.7406	4.3	5.2
340	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC/MCC	1.1878	2.4	2.9
341	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W MCC	2.2845	4.6	6.3
342	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.4188	2.7	3.5
343	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC/MCC	1.0853	1.7	2.0
344	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W MCC	2.9872	7.6	10.1
345	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.6376	4.6	5.7
346	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1.2366	3.2	3.8
347	06	SURG	ANAL & STOMAL PROCEDURES W MCC	2.4111	5.7	7.8
348	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.4000	3.6	4.7
349	06	SURG	ANAL & STOMAL PROCEDURES W/O CC/MCC	0.9497	2.1	2.6
350	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W MCC	2.4465	5.1	6.9
351	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W CC	1.5001	3.4	4.1
352	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W/O CC/MCC	1.0535	2.1	2.5
353	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W MCC	2.9659	6.0	7.8
354	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W CC	1.7310	3.8	4.7
355	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W/O CC/MCC	1.3548	2.5	3.0
356	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W MCC	3.9757	7.8	10.3

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
357	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.1367	4.7	5.9
358	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	1.3483	2.8	3.5
368	06	MED	MAJOR ESOPHAGEAL DISORDERS W MCC	1.9440	4.7	6.2
369	06	MED	MAJOR ESOPHAGEAL DISORDERS W CC	1.1088	3.2	3.9
370	06	MED	MAJOR ESOPHAGEAL DISORDERS W/O CC/MCC	0.7433	2.2	2.8
371	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W MCC	1.7388	5.4	7.0
372	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC	1.0384	4.0	4.9
373	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W/O CC/MCC	0.7576	3.1	3.7
374	06	MED	DIGESTIVE MALIGNANCY W MCC	2.0650	5.6	7.5
375	06	MED	DIGESTIVE MALIGNANCY W CC	1.2067	3.7	4.8
376	06	MED	DIGESTIVE MALIGNANCY W/O CC/MCC	0.9157	2.5	3.1
377	06	MED	G.I. HEMORRHAGE W MCC	1.7888	4.5	5.7
378	06	MED	G.I. HEMORRHAGE W CC	0.9903	3.0	3.6
379	06	MED	G.I. HEMORRHAGE W/O CC/MCC	0.6532	2.1	2.5
380	06	MED	COMPLICATED PEPTIC ULCER W MCC	1.9460	5.1	6.6
381	06	MED	COMPLICATED PEPTIC ULCER W CC	1.0950	3.3	4.0
382	06	MED	COMPLICATED PEPTIC ULCER W/O CC/MCC	0.7678	2.5	2.9
383	06	MED	UNCOMPLICATED PEPTIC ULCER W MCC	1.3510	4.0	5.0
384	06	MED	UNCOMPLICATED PEPTIC ULCER W/O MCC	0.8553	2.6	3.2
385	06	MED	INFLAMMATORY BOWEL DISEASE W MCC	1.6979	5.3	7.3
386	06	MED	INFLAMMATORY BOWEL DISEASE W CC	0.9801	3.5	4.4
387	06	MED	INFLAMMATORY BOWEL DISEASE W/O CC/MCC	0.6967	2.8	3.3
388	06	MED	G.I. OBSTRUCTION W MCC	1.5307	4.8	6.4
389	06	MED	G.I. OBSTRUCTION W CC	0.8432	3.3	4.0
390	06	MED	G.I. OBSTRUCTION W/O CC/MCC	0.5910	2.5	2.9
391	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W MCC	1.2215	3.7	4.9
392	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	0.7554	2.6	3.2

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
393	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W MCC	1.6326	4.4	6.1
394	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W CC	0.9411	3.1	4.0
395	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W/O CC/MCC	0.6765	2.3	2.8
405	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W MCC	5.3791	9.6	12.8
406	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	2.8326	5.6	7.0
407	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC/MCC	2.0068	3.8	4.5
408	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W MCC	4.0465	9.2	11.9
409	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	2.3227	5.6	6.9
410	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC/MCC	1.6526	3.7	4.5
411	07	SURG	CHOLECYSTECTOMY W C.D.E. W MCC	3.9981	8.3	11.1
412	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	2.3819	5.5	6.5
413	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC/MCC	1.6862	3.5	4.3
414	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W MCC	3.5772	8.0	9.8
415	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	2.0188	5.2	6.1
416	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC/MCC	1.3931	3.2	3.8
417	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W MCC	2.4234	5.4	6.7
418	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.6642	3.7	4.4
419	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC/MCC	1.3042	2.5	2.9
420	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W MCC	3.5176	7.7	10.5

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
421	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W CC	1.7791	4.1	5.4
422	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W/O CC/MCC	1.5076	2.8	3.4
423	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W MCC	3.9460	8.6	12.3
424	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W CC	2.1911	5.6	7.4
425	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W/O CC/MCC	1.4929	3.4	4.1
432	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W MCC	1.8260	4.7	6.4
433	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W CC	1.0279	3.3	4.2
434	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W/O CC/MCC	0.6511	2.3	2.8
435	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W MCC	1.6977	4.8	6.3
436	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W CC	1.1359	3.5	4.5
437	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W/O CC/MCC	0.8658	2.4	3.1
438	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W MCC	1.6382	4.6	6.3
439	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W CC	0.8623	3.2	4.0
440	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W/O CC/MCC	0.6213	2.5	2.9
441	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W MCC	1.8572	4.7	6.5
442	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	0.9389	3.2	4.1
443	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC/MCC	0.6958	2.5	3.0
444	07	MED	DISORDERS OF THE BILIARY TRACT W MCC	1.6109	4.4	5.7
445	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.0676	3.2	3.9
446	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC/MCC	0.7950	2.3	2.7

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
453	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W MCC	9.4969	7.6	9.7
454	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W CC	6.3368	4.0	4.7
455	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W/O CC/MCC	5.0000	2.6	3.0
456	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W MCC	9.1252	9.5	11.6
457	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W CC	6.5446	5.3	6.1
458	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W/O CC/MCC	5.1212	3.2	3.6
459	08	SURG	SPINAL FUSION EXCEPT CERVICAL W MCC	6.3848	6.3	7.9
460	08	SURG	SPINAL FUSION EXCEPT CERVICAL W/O MCC	4.0375	2.9	3.4
461	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W MCC	4.4825	5.6	6.7
462	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W/O MCC	3.1941	2.9	3.2
463	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W MCC	5.1319	9.8	13.0
464	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W CC	2.9440	5.5	7.0
465	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W/O CC/MCC	1.8374	2.7	3.5
466	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W MCC	5.1132	6.6	8.3
467	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W CC	3.4704	3.4	4.1
468	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W/O CC/MCC	2.7914	2.2	2.5
469	08	SURG	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W MCC OR TOTAL ANKLE REPLACEMENT	3.1742	4.9	6.2

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
470	08	SURG	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	1.9898	2.2	2.5
471	08	SURG	CERVICAL SPINAL FUSION W MCC	5.0107	6.3	8.6
472	08	SURG	CERVICAL SPINAL FUSION W CC	2.9468	2.4	3.2
473	08	SURG	CERVICAL SPINAL FUSION W/O CC/MCC	2.3729	1.5	1.8
474	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W MCC	3.7951	8.9	11.1
475	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W CC	2.1488	5.8	7.1
476	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W/O CC/MCC	1.1507	3.1	4.0
477	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	3.1384	8.2	10.2
478	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	2.2792	5.3	6.6
479	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	1.7980	3.4	4.2
480	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC	3.0304	6.4	7.5
481	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC	2.0623	4.4	4.8
482	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC	1.6645	3.5	3.7
483	08	SURG	MAJOR JOINT/LIMB REATTACHMENT PROCEDURE OF UPPER EXTREMITIES	2.3835	1.6	1.9
485	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W MCC	3.3041	8.0	9.6
486	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.2184	5.3	6.3
487	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC/MCC	1.6502	3.7	4.2
488	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION W CC/MCC	2.1125	3.8	5.0
489	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION W/O CC/MCC	1.2974	2.1	2.5

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
492	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W MCC	3.3905	6.1	7.7
493	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W CC	2.2461	4.0	4.8
494	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W/O CC/MCC	1.7539	2.7	3.2
495	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W MCC	3.4623	7.3	9.8
496	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W CC	1.9609	3.5	4.5
497	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W/O CC/MCC	1.4350	1.9	2.4
498	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W CC/MCC	2.2780	5.1	6.8
499	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W/O CC/MCC	1.1192	2.1	2.6
500	08	SURG	SOFT TISSUE PROCEDURES W MCC	3.0680	7.3	9.7
501	08	SURG	SOFT TISSUE PROCEDURES W CC	1.6874	4.2	5.2
502	08	SURG	SOFT TISSUE PROCEDURES W/O CC/MCC	1.2911	2.5	3.0
503	08	SURG	FOOT PROCEDURES W MCC	2.5622	6.8	8.5
504	08	SURG	FOOT PROCEDURES W CC	1.7295	4.8	5.8
505	08	SURG	FOOT PROCEDURES W/O CC/MCC	1.5798	2.8	3.4
506	08	SURG	MAJOR THUMB OR JOINT PROCEDURES	1.4103	3.8	4.8
507	08	SURG	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W CC/MCC	1.9425	4.5	5.9
508	08	SURG	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W/O CC/MCC	1.4474	2.1	2.6
509	08	SURG	ARTHROSCOPY	1.6703	4.4	5.6
510	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W MCC	2.7324	5.0	6.3
511	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W CC	1.8473	3.4	4.0
512	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W/O CC/MCC	1.5221	2.2	2.5
513	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W CC/MCC	1.6396	4.1	5.3

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
514	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W/O CC/MCC	0.9998	2.3	2.9
515	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W MCC	3.0820	6.4	8.3
516	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.8854	3.8	4.7
517	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC/MCC	1.3809	2.2	2.7
518	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W MCC OR DISC DEVICE/NEUROSTIM	3.1002	3.4	5.4
519	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W CC	1.8620	3.1	4.0
520	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC	1.3141	1.9	2.3
533	08	MED	FRACTURES OF FEMUR W MCC	1.5305	4.2	5.7
534	08	MED	FRACTURES OF FEMUR W/O MCC	0.7755	2.9	3.5
535	08	MED	FRACTURES OF HIP & PELVIS W MCC	1.2548	3.8	4.9
536	08	MED	FRACTURES OF HIP & PELVIS W/O MCC	0.7570	2.9	3.4
537	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W CC/MCC	0.9105	3.1	3.7
538	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W/O CC/MCC	0.7270	2.5	2.9
539	08	MED	OSTEOMYELITIS W MCC	2.0192	6.1	8.2
540	08	MED	OSTEOMYELITIS W CC	1.2969	4.5	5.7
541	08	MED	OSTEOMYELITIS W/O CC/MCC	0.8827	3.2	4.0
542	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W MCC	1.8253	5.2	6.9
543	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W CC	1.0725	3.7	4.6
544	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W/O CC/MCC	0.7984	2.8	3.3
545	08	MED	CONNECTIVE TISSUE DISORDERS W MCC	2.4791	5.6	8.0
546	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.2144	3.6	4.6

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
547	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC/MCC	0.8576	2.7	3.3
548	08	MED	SEPTIC ARTHRITIS W MCC	2.0672	6.1	7.8
549	08	MED	SEPTIC ARTHRITIS W CC	1.2442	4.1	5.1
550	08	MED	SEPTIC ARTHRITIS W/O CC/MCC	0.9238	3.0	3.6
551	08	MED	MEDICAL BACK PROBLEMS W MCC	1.5916	4.4	5.7
552	08	MED	MEDICAL BACK PROBLEMS W/O MCC	0.9010	3.0	3.6
553	08	MED	BONE DISEASES & ARTHROPATHIES W MCC	1.2376	3.9	5.0
554	08	MED	BONE DISEASES & ARTHROPATHIES W/O MCC	0.7569	2.8	3.4
555	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W MCC	1.2792	3.7	5.0
556	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC	0.7677	2.7	3.3
557	08	MED	TENDONITIS, MYOSITIS & BURSITIS W MCC	1.4324	4.6	5.7
558	08	MED	TENDONITIS, MYOSITIS & BURSITIS W/O MCC	0.8635	3.2	3.8
559	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	1.7987	4.8	6.6
560	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	1.0217	3.6	4.6
561	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	0.7561	2.7	3.5
562	08	MED	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W MCC	1.4081	4.1	5.2
563	08	MED	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W/O MCC	0.8381	3.0	3.4
564	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W MCC	1.5722	4.7	6.1
565	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W CC	0.9758	3.4	4.1
566	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W/O CC/MCC	0.7623	2.6	3.2
570	09	SURG	SKIN DEBRIDEMENT W MCC	3.0347	7.6	10.2
571	09	SURG	SKIN DEBRIDEMENT W CC	1.7029	5.2	6.5

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
572	09	SURG	SKIN DEBRIDEMENT W/O CC/MCC	1.1786	3.4	4.2
573	09	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W MCC	5.2515	10.7	15.3
574	09	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W CC	3.0459	7.5	10.4
575	09	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	1.7586	4.8	6.0
576	09	SURG	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W MCC	4.8807	8.4	12.8
577	09	SURG	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W CC	2.5092	4.7	6.9
578	09	SURG	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	1.5297	2.7	3.5
579	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W MCC	2.7978	6.5	8.8
580	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.5898	4.1	5.3
581	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC/MCC	1.2364	2.4	3.0
582	09	SURG	MASTECTOMY FOR MALIGNANCY W CC/MCC	1.5695	2.4	3.4
583	09	SURG	MASTECTOMY FOR MALIGNANCY W/O CC/MCC	1.3781	1.7	2.0
584	09	SURG	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W CC/MCC	1.8714	3.6	4.7
585	09	SURG	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W/O CC/MCC	1.5657	2.2	2.7
592	09	MED	SKIN ULCERS W MCC	1.7082	5.4	7.1
593	09	MED	SKIN ULCERS W CC	1.1294	4.2	5.3
594	09	MED	SKIN ULCERS W/O CC/MCC	0.8102	3.2	3.9
595	09	MED	MAJOR SKIN DISORDERS W MCC	1.9869	5.2	7.1
596	09	MED	MAJOR SKIN DISORDERS W/O MCC	1.0115	3.5	4.4
597	09	MED	MALIGNANT BREAST DISORDERS W MCC	1.7200	4.9	6.6
598	09	MED	MALIGNANT BREAST DISORDERS W CC	1.1623	3.5	4.7
599	09	MED	MALIGNANT BREAST DISORDERS W/O CC/MCC	0.7164	2.2	2.9

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
600	09	MED	NON-MALIGNANT BREAST DISORDERS W CC/MCC	0.9560	3.5	4.3
601	09	MED	NON-MALIGNANT BREAST DISORDERS W/O CC/MCC	0.6192	2.7	3.0
602	09	MED	CELLULITIS W MCC	1.4440	4.7	5.9
603	09	MED	CELLULITIS W/O MCC	0.8477	3.3	3.9
604	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W MCC	1.4168	3.9	5.0
605	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W/O MCC	0.8605	2.7	3.3
606	09	MED	MINOR SKIN DISORDERS W MCC	1.3808	4.2	5.8
607	09	MED	MINOR SKIN DISORDERS W/O MCC	0.8010	2.8	3.6
614	10	SURG	ADRENAL & PITUITARY PROCEDURES W CC/MCC	2.3636	3.5	4.8
615	10	SURG	ADRENAL & PITUITARY PROCEDURES W/O CC/MCC	1.4812	2.0	2.3
616	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W MCC	4.1352	10.1	12.7
617	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W CC	2.0736	5.9	7.0
618	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W/O CC/MCC	1.1593	3.5	4.3
619	10	SURG	O.R. PROCEDURES FOR OBESITY W MCC	2.9207	3.0	4.7
620	10	SURG	O.R. PROCEDURES FOR OBESITY W CC	1.8096	2.0	2.5
621	10	SURG	O.R. PROCEDURES FOR OBESITY W/O CC/MCC	1.5783	1.5	1.7
622	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W MCC	3.7980	8.7	12.0
623	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W CC	1.9232	5.5	6.6
624	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W/O CC/MCC	1.2960	3.3	4.0
625	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W MCC	2.7833	4.8	7.0

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
626	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W CC	1.6106	2.5	3.6
627	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W/O CC/MCC	1.0850	1.4	1.7
628	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W MCC	3.6750	7.3	10.0
629	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.3387	6.0	7.2
630	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC/MCC	1.5345	2.9	3.6
637	10	MED	DIABETES W MCC	1.3813	3.9	5.1
638	10	MED	DIABETES W CC	0.8722	2.9	3.6
639	10	MED	DIABETES W/O CC/MCC	0.6319	2.1	2.6
640	10	MED	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W MCC	1.1902	3.3	4.5
641	10	MED	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W/O MCC	0.7519	2.6	3.3
642	10	MED	INBORN AND OTHER DISORDERS OF METABOLISM	1.2635	3.2	4.3
643	10	MED	ENDOCRINE DISORDERS W MCC	1.6341	5.0	6.3
644	10	MED	ENDOCRINE DISORDERS W CC	1.0125	3.5	4.3
645	10	MED	ENDOCRINE DISORDERS W/O CC/MCC	0.7429	2.7	3.2
652	11	SURG	KIDNEY TRANSPLANT	3.3146	5.3	6.1
653	11	SURG	MAJOR BLADDER PROCEDURES W MCC	5.4890	10.5	13.5
654	11	SURG	MAJOR BLADDER PROCEDURES W CC	2.8733	6.2	7.3
655	11	SURG	MAJOR BLADDER PROCEDURES W/O CC/MCC	2.0772	3.7	4.4
656	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W MCC	3.3276	6.0	7.9
657	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W CC	1.9474	3.6	4.3
658	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W/O CC/MCC	1.5664	2.3	2.6

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
659	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W MCC	2.7271	6.1	8.2
660	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W CC	1.4476	3.2	4.2
661	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W/O CC/MCC	1.0728	2.0	2.3
662	11	SURG	MINOR BLADDER PROCEDURES W MCC	3.1787	7.3	10.3
663	11	SURG	MINOR BLADDER PROCEDURES W CC	1.6403	3.9	5.2
664	11	SURG	MINOR BLADDER PROCEDURES W/O CC/MCC	1.1857	2.0	2.4
665	11	SURG	PROSTATECTOMY W MCC	3.1788	8.2	10.5
666	11	SURG	PROSTATECTOMY W CC	1.7791	4.2	5.8
667	11	SURG	PROSTATECTOMY W/O CC/MCC	1.0804	2.2	2.8
668	11	SURG	TRANSURETHRAL PROCEDURES W MCC	2.8146	7.1	9.2
669	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.5825	4.0	5.2
670	11	SURG	TRANSURETHRAL PROCEDURES W/O CC/MCC	0.9635	2.1	2.6
671	11	SURG	URETHRAL PROCEDURES W CC/MCC	1.6835	3.9	5.3
672	11	SURG	URETHRAL PROCEDURES W/O CC/MCC	1.0569	1.9	2.3
673	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W MCC	3.5773	7.9	10.9
674	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W CC	2.3121	5.3	7.0
675	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W/O CC/MCC	1.6253	2.8	3.6
682	11	MED	RENAL FAILURE W MCC	1.5320	4.5	5.9
683	11	MED	RENAL FAILURE W CC	0.9190	3.2	4.0
684	11	MED	RENAL FAILURE W/O CC/MCC	0.6198	2.3	2.7
686	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W MCC	1.7176	5.1	6.8
687	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.0537	3.3	4.3
688	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC/MCC	0.7909	2.0	2.4
689	11	MED	KIDNEY & URINARY TRACT INFECTIONS W MCC	1.1116	3.9	4.8

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
690	11	MED	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	0.7941	3.0	3.6
691	11	MED	URINARY STONES W ESW LITHOTRIPSY W CC/MCC	1.6242	3.0	3.9
692	11	MED	URINARY STONES W ESW LITHOTRIPSY W/O CC/MCC	1.1306	2.0	2.4
693	11	MED	URINARY STONES W/O ESW LITHOTRIPSY W MCC	1.3236	3.8	5.1
694	11	MED	URINARY STONES W/O ESW LITHOTRIPSY W/O MCC	0.7021	2.1	2.6
695	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W MCC	1.1487	3.6	4.7
696	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W/O MCC	0.6886	2.4	3.0
697	11	MED	URETHRAL STRICTURE	0.9600	2.5	3.6
698	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W MCC	1.6151	4.9	6.2
699	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W CC	1.0279	3.4	4.2
700	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W/O CC/MCC	0.7597	2.5	3.1
707	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC/MCC	1.7914	2.3	3.2
708	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC/MCC	1.4065	1.3	1.4
709	12	SURG	PENIS PROCEDURES W CC/MCC	2.0318	3.6	5.8
710	12	SURG	PENIS PROCEDURES W/O CC/MCC	1.6695	1.7	2.2
711	12	SURG	TESTES PROCEDURES W CC/MCC	2.0835	5.2	7.2
712	12	SURG	TESTES PROCEDURES W/O CC/MCC	1.0768	2.4	2.9
713	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC/MCC	1.4634	2.9	4.2
714	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC/MCC	0.9105	1.7	2.1
715	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W CC/MCC	2.2099	5.4	7.6

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
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	1.4630	1.5	1.8
717	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W CC/MCC	1.9543	4.2	5.8
718	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W/O CC/MCC	1.2326	2.5	3.0
722	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W MCC	1.6597	5.1	7.0
723	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W CC	1.1015	3.5	4.5
724	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.6892	1.9	2.5
725	12	MED	BENIGN PROSTATIC HYPERTROPHY W MCC	1.2143	4.0	5.1
726	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O MCC	0.7645	2.6	3.3
727	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W MCC	1.4380	4.7	6.0
728	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W/O MCC	0.7914	3.0	3.6
729	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W CC/MCC	1.0820	3.3	4.5
730	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W/O CC/MCC	0.5684	1.9	2.3
734	13	SURG	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W CC/MCC	2.3059	3.7	5.2
735	13	SURG	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W/O CC/MCC	1.3650	1.8	2.1
736	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W MCC	4.0306	8.9	11.6
737	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W CC	2.0314	4.6	5.4
738	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W/O CC/MCC	1.3923	2.8	3.1

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
739	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W MCC	3.5977	6.6	9.4
740	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.7429	3.0	4.0
741	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC/MCC	1.3278	1.7	2.0
742	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC/MCC	1.7140	3.0	3.9
743	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	1.1156	1.8	2.0
744	13	SURG	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W CC/MCC	1.6903	4.1	5.6
745	13	SURG	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W/O CC/MCC	1.0694	2.1	2.6
746	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES W CC/MCC	1.6777	3.5	5.1
747	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES W/O CC/MCC	0.9582	1.6	2.0
748	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	1.2940	1.6	2.0
749	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W CC/MCC	2.6020	5.7	7.8
750	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	1.2239	2.4	2.9
754	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W MCC	1.8414	5.2	7.1
755	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.0699	3.3	4.4
756	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.7801	2.2	2.6
757	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W MCC	1.4409	4.9	6.3
758	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W CC	1.0204	3.7	4.6
759	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.7107	2.6	3.2

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
760	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W CC/MCC	0.8717	2.6	3.3
761	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W/O CC/MCC	0.5494	1.8	2.1
768	14	SURG	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	1.1314	2.7	4.2
769	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	1.4579	3.2	4.3
770	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	1.0679	1.8	2.6
776	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.6590	2.5	3.1
779	14	MED	ABORTION W/O D&C	0.7543	1.7	2.7
783	14	SURG	CESAREAN SECTION W STERILIZATION W MCC	1.7455	4.6	6.3
784	14	SURG	CESAREAN SECTION W STERILIZATION W CC	1.1021	3.4	4.1
785	14	SURG	CESAREAN SECTION W STERILIZATION W/O CC/MCC	0.8455	2.7	3.0
786	14	SURG	CESAREAN SECTION W/O STERILIZATION W MCC	1.5548	4.4	5.9
787	14	SURG	CESAREAN SECTION W/O STERILIZATION W CC	1.0811	3.5	4.2
788	14	SURG	CESAREAN SECTION W/O STERILIZATION W/O CC/MCC	0.9007	3.0	3.2
789	15	MED	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.6637	1.8	1.8
790	15	MED	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	5.4863	17.9	17.9
791	15	MED	PREMATURITY W MAJOR PROBLEMS	3.7470	13.3	13.3
792	15	MED	PREMATURITY W/O MAJOR PROBLEMS	2.2608	8.6	8.6
793	15	MED	FULL TERM NEONATE W MAJOR PROBLEMS	3.8489	4.7	4.7
794	15	MED	NEONATE W OTHER SIGNIFICANT PROBLEMS	1.3623	3.4	3.4
795	15	MED	NORMAL NEWBORN	0.1844	3.1	3.1

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
796	14	SURG	VAGINAL DELIVERY W STERILIZATION/D&C W MCC	1.4682	3.4	5.0
797	14	SURG	VAGINAL DELIVERY W STERILIZATION/D&C W CC	0.8469	2.2	2.4
798	14	SURG	VAGINAL DELIVERY W STERILIZATION/D&C WO CC/MCC	0.8469	2.2	2.4
799	16	SURG	SPLENECTOMY W MCC	4.7016	8.3	11.0
800	16	SURG	SPLENECTOMY W CC	2.6268	4.7	6.1
801	16	SURG	SPLENECTOMY W/O CC/MCC	1.5563	2.5	2.8
802	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W MCC	3.3472	7.4	10.0
803	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W CC	1.7221	4.1	5.2
804	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W/O CC/MCC	1.2305	2.1	2.6
805	14	MED	VAGINAL DELIVERY W/O STERILIZATION/D&C W MCC	1.0232	3.0	4.1
806	14	MED	VAGINAL DELIVERY W/O STERILIZATION/D&C W CC	0.7074	2.4	2.7
807	14	MED	VAGINAL DELIVERY W/O STERILIZATION/D&C W/O CC/MCC	0.6140	2.1	2.2
808	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W MCC	2.1492	5.5	7.5
809	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W CC	1.2045	3.6	4.5
810	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W/O CC/MCC	0.9220	2.6	3.2
811	16	MED	RED BLOOD CELL DISORDERS W MCC	1.3560	3.7	4.9
812	16	MED	RED BLOOD CELL DISORDERS W/O MCC	0.8832	2.7	3.5
813	16	MED	COAGULATION DISORDERS	1.6115	3.7	4.9
814	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W MCC	1.6630	4.5	6.3
815	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.9777	3.1	3.9
816	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC/MCC	0.7216	2.2	2.7

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
817	14	SURG	OTHER ANTEPARTUM DIAGNOSES W O.R. PROCEDURE W MCC	2.5317	3.8	6.5
818	14	SURG	OTHER ANTEPARTUM DIAGNOSES W O.R. PROCEDURE W CC	1.3585	2.8	4.1
819	14	SURG	OTHER ANTEPARTUM DIAGNOSES W O.R. PROCEDURE W/O CC/MCC	0.8390	1.6	2.1
820	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W MCC	5.4437	10.9	15.2
821	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC	2.3943	4.3	6.1
822	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/O CC/MCC	1.2098	1.9	2.4
823	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER PROC W MCC	4.5246	10.4	13.8
824	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER PROC W CC	2.1944	5.3	7.1
825	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER PROC W/O CC/MCC	1.3590	2.5	3.5
826	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W MCC	4.9479	9.9	12.7
827	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC	2.2517	4.7	6.1
828	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC/MCC	1.6354	3.0	3.7
829	17	SURG	MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS W OTHER PROCEDURE W CC/MCC	3.1097	6.4	9.6
830	17	SURG	MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS W OTHER PROCEDURE W/O CC/MCC	1.4188	2.6	3.2
831	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O O.R. PROCEDURE W MCC	1.0281	3.2	4.5
832	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O O.R. PROCEDURE W CC	0.7188	2.5	3.6
833	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O O.R. PROCEDURE W/O CC/MCC	0.4803	1.9	2.5

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
834	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W MCC	5.5078	10.0	16.5
835	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W CC	2.1360	4.5	7.1
836	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W/O CC/MCC	1.2126	2.6	3.9
837	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX OR W HIGH DOSE CHEMO AGENT W MCC	5.3741	12.8	18.3
838	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX W CC OR HIGH DOSE CHEMO AGENT	2.3526	5.8	7.8
839	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX W/O CC/MCC	1.2559	4.5	4.9
840	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W MCC	3.2929	7.0	10.0
841	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.6348	4.2	5.7
842	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC/MCC	1.1211	2.9	3.8
843	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W MCC	1.8460	5.3	7.3
844	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.1788	3.7	4.9
845	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC/MCC	0.8662	2.6	3.4
846	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W MCC	2.8179	6.2	8.7
847	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W CC	1.3265	3.6	4.1
848	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W/O CC/MCC	0.9326	2.9	3.3
849	17	MED	RADIOTHERAPY	1.9702	5.0	7.0
853	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	5.0571	9.9	12.8
854	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W CC	2.2028	5.7	7.1
855	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W/O CC/MCC	1.5600	3.6	4.5

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
856	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W MCC	4.4883	8.9	12.0
857	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W CC	2.0567	5.4	6.7
858	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W/O CC/MCC	1.3801	3.7	4.5
862	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W MCC	1.8277	5.0	6.6
863	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W/O MCC	0.9848	3.5	4.3
864	18	MED	FEVER AND INFLAMMATORY CONDITIONS	0.8643	2.8	3.4
865	18	MED	VIRAL ILLNESS W MCC	1.3822	3.9	5.3
866	18	MED	VIRAL ILLNESS W/O MCC	0.8204	2.7	3.4
867	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W MCC	2.1329	5.6	7.6
868	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W CC	1.0769	3.6	4.6
869	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W/O CC/MCC	0.7679	2.7	3.3
870	18	MED	SEPTICEMIA OR SEVERE SEPSIS W MV >96 HOURS OR PERIPHERAL EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)	6.2953	12.4	14.4
871	18	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W MCC	1.8564	4.8	6.3
872	18	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W/O MCC	1.0529	3.7	4.4
876	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	3.3014	7.2	14.8
880	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	0.8111	2.6	3.6
881	19	MED	DEPRESSIVE NEUROSES	0.7585	3.8	5.0
882	19	MED	NEUROSES EXCEPT DEPRESSIVE	0.7750	3.2	4.4
883	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	1.3199	4.8	8.0
884	19	MED	ORGANIC DISTURBANCES & INTELLECTUAL DISABILITY	1.3479	4.3	6.7

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
885	19	MED	PSYCHOSES	1.1961	5.8	8.2
886	19	MED	BEHAVIORAL & DEVELOPMENTAL DISORDERS	0.9887	3.7	6.3
887	19	MED	OTHER MENTAL DISORDER DIAGNOSES	1.0645	3.0	4.7
894	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.5169	2.1	2.9
895	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY	1.4328	8.6	11.5
896	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W MCC	1.7468	4.9	6.9
897	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O MCC	0.8208	3.4	4.3
901	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W MCC	4.4649	9.2	13.7
902	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W CC	1.9204	4.9	6.6
903	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W/O CC/MCC	1.1639	2.9	3.7
904	21	SURG	SKIN GRAFTS FOR INJURIES W CC/MCC	3.2260	6.7	9.8
905	21	SURG	SKIN GRAFTS FOR INJURIES W/O CC/MCC	1.7692	3.5	4.8
906	21	SURG	HAND PROCEDURES FOR INJURIES	1.8432	2.8	4.7
907	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W MCC	4.2161	7.2	10.2
908	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	1.9928	4.0	5.2
909	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC/MCC	1.3254	2.5	3.1
913	21	MED	TRAUMATIC INJURY W MCC	1.4719	3.6	5.2
914	21	MED	TRAUMATIC INJURY W/O MCC	0.8378	2.5	3.2
915	21	MED	ALLERGIC REACTIONS W MCC	1.6769	3.7	4.9
916	21	MED	ALLERGIC REACTIONS W/O MCC	0.6353	1.8	2.2
917	21	MED	POISONING & TOXIC EFFECTS OF DRUGS W MCC	1.4737	3.5	4.8
918	21	MED	POISONING & TOXIC EFFECTS OF DRUGS W/O MCC	0.7787	2.3	3.1
919	21	MED	COMPLICATIONS OF TREATMENT W MCC	1.8243	4.3	6.0

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
920	21	MED	COMPLICATIONS OF TREATMENT W CC	1.0031	2.9	3.8
921	21	MED	COMPLICATIONS OF TREATMENT W/O CC/MCC	0.7066	2.2	2.7
922	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W MCC	1.5584	3.8	5.6
923	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O MCC	0.8698	2.7	3.9
927	22	SURG	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV >96 HRS W SKIN GRAFT	18.3845	22.2	29.0
928	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC/MCC	5.8756	10.7	15.0
929	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W/O CC/MCC	2.9722	5.8	7.9
933	22	MED	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV >96 HRS W/O SKIN GRAFT	2.8603	2.6	4.5
934	22	MED	FULL THICKNESS BURN W/O SKIN GRAFT OR INHAL INJ	1.8335	4.2	6.0
935	22	MED	NON-EXTENSIVE BURNS	1.8217	3.4	5.3
939	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W MCC	3.2787	6.5	9.4
940	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W CC	2.1745	3.7	5.0
941	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W/O CC/MCC	1.8514	2.3	3.0
945	23	MED	REHABILITATION W CC/MCC	1.3649	9.4	11.6
946	23	MED	REHABILITATION W/O CC/MCC	1.0427	7.1	7.9
947	23	MED	SIGNS & SYMPTOMS W MCC	1.2056	3.5	4.8
948	23	MED	SIGNS & SYMPTOMS W/O MCC	0.7802	2.6	3.3
949	23	MED	AFTERCARE W CC/MCC	1.1462	4.5	6.4
950	23	MED	AFTERCARE W/O CC/MCC	0.7449	3.4	4.8
951	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	0.7984	2.5	3.4
955	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	6.0969	7.4	10.8

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
956	24	SURG	LIMB REATTACHMENT, HIP & FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	3.7838	6.1	7.5
957	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W MCC	7.5985	9.7	13.6
958	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W CC	4.1798	7.0	8.7
959	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	2.4507	3.8	4.7
963	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W MCC	2.7950	5.3	8.0
964	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W CC	1.4749	4.0	4.9
965	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	0.9743	2.7	3.2
969	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE W MCC	5.5987	11.7	15.9
970	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE W/O MCC	2.7877	6.5	8.7
974	25	MED	HIV W MAJOR RELATED CONDITION W MCC	2.7230	6.4	9.0
975	25	MED	HIV W MAJOR RELATED CONDITION W CC	1.2899	4.1	5.3
976	25	MED	HIV W MAJOR RELATED CONDITION W/O CC/MCC	0.9386	3.1	3.9
977	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.1699	3.4	4.6
981		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	4.3705	8.4	11.4
982		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	2.4529	4.9	6.5
983		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.5691	2.5	3.3
987		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	3.3326	8.1	10.8
988		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W CC	1.6931	4.4	5.9
989		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.0407	2.1	2.8
998		**	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	.	.	.

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
999		**	UNGROUPABLE	.	.	.

**MS-DRGs 998 and 999 contain cases that could not be assigned to valid DRGs.

Final Exhibit #2			
Hospital Base Rates and Cost To Charge Ratios (CCRs)			
For Hospital Discharge Dates of Service on and after 1/1/2019			
Provider Number	Name	Individual Hospital Base Rate	Cost to Charge Ratio (CCR)
60001	NORTH COLORADO MEDICAL CENTER	$ 6,928.63	0.268
60003	LONGMONT UNITED HOSPITAL	$ 6,414.55	0.323
60004	PLATTE VALLEY MEDICAL CENTER	$ 6,295.02	0.42
60006	MONTROSE MEMORIAL HOSPITAL	$ 6,128.69	0.404
60008	SAN LUIS VALLEY REGIONAL MEDICAL CENTER	$ 6,063.49	0.386
60009	EXEMPLA LUTHERAN MEDICAL CENTER	$ 6,369.71	0.235
60010	POUDRE VALLEY HOSPITAL	$ 6,632.49	0.302
60011	DENVER HEALTH MEDICAL CENTER	$ 8,183.68	0.324
60012	CENTURA HEALTH-ST MARY CORWIN MEDICAL CENTER	$ 7,040.75	0.229
60013	MERCY REGIONAL MEDICAL CENTER	$ 8,029.30	0.287
60014	PRESBYTERIAN/ST LUKE'S MEDICAL CENTER	$ 6,904.09	0.154
60015	CENTURA HEALTH-ST ANTHONY CENTRAL HOSPITAL	$ 6,364.03	0.205
60016	CENTURA HEALTH-ST THOMAS MORE HOSP & PROG CARE CTR	$ 6,957.06	0.37
60020	PARKVIEW MEDICAL CENTER INC	$ 6,737.81	0.164
60022	MEMORIAL HEALTH SYSTEM	$ 6,568.28	0.221
60023	ST MARY'S HOSPITAL AND MEDICAL CENTER	$ 6,994.18	0.308
60024	UNIVERSITY OF COLORADO HOSPITAL ANSCHUTZ INPATIENT	$ 7,900.99	0.169
60027	BOULDER COMMUNITY HOSPITAL	$ 6,311.17	0.218
60028	EXEMPLA SAINT JOSEPH HOSPITAL	$ 7,000.06	0.196
60030	MCKEE MEDICAL CENTER	$ 6,501.58	0.366
60031	CENTURA HEALTH-PENROSE ST FRANCIS HEALTH SERVICES	$ 6,385.76	0.212
60032	ROSE MEDICAL CENTER	$ 6,734.01	0.136
60034	SWEDISH MEDICAL CENTER	$ 6,537.87	0.12
60036	ARKANSAS VALLEY REGIONAL MEDICAL CENTER	CAH	CAH
60043	KEEFE MEMORIAL HOSPITAL	CAH	CAH
60044	COLORADO PLAINS MEDICAL CENTER	$ 6,621.22	0.264
60049	YAMPA VALLEY MEDICAL CENTER	$ 9,490.46	0.539
60054	COMMUNITY HOSPITAL	$ 6,063.49	0.322
60064	CENTURA HEALTH-PORTER ADVENTIST HOSPITAL	$ 6,269.52	0.23
60065	NORTH SUBURBAN MEDICAL CENTER	$ 6,597.26	0.115
60071	DELTA COUNTY MEMORIAL HOSPITAL	$ 6,063.49	0.427
60075	VALLEY VIEW HOSPITAL ASSOCIATION	$ 8,299.43	0.414
60076	STERLING REGIONAL MEDCENTER	$ 7,873.82	0.495

Final Exhibit #2			
Hospital Base Rates and Cost To Charge Ratios (CCRs)			
For Hospital Discharge Dates of Service on and after 1/1/2019			
Provider Number	Name	Individual Hospital Base Rate	Cost to Charge Ratio (CCR)
60096	VAIL VALLEY MEDICAL CENTER	$ 12,152.56	0.516
60100	MEDICAL CENTER OF AURORA, THE	$ 6,464.50	0.146
60103	CENTURA HEALTH-AVISTA ADVENTIST HOSPITAL	$ 6,295.02	0.3
60104	CENTURA HEALTH-ST ANTHONY NORTH HOSPITAL	$ 7,175.00	0.272
60107	NATIONAL JEWISH HEALTH	$ -	0
60112	SKY RIDGE MEDICAL CENTER	$ 6,140.31	0.115
60113	CENTURA HEALTH-LITTLETON ADVENTIST HOSPITAL	$ 6,187.10	0.198
60114	PARKER ADVENTIST HOSPITAL	$ 6,244.85	0.231
60116	EXEMPLA GOOD SAMARITAN MEDICAL CENTER LLC	$ 6,201.63	0.21
60117	ANIMAS SURGICAL HOSPITAL, LLC	$ 6,063.49	0.356
60118	ST ANTHONY SUMMIT MEDICAL CENTER	$ 6,295.02	0.338
60119	MEDICAL CENTER OF THE ROCKIES	$ 6,287.96	0.257
60124	ORTHOCOLORADO HOSPITAL AT ST ANTHONY MED CAMPUS	$ 6,125.10	0.184
60125	CASTLE ROCK ADVENTIST HOSPITAL	$ 6,188.03	0.274
60126	BANNER FORT COLLINS MEDICAL CENTER	$ 6,063.49	0.535
69999	ANY NEW HOSPITAL	$ 6,188.03	0.274

Final Exhibit #3	
Critical Access Hospitals	
Effective for Dates of Service on and After 1/1/2019	
Hospital Name	**Location in Colorado**
Arkansas Valley Regional Medical Center	La Junta
Aspen Valley Hospital	Aspen
Colorado Canyon Hospital and Medical Center	Fruita
East Morgan County Hospital	Brush
Estes Park Medical Center	Estes Park
Grand River Hospital District	Rifle
Gunnison Valley Hospital	Gunnison
Haxtun Hospital District	Haxtun
Heart of the Rockies Regional Medical Center	Salida
Keefe Memorial Hospital	Cheyenne Wells
Kit Carson County Memorial Hospital	Burlington
Lincoln Community Hospital	Hugo
Melissa Memorial Hospital	Holyoke
Middle Park Medical Center	Kremmling/Granby
Mt San Rafael Hospital	Trinidad
Pagosa Springs Medical Center	Pagosa Springs
Pikes Peak Regional Hospital	Woodland Park
Pioneers Medical Center	Meeker
Prowers Medical Center	Lamar
Rangely District Hospital	Rangely
Rio Grande Hospital	Del Norte
San Luis Valley Hospital	La Jara
Sedgwick County Health Center	Julesburg
Southeast Colorado Hospital	Springfield
Southwest Memorial Hospital	Cortez
Spanish Peaks Regional Health Center	Walsenburg
St Vincent General Hospital District	Leadville
The Memorial Hospital	Craig
UC Health Pikes Peak Regional Hospital	Woodland Park
Weisbrod Memorial County Hospital	Eads
Wray Community District Hospital	Wray
Yuma District Hospital	Yuma

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
701	Sr89 strontium	$2,532.58	$2,152.69	
726	Dexrazoxane HCl injection	$401.79	$341.52	
731	Sargramostim injection	$68.02	$57.82	
736	Amphotericin b liposome inj	$37.27	$31.68	
738	Rasburicase	$474.32	$403.17	
751	Mechlorethamine hcl inj	$526.46	$447.49	
752	Dactinomycin injection	$2,527.22	$2,148.14	
759	Naltrexone, depot form	$5.86	$4.98	
800	Leuprolide acetate	$1,957.41	$1,663.80	
802	Etoposide oral	$132.80	$112.88	
807	Aldesleukin injection	$6,477.09	$5,505.53	
809	Bcg live intravesical vac	$239.01	$203.16	
810	Goserelin acetate implant	$676.25	$574.81	
812	Carmustine injection	$6,935.01	$5,894.76	
820	Daunorubicin injection	$78.42	$66.66	
823	Docetaxel injection	$3.13	$2.66	
825	Nelarabine injection	$273.45	$232.43	
832	Idarubicin hcl injection	$78.12	$66.40	
836	Interferon alfa-2b inj	$56.67	$48.17	
838	Interferon gamma 1-b inj	$11,354.64	$9,651.44	
840	Inj melphalan hydrochl	$2,147.40	$1,825.29	
843	Pegaspargase injection	$25,815.73	$21,943.37	
844	Pentostatin injection	$3,560.36	$3,026.31	
849	Rituximab injection	$1,580.10	$1,343.09	
850	Streptozocin injection	$606.07	$515.16	
851	Thiotepa injection	$1,349.85	$1,147.37	
856	Porfimer sodium injection	$38,195.22	$32,465.94	
858	Inj cladribine	$38.12	$32.40	
864	Mitoxantrone hydrochl	$57.67	$49.02	
868	Oral aprepitant	$12.02	$10.22	
873	Hyalgan supartz visco-3 dose	$153.37	$130.36	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
874	Synvisc or synvisc-one	$22.07	$18.76	
875	Euflexxa inj per dose	$279.41	$237.50	
877	Orthovisc inj per dose	$252.19	$214.36	
887	Azathioprine parenteral	$423.29	$359.80	
890	Lymphocyte immune globulin	$3,497.00	$2,972.45	
901	Alpha 1 proteinase inhibitor	$8.17	$6.94	
902	Injection,onabotulinumtoxinA	$11.03	$9.38	
903	Cytomegalovirus imm IV /vial	$2,032.43	$1,727.57	
910	Interferon beta-1b / .25 MG	$683.57	$581.03	
925	Factor viii	$1.95	$1.66	
927	Factor viii recombinant	$2.30	$1.96	
928	Factor ix complex	$2.53	$2.15	
929	Anti-inhibitor	$3.61	$3.07	
931	Factor IX non-recombinant	$2.07	$1.76	
932	Factor ix recombinant nos	$2.72	$2.31	
943	Octagam injection	$64.06	$54.45	
944	Gammagard liquid injection	$73.30	$62.31	
946	Hepagam b im injection	$113.71	$96.65	
947	Flebogamma injection	$60.58	$51.49	
948	Gamunex-C/Gammaked	$73.27	$62.28	
961	Albumin (human),5%, 50ml	$21.24	$18.05	
963	Albumin (human), 5%, 250 ml	$98.50	$83.73	
964	Albumin (human), 25%, 20 ml	$40.48	$34.41	
965	Albumin (human), 25%, 50ml	$96.19	$81.76	
1015	Injection glatiramer acetate	$381.09	$323.93	
1052	Injection, voriconazole	$4.03	$3.43	
1064	I131 iodide cap, rx	$35.96	$30.57	
1083	Adalimumab injection	$2,118.47	$1,800.70	
1138	Hepagam b intravenous, inj	$113.71	$96.65	
1139	Protein c concentrate	$27.29	$23.20	
1142	Supprelin LA implant	$52,158.02	$44,334.32	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
1150	I131 iodide sol, rx	$21.38	$18.17	
1166	Cytarabine liposome inj	$1,132.03	$962.23	
1168	Inj, temsirolimus	$129.05	$109.69	
1178	Busulfan injection	$56.52	$48.04	
1203	Verteporfin injection	$19.36	$16.46	
1207	Octreotide injection, depot	$343.22	$291.74	
1213	Antihemophilic viii/vwf comp	$1.76	$1.50	
1214	Inj IVIG privigen 500 mg	$69.27	$58.88	
1232	Mitomycin injection	$253.46	$215.44	
1235	Valrubicin injection	$2,156.98	$1,833.43	
1236	Levoleucovorin injection	$0.55	$0.47	
1237	Inj iron dextran	$23.46	$19.94	
1238	Topotecan oral	$186.62	$158.63	
1253	Triamcinolone A inj PRS-free	$6.97	$5.92	
1263	Antithrombin iii injection	$6.72	$5.71	
1268	Xyntha inj	$2.30	$1.96	
1274	Edetate calcium disodium inj	$10,059.00	$8,550.15	
1280	Corticotropin injection	$6,775.71	$5,759.35	
1281	Bevacizumab injection	$3.45	$2.93	
1289	AbobotulinumtoxinA	$14.83	$12.61	
1291	Rilonacept injection	$43.36	$36.86	
1295	Sm 153 lexidronam	$24,055.30	$20,447.01	
1296	Degarelix injection	$6.54	$5.56	
1297	Ferumoxytol, non-esrd	$1.67	$1.42	
1311	Canakinumab injection	$194.46	$165.29	
1312	Hizentra injection	$17.70	$15.05	
1327	Imiglucerase injection	$75.05	$63.79	
1340	Collagenase, clost hist inj	$75.30	$64.01	
1341	Amobarbital 125 MG inj	$421.24	$358.05	
1352	Wilate injection	$1.85	$1.57	
1353	Belimumab injection	$77.27	$65.68	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
1408	Cyclophosphamide 100 MG inj	$76.09	$64.68	
1413	Lumizyme injection	$287.56	$244.43	
1415	Glassia injection	$8.42	$7.16	
1416	Factor xiii anti-hem factor	$14.79	$12.57	
1417	Gel-one	$938.83	$798.01	
1420	Aflibercept injection	$1,749.50	$1,487.08	
1421	Imported lipodox inj	$915.17	$777.89	
1426	Eribulin mesylate injection	$199.03	$169.18	
1431	Centruroides immune f(ab)	$8,026.23	$6,822.30	
1433	Calcitonin salmon injection	$4.080.64	$3.468.54	
1440	Inj desmopressin acetate	$23.22	$19.74	
1442	Non-HEU TC-99M add-on/dose	$18.00	$15.30	
1443	Icatibant injection	$633.27	$538.28	
1446	Visualization adjunct	$7.06	$6.00	
1458	Phentolaine mesylate inj	$700.35	$595.30	
1466	Inj, vincristine sul lip 1mg	$4,863.20	$4,133.72	
1467	Factor ix recombinan rixubis	$2.48	$2.11	
1468	Inj Aripiprazole Ext Rel 1mg	$9.04	$7.68	
1469	Inj filgrastim excl biosimil	$1.80	$1.53	
1471	Injection, Pertuzumab, 1 mg	$20.58	$17.49	
1472	Inj beta interferon im 1 mcg	$90.31	$76.76	
1474	Certolizumab pegol inj 1mg	$14.28	$12.14	
1475	Golimumab for iv use 1mg	$43.70	$37.15	
1476	Obinutuzumab inj	$109.15	$92.78	
1478	Human fibrinogen conc inj	$2.10	$1.79	
1480	Elosulfase alfa, injection	$415.65	$353.30	
1482	Darbepoetin alfa, esrd use	$7.03	$5.98	
1484	Pentazocine injection	$119.47	$101.55	
1485	Ferumoxytol, esrd use	$1.67	$1.42	
1486	Factor ix fc fusion recomb	$5.39	$4.58	
1488	Injection, ramucirumab	$102.66	$87.26	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
1489	Injection, vedolizumab	$33.41	$28.40	
1490	Inj pembrolizumab	$86.16	$73.24	
1491	New Technology - Level 1A ($0-$10)	$9.00	$7.65	
1492	New Technology - Level 1B ($11-$20)	$27.90	$23.72	
1493	New Technology - Level 1C ($21-$30)	$45.90	$39.02	
1494	New Technology - Level 1D ($31-$40)	$63.90	$54.32	
1495	New Technology - Level 1E ($41-$50)	$81.90	$69.62	
1496	New Technology - Level 1A ($0-$10)	$9.00	$7.65	
1497	New Technology - Level 1B ($11-$20)	$27.90	$23.72	
1498	New Technology - Level 1C ($21-$30)	$45.90	$39.02	
1499	New Technology - Level 1D ($31-$40)	$63.90	$54.32	
1500	New Technology - Level 1E ($41-$50)	$81.90	$69.62	
1502	New Technology - Level 2 ($51 - $100)	$135.90	$115.52	
1503	New Technology - Level 3 ($101 - $200)	$270.90	$230.27	
1504	New Technology - Level 4 ($201 - $300)	$450.90	$383.27	
1505	New Technology - Level 5 ($301 - $400)	$630.90	$536.27	
1506	New Technology - Level 6 ($401 - $500)	$810.90	$689.27	
1507	New Technology - Level 7 ($501 - $600)	$990.90	$842.27	
1508	New Technology - Level 8 ($601 - $700)	$1,170.90	$995.27	
1509	New Technology - Level 9 ($701 - $800)	$1,350.90	$1,148.27	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
1510	New Technology - Level 10 ($801 - $900)	$1,530.90	$1,301.27	
1511	New Technology - Level 11 ($901 - $1000)	$1,710.90	$1,454.27	
1512	New Technology - Level 12 ($1001 - $1100)	$1,890.90	$1,607.27	
1513	New Technology - Level 13 ($1101 - $1200)	$2,070.90	$1,760.27	
1514	New Technology - Level 14 ($1201- $1300)	$2,250.90	$1,913.27	
1515	New Technology - Level 15 ($1301 - $1400)	$2,430.90	$2,066.27	
1516	New Technology - Level 16 ($1401 - $1500)	$2,610.90	$2,219.27	
1517	New Technology - Level 17 ($1501-$1600)	$2,790.90	$2,372.27	
1518	New Technology - Level 18 ($1601-$1700)	$2,970.90	$2,525.27	
1519	New Technology - Level 19 ($1701-$1800)	$3,150.90	$2,678.27	
1520	New Technology - Level 20 ($1801-$1900)	$3,330.90	$2,831.27	
1521	New Technology - Level 21 ($1901-$2000)	$3,510.90	$2,984.27	
1522	New Technology - Level 22 ($2001-$2500)	$4,050.90	$3,443.27	
1523	New Technology - Level 23 ($2501-$3000)	$4,950.90	$4,208.27	
1524	New Technology - Level 24 ($3001-$3500)	$5,850.90	$4,973.27	
1525	New Technology - Level 25 ($3501-$4000)	$6,750.90	$5,738.27	
1526	New Technology - Level 26 ($4001-$4500)	$7,650.90	$6,503.27	
1527	New Technology - Level 27 ($4501-$5000)	$8,550.90	$7,268.27	
1528	New Technology - Level 28 ($5001-$5500)	$9,450.90	$8,033.27	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
1529	New Technology - Level 29 ($5501-$6000)	$10,350.90	$8,798.27	
1530	New Technology - Level 30 ($6001-$6500)	$11,250.90	$9,563.27	
1531	New Technology - Level 31 ($6501-$7000)	$12,150.90	$10,328.27	
1532	New Technology - Level 32 ($7001-$7500)	$13,050.90	$11,093.27	
1533	New Technology - Level 33 ($7501-$8000)	$13,950.90	$11,858.27	
1534	New Technology - Level 34 ($8001-$8500)	$14,850.90	$12,623.27	
1535	New Technology - Level 35 ($8501-$9000)	$15,750.90	$13,388.27	
1536	New Technology - Level 36 ($9001-$9500)	$16,650.90	$14,153.27	
1537	New Technology - Level 37 ($9501-$10000)	$17,550.90	$14,918.27	
1539	New Technology - Level 2 ($51 - $100)	$135.90	$115.52	
1540	New Technology - Level 3 ($101 - $200)	$270.90	$230.27	
1541	New Technology - Level 4 ($201 - $300)	$450.90	$383.27	
1542	New Technology - Level 5 ($301 - $400)	$630.90	$536.27	
1543	New Technology - Level 6 ($401 - $500)	$810.90	$689.27	
1544	New Technology - Level 7 ($501 - $600)	$990.90	$842.27	
1545	New Technology - Level 8 ($601 - $700)	$1,170.90	$995.27	
1546	New Technology - Level 9 ($701 - $800)	$1,350.90	$1,148.27	
1547	New Technology - Level 10 ($801 - $900)	$1,530.90	$1,301.27	
1548	New Technology - Level 11 ($901 - $1000)	$1,710.90	$1,454.27	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
1549	New Technology - Level 12 ($1001 - $1100)	$1,890.90	$1,607.27	
1550	New Technology - Level 13 ($1101 - $1200)	$2,070.90	$1,760.27	
1551	New Technology - Level 14 ($1201- $1300)	$2,250.90	$1,913.27	
1552	New Technology - Level 15 ($1301 - $1400)	$2,430.90	$2,066.27	
1553	New Technology - Level 16 ($1401 - $1500)	$2,610.90	$2,219.27	
1554	New Technology - Level 17 ($1501-$1600)	$2,790.90	$2,372.27	
1555	New Technology - Level 18 ($1601-$1700)	$2,970.90	$2,525.27	
1556	New Technology - Level 19 ($1701-$1800)	$3,150.90	$2,678.27	
1557	New Technology - Level 20 ($1801-$1900)	$3,330.90	$2,831.27	
1558	New Technology - Level 21 ($1901-$2000)	$3,510.90	$2,984.27	
1559	New Technology - Level 22 ($2001-$2500)	$4,050.90	$3,443.27	
1560	New Technology - Level 23 ($2501-$3000)	$4,950.90	$4,208.27	
1561	New Technology - Level 24 ($3001-$3500)	$5,850.90	$4,973.27	
1562	New Technology - Level 25 ($3501-$4000)	$6,750.90	$5,738.27	
1563	New Technology - Level 26 ($4001-$4500)	$7,650.90	$6,503.27	
1564	New Technology - Level 27 ($4501-$5000)	$8,550.90	$7,268.27	
1565	New Technology - Level 28 ($5001-$5500)	$9,450.90	$8,033.27	
1566	New Technology - Level 29 ($5501-$6000)	$10,350.90	$8,798.27	
1567	New Technology - Level 30 ($6001-$6500)	$11,250.90	$9,563.27	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
1568	New Technology - Level 31 ($6501-$7000)	$12,150.90	$10,328.27	
1569	New Technology - Level 32 ($7001-$7500)	$13,050.90	$11,093.27	
1570	New Technology - Level 33 ($7501-$8000)	$13,950.90	$11,858.27	
1571	New Technology - Level 34 ($8001-$8500)	$14,850.90	$12,623.27	
1572	New Technology - Level 35 ($8501-$9000)	$15,750.90	$13,388.27	
1573	New Technology - Level 36 ($9001-$9500)	$16,650.90	$14,153.27	
1574	New Technology - Level 37 ($9501-$10000)	$17,550.90	$14,918.27	
1575	New Technology - Level 38 ($10,001-$15,000)	$22,500.90	$19,125.77	
1576	New Technology - Level 39 ($15,001-$20,000)	$31,500.90	$26,775.77	
1577	New Technology - Level 40 ($20,001-$25,000)	$40,500.90	$34,425.77	
1578	New Technology - Level 41 ($25,001-$30,000)	$49,500.90	$42,075.77	
1579	New Technology - Level 42 ($30,001-$40,000)	$63,000.90	$53,550.77	
1580	New Technology - Level 43 ($40,001-$50,000)	$81,000.90	$68,850.77	
1581	New Technology - Level 44 ($50,001-$60,000)	$99,000.90	$84,150.77	
1582	New Technology - Level 45 ($60,001-$70,000)	$117,000.90	$99,450.77	
1583	New Technology - Level 46 ($70,001-$80,000)	$135,000.90	$114,750.77	
1584	New Technology - Level 47 ($80,001-$90,000)	$153,000.90	$130,050.77	
1585	New Technology - Level 48 ($90,001-$100,000)	$171,000.90	$145,350.77	
1589	New Technology - Level 38 ($10,001-$15,000)	$22,500.90	$19,125.77	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
1590	New Technology - Level 39 ($15,001-$20,000)	$31,500.90	$26,775.77	
1591	New Technology - Level 40 ($20,001-$25,000)	$40,500.90	$34,425.77	
1592	New Technology - Level 41 ($25,001-$30,000)	$49,500.90	$42,075.77	
1593	New Technology - Level 42 ($30,001-$40,000)	$63,000.90	$53,550.77	
1594	New Technology - Level 43 ($40,001-$50,000)	$81,000.90	$68,850.77	
1595	New Technology - Level 44 ($50,001-$60,000)	$99,000.90	$84,150.77	
1596	New Technology - Level 45 ($60,001-$70,000)	$117,000.90	$99,450.77	
1597	New Technology - Level 46 ($70,001-$80,000)	$135,000.90	$114,750.77	
1598	New Technology - Level 47 ($80,001-$90,000)	$153,000.90	$130,050.77	
1599	New Technology - Level 48 ($90,001-$100,000)	$171,000.90	$145,350.77	
1607	Eptifibatide injection	$36.89	$31.36	
1608	Etanercept injection	$1,059.42	$900.51	
1609	Rho(D) immune globulin h, sd	$45.56	$38.73	
1613	Trastuzumab injection	$181.17	$153.99	
1630	Hep b ig, im	$208.80	$177.48	
1631	Baclofen intrathecal trial	$77.19	$65.61	
1643	Y90 ibritumomab, rx	$85,903.58	$73,018.04	
1656	Factor viii fc fusion recomb	$3.63	$3.09	
1658	Injection, belinostat, 10mg	$64.99	$55.24	
1660	Injection, oritavancin	$41.83	$35.56	
1662	Inj tedizolid phosphate	$2.47	$2.10	
1669	Erythro lactobionate /500 mg	$130.24	$110.70	
1670	Tetanus immune globulin inj	$874.07	$742.96	
1675	P32 Na phosphate	$460.80	$391.68	
1683	Basiliximab	$6,384.31	$5,426.66	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
1684	Corticorelin ovine triflutal	$15.51	$13.18	
1685	Darbepoetin alfa, non-esrd	$7.03	$5.98	
1686	Epoetin alfa, non-esrd	$21.84	$18.56	
1687	Digoxin immune fab (ovine)	$6,158.87	$5,235.04	
1688	Ethanolamine oleate	$799.38	$679.47	
1689	Fomepizole	$13.58	$11.54	
1690	Hemin	$40.24	$34.20	
1694	Ziconotide injection	$13.39	$11.38	
1695	Nesiritide injection	$131.98	$112.18	
1696	Palifermin injection	$34.37	$29.21	
1697	Pegaptanib sodium injection	$1,298.25	$1,103.51	
1700	Inj secretin synthetic human	$62.61	$53.22	
1701	Treprostinil injection	$110.23	$93.70	
1704	Humate-P, inj	$1.97	$1.67	
1705	Factor viia	$3.58	$3.04	
1709	Azacitidine injection	$2.84	$2.41	
1710	Clofarabine injection	$261.81	$222.54	
1711	Vantas implant	$5,914.86	$5,027.63	
1712	Paclitaxel protein bound	$19.86	$16.88	
1739	Pegademase bovine, 25 iu	$646.18	$549.25	
1743	Nandrolone decanoate 50 mg	$130.64	$111.04	
1745	Radium ra223 dichloride ther	$235.98	$200.58	
1746	Factor xiii recomb a-subunit	$27.16	$23.09	
1747	Monovisc inj per dose	$1,524.17	$1,295.54	
1748	Inj tbo filgrastim 1 microg	$1.10	$0.94	
1761	Rolapitant, oral, 1mg	$4.06	$3.45	
1809	Injection, alemtuzumab	$3,262.98	$2,773.53	
1822	Inj filgrastim gcsf biosimil	$1.25	$1.06	
1823	Injection, dalbavancin	$26.58	$22.59	
1824	Ceftaroline fosamil inj	$4.69	$3.99	
1825	Ceftazidime and avibactam	$138.74	$117.93	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
1826	Hyqvia 100mg immuneglobulin	$25.31	$21.51	
1827	Factor viii recomb obizur	$5.08	$4.32	
1828	Carbidopa levodopa ent 100ml	$3.85	$3.27	
1829	Penicillin g benzathine inj	$23.05	$19.59	
1832	Dimethyl sulfoxide 50% 50 ml	$998.22	$848.49	
1844	Factor viii pegylated recomb	$3.20	$2.72	
1845	Tacrol envarsus ex rel oral	$2.22	$1.89	
1846	Factor viii nuwiq recomb 1iu	$2.94	$2.50	
1847	Inj., infliximab biosimilar	$135.93	$115.54	
1848	Artiss fibrin sealant	$200.47	$170.40	
1849	Foscarnet sodium injection	$135.31	$115.01	
1850	Gamma globulin 1 cc inj	$59.32	$50.42	
1851	Gamma globulin > 10 cc inj	$593.24	$504.25	
1852	Interferon beta-1a inj	$1,087.92	$924.73	
1853	Minocycline hydrochloride	$2.85	$2.42	
1854	Pentobarbital sodium inj	$92.14	$78.32	
1856	Factor viii recomb novoeight	$2.26	$1.92	
1857	Inj, factor x, (human), 1iu	$12.31	$10.46	
1858	Leuprolide acetate injeciton	$47.94	$40.75	
1859	Argatroban nonesrd use 1mg	$2.69	$2.29	
1860	Monoclonal antibodies	$12.24	$10.40	
1861	Inj., bendeka 1 mg	$42.59	$36.20	
1862	Gelsyn-3 injection 0.1 mg	$3.92	$3.33	
1863	Inj diclofenac sodium 0.5mg	$0.33	$0.28	
1901	New Technology - Level 49 ($100,001-$115,000)	$193,500.90	$164,475.77	
1902	New Technology - Level 49 ($100,001-$115,000)	$193,500.90	$164,475.77	
1903	New Technology - Level 50 ($115,001-$130,000)	$220,500.90	$187,425.77	
1904	New Technology - Level 50 ($115,001-$130,000)	$220,500.90	$187,425.77	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
1905	New Technology - Level 51 ($130,001-$145,000)	$247,500.90	$210,375.77	
1906	New Technology - Level 51 ($130,001-$145,000)	$247,500.90	$210,375.77	
1907	New Technology - Level 52 ($145,001-$160,000)	$274,500.90	$233,325.77	
1908	New Technology - Level 52 ($145,001-$160,000)	$274,500.90	$233,325.77	
2616	Brachytx, non-str,Yttrium-90	$30,091.66	$25,577.91	
2632	Iodine I-125 sodium iodide	$47.97	$40.77	
2634	Brachytx, non-str, HA, I-125	$211.79	$180.02	
2635	Brachytx, non-str, HA, P-103	$46.69	$39.69	
2636	Brachy linear, non-str,P-103	$48.74	$41.43	
2638	Brachytx, stranded, I-125	$62.51	$53.13	
2639	Brachytx, non-stranded,I-125	$62.39	$53.03	
2640	Brachytx, stranded, P-103	$141.70	$120.45	
2641	Brachytx, non-stranded,P-103	$115.69	$98.34	
2642	Brachytx, stranded, C-131	$158.20	$134.47	
2643	Brachytx, non-stranded,C-131	$157.32	$133.72	
2644	Brachytx cesium-131 chloride	$189.16	$160.79	
2645	Brachytx, non-str, Gold-198	$220.70	$187.60	
2646	Brachytx, non-str, HDR Ir-192	$530.26	$450.72	
2647	Brachytx, NS, Non-HDRIr-192	$34.49	$29.32	
2648	Brachytx planar, p-103	$8.44	$7.17	
2698	Brachytx, stranded, NOS	$62.51	$53.13	
2699	Brachytx, non-stranded, NOS	$34.49	$29.32	
2731	Immune globulin, powder	$61.95	$52.66	
2770	Quinupristin/dalfopristin	$752.76	$639.85	
4001	Echo guidance radiotherapy	$42.77	$36.35	
4002	Stereoscopic x-ray guidance	$103.66	$88.11	
4003	Radiation treatment delivery, MeV <= 5; simple	$364.14	$309.52	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
4004	Radiation treatment delivery, 6-10 MeV; simple	$270.18	$229.65	
4005	Radiation treatment delivery, 11-19 MeV; simple	$269.53	$229.10	
4006	Radiation treatment delivery, MeV>=20; simple	$270.18	$229.65	
4007	Radiation treatment delivery, MeV<=5; intermediate	$546.86	$464.83	
4008	Radiation treatment delivery, 6-10 MeV; intermediate	$373.86	$317.78	
4009	Radiation treatment delivery, 11-19 MeV; intermediate	$372.56	$316.68	
4010	Radiation treatment delivery, MeV >=20; intermediate	$369.97	$314.47	
4011	Radiation treatment delivery, MeV<=5; complex	$519.64	$441.69	
4012	Radiation treatment delivery, 6-10 MeV; complex	$494.37	$420.21	
4013	Radiation treatment delivery, 11-19 MeV; complex	$494.37	$420.21	
4014	Radiation treatment delivery, MeV >=20; complex	$495.02	$420.77	
4015	Radiation tx delivery imrt	$645.34	$548.54	
4016	Delivery comp imrt	$643.39	$546.88	
5012	Clinic Visits and Related Services	$204.64	N/A	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
5021	Level 1 Type A ED Visits	$123.59	N/A	-
5022	Level 2 Type A ED Visits	$224.37	N/A	-
5023	Level 3 Type A ED Visits	$394.38	N/A	-
5024	Level 4 Type A ED Visits	$639.95	N/A	-
-	-	-	-	-
-	-	-	-	-
5025	Level 5 Type A ED Visits	$937.53	N/A	-
5031	Level 1 Type B ED Visits	$184.48	N/A	-
5032	Level 2 Type B ED Visits	$163.48	N/A	-
5033	Level 3 Type B ED Visits	$283.79	N/A	-
5034	Level 4 Type B ED Visits	$376.22	N/A	-
5035	Level 5 Type B ED Visits	$514.58	N/A	-
5041	Critical Care	$1,320.53	N/A	-
5045	Trauma Response with Critical Care	N/A	N/A	See Rule 18-6(J)(for Trauma Activation Fees
5051	Level 1 Skin Procedures	$304.11	$258.49	-
5052	Level 2 Skin Procedures	$559.44	$475.52	-
5053	Level 3 Skin Procedures	$878.76	$746.95	-
5054	Level 4 Skin Procedures	$2,823.17	$2,399.69	-
5055	Level 5 Skin Procedures	$4,878.86	$4,147.03	-
5061	Hyperbaric Oxygen	$205.51	$174.68	-
5071	Level 1 Excision/ Biopsy/ Incision and Drainage	$1,031.13	$876.46	-
5072	Level 2 Excision/ Biopsy/ Incision and Drainage	$2,426.45	$2,062.48	-
5073	Level 3 Excision/ Biopsy/ Incision and Drainage	$4,184.77	$3,557.05	-

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
5091	Level 1 Breast/Lymphatic Surgery and Related Procedures	$4,910.11	$4,173.59	
5092	Level 2 Breast/Lymphatic Surgery and Related Procedures	$8,661.38	$7,362.17	
5093	Level 3 Breast/Lymphatic Surgery and Related Procedures	$13,297.91	$11,303.22	
5094	Level 4 Breast/Lymphatic Surgery and Related Procedures	$20,499.39	$17,424.48	
5101	Level 1 Strapping and Cast Application	$243.76	$207.20	
5102	Level 2 Strapping and Cast Application	$427.10	$363.04	
5111	Level 1 Musculoskeletal Procedures	$386.82	$328.80	
5112	Level 2 Musculoskeletal Procedures	$2,429.89	$2,065.41	
5113	Level 3 Musculoskeletal Procedures	$4,761.41	$4,047.20	
5114	Level 4 Musculoskeletal Procedures	$10,091.56	$8,577.83	
5115	Level 5 Musculoskeletal Procedures	$18,221.26	$15,488.07	
5116	Level 6 Musculoskeletal Procedures	$27,667.80	$23,517.63	
5151	Level 1 Airway Endoscopy	$282.74	$240.33	
5152	Level 2 Airway Endoscopy	$675.85	$574.47	
5153	Level 3 Airway Endoscopy	$2,382.66	$2,025.26	
5154	Level 4 Airway Endoscopy	$4,709.83	$4,003.36	
5155	Level 5 Airway Endoscopy	$8,755.51	$7,442.18	
5161	Level 1 ENT Procedures	$321.30	$273.11	
5162	Level 2 ENT Procedures	$827.77	$703.60	
5163	Level 3 ENT Procedures	$2,048.72	$1,741.41	
5164	Level 4 ENT Procedures	$3,958.31	$3,364.56	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
5165	Level 5 ENT Procedures	$7,809.82	$6,638.35	
5166	Cochlear Implant Procedure	$58,679.96	$49,877.97	
5181	Level 1 Vascular Procedures	$1,102.63	$937.24	
5182	Level 2 Vascular Procedures	$1,769.35	$1,503.95	
5183	Level 3 Vascular Procedures	$4,486.93	$3,813.89	
5184	Level 4 Vascular Procedures	$7,676.93	$6,525.39	
5191	Level 1 Endovascular Procedures	$5,064.48	$4,304.81	
5192	Level 2 Endovascular Procedures	$9,153.00	$7,780.05	
5193	Level 3 Endovascular Procedures	$18,918.83	$16,081.01	
5194	Level 4 Endovascular Procedures	$28,836.70	$24,511.20	
5200	Implantation Wireless PA Pressure Monitor	$58,731.43	$49,921.72	
5211	Level 1 Electrophysiologic Procedures	$1,636.67	$1,391.17	
5212	Level 2 Electrophysiologic Procedures	$9,565.78	$8,130.91	
5213	Level 3 Electrophysiologic Procedures	$33,329.03	$28,329.68	
5221	Level1 Pacemaker and Similar Procedures	$5,162.31	$4,387.96	
5222	Level 2 Pacemaker and Similar Procedures	$13,267.78	$11,277.61	
5223	Level 3 Pacemaker and Similar Procedures	$17,546.38	$14,914.42	
5224	Level 4 Pacemaker and Similar Procedures	$31,653.97	$26,905.87	
5231	Level 1 ICD and Similar Procedures	$39,798.94	$33,829.10	
5232	Level 2 ICD and Similar Procedures	$55,731.83	$47,372.06	
5241	Level 1 Blood Product Exchange and Related Services	$675.13	$573.86	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
5242	Level 2 Blood Product Exchange and Related Services	$2,199.13	$1,869.26	
5243	Level 3 Blood Product Exchange and Related Services	$6,660.20	$5,661.17	
5244	Level 4 Blood Product Exchange and Related Services	$54,798.16	$46,578.44	
5301	Level 1 Upper GI Procedures	$1,338.28	$1,137.54	
5302	Level 2 Upper GI Procedures	$2,569.30	$2,183.91	
5303	Level 3 Upper GI Procedures	$4,938.19	$4,197.46	
5311	Level 1 Lower GI Procedures	$1,277.96	$1,086.27	
5312	Level 2 Lower GI Procedures	$1,685.50	$1,432.68	
5313	Level 3 Lower GI Procedures	$4,168.13	$3,542.91	
5331	Complex GI Procedures	$7,728.52	$6,569.24	
5341	Abdominal/Peritoneal/Biliary and Related Procedures	$5,240.09	$4,454.08	
5361	Level 1 Laparoscopy and Related Services	$8,079.62	$6,867.68	
5362	Level 2 Laparoscopy and Related Services	$13,671.76	$11,621.00	
5371	Level 1 Urology and Related Services	$413.15	$351.18	
5372	Level 2 Urology and Related Services	$1,018.08	$865.37	
5373	Level 3 Urology and Related Services	$3,052.22	$2,594.39	
5374	Level 4 Urology and Related Services	$4,854.17	$4,126.04	
5375	Level 5 Urology and Related Services	$6,670.85	$5,670.22	
5376	Level 6 Urology and Related Services	$13,673.27	$11,622.28	
5377	Level 7 Urology and Related Services	$28,256.08	$24,017.67	
5401	Dialysis	$1,076.45	$914.98	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
5411	Level 1 Gynecologic Procedures	$289.26	$245.87	
5412	Level 2 Gynecologic Procedures	$483.03	$410.58	
5413	Level 3 Gynecologic Procedures	$1,036.08	$880.67	
5414	Level 4 Gynecologic Procedures	$4,090.99	$3,477.34	
5415	Level 5 Gynecologic Procedures	$7,401.26	$6,291.07	
5416	Level 6 Gynecologic Procedures	$11,317.25	$9,619.66	
5431	Level 1 Nerve Procedures	$2,898.90	$2,464.07	
5432	Level 2 Nerve Procedures	$8,329.66	$7,080.21	
5441	Level 1 Nerve Injections	$440.46	$374.39	
5442	Level 2 Nerve Injections	$978.08	$831.37	
5443	Level 3 Nerve Injections	$1,209.92	$1,028.43	
5461	Level 1 Neurostimulator and Related Procedures	$5,182.88	$4,405.45	
5462	Level 2 Neurostimulator and Related Procedures	$10,900.10	$9,265.09	
5463	Level 3 Neurostimulator and Related Procedures	$33,064.00	$28,104.40	
5464	Level 4 Neurostimulator and Related Procedures	$50,205.22	$42,674.44	
5471	Implantation of Drug Infusion Device	$29,593.44	$25,154.42	
5481	Laser Eye Procedures	$878.36	$746.61	
5491	Level 1 Intraocular Procedures	$3,457.96	$2,939.27	
5492	Level 2 Intraocular Procedures	$6,499.35	$5,524.45	
5493	Level 3 Intraocular Procedures	$16,536.74	$14,056.23	
5494	Level 4 Intraocular Procedures	$17,158.34	$14,584.59	
5495	Level 5 Intraocular Procedures	$31,610.32	$26,868.77	
5501	Level 1 Extraocular, Repair, and Plastic Eye Procedures	$481.79	$409.52	
5502	Level 2 Extraocular, Repair, and Plastic Eye Procedures	$1,455.07	$1,236.81	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
5503	Level 3 Extraocular, Repair, and Plastic Eye Procedures	$3,260.43	$2,771.37	
5504	Level 4 Extraocular, Repair, and Plastic Eye Procedures	$5,312.83	$4,515.91	
5521	Level 1 Imaging without Contrast	$111.82	$95.05	
5522	Level 2 Imaging without Contrast	$206.03	$175.13	
5523	Level 3 Imaging without Contrast	$418.16	$355.44	
5524	Level 4 Imaging without Contrast	$876.04	$744.63	
5571	Level 1 Imaging with Contrast	$454.93	$386.69	
5572	Level 2 Imaging with Contrast	$821.47	$698.25	
5573	Level 3 Imaging with Contrast	$1,227.38	$1,043.27	
5591	Level 1 Nuclear Medicine and Related Services	$628.99	$534.64	
5592	Level 2 Nuclear Medicine and Related Services	$815.54	$693.21	
5593	Level 3 Nuclear Medicine and Related Services	$2,164.82	$1,840.10	
5594	Level 4 Nuclear Medicine and Related Services	$2,479.00	$2,107.15	
5611	Level 1 Therapeutic Radiation Treatment Preparation	$225.63	$191.79	
5612	Level 2 Therapeutic Radiation Treatment Preparation	$581.56	$494.33	
5613	Level 3 Therapeutic Radiation Treatment Preparation	$2,136.02	$1,815.62	
5621	Level 1 Radiation Therapy	$224.51	$190.83	
5622	Level 2 Radiation Therapy	$395.69	$336.34	
5623	Level 3 Radiation Therapy	$940.16	$799.14	
5624	Level 4 Radiation Therapy	$1,285.40	$1,092.59	
5625	Level 5 Radiation Therapy	$1,896.34	$1,611.89	
5626	Level 6 Radiation Therapy	$3,019.00	$2,566.15	
5627	Level 7 Radiation Therapy	$13,618.24	$11,575.50	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
5661	Therapeutic Nuclear Medicine	$429.26	$364.87	
5671	Level 1 Pathology	$80.46	$68.39	
5672	Level 2 Pathology	$232.52	$197.64	
5673	Level 3 Pathology	$387.77	$329.60	
5674	Level 4 Pathology	$973.73	$827.67	
5691	Level 1 Drug Administration	$66.65	$56.65	
5692	Level 2 Drug Administration	$104.76	$89.05	
5693	Level 3 Drug Administration	$343.96	$292.37	
5694	Level 4 Drug Administration	$535.63	$455.29	
5721	Level1 Diagnostic Tests and Related Services	$245.38	$208.57	
5722	Level 2 Diagnostic Tests and Related Services	$447.89	$380.71	
5723	Level 3 Diagnostic Tests and Related Services	$799.90	$679.92	
5724	Level 4 Diagnostic Tests and Related Services	$1,625.36	$1,381.56	
5731	Level 1 Minor Procedures	$31.45	$26.73	
5732	Level 2 Minor Procedures	$57.24	$48.65	
5733	Level 3 Minor Procedures	$100.73	$85.62	
5734	Level 4 Minor Procedures	$189.07	$160.71	
5735	Level 5 Minor Procedures	$594.02	$504.92	
5741	Level 1 Electronic Analysis of Devices	$67.93	$57.74	
5742	Level 2 Electronic Analysis of Devices	$207.32	$176.22	
5743	Level 3 Electronic Analysis of Devices	$471.40	$400.69	
5771	Cardiac Rehabilitation	$209.99	$178.49	
5781	Resuscitation and Cardioversion	$922.79	$784.37	
5791	Pulmonary Treatment	$335.48	$285.16	
5801	Ventilation Initiation and Management	$829.26	$704.87	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
5811	Manipulation Therapy	$48.29	$41.05	
5821	Level 1 Health and Behavior Services	$54.76	$46.55	
5822	Level 2 Health and Behavior Services	$129.49	$110.07	
5823	Level 3 Health and Behavior Services	$223.11	$189.64	
5853	Partial Hospitalization (3 or more services) for CMHCs	$257.96	$219.27	
5863	Partial Hospitalization (3 or more services) for Hospital-based PHPs	$374.81	$318.59	
5871	Dental Procedures	$1,390.37	$1,181.81	
5881	Ancillary Outpatient Services When Patient Dies	$12,739.99	$10,828.99	
7000	Amifostine	$1,753.27	$1,490.28	
7011	Oprelvekin injection	$840.99	$714.84	
7034	Somatropin injection	$134.37	$114.21	
7035	Teniposide	$4,435.05	$3,769.79	
7041	Tirofiban HCl	$16.37	$13.91	
7043	Infliximab not biosimil 10mg	$154.46	$131.29	
7046	Doxorubicin inj 10mg	$694.38	$590.22	
7048	Alteplase recombinant	$152.91	$129.97	
7308	Aminolevulinic acid hcl top	$728.26	$619.02	
8004	Ultrasound Composite	$539.80	$458.83	
8005	CT and CTA without Contrast Composite	$494.71	$420.50	
8006	CT and CTA with Contrast Composite	$901.53	$766.30	
8007	MRI and MRA without Contrast Composite	$1,001.11	$850.94	
8008	MRI and MRA with Contrast Composite	$1,569.35	$1,333.95	
8010	Mental Health Services Composite	$374.81	$318.59	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
8011	Comprehensive Observation Services	$4,229.68	$3,595.23	
9002	Tenecteplase injection	$200.79	$170.67	
9003	Palivizumab	$2,725.51	$2,316.68	
9005	Reteplase injection	$4.143.44	$3.521.92	
9006	Tacrolimus injection	$338.10	$287.39	
9012	Arsenic trioxide injection	$127.90	$108.72	
9014	Injection, cerliponase alfa	$171.72	$145.96	
9015	C-1 esterase, haegarda	$17.94	$15.25	
9016	Inj, triptorelin ext rel	$5,088.00	$4,324.80	
9018	Inj, rimabotulinumtoxinB	$21.58	$18.34	
9019	Caspofungin acetate	$32.64	$27.74	
9024	Amphotericin b lipid complex	$26.86	$22.83	
9028	Inj. inotuzumab ozogamicin	$3,964.40	$3,369.74	
9029	Injection, guselkumab	$184.77	$157.05	
9031	Inj, etelcalcetide, 0.1 mg	$6.24	$5.30	
9032	Baclofen 10 MG injection	$320.14	$272.12	
9033	Cidofovir injection	$838.59	$712.80	
9034	Inj cuvitru, 100 mg	$24.82	$21.10	
9038	Inj estrogen conjugate	$543.09	$461.63	
9042	Glucagon hydrochloride	$394.46	$335.29	
9043	Inj, afstyla, 1 i.u.	$2.55	$2.17	
9044	Ibutilide fumarate injection	$360.09	$306.08	
9052	Fluciclovine F-18	$701.19	$596.01	
9056	Gallium Ga-68	$120.13	$102.11	
9058	Buprenorphine implant 74.2mg	$2,262.79	$1,923.37	
9059	Vonvendi inj 1 iu vwf:rco	$4.10	$3.49	
9064	Aripiprazole injection	$1.36	$1.16	
9065	Argatroban esrd dialysis 1mg	$2.69	$2.29	
9066	Inj dihydroergotamine mesylt	$188.58	$160.29	
9071	Capsaicin 8% patch	$5.68	$4.83	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
9072	Fosphenytoin inj pe	$7.04	$5.98	
9074	Makena, 10 mg	$49.70	$42.25	
9075	Inj, kovaltry, 1 i.u.	$2.24	$1.90	
9076	Dimecaprol injection	$92.21	$78.38	
9077	Epoetin beta non esrd	$2.93	$2.49	
9078	Testosterone undecanoate 1mg	$2.32	$1.97	
9079	Genvisc 850, inj, 1mg	$11.56	$9.83	
9080	Fludarabine phosphate inj	$152.44	$129.57	
9081	Tisagenlecleucel car-pos t	$906,300.00	$770,355.00	
9104	Antithymocyte globuln rabbit	$1,281.96	$1,089.67	
9108	Thyrotropin injection	$2,884.74	$2,452.03	
9119	Injection, pegfilgrastim 6mg	$7,996.15	$6,796.73	
9120	Injection, Fulvestrant	$174.38	$148.22	
9122	Triptorelin pamoate	$748.40	$636.14	
9124	Daptomycin injection	$0.90	$0.77	
9125	Risperidone, long acting	$16.12	$13.70	
9126	Natalizumab injection	$34.95	$29.71	
9130	Inj, Imm Glob Bivigam, 500mg	$126.93	$107.89	
9131	Inj, Ado-trastuzumab Emt 1mg	$54.37	$46.21	
9132	Kcentra, per i.u.	$3.35	$2.85	
9133	Rabies ig, im/sc	$544.45	$462.78	
9134	Rabies ig, heat treated	$598.38	$508.62	
9135	Varicella-zoster ig, im	$2,442.65	$2,076.25	
9139	Rabies vaccine, im	$512.96	$436.02	
9140	Rabies vaccine, id	$353.77	$300.70	
9171	Factor ix idelvion inj	$7.48	$6.36	
9207	Bortezomib injection	$84.51	$71.83	
9208	Agalsidase beta injection	$308.53	$262.25	
9209	Laronidase injection	$55.11	$46.84	
9210	Palonosetron hcl	$36.54	$31.06	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
9213	Pemetrexed injection	$119.36	$101.46	
9214	Bevacizumab injection	$137.99	$117.29	
9215	Cetuximab injection	$106.60	$90.61	
9217	Leuprolide acetate suspnsion	$380.17	$323.14	
9224	Galsulfase injection	$684.85	$582.12	
9225	Fluocinolone acetonide implt	$36,180.30	$30,753.26	
9228	Tigecycline injection	$5.08	$4.32	
9229	Ibandronate sodium injection	$152.79	$129.87	
9230	Abatacept injection	$87.39	$74.28	
9231	Decitabine injection	$29.04	$24.68	
9232	Idursulfase injection	$977.15	$830.58	
9233	Ranibizumab injection	$695.79	$591.42	
9234	Alglucosidase alfa injection	$287.33	$244.23	
9235	Panitumumab injection	$200.50	$170.43	
9236	Eculizumab injection	$411.06	$349.40	
9237	Inj, lanreotide acetate	$102.05	$86.74	
9240	Injection, ixabepilone	$131.40	$111.69	
9242	Injection, fosaprepitant	$3.68	$3.13	
9243	Inj., treanda 1 mg	$54.24	$46.10	
9245	Romiplostim injection	$122.50	$104.13	
9251	C1 esterase inhibitor inj	$102.90	$87.47	
9252	Plerixafor injection	$565.99	$481.09	
9253	Temozolomide injection	$17.21	$14.63	
9255	Paliperidone palmitate inj	$18.67	$15.87	
9256	Dexamethasone intra implant	$361.00	$306.85	
9258	Telavancin injection	$9.68	$8.23	
9259	Pralatrexate injection	$462.79	$393.37	
9260	Ofatumumab injection	$101.64	$86.39	
9261	Ustekinumab sub cu inj, 1 mg	$336.81	$286.29	
9263	Ecallantide injection	$813.81	$691.74	
9264	Tocilizumab injection	$8.15	$6.93	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
9265	Romidepsin injection	$592.57	$503.68	
9269	C-1 esterase, berinert	$88.03	$74.83	
9270	Gammaplex IVIG	$72.06	$61.25	
9271	Velaglucerase alfa	$619.07	$526.21	
9272	Inj, denosumab	$31.95	$27.16	
9273	Sipuleucel-T auto CD54+	$71,863.30	$61,083.81	
9274	Crotalidae Poly Immune Fab	$5,403.60	$4,593.06	
9276	Cabazitaxel injection	$286.46	$243.49	
9278	Incobotulinumtoxin A	$9.14	$7.77	
9281	Injection, pegloticase	$3,708.86	$3,152.53	
9284	Ipilimumab injection	$264.03	$224.43	
9286	Belatacept injection	$7.04	$5.98	
9287	Brentuximab vedotin inj	$260.92	$221.78	
9289	Erwinaze injection	$724.94	$616.20	
9293	Injection, glucarpidase	$536.91	$456.37	
9294	Inj, taliglucerase alfa 10 u	$72.69	$61.79	
9295	Injection, Carfilzomib, 1 mg	$59.73	$50.77	
9296	Inj, ziv-aflibercept, 1mg	$14.57	$12.38	
9297	Inj, Omacetaxine Mep, 0.01mg	$5.12	$4.35	
9298	Inj, Ocriplasmin, 0.125 mg	$1,884.24	$1,601.60	
9300	Omalizumab injection	$62.89	$53.46	
9301	Aminolevulinic acid, 10% gel	$2.51	$2.13	
9302	Inj, daunorubicin-cytarabine	$336.07	$285.66	
9441	Inj ferric carboxymaltos 1mg	$1.89	$1.61	
9445	Injection, ruconest	$50.36	$42.81	
9448	Netupitant palonosetron oral	$717.89	$610.21	
9449	Injection, blinatumomab	$193.93	$164.84	
9450	Fluocinol acet intravit imp	$882.86	$750.43	
9451	Injection, peramivir	$3.02	$2.57	
9452	Inj ceftolozane tazobactam	$9.25	$7.86	
9453	Injection, nivolumab	$48.22	$40.99	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
9454	Inj, pasireotide long acting	$490.18	$416.65	
9455	Injection, siltuximab	$166.91	$141.87	
9456	Injection, isavuconazonium	$1.24	$1.05	
9458	Florbetaben f18 diagnostic	$5,342.40	$4,541.04	
9459	Flutemetamol f18 diagnostic	$6,296.40	$5,351.94	
9460	Injection, cangrelor	$27.22	$23.14	
9461	Choline c-11, diagnostic, per study dose up to 20 millicuries	$10,260.00	$8,721.00	
9470	Aripiprazole lauroxil 1mg	$4.37	$3.71	
9471	Hymovis injection 1 mg	$34.66	$29.46	
9472	Inj talimogene laherparepvec	$86.88	$73.85	
9473	Injection, mepolizumab, 1mg	$51.91	$44.12	
9474	Inj irinotecan liposome 1 mg	$77.25	$65.66	
9475	Injection, necitumumab, 1 mg	$9.66	$8.21	
9476	Injection, daratumumab 10 mg	$89.10	$75.74	
9477	Injection, elotuzumab, 1mg	$11.42	$9.71	
9478	Inj sebelipase alfa 1 mg	$954.00	$810.90	
9479	Instill, ciprofloxacin otic	$53.94	$45.85	
9480	Injection trabectedin 0.1mg	$523.15	$444.68	
9481	Injection, reslizumab	$16.39	$13.93	
9482	Sotalol hydrochloride IV	$17.97	$15.27	
9483	Inj, atezolizumab,10 mg	$136.43	$115.97	
9484	Inj, eteplirsen, 10 mg	$304.68	$258.98	
9485	Inj, olaratumab, 10 mg	$89.91	$76.42	
9486	Inj, granisetron, xr, 0.1 mg	$8.29	$7.05	
9487	Ustekinumab, iv inject,1 mg	$23.13	$19.66	
9488	Conivaptan hcl	$55.32	$47.02	
9489	Inj, nusinersen, 0.1mg	$1,985.93	$1,688.04	
9490	Inj, bezlotoxumab, 10 mg	$72.33	$61.48	
9491	Injection, avelumab, 10 mg	$142.87	$121.44	
9492	Injection, durvalumab	$132.47	$112.60	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
9493	Injection, edaravone	$34.53	$29.35	
9494	Injection, ocrelizumab	$102.75	$87.34	
9495	Gemtuzumab ozogamicin inj	$347.68	$295.53	
9497	Loxapine, inhalation powder	$271.13	$230.46	
9500	Platelets, irradiated	$322.45	$274.08	
9501	Platelet pheres leukoreduced	$858.60	$729.81	
9502	Platelet pheresis irradiated	$998.01	$848.31	
9503	Fr frz plasma donor retested	$87.03	$73.98	
9504	RBC deglycerolized	$757.49	$643.87	
9505	RBC irradiated	$384.82	$327.10	
9507	Platelets, pheresis	$758.16	$644.44	
9508	Plasma 1 donor frz w/in 8 hr	$130.34	$110.79	
9509	Frozen plasma, pooled, sd	$109.03	$92.68	
9510	Whole blood for transfusion	$282.46	$240.09	
9511	Cryoprecipitate each unit	$79.22	$67.34	
9512	RBC leukocytes reduced	$330.79	$281.17	
9513	Plasma, frz between 8-24hour	$133.63	$113.59	
9514	Plasma protein fract,5%,50ml	$27.72	$23.56	
9515	Platelets, each unit	$206.91	$175.87	
9516	Plaelet rich plasma unit	$222.32	$188.97	
9517	Red blood cells unit	$257.02	$218.47	
9518	Washed red blood cells unit	$691.70	$587.95	
9519	Plasmaprotein fract,5%,250ml	$84.42	$71.76	
9520	Blood split unit	$184.82	$157.10	
9521	Platelets leukoreduced irrad	$301.77	$256.50	
9522	RBC leukoreduced irradiated	$468.36	$398.11	
9523	Cryoprecipitatereducedplasma	$189.97	$161.47	
9524	Blood, l/r, cmv-neg	$346.81	$294.79	
9525	Platelets, hla-m, l/r, unit	$1,384.78	$1,177.06	
9526	Platelets leukocytes reduced	$210.06	$178.55	
9527	Blood, l/r, froz/degly/wash	$510.30	$433.76	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	Group Title	Outpatient Hospital Rate 180% of Medicare $	ASC Rate is 85% of Hospital Rate	Notes
9528	Plt, aph/pher, l/r, cmv-neg	$611.91	$520.12	
9529	Blood, l/r, irradiated	$279.43	$237.52	
9530	Plate pheres leukoredu irrad	$1,124.39	$955.73	
9531	Plt, pher, l/r cmv-neg, irr	$971.69	$825.94	
9532	RBC, frz/deg/wsh, l/r, irrad	$507.15	$431.08	
9533	RBC, l/r, cmv-neg, irrad	$428.49	$364.22	
9534	Pathogen reduced plasma pool	$133.63	$113.59	
9535	Pathogen reduced plasma sing	$130.34	$110.79	
9536	Platelets, pathogen reduced	$1,124.39	$955.73	

Final Exhibit #5

Rural Health Clinics

find the most updated list at: https://www.colorado.gov/pacific/cdphe/find-and-compare-facilities

(effective 1/1/2019)

Facility	Address	City	State	Zip	County	Phone	Fax
AKRON CLINIC	82 MAIN	Akron	CO	80720	Washington	(970)345-6336	(970)345-6576
ARKANSAS VALLEY FAMILY PRACTICE, LLC	2317 SAN JUAN AVE	La Junta	CO	81050	Otero	(719)383-2325	(719)383-2327
BASIN CLINIC	421 WEST ADAMS ROAD	Naturita	CO	80723	Montrose	(970)865-2665	(970)825-2674
BANNER FAMILY MEDICINE BRUSH CLINIC	2400 W EDISON	Brush	CO	81211	Morgan	(970)842-6740	(970)842-6241
BUENA VISTA HEALTH CENTER	28374 COUNTY ROAD 317	Buena Vista	CO	81211	Chaffee	(719)395-9048	(719)395-9064
BUTTON FAMILY PRACTICE	715 SOUTH 9TH STREET	Canon City	CO	81212	Fremont	(719)269-8820	(719)204-0230
CENTENNIAL FAMILY HEALTH CENTER	319 MAIN STREET	Ordway	CO	81063	Crowley	(719)267-3503	(719)267-4153
CORTEZ PRIMARY CARE CLINIC	118 NORTH CHESTNUT	Cortez	CO	81321	Montezuma	(970)564-9777	(970)564-8833
CREEDE FAMILY PRACTICE OF RIO GRANDE HOSPITAL	802 RIO GRANDE AVENUE	Creede	CO	81130	Mineral	(719)658-0929	(719)657-2851
CUSTER COUNTY MEDICAL CENTER	704 EDWARDS	Westcliffe	CO	81252	Custer	(719)783-2380	(719)783-2377
EADS MEDICAL CLINIC	1211 LUTHER STREET	Eads	CO	81036	Kiowa	(719)438-2251	(719)438-2254
EASTERN PLAINS MEDICAL CLINIC OF CALHAN	560 CRYSTOLA STREET	Calhan	CO	80808	El Paso	(719)347-0100	(719)347-0551
FAMILY PRACTICE OF HOLYOKE	1001 EAST JOHNSON STREET	Holyoke	CO	80734	Phillips	(970)854-2500	(970)854-3440
FLORENCE MEDICAL CENTER	501 W 5TH ST	Florence	CO	81226	Fremont	(719)784-4816	(719)784-6014
GRAND RIVER HEALTH CLINIC WEST	201 SIPPERELLE DRIVE	Parachute	CO	81635	Garfield	(970)285-7046	(970)285-6064
GRAND RIVER PRIMARY CARE	501 AIRPORT ROAD	Rifle	CO	81650	Garfield	(970)625-1100	(970)625-0725

Final Exhibit #5

Rural Health Clinics

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(effective 1/1/2019)

Facility	Address	City	State	Zip	County	Phone	Fax
KIT CARSON CLINIC	102 EAST 2ND AVENUE	Kit Carson	CO	80825	Cheyenne	(719)962-3501	(719)962-3403
LAKE CITY AREA MEDICAL CENTER	700 N HENSON STREET	Lake City	CO	81235	Hinsdale	(970)944-2331	(970)944-2320
LAMAR MEDICAL CLINIC	403 KENDALL DRIVE	Lamar	CO	81052	Prowers	(719)336-6767	(719)336-7217
MANCOS VALLEY HEALTH CENTER	111 RAILROAD AVE	Mancos	CO	81328	Montezuma	(970)564-2104	(970)564-2134
MEEKER FAMILY HEALTH CENTER	345 CLEVELAND STREET	Meeker	CO	81641	Rio Blanco	(970)878-4014	(970)878-3285
MEMORIAL HOSPITAL	750 Hospital Loop	Craig	CO	81625	Moffat	(970) 826-3161	(970) 826-3285
MIDDLE PARK MEDICAL CENTER	47 Cooper Creek Way	Winter Park	CO	80482	Grand	(970)887-5800	(970)724-9606
MONTE VISTA RHC OF RIO GRANDE HOSPITAL	1033 2ND AVENUE	Monte Vista	CO	81144	Rio Grande	(719)852-8827	(719)852-2739
MT SAN RAFAEL HOSPITAL HEALTH CLINIC	400 BENEDICTA STE A	Trinidad	CO	81082	Las Animas	(719)846-2206	(719)846-7823
NORTH PARK MEDICAL CENTER - WALDEN	350 MCKINLEY STREET	Walden	CO	80480	Jackson	(970)723-4255	(970)723-4268
PAGOSA MOUNTAIN CLINIC	95 SOUTH PAGOSA BLVD	Pagosa Springs	CO	81147	Archuleta	(970)731-3700	(970)731-3707
PARKE HEALTH CLINIC	182 16TH ST	Burlington	CO	80807	Kit Carson	(719)346-9481	(719)346-9485
PEDIATRIC ASSOCIATION OF CANON CITY	1335 PHAY AVENUE, SUITE A	Canon City	CO	81212	Fremont	(719)269-1727	(719)269-1730
PRAIRIE VIEW RURAL HEALTH CLINIC	615 WEST 5TH NORTH	Cheyenne Wells	CO	80810	Cheyenne	(719)767-5669	(719)767-5098
RIO GRANDE HOSPITAL CLINIC	0310C COUNTY RD 14	Del Norte	CO	81132	Rio Grande	(719)657-2418	(719)658-3001
ROCKY FORD FAMILY HEALTH	1014 ELM AVENUE	Rocky Ford	CO	81067	Otero	(719)254-7421	(719)254-6966

Final Exhibit #5

Rural Health Clinics

find the most updated list at: https://www.colorado.gov/pacific/cdphe/find-and-compare-facilities

(effective 1/1/2019)

Facility	Address	City	State	Zip	County	Phone	Fax
CENTER							
SABATINI PEDIATRICS PC	612 YALE PLACE	Canon City	CO	81212	Fremont	(719)275-3442	(719)275-2306
SAN LUIS VALLEY HEALTH ANTONITO CLINIC	115 MAIN STREET	Antonito	CO	81120	Conejos	(719)376-2308	(719)376-2395
SAN LUIS VALLEY LA JARA MEDICAL CLINIC	509 MAIN STREET	La Jara	CO	81140	Conejos	(719)274-5000	(719)274-4111
SOUTHEAST COLORADO PHYSICIANS CLINIC	900 CHURCH STREET	Springfield	CO	81073	Baca	(719)523-6628	(719)523-4513
SOUTHWEST MEMORIAL PRIMARY CARE	33 NORTH ELM STREET	Cortez	CO	81321	Montezuma	(970)565-8556	(970)564-1134
SOUTHWEST SCHOOL-BASED HEALTH CENTER	418 S SLIGO STREET	Cortez	CO	81321	Montezuma	(970)564-2104	(970)564-2134
SOUTHWEST WALK-IN CARE	2095 NORTH DOLORES ROAD, STE C	Cortez	CO	81321	Montezuma	(970)564-1037	(970)564-1041
SPANISH PEAKS FAMILY CLINIC	23400 US HIGHWAY 160	Walsenburg	CO	81089	Huerfano	(719)738-4591	(719)738-4553
STERLING REGIONAL MEDICAL CENTER	102 Hays Ave	Sterling	CO	80751	Logan	(970)521-3223	(970)521-3266
STRATTON MEDICAL CLINIC	500 NEBRASKA AVENUE	Stratton	CO	80836	Kit Carson	(719)348-4650	(719)348-4653
SURFACE CREEK FAMILY PRACTICE	255 SW 8TH AVE	Cedaredge	CO	81413	Delta	(970)856-3146	(970)856-4385
VALLEY MEDICAL CLINIC	116 E NINTH STREET	Julesburg	CO	80737	Sedgwick	(970)474-3376	(970)474-2461
WALSH MEDICAL CLINIC	137 KANSAS STREET	Walsh	CO	81090	Baca	(719)324-5253	(719)324-5621
WASHINGTON COUNTY CLINIC	482 ADAMS AVENUE	Akron	CO	80720	Washington	(970)345-2262	(970)345-2265
YUMA CLINIC	1000 W 8TH	Yuma	CO	80759	Yuma	(970)848-	(970)848-

Final Exhibit #5							
Rural Health Clinics							
find the most updated list at: https://www.colorado.gov/pacific/cdphe/find-and-compare-facilities							
(effective 1/1/2019)							
Facility	**Address**	**City**	**State**	**Zip**	**County**	**Phone**	**Fax**
	AVENUE					4676	4952

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D0120	$62.25
D0140	$104.38
D0145	$97.00
D0150	$109.75
D0160	$219.75
D0170	$73.13
D0171	$73.13
D0180	$119.00
D0190	$62.25
D0191	$44.13
D0210	$170.88
D0220	$33.88
D0230	$30.88
D0240	$52.88
D0250	$64.75
D0251	$59.75
D0270	$33.75
D0272	$54.00
D0273	$65.63
D0274	$76.00
D0277	$114.75
D0310	$512.88
D0320	$906.00
D0321	BR
D0322	$734.88
D0330	$159.00
D0340	$179.63
D0350	$85.25
D0351	$85.25
D0364	$285.50
D0365	$364.25
D0366	$364.25

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D0367	$410.38
D0368	$422.50
D0369	$239.38
D0370	$136.88
D0371	BR
D0380	$294.00
D0381	$398.38
D0382	$398.38
D0383	$398.38
D0384	$427.50
D0385	$2,624.38
D0386	$656.38
D0391	BR
D0393	BR
D0394	BR
D0395	BR
D0414	$65.13
D0415	$47.25
D0416	$70.13
D0417	$63.38
D0418	$65.13
D0422	$47.25
D0423	BR
D0425	$40.63
D0431	$65.13
D0460	$65.13
D0470	$143.63
D0472	$89.88
D0473	$189.13
D0474	$212.00
D0475	$114.13
D0476	$110.75

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D0477	$151.75
D0478	$138.63
D0479	$212.00
D0480	$130.50
D0481	$489.50
D0482	$163.13
D0483	$163.13
D0484	$244.75
D0485	$337.63
D0486	$156.75
D0502	BR
D0600	BR
D0601	$97.75
D0602	$97.75
D0603	$97.75
D0999	BR
D1110	$111.75
D1120	$77.25
D1206	$62.50
D1208	$41.38
D1310	$58.38
D1320	$63.38
D1330	$80.00
D1351	$65.13
D1352	$83.63
D1353	$83.63
D1354	$65.13
D1510	$413.00
D1515	$577.88
D1520	$454.00
D1525	$702.13
D1550	$89.38

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D1555	$86.13
D1575	$454.00
D1999	BR
D2140	$180.38
D2150	$233.25
D2160	$281.75
D2161	$343.50
D2330	$194.25
D2331	$247.88
D2332	$303.63
D2335	$358.88
D2390	$398.00
D2391	$227.50
D2392	$297.88
D2393	$370.00
D2394	$453.38
D2410	$345.38
D2420	$575.88
D2430	$998.00
D2510	$913.63
D2520	$1,036.38
D2530	$1,194.50
D2542	$1,171.38
D2543	$1,225.50
D2544	$1,274.38
D2610	$1,074.88
D2620	$1,134.75
D2630	$1,208.25
D2642	$1,174.63
D2643	$1,266.88
D2644	$1,343.63
D2650	$706.50

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D2651	$841.38
D2652	$884.63
D2662	$767.63
D2663	$902.88
D2664	$967.13
D2710	$573.00
D2712	$573.00
D2720	$1,411.88
D2721	$1,323.25
D2722	$1,352.25
D2740	$1,449.00
D2750	$1,429.63
D2751	$1,331.00
D2752	$1,363.38
D2780	$1,371.50
D2781	$1,290.88
D2782	$1,332.88
D2783	$1,410.25
D2790	$1,379.88
D2791	$1,307.13
D2792	$1,331.00
D2794	$1,411.88
D2799	$573.00
D2910	$127.13
D2915	$127.13
D2920	$128.75
D2921	$185.25
D2929	$509.75
D2930	$351.00
D2931	$396.88
D2932	$423.38
D2933	$485.25

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D2934	$485.25
D2940	$134.25
D2941	$134.25
D2949	$134.25
D2950	$335.25
D2951	$75.75
D2952	$529.25
D2953	$264.50
D2954	$423.38
D2955	$326.50
D2957	$211.50
D2960	$1,023.38
D2961	$1,160.75
D2962	$1,261.38
D2971	$202.75
D2975	$617.38
D2980	$247.00
D2981	$247.00
D2982	$247.00
D2983	$247.00
D2990	$88.13
D2999	BR
D3110	$117.75
D3120	$94.00
D3220	$241.00
D3221	$264.63
D3222	$245.00
D3230	$244.00
D3240	$300.25
D3310	$957.50
D3320	$1,173.50
D3330	$1,455.00

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D3331	$375.50
D3332	$713.63
D3333	$328.75
D3346	$1,276.75
D3347	$1,502.13
D3348	$1,858.88
D3351	$603.38
D3352	$270.50
D3353	$832.50
D3355	$603.38
D3356	$270.50
D3357	BR
D3410	$1,196.25
D3421	$1,331.25
D3425	$1,508.38
D3426	$509.63
D3427	$1,081.75
D3428	$1,576.88
D3429	$1,504.13
D3430	$374.38
D3431	$1,851.63
D3432	$1,591.63
D3450	$780.25
D3460	$2,912.50
D3470	$1,487.63
D3910	$208.25
D3920	$592.75
D3950	$270.50
D3999	BR
D4210	$1,106.88
D4211	$492.00
D4212	$393.63

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D4230	$1,549.50
D4231	$737.88
D4240	$1,401.88
D4241	$811.75
D4245	$1,032.88
D4249	$1,537.25
D4260	$2,336.50
D4261	$1,254.13
D4263	$836.25
D4264	$713.00
D4265	BR
D4266	$860.88
D4267	$1,106.88
D4268	BR
D4270	$1,660.13
D4273	$2,029.00
D4274	$1,151.00
D4275	$1,524.88
D4276	$2,275.00
D4277	$1,721.63
D4278	$565.75
D4283	$1,728.88
D4285	$1,301.13
D4320	$565.63
D4321	$514.00
D4341	$325.50
D4342	$188.50
D4346	$188.50
D4355	$222.63
D4381	BR
D4910	$200.50
D4920	$145.88

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D4921	BR
D4999	BR
D5110	$2,197.63
D5120	$2,197.63
D5130	$2,396.00
D5140	$2,396.00
D5211	$1,854.75
D5212	$2,155.50
D5213	$2,428.00
D5214	$2,428.00
D5221	$2,023.50
D5222	$2,350.00
D5223	$2,646.63
D5224	$2,646.63
D5225	$1,854.75
D5226	$2,155.50
D5281	$1,415.63
D5410	$120.38
D5411	$120.38
D5421	$120.38
D5422	$120.38
D5511	BR
D5512	BR
D5520	$200.38
D5611	BR
D5612	BR
D5621	BR
D5622	BR
D5630	$341.00
D5640	$220.63
D5650	$300.75
D5660	$360.88

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D5670	$882.25
D5671	$882.25
D5710	$892.38
D5711	$852.25
D5720	$842.25
D5721	$842.25
D5730	$503.25
D5731	$503.25
D5740	$461.00
D5741	$461.00
D5750	$671.63
D5751	$671.63
D5760	$661.75
D5761	$661.75
D5810	$1,062.75
D5811	$1,142.75
D5820	$822.00
D5821	$872.25
D5850	$210.63
D5851	$210.63
D5862	BR
D5863	$2,326.00
D5864	$3,068.00
D5865	$2,326.00
D5866	$3,188.13
D5867	BR
D5875	BR
D5899	BR
D5911	$557.38
D5912	$557.38
D5913	$11,738.25
D5914	$11,738.25

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Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D5915	$15,884.75
D5916	$4,236.88
D5919	BR
D5922	BR
D5923	BR
D5924	BR
D5925	BR
D5926	BR
D5927	BR
D5928	BR
D5929	BR
D5931	$6,320.50
D5932	$11,820.38
D5933	BR
D5934	$10,773.63
D5935	$9,374.13
D5936	$10,528.88
D5937	$1,323.38
D5951	$1,720.50
D5952	$5,586.38
D5953	$10,609.38
D5954	$9,831.38
D5955	$9,093.38
D5958	BR
D5959	BR
D5960	BR
D5982	$892.38
D5983	$2,005.13
D5984	$2,005.13
D5985	$2,005.13
D5986	$200.38
D5987	$3,007.75

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Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D5988	$601.50
D5991	$230.50
D5992	BR
D5993	BR
D5994	$230.50
D5999	BR
D6010	$3,671.50
D6011	BR
D6012	$3,468.88
D6013	$3,671.50
D6040	$12,632.25
D6050	$9,424.13
D6051	BR
D6052	$1,555.88
D6055	$1,103.00
D6056	$762.00
D6057	$942.38
D6058	$2,113.25
D6059	$2,085.50
D6060	$1,971.00
D6061	$2,011.13
D6062	$2,003.00
D6063	$1,744.38
D6064	$1,824.75
D6065	$2,079.13
D6066	$2,025.13
D6067	$1,965.13
D6068	$2,095.38
D6069	$2,085.50
D6070	$1,971.00
D6071	$2,011.13
D6072	$2,035.13

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Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D6073	$1,858.88
D6074	$1,975.13
D6075	$2,079.13
D6076	$2,025.13
D6077	$1,965.13
D6080	$172.50
D6081	$88.25
D6085	$605.75
D6090	BR
D6091	$832.25
D6092	$162.38
D6093	$254.88
D6094	$1,654.25
D6095	BR
D6096	BR
D6100	BR
D6101	$595.38
D6102	$818.00
D6103	$681.63
D6104	$681.63
D6110	$2,741.13
D6111	$2,741.13
D6112	$2,741.13
D6113	$2,741.13
D6114	$4,800.13
D6115	$4,800.13
D6116	$3,681.38
D6117	$3,681.38
D6118	BR
D6119	BR
D6190	$371.00
D6194	$1,704.50

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Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D6199	BR
D6205	$942.63
D6210	$1,441.13
D6211	$1,350.25
D6212	$1,405.00
D6214	$1,450.00
D6240	$1,422.75
D6241	$1,314.00
D6242	$1,386.50
D6245	$1,468.13
D6250	$1,405.00
D6251	$1,296.00
D6252	$1,337.50
D6253	$605.38
D6545	$543.25
D6548	$597.50
D6549	$391.75
D6600	$1,078.00
D6601	$1,130.75
D6602	$1,152.13
D6603	$1,267.38
D6604	$1,129.13
D6605	$1,196.63
D6606	$1,111.00
D6607	$1,232.63
D6608	$1,171.88
D6609	$1,223.00
D6610	$1,242.75
D6611	$1,359.38
D6612	$1,236.00
D6613	$1,292.13
D6614	$1,209.63

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Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D6615	$1,257.50
D6624	$1,152.13
D6634	$1,209.63
D6710	$1,234.38
D6720	$1,440.25
D6721	$1,366.13
D6722	$1,390.75
D6740	$1,514.25
D6750	$1,474.75
D6751	$1,376.00
D6752	$1,409.00
D6780	$1,390.75
D6781	$1,390.75
D6782	$1,292.13
D6783	$1,431.88
D6790	$1,423.75
D6791	$1,349.50
D6792	$1,399.13
D6793	$584.38
D6794	$1,399.13
D6920	$355.75
D6930	$207.63
D6940	$470.50
D6950	$909.13
D6980	BR
D6985	$790.50
D6999	BR
D7111	$163.00
D7140	$216.63
D7210	$332.00
D7220	$416.00
D7230	$553.75

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D7240	$649.88
D7241	$816.50
D7250	$350.88
D7251	$688.00
D7260	$2,856.88
D7261	$1,190.13
D7270	$892.75
D7272	$1,190.13
D7280	$833.13
D7282	$416.63
D7283	$357.25
D7285	$1,666.63
D7286	$714.13
D7287	$285.63
D7288	$285.63
D7290	$714.13
D7291	BR
D7292	$1,142.63
D7293	$714.13
D7294	$595.25
D7295	BR
D7296	BR
D7297	BR
D7979	BR
D7310	$491.75
D7311	$430.50
D7320	$799.25
D7321	$676.13
D7340	$3,381.38
D7350	$9,837.13
D7410	$1,475.50
D7411	$2,336.38

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Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D7412	$2,582.13
D7413	$1,721.50
D7414	$2,582.13
D7415	$2,889.75
D7440	$2,336.38
D7441	$3,442.75
D7450	$1,475.50
D7451	$2,016.63
D7460	$1,475.50
D7461	$2,016.63
D7465	$799.25
D7471	$1,827.25
D7472	$2,171.75
D7473	$2,048.63
D7485	$1,827.25
D7490	$14,755.75
D7510	$528.63
D7511	$799.25
D7520	$2,518.50
D7521	$2,766.63
D7530	$907.38
D7540	$1,005.75
D7550	$627.38
D7560	$4,980.00
D7610	$8,053.88
D7620	$6,040.00
D7630	$10,471.63
D7640	$6,645.13
D7650	$5,033.88
D7660	$2,968.38
D7670	$2,316.75
D7671	$4,365.25

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D7680	$15,102.25
D7710	$9,466.00
D7720	$6,645.13
D7730	$13,693.25
D7740	$6,775.38
D7750	$8,617.25
D7760	$3,457.88
D7770	$4,684.88
D7771	$3,615.25
D7780	$20,136.63
D7810	$8,858.13
D7820	$1,451.13
D7830	$831.38
D7840	$12,075.13
D7850	$10,427.50
D7852	$11,940.00
D7854	$12,320.88
D7856	$8,742.50
D7858	$24,919.63
D7860	$10,621.63
D7865	$17,116.50
D7870	$565.63
D7871	$1,131.50
D7872	$6,037.38
D7873	$7,269.75
D7874	$10,427.50
D7875	$11,423.38
D7876	$12,316.00
D7877	$10,869.75
D7880	$1,357.63
D7881	$147.63
D7899	BR

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D7910	$806.50
D7911	$2,014.38
D7912	$3,625.00
D7920	$5,939.13
D7921	$548.63
D7940	BR
D7941	$15,124.38
D7943	$13,894.75
D7944	$12,382.25
D7945	$16,477.38
D7946	$20,412.25
D7947	$17,165.88
D7948	$22,281.13
D7949	$29,019.50
D7950	BR
D7951	BR
D7952	BR
D7953	$836.25
D7955	BR
D7960	$676.13
D7963	$1,106.50
D7970	$983.88
D7971	$368.88
D7972	$1,377.38
D7980	$1,549.50
D7981	BR
D7982	$3,664.25
D7983	$3,516.50
D7990	$3,024.88
D7991	$7,377.75
D7995	BR
D7996	BR

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D7997	$565.63
D7998	$2,459.50
D7999	BR
D8010	BR
D8020	BR
D8030	BR
D8040	BR
D8050	BR
D8060	BR
D8070	BR
D8080	BR
D8090	BR
D8210	BR
D8220	BR
D8660	$700.13
D8670	$525.09
D8680	$1,154.73
D8681	BR
D8690	$545.76
D8691	$512.95
D8692	$571.28
D8693	$528.75
D8694	BR
D8695	BR
D8999	BR
D9110	$166.25
D9120	$188.13
D9210	$84.25
D9211	$92.63
D9212	$144.88
D9215	$69.50
D9219	$165.25

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D9222	BR
D9223	$377.00
D9230	$139.38
D9239	BR
D9243	$319.13
D9248	$203.00
D9310	$242.38
D9311	$242.38
D9410	$277.25
D9420	$448.63
D9430	$151.94
D9440	$151.63
D9450	$76.00
D9610	BR
D9612	BR
D9630	BR
D9910	$91.00
D9911	$127.63
D9920	BR
D9930	BR
D9932	$223.88
D9933	$223.88
D9934	$223.88
D9935	$223.88
D9940	$754.13
D9941	$260.13
D9942	$312.13
D9943	$156.00
D9950	$494.25
D9951	$221.00
D9952	$1,040.25
D9970	$117.00

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D9971	$150.88
D9972	$520.00
D9973	$86.00
D9974	$455.25
D9975	$520.00
D9985	BR
D9986	BR
D9987	BR
D9991	$91.00
D9992	$91.00
D9993	$91.00
D9994	$124.88
D9995	BR
D9996	BR
D9999	BR

Exhibit #7

Evaluation and Management (E&M) Documentation Guidelines for Colorado Workers' Compensation Claims

Effective for Dates of Service on and after 1/1/2019

This E&M Guidelines for Colorado Workers' Compensation Claims is intended for the providers who manage injured workers' medical and non-medical care. Providers may also use the "1997 Documentation Guidelines for Evaluation and Management Services" as developed by Medicare. The Level of Service is determined by these three components:

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

OR Time (as per CPT© and Rule 18)

Documentation requirements for any billed office visit:

- Chief complaint and medical necessity.
- Patient specific and pertain directly to the current visit.
- Information copied directly from prior records without change is not considered current or counted.
- CPT© criteria for a consultation is required to bill a consultation code.

Table I – History (Hx) Component: All three elements in the table must be met and documented.

HISTORY ELEMENTS	Requirements for a Problem Focused (PF) Level	Requirements for an Extended Problem Focused (EPF) Level	Requirements for a Detailed (D) Level	Requirements for a Comprehensive (C) Level
A. History of Present Illness/Injury (HPI)	1-3 elements	1-3 elements	4+ elements (requires a detailed patient specific description of the patient's progress with the current TX plan, which **should include objective functional gains/losses, ADLs)**	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)**
B. Review of Systems (ROS)	Present	Present	Present	Present
C. Past Medical, Family and Social/Work History (PMFSH)	None	None	Pertinent 1-2 types of histories	Pertinent 3 or more types of histories

A. HPI Elements represents the injured worker relaying their condition to the physician and should include the following:

1. Location (where?)
2. Quality (sharp, dull?)
3. Severity (pain level 1-10 or pain diagram)
4. Duration (how long?)
5. Timing (how often, regularity of occurrence, only at night, etc.?)
6. Context (what ADLs or functions aggravates/relieves, accident described?)
7. Modifying factors (doing what, what makes it worse or better?)
8. Associated signs (nausea, numbness or tingling when?)

For the provider to achieve an *"extended" HPI* in an initial patient/injured workers visit it is necessary for the provider to discuss the causality of the patient/injured worker's work related injury(s) to the patient/injured worker's job duties.

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

B. Review of Systems (ROS): Review of systems should be qualitative versus quantitative, documenting what is pertinent to that patient for the date of service.

1. Constitutional symptoms (e.g., fever, weight loss)

2. Eyes

3. Ears, Nose, Mouth, Throat

4. Cardiovascular

5. Respiratory

6. Gastrointestinal

7. Genitourinary

8. Musculoskeletal

9. Integumentary (skin and/or breast)

10. Neurological

11. Psychiatric

12. Endocrine

13. Hematologic/Lymphatic

14. Allergic/Immunologic

C. PMFSH consists of a review of four areas (NOTE: Employers should **not** have access to any patient's or the family's genetic/hereditary diagnoses or testing information, etc.)

1. Past history – the patient's past experiences with illnesses, operations, injuries and treatments.

2. Family history – a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk and any family situations that can interfere with or support the injured worker's treatment plan and returning to work.

3. Occupational/Social History/Military – an age appropriate review of past and current work activities, occupational history, current work status, any work situations that support or interfere with return to work. For established visits specific updates of progress must be discussed.

4. Non-Occupational/Social History – Hobbies, current recreational physical activities and the patient's support relationships, etc. For established visits specific updates of progress must be discussed.

TABLE II: Examination Component: Each bullet is counted only when it is pertinent and related to the workers' compensation injury and the medical decision making process.

Physician's Examination Component	
Level of Examination Performed and Documented	**# of Bullets Required for each level**
Problem Focused	1-5 elements identified by a bullet as indicated in the guideline
Expanded Problem Focused	6 elements identified by a bullet as indicated in this guideline
Detailed	7-12 elements identified by a bullet as indicated in this guideline
Comprehensive	>13 elements identified by a bullet as indicated in this guideline

Examination Components:

Constitutional Measurement:

- Vital signs (may be measured and recorded by ancillary staff) – any of three (3) vital signs is counted as one bullet:

  1. sitting or standing blood pressure
  2. supine blood pressure
  3. pulse rate and regularity
  4. respiration
  5. temperature
  6. height
  7. weight or BMI

- One bullet for commenting on the general appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)

Musculoskeletal: Each of the six body areas with three (3) assessments is counted as one bullet.

1. head and or neck
2. spine or ribs and pelvis or all three
3. right upper extremity (shoulder, elbow, wrist, entire hand)
4. left upper extremity (shoulder, elbow, wrist, entire hand)
5. right lower extremity (hip, knee, ankle, entire foot)
6. left lower extremity (hip, knee, ankle, entire foot)

Assessment of a given body area includes:

- Inspection, percussion and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions
- Assessment of range of motion with notation of any pain (e.g., straight leg raise), crepitation or

contracture

- Assessment of stability with notation of any dislocation (luxation), subluxation or laxity
- Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (fasciculation, tardive dyskinesia)
- Inspection and/or palpation of digits and nails (e.g., clubbing, cyanosis, inflammatory conditions, petechia, ischemia, infections, nodes)

Gait and Station: assessment equals one bullet

Neck: One bullet for both examinations.

- Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) and
- Examination of thyroid (e.g., enlargement, tenderness, mass)

Neurological: One bullet for each neurological examination/assessment(s) per extremity.

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

Cardiovascular:

1. One bullet per extremity examination/assessment of peripheral vascular system by:
    a. Observation (e.g., swelling, varicosities)
    b. Palpation (e.g., pulses, temperature, edema, tenderness)
2. One bullet for palpation of heart (e.g., location, size, thrills)
3. One bullet for auscultation of heart with notation of abnormal sounds and murmurs
4. One bullet for examination of each one of the following:
    a. carotid arteries (e.g., pulse amplitude, bruits)
    b. abdominal aorta (e.g., size, bruits)
    c. femoral arteries (e.g., pulse amplitude, bruits)

Skin: One bullet for pertinent body part(s) inspection and/or palpation of skin and subcutaneous tissue (e.g., scars, rashes, lesions, café au lait spots, ulcers)

Respiratory: One bullet for each examination/assessment.

1. Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)
2. Percussion of chest (e.g., dullness, flatness, hyperresonance)
3. Palpation of chest (e.g., tactile fremitus)
4. Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)

Gastrointestinal: One bullet for each examination /assessment.

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

2. Examination of presence or absence of hernia

3. Examination (when indicated) of anus, perineum and rectum, including sphincter tone, present of hemorrhoids, rectal masses and/or obtain stool sample of occult blood test when indicated

Psychiatric:

1. One bullet for assessment of mood and affect (e.g., depression, anxiety, agitation) if not counted under the Neurological system

2. One bullet for a mental status examination which includes:

a. Attention span and concentration; and

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

c. Recent and remote memory; and

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

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

1. Inspection of conjunctivae and lids; and

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

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

Ears and Nose, Mouth and Throat:

One bullet for all of the following examination/assessment:

1. External inspection of ears and nose (e.g., overall appearance, scars, lesions, asses)

2. Otoscopic examination of external auditory canals and tympanic membranes

3. Assessment of hearing with tuning fork and clinical speech reception thresholds (e.g., whispered voice, finger rub, tuning fork)

One bullet for all of the following examinations/assessments:

1. Inspection of nasal mucosa, septum and turbinates

2. Inspection of lips, teeth and gums

3. Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx (e.g., asymmetry, lesions, hydration of mucosal surfaces)

Genitourinary MALE: One bullet for each of the following examination of the male genitalia:

1. The scrotal contents (e.g., hydrocele, spermatocele, tenderness of cord, testicular mass)

2. Epididymides (e.g., size, symmetry, masses)

3. Testes (e.g., size symmetry, masses)

4. Urethral meatus (e.g., size location, lesions, discharge)

5. Examination of the penis (e.g., lesions, presence of absence of foreskin, foreskin retract ability, plaque, masses, scarring, deformities)

6. Digital rectal examination of prostate gland (e.g., size, symmetry, nodularity, tenderness)

7. Inspection of anus and perineum

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

1. Examination of external genitalia (e.g., general appearance, hair distribution, lesions) and vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele rectocele)
2. Examination of urethra (e.g., masses, tenderness, scarring)
3. Examination of bladder (e.g., fullness, masses, tenderness)
4. Cervix (e.g., general appearance, lesions, discharge)
5. Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent or support)
6. Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity)

Chest: One bullet for both examinations/assessments of both breasts.

1. Inspection of breasts (e.g., symmetry, nipple discharge); and
2. Palpation of breasts and axillae (e.g., masses or lumps, tenderness)

Lymphatic palpation of lymph nodes: Two or more areas is counted as one bullet.

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

Verify all of the completed examination components listed in the report documents the relevance/relatedness to the injury and or "reasonable and necessity" for that specified patient's condition. Any examination bullet that is not clearly related to the injury or a patient's specific condition will not be counted/considered in the total number of bullets for the level of service.

TABLE III: Medical Decision Making Component (MDM): TABLES A, B, AND C

Overall MDM is determined by the highest 2 out of 3 categories below:

Table III.

Medical Decision Making (MDM) Component			
Type of Decision Making	**A. # of Points for the # of Diagnosis and Management Options**	**B. # of Points for Amount and Complexity of Data**	**C. Level of Risk**
Straightforward	0-1	0-1	Minimal
Low	2	2	Low
Moderate	3	3	Moderate
High	4+	4+	High

TABLE III A:

A. Number of Diagnosis & Management Options					
Category of Problem(s)	**Occurrence of Problem(s)**		**Value**		**Total**
Self-limited or minor problem	(max 2)	X	1		
Established problem, stable or improved		X	1		
Established problem, minor worsening		X	2		
New problem with no additional workup planned or established patient with worsening of condition and no additional workup planned	(max 1)	X	3		
New problem, additional workup planned or established patient with less than anticipated improvement or worsening of condition and additional workup planned		X	4		

TABLE III B:

B. Amount and/or Complexity of Data Reviewed	
Date Type:	Points
Lab(s) ordered and/or reports reviewed	1
X-ray (s) ordered and/or reports reviewed	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than the patient	1
Medicine section (90701-99199) ordered and /or physical therapy records reviewed and commented on progress 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	

TABLE III C:

C. Table of Risk (the highest one in any category determines the overall risk for this portion.)			
Level of Risk	**Presenting Problem(s)**	**Diagnostic Procedure(s) Ordered**	**Management Option(s) Section**
Minimal	One self-limiting or minor problem, e.g., cold, insect bite, tinea corporis, minor non-sutured laceration.	Lab tests requiring venipuncture; Chest X-rays; EKG, EEG; Urinalysis; Ultrasound; KOH prep	Rest; Gargles; Elastic bandages; Superficial dressings
Low	Two or more self-limited or minor problems; One stable chronic illness, e.g., well controlled HTN, DM2, cataract, BPH; Acute, uncomplicated illness or injury, e.g., allergic rhinitis, sprain.	Physiologic tests not under stress, e.g., PFTs; Non-cardiovascular imaging studies with contrast, e.g., barium enema; Superficial needle biopsy; ABG; Skin biopsies	Over the counter drugs; Minor surgery with no identified risk factors; PT/OT; IV fluids w/o additives; Simple or layered closure; Vaccine injection
Moderate	One or more chronic illness with mild exacerbation, progression or side effects of treatment; Two or more stable chronic illnesses; Undiagnosed new problem with uncertain prognosis, e.g., new extremity neurologic complaints; Acute illness with systemic symptoms, e.g., pyelonephritis colitis; Acute complicated injury, e.g., head injury, with brief loss of consciousness.	Physiologic tests under stress, e.g., cardiac stress test; Discography; Diagnostic injections; Deep needle, or incisional biopsies; Cardiovascular imaging studies, with contrast, and no identified risk factors, e.g., arteriogram, cardiac catheterization; Obtain fluid from body cavity, e.g., LP/thoracentesis.	Minor surgery, with identified risk factors; Elective major surgery (open, percutaneous, or endoscopic), with no identified risk factors; Prescription drug management; Therapeutic nuclear medicine; IV fluids, with additives; Closed treatment of fracture or dislocation, without manipulation; Inability to return the injured worker to work and requires detailed functional improvement plan.

High	One or more chronic illness, with severe exacerbation, progression or side effects of treatment; Acute or chronic illness or injury, which poses a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolism, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness, with potential threat to self or others; An abrupt change in neurological status, e.g., seizure, TIA, weakness, sensory loss.	Cardiovascular imaging studies with contrast, with identified risk factors; Cardiac EP studies; Diagnostic endoscopies, with identified risk factors.	Elective major surgery (open, percutaneous, endoscopic), with identified risk factors; Emergency major surgery; Parenteral controlled substances; Decision not to resuscitate, or to de- escalate care because of poor prognosis; Potential for permanent work restrictions or total disability which would significantly restrict employment opportunities; Management of addiction behavior or other significant psychiatric condition; Treatment plan for patients with symptoms causing severe functional deficits without supporting physiological findings or verified related medical diagnosis.

Time Component:

- If greater than 50% of a physician's time at an E&M visit is spent either face-to-face with the patient counseling and/or coordination of care, with or without an interpreter, and there is detailed patient specific documentation of the counseling and/or coordination of care, then time can determine the level of service.
- If time is used to establish the level of visit and total amount of time falls in between two levels, then the provider's time shall be more than half way to reaching the higher level.

A. Counseling: Primary care physicians should have *shared decision making conferences* with their patients to *establish viable functional goals* prior to making referrals for diagnostic testing and/or to specialists. Shared decision making occurs when the physician shares with the patient all the treatment alternatives reflected in the Colorado Medical Treatment Guidelines as well as any possible side effects or limitations, and the patient shares with the primary physician their desired outcome from the treatment. Patients should be encouraged to express their goals, outcome expectations and desires from treatment as well as any personal habits or traits that may be impacted by procedures or their possible side effects.

1. The physician's time spent face-to-face with the patient and/or their family counseling him/her or them in one or more of the following:

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

B. Coordination of Care: Coordination of care requires the physician to either call another health care provider (outside of their own clinic) regarding the patient's diagnosis and/or treatment or the physician telephones or visits the employer in person to safely return the patient to work.

Table V: New Patient/Office Consultations Level of Service: CPT consultation criteria must be met before a consultation can be billed for any level of service.

New Patient/ Level of Service (requires all three key components at the same level or higher)	**History**	**Examination**	**Medical Decision Making (MDM)**	**Average Time** (minutes) as listed for the specific CPT© code
99201/99241	Problem Focused (PF)	PF	Straight Forward (SF)	10
99202/99242	Extended PF	EPF	SF	20
99203/99243	Detailed (D)	D	Low	30
99204/99244	Comprehensive (C)	C	Moderate	45
99205/99245	Comprehensive (C)	C	High	60

Table VI: Established Patient Office Visit Level of Service

Established Patient/ Level of Service (Requires at least **two of the three key** components at the same level or higher and one of the two must be MDM)	**History**	**Examination**	**Medical Decision Making (MDM)**	**Average Time** (minutes) as listed for the specific CPT© code
99211	N/A	N/A	N/A	5
99212	Problem Focused (PF)	PF	SF	10
99213	Extended PF	EPF	Low	15
99214	Detailed (D)	D	Moderate	25
99215	Comprehensive (C)	C	High	40

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
36415		$5.10	Routine venipuncture
36416		$5.10	Capillary blood collection
78267		$18.80	Breath tst attain/anal c-14
78268		$160.50	Breath test analysis c-14
80047		$23.34	Metabolic panel ionized ca
80047	QW	$23.34	Metabolic panel ionized ca
80048		$17.75	Metabolic panel total ca
80048	QW	$17.75	Metabolic panel total ca
80050		$49.30	General Health Panel (80053+85004+85027)
80051		$14.72	Electrolyte panel
80051	QW	$14.72	Electrolyte panel
80053		$22.17	Comprehen metabolic panel
80053	QW	$22.17	Comprehen metabolic panel
80055		$100.33	Obstetric panel
80061		$28.10	Lipid panel
80061	QW	$28.10	Lipid panel
80069		$18.22	Renal function panel
80069	QW	$18.22	Renal function panel
80074		$99.98	Acute hepatitis panel
80076		$17.15	Hepatic function panel
80081		$157.11	Obstetric panel
80150		$31.64	Assay of amikacin
80155		$65.57	Drug assay caffeine
80156		$30.57	Assay carbamazepine total
80157		$27.81	Assay carbamazepine free
80158		$37.88	Drug assay cyclosporine
80159		$38.81	Drug assay clozapine
80162		$27.86	Assay of digoxin total
80163		$27.86	Assay of digoxin free
80164		$28.42	Assay dipropylacetic acd tot
80165		$28.42	Dipropylacetic acid free
80168		$34.29	Assay of ethosuximide
80169		$28.83	Drug assay everolimus

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
80170		$34.37	Assay of gentamicin
80171		$36.84	Drug screen quant gabapentin
80173		$30.57	Assay of haloperidol
80175		$27.81	Drug screen quan lamotrigine
80176		$30.84	Assay of lidocaine
80177		$27.81	Drug scrn quan levetiracetam
80178		$13.87	Assay of lithium
80178	QW	$13.87	Assay of lithium
80180		$37.88	Drug scrn quan mycophenolate
80183		$27.81	Drug scrn quant oxcarbazepin
80184		$26.01	Assay of phenobarbital
80185		$27.81	Assay of phenytoin total
80186		$28.88	Assay of phenytoin free
80188		$34.82	Assay of primidone
80190		$102.00	Assay of procainamide
80192		$35.16	Assay of procainamide
80194		$30.65	Assay of quinidine
80195		$28.83	Assay of sirolimus
80197		$28.83	Assay of tacrolimus
80198		$29.68	Assay of theophylline
80199		$46.09	Drug screen quant tiagabine
80200		$33.85	Assay of tobramycin
80201		$25.02	Assay of topiramate
80202		$28.42	Assay of vancomycin
80203		$27.81	Drug screen quant zonisamide
80299		$31.69	Quantitative assay drug
80305		$22.88	Drug test prsmv dir opt obs
80305	QW	$22.88	Drug test prsmv dir opt obs
80306		$30.53	Drug test prsmv instrmnt
80307		$122.11	Drug test prsmv chem anlyzr
80400		$68.46	Acth stimulation panel
80402		$182.50	Acth stimulation panel
80406		$164.25	Acth stimulation panel

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
80408		$263.40	Aldosterone suppression eval
80410		$56.24	Calcitonin stimul panel
80412		$1,362.75	Crh stimulation panel
80414		$108.38	Testosterone response
80415		$117.28	Estradiol response panel
80416		$355.84	Renin stimulation panel
80417		$92.33	Renin stimulation panel
80418		$1,216.23	Pituitary evaluation panel
80420		$275.20	Dexamethasone panel
80422		$96.70	Glucagon tolerance panel
80424		$105.98	Glucagon tolerance panel
80426		$311.47	Gonadotropin hormone panel
80428		$140.00	Growth hormone panel
80430		$219.86	Growth hormone panel
80432		$283.54	Insulin suppression panel
80434		$484.55	Insulin tolerance panel
80435		$216.21	Insulin tolerance panel
80436		$191.34	Metyrapone panel
80438		$105.81	Trh stimulation panel
80439		$141.07	Trh stimulation panel
81000		$6.83	Urinalysis nonauto w/scope
81001		$6.66	Urinalysis auto w/scope
81002		$5.92	Urinalysis nonauto w/o scope
81003		$4.71	Urinalysis auto w/o scope
81003	QW	$4.71	Urinalysis auto w/o scope
81005		$4.54	Urinalysis
81007		$50.97	Urine screen for bacteria
81007	QW	$50.97	Urine screen for bacteria
81015		$6.39	Microscopic exam of urine
81020		$7.99	Urinalysis glass test
81025		$14.64	Urine pregnancy test
81050		$6.31	Urinalysis volume measure
81105		$256.51	Hpa-1 genotyping

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
81106		$256.51	Hpa-2 genotyping
81107		$256.51	Hpa-3 genotyping
81108		$256.51	Hpa-4 genotyping
81109		$256.51	Hpa-5 genotyping
81110		$256.51	Hpa-6 genotyping
81111		$256.51	Hpa-9 genotyping
81112		$256.51	Hpa-15 genotyping
81120		$328.53	Idh1 common variants
81121		$502.84	Idh2 common variants
81161		$474.30	Dmd dup/delet analysis
81162		$3,829.98	Brca1&2 seq & full dup/del
81170		$510.00	Abl1 gene
81175		$1,201.93	Asxl1 full gene sequence
81176		$507.69	Asxl1 gene target seq alys
81200		$80.33	Aspa gene
81201		$1,326.00	Apc gene full sequence
81202		$476.00	Apc gene known fam variants
81203		$340.00	Apc gene dup/delet variants
81205		$161.48	Bckdhb gene
81206		$344.11	Bcr/abl1 gene major bp
81207		$303.98	Bcr/abl1 gene minor bp
81208		$364.85	Bcr/abl1 gene other bp
81209		$66.83	Blm gene
81210		$298.18	Braf gene
81211		$4,072.93	Brca1&2 seq & com dup/del
81212		$748.00	Brca1&2 185&5385&6174 var
81213		$940.10	Brca1&2 uncom dup/del var
81214		$2,212.41	Brca1 full seq & com dup/del
81215		$637.93	Brca1 gene known fam variant
81216		$314.70	Brca2 gene full sequence
81217		$637.93	Brca2 gene known fam variant
81218		$507.69	Cebpa gene full sequence
81219		$255.27	Calr gene com variants

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
81220		$946.22	Cftr gene com variants
81221		$165.27	Cftr gene known fam variants
81222		$739.62	Cftr gene dup/delet variants
81223		$848.30	Cftr gene full sequence
81224		$286.88	Cftr gene intron poly t
81225		$495.31	Cyp2c19 gene com variants
81226		$766.55	Cyp2d6 gene com variants
81227		$297.18	Cyp2c9 gene com variants
81228		$1,530.00	Cytogen micrarray copy nmbr
81229		$1,972.00	Cytogen m array copy no&snp
81230		$297.18	Cyp3a4 gene common variants
81231		$297.18	Cyp3a5 gene common variants
81232		$297.18	Dpyd gene common variants
81235		$551.79	Egfr gene com variants
81238		$1,020.00	F9 full gene sequence
81240		$111.67	F2 gene
81241		$128.25	F5 gene
81242		$62.25	Fancc gene
81243		$96.97	Fmr1 gene detection
81244		$76.31	Fmr1 gene characterization
81245		$281.37	Flt3 gene
81246		$141.10	Flt3 gene analysis
81247		$297.18	G6pd gene alys cmn variant
81248		$637.93	G6pd known familial variant
81249		$1,020.00	G6pd full gene sequence
81250		$99.43	G6pc gene
81251		$80.33	Gba gene
81252		$171.90	Gjb2 gene full sequence
81253		$104.58	Gjb2 gene known fam variants
81254		$59.50	Gjb6 gene com variants
81255		$87.47	Hexa gene
81256		$137.17	Hfe gene
81257		$173.84	Hba1/hba2 gene

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
81258		$637.93	Hba1/hba2 gene fam vrnt
81259		$1,020.00	Hba1/hba2 full gene sequence
81260		$66.83	Ikbkap gene
81261		$415.53	Igh gene rearrange amp meth
81262		$116.54	Igh gene rearrang dir probe
81263		$618.12	Igh vari regional mutation
81264		$313.40	Igk rearrangeabn clonal pop
81265		$451.33	Str markers specimen anal
81266		$518.18	Str markers spec anal addl
81267		$435.40	Chimerism anal no cell selec
81268		$547.33	Chimerism anal w/cell select
81269		$344.08	Hba1/hba2 gene dup/del vrnts
81270		$192.39	Jak2 gene
81272		$560.17	Kit gene targeted seq analys
81273		$212.28	Kit gene analys d816 variant
81275		$328.53	Kras gene variants exon 2
81276		$328.53	Kras gene addl variants
81280		$707.34	Long qt synd gene full seq
81281		$484.50	Long qt synd known fam var
81282		$2,125.00	Long qt syn gene dup/dlt var
81283		$128.25	Ifnl3 gene
81287		$211.89	Mgmt gene methylation anal
81288		$326.94	Mlh1 gene
81290		$66.83	Mcoln1 gene
81291		$111.08	Mthfr gene
81292		$1,148.18	Mlh1 gene full seq
81293		$562.70	Mlh1 gene known variants
81294		$344.08	Mlh1 gene dup/delete variant
81295		$648.89	Msh2 gene full seq
81296		$574.14	Msh2 gene known variants
81297		$362.61	Msh2 gene dup/delete variant
81298		$1,091.15	Msh6 gene full seq
81299		$523.60	Msh6 gene known variants

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
81300		$404.60	Msh6 gene dup/delete variant
81301		$607.72	Microsatellite instability
81302		$897.38	Mecp2 gene full seq
81303		$204.00	Mecp2 gene known variant
81304		$255.00	Mecp2 gene dup/delet variant
81310		$419.08	Npm1 gene
81311		$502.84	Nras gene variants exon 2&3
81313		$433.59	Pca3/klk3 antigen
81314		$560.17	Pdgfra gene
81315		$435.10	Pml/raralpha com breakpoints
81316		$435.10	Pml/raralpha 1 breakpoint
81317		$1,201.93	Pms2 gene full seq analysis
81318		$562.70	Pms2 known familial variants
81319		$345.95	Pms2 gene dup/delet variants
81321		$1,020.00	Pten gene full sequence
81322		$89.85	Pten gene known fam variant
81323		$510.00	Pten gene dup/delet variant
81324		$1,289.21	Pmp22 gene dup/delet
81325		$1,308.29	Pmp22 gene full sequence
81326		$89.85	Pmp22 gene known fam variant
81327		$ -	Sept9 methylation analysis
81328		$297.18	Slco1b1 gene com variants
81330		$79.90	Smpd1 gene common variants
81331		$86.82	Snrpn/ube3a gene
81332		$91.61	Serpina1 gene
81334		$560.17	Runx1 gene targeted seq alys
81335		$297.18	Tpmt gene com variants
81340		$438.46	Trb@ gene rearrange amplify
81341		$104.07	Trb@ gene rearrange dirprobe
81342		$422.89	Trg gene rearrangement anal
81346		$297.18	Tyms gene com variants
81350		$397.80	Ugt1a1 gene
81355		$149.94	Vkorc1 gene

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
81361		$297.18	Hbb gene com variants
81362		$637.93	Hbb gene known fam variant
81363		$344.08	Hbb gene dup/del variants
81364		$551.79	Hbb full gene sequence
81370		$843.97	Hla i & ii typing lr
81371		$687.68	Hla i & ii type verify lr
81372		$686.10	Hla i typing complete lr
81373		$233.72	Hla i typing 1 locus lr
81374		$152.68	Hla i typing 1 antigen lr
81375		$463.28	Hla ii typing ag equiv lr
81376		$256.51	Hla ii typing 1 locus lr
81377		$192.70	Hla ii type 1 ag equiv lr
81378		$725.27	Hla i & ii typing hr
81379		$703.89	Hla i typing complete hr
81380		$372.01	Hla i typing 1 locus hr
81381		$288.83	Hla i typing 1 allele hr
81382		$259.57	Hla ii typing 1 loc hr
81383		$229.04	Hla ii typing 1 allele hr
81400		$108.73	Mopath procedure level 1
81401		$232.90	Mopath procedure level 2
81402		$255.56	Mopath procedure level 3
81403		$314.84	Mopath procedure level 4
81404		$467.21	Mopath procedure level 5
81405		$512.30	Mopath procedure level 6
81406		$480.90	Mopath procedure level 7
81407		$1,438.66	Mopath procedure level 8
81408		$3,400.00	Mopath procedure level 9
81410		$856.80	Aortic dysfunction/dilation
81411		$2,295.32	Aortic dysfunction/dilation
81412		$4,162.55	Ashkenazi jewish assoc dis
81413		$1,227.57	Car ion chnnlpath inc 10 gns
81414		$1,227.57	Car ion chnnlpath inc 2 gns
81415		$8,126.00	Exome sequence analysis

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
81416		$20,400.00	Exome sequence analysis
81417		$544.00	Exome re-evaluation
81420		$1,290.39	Fetal chrmoml aneuploidy
81422		$1,290.39	Fetal chrmoml microdeltj
81425		$ -	Genome sequence analysis
81426		$ -	Genome sequence analysis
81427		$ -	Genome re-evaluation
81430		$2,762.50	Hearing loss sequence analys
81431		$1,155.27	Hearing loss dup/del analys
81432		$1,425.16	Hrdtry brst ca-rlatd dsordrs
81433		$921.21	Hrdtry brst ca-rlatd dsordrs
81434		$1,016.45	Hereditary retinal disorders
81435		$1,227.57	Hereditary colon ca dsordrs
81436		$1,227.57	Hereditary colon ca dsordrs
81437		$921.21	Heredtry nurondcrn tum dsrdr
81438		$921.21	Heredtry nurondcrn tum dsrdr
81439		$1,227.57	Hrdtry cardmypy gene panel
81440		$5,650.80	Mitochondrial gene
81442		$3,644.12	Noonan spectrum disorders
81445		$1,016.45	Targeted genomic seq analys
81448		$1,227.57	Hrdtry perph neurphy panel
81450		$1,291.20	Targeted genomic seq analys
81455		$4,963.32	Targeted genomic seq analys
81460		$2,187.90	Whole mitochondrial genome
81465		$1,591.20	Whole mitochondrial genome
81470		$ -	X-linked intellectual dblt
81471		$ -	X-linked intellectual dblt
81490		$1,429.11	Autoimmune rheumatoid arthr
81493		$1,785.00	Cor artery disease mrna
81500		$442.85	Onco (ovar) two proteins
81503		$1,524.90	Onco (ovar) five proteins
81504		$884.00	Oncology tissue of origin
81506		$137.75	Endo assay seven anal

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
81507		$1,351.50	Fetal aneuploidy trisom risk
81508		$92.31	Ftl cgen abnor two proteins
81509		$2,528.53	Ftl cgen abnor 3 proteins
81510		$94.42	Ftl cgen abnor three anal
81511		$260.95	Ftl cgen abnor four anal
81512		$118.18	Ftl cgen abnor five anal
81519		$6,584.10	Oncology breast mrna
81520		$5,268.33	Onc breast mrna 58 genes
81521		$6,584.10	Onc breast mrna 70 genes
81525		$5,297.20	Oncology colon mrna
81528		$865.08	Oncology colorectal scr
81535		$985.08	Oncology gynecologic
81536		$301.85	Oncology gynecologic
81538		$4,880.70	Oncology lung
81539		$1,292.00	Oncology prostate prob score
81540		$6,375.00	Oncology tum unknown origin
81541		$6,584.10	Onc prostate mrna 46 genes
81545		$6,120.00	Oncology thyroid
81551		$ -	Onc prostate 3 genes
81595		$5,508.00	Cardiology hrt trnspl mrna
82009		$9.49	Test for acetone/ketones
82010		$17.15	Acetone assay
82010	QW	$17.15	Acetone assay
82013		$23.44	Acetylcholinesterase assay
82016		$29.12	Acylcarnitines qual
82017		$35.41	Acylcarnitines quant
82024		$81.06	Assay of acth
82030		$54.15	Assay of adp & amp
82040		$10.39	Assay of serum albumin
82040	QW	$10.39	Assay of serum albumin
82042		$13.23	Other source albumin quan ea
82042	QW	$13.23	Other source albumin quan ea
82043		$12.14	Ur albumin quantitative

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
82043	QW	$12.14	Ur albumin quantitative
82044		$10.59	Ur albumin semiquantitative
82044	QW	$10.59	Ur albumin semiquantitative
82045		$71.23	Albumin ischemia modified
82075		$51.00	Assay of breath ethanol
82085		$20.38	Assay of aldolase
82088		$85.53	Assay of aldosterone
82103		$28.20	Alpha-1-antitrypsin total
82104		$30.36	Alpha-1-antitrypsin pheno
82105		$35.21	Alpha-fetoprotein serum
82106		$35.21	Alpha-fetoprotein amniotic
82107		$135.18	Alpha-fetoprotein l3
82108		$53.48	Assay of aluminum
82120		$10.18	Amines vaginal fluid qual
82120	QW	$10.18	Amines vaginal fluid qual
82127		$29.12	Amino acid single qual
82128		$29.12	Amino acids mult qual
82131		$39.07	Amino acids single quant
82135		$34.53	Assay aminolevulinic acid
82136		$35.41	Amino acids quant 2-5
82139		$35.41	Amino acids quan 6 or more
82140		$30.58	Assay of ammonia
82143		$15.90	Amniotic fluid scan
82150		$13.60	Assay of amylase
82150	QW	$13.60	Assay of amylase
82154		$60.52	Androstanediol glucuronide
82157		$61.44	Assay of androstenedione
82160		$52.48	Assay of androsterone
82163		$43.08	Assay of angiotensin ii
82164		$30.65	Angiotensin i enzyme test
82172		$35.85	Assay of apolipoprotein
82175		$39.81	Assay of arsenic
82180		$20.74	Assay of ascorbic acid

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
82190		$31.30	Atomic absorption
82232		$33.95	Assay of beta-2 protein
82239		$35.94	Bile acids total
82240		$55.78	Bile acids cholylglycine
82247		$10.52	Bilirubin total
82247	QW	$10.52	Bilirubin total
82248		$10.52	Bilirubin direct
82252		$9.57	Fecal bilirubin test
82261		$35.41	Assay of biotinidase
82270		$7.45	Occult blood feces
82271		$9.04	Occult blood other sources
82271	QW	$9.04	Occult blood other sources
82272		$7.19	Occult bld feces 1-3 tests
82274		$33.39	Assay test for blood fecal
82274	QW	$33.39	Assay test for blood fecal
82286		$10.83	Assay of bradykinin
82300		$48.59	Assay of cadmium
82306		$62.14	Vitamin d 25 hydroxy
82308		$56.24	Assay of calcitonin
82310		$10.83	Assay of calcium
82310	QW	$10.83	Assay of calcium
82330		$28.70	Assay of calcium
82330	QW	$28.70	Assay of calcium
82331		$22.68	Calcium infusion test
82340		$12.65	Assay of calcium in urine
82355		$24.29	Calculus analysis qual
82360		$27.01	Calculus assay quant
82365		$27.06	Calculus spectroscopy
82370		$26.28	X-ray assay calculus
82373		$37.89	Assay c-d transfer measure
82374		$10.25	Assay blood carbon dioxide
82374	QW	$10.25	Assay blood carbon dioxide
82375		$25.86	Assay carboxyhb quant

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
82376		$23.92	Assay carboxyhb qual
82378		$39.80	Carcinoembryonic antigen
82379		$35.41	Assay of carnitine
82380		$19.36	Assay of carotene
82382		$46.41	Assay urine catecholamines
82383		$52.58	Assay blood catecholamines
82384		$53.01	Assay three catecholamines
82387		$37.89	Assay of cathepsin-d
82390		$22.54	Assay of ceruloplasmin
82397		$29.63	Chemiluminescent assay
82415		$26.59	Assay of chloramphenicol
82435		$9.66	Assay of blood chloride
82435	QW	$9.66	Assay of blood chloride
82436		$10.56	Assay of urine chloride
82438		$10.25	Assay other fluid chlorides
82441		$12.61	Test for chlorohydrocarbons
82465		$9.13	Assay bld/serum cholesterol
82465	QW	$9.13	Assay bld/serum cholesterol
82480		$16.52	Assay serum cholinesterase
82482		$16.68	Assay rbc cholinesterase
82485		$43.35	Assay chondroitin sulfate
82495		$42.57	Assay of chromium
82507		$58.36	Assay of citrate
82523		$39.22	Collagen crosslinks
82523	QW	$39.22	Collagen crosslinks
82525		$26.04	Assay of copper
82528		$47.26	Assay of corticosterone
82530		$35.07	Cortisol free
82533		$34.20	Total cortisol
82540		$9.72	Assay of creatine
82542		$40.95	Col chromotography qual/quan
82550		$13.67	Assay of ck (cpk)
82550	QW	$13.67	Assay of ck (cpk)

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
82552		$28.10	Assay of cpk in blood
82553		$24.24	Creatine mb fraction
82554		$24.91	Creatine isoforms
82565		$10.76	Assay of creatinine
82565	QW	$10.76	Assay of creatinine
82570		$10.86	Assay of urine creatinine
82570	QW	$10.86	Assay of urine creatinine
82575		$19.84	Creatinine clearance test
82585		$24.04	Assay of cryofibrinogen
82595		$13.57	Assay of cryoglobulin
82600		$40.72	Assay of cyanide
82607		$31.64	Vitamin b-12
82608		$30.06	B-12 binding capacity
82610		$31.48	Cystatin c
82615		$17.14	Test for urine cystines
82626		$53.04	Dehydroepiandrosterone
82627		$46.67	Dehydroepiandrosterone
82633		$65.03	Desoxycorticosterone
82634		$61.44	Deoxycortisol
82638		$25.70	Assay of dibucaine number
82652		$80.80	Vit d 1 25-dihydroxy
82656		$24.21	Pancreatic elastase fecal
82657		$37.89	Enzyme cell activity
82658		$74.85	Enzyme cell activity ra
82664		$104.55	Electrophoretic test
82668		$39.44	Assay of erythropoietin
82670		$58.63	Assay of estradiol
82671		$67.80	Assay of estrogens
82672		$45.53	Assay of estrogen
82677		$50.75	Assay of estriol
82679		$52.38	Assay of estrone
82679	QW	$52.38	Assay of estrone
82693		$31.28	Assay of ethylene glycol

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
82696		$49.50	Assay of etiocholanolone
82705		$10.69	Fats/lipids feces qual
82710		$35.28	Fats/lipids feces quant
82715		$39.05	Assay of fecal fat
82725		$31.91	Assay of blood fatty acids
82726		$37.89	Long chain fatty acids
82728		$28.61	Assay of ferritin
82731		$135.18	Assay of fetal fibronectin
82735		$38.91	Assay of fluoride
82746		$30.86	Assay of folic acid serum
82747		$36.35	Assay of folic acid rbc
82757		$36.38	Assay of semen fructose
82759		$45.08	Assay of rbc galactokinase
82760		$23.49	Assay of galactose
82775		$44.22	Assay galactose transferase
82776		$19.96	Galactose transferase test
82777		$75.23	Galectin-3
82784		$19.52	Assay iga/igd/igg/igm each
82785		$34.54	Assay of ige
82787		$16.83	Igg 1 2 3 or 4 each
82800		$18.70	Blood ph
82803		$44.32	Blood gases any combination
82805		$133.91	Blood gases w/o2 saturation
82810		$18.31	Blood gases o2 sat only
82820		$22.68	Hemoglobin-oxygen affinity
82930		$11.42	Gastric analy w/ph ea spec
82938		$37.13	Gastrin test
82941		$37.01	Assay of gastrin
82943		$29.99	Assay of glucagon
82945		$8.25	Glucose other fluid
82946		$31.64	Glucagon tolerance test
82947		$8.25	Assay glucose blood quant
82947	QW	$8.25	Assay glucose blood quant

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
82948		$8.57	Reagent strip/blood glucose
82950		$9.96	Glucose test
82950	QW	$9.96	Glucose test
82951		$27.01	Glucose tolerance test (gtt)
82951	QW	$27.01	Glucose tolerance test (gtt)
82952		$8.23	Gtt-added samples
82952	QW	$8.23	Gtt-added samples
82955		$20.35	Assay of g6pd enzyme
82960		$12.70	Test for g6pd enzyme
82962		$5.58	Glucose blood test
82963		$45.08	Assay of glucosidase
82965		$22.36	Assay of gdh enzyme
82977		$15.11	Assay of ggt
82977	QW	$15.11	Assay of ggt
82978		$29.92	Assay of glutathione
82979		$19.82	Assay rbc glutathione
82985		$31.64	Assay of glycated protein
82985	QW	$31.64	Assay of glycated protein
83001		$39.00	Assay of gonadotropin (fsh)
83001	QW	$39.00	Assay of gonadotropin (fsh)
83002		$38.86	Assay of gonadotropin (lh)
83002	QW	$38.86	Assay of gonadotropin (lh)
83003		$34.99	Assay growth hormone (hgh)
83006		$128.52	Growth stimulation gene 2
83009		$141.37	H pylori (c-13) blood
83010		$26.40	Assay of haptoglobin quant
83012		$45.71	Assay of haptoglobins
83013		$141.37	H pylori (c-13) breath
83014		$16.49	H pylori drug admin
83015		$39.53	Heavy metal qual any anal
83018		$46.10	Heavy metal quant each nes
83020		$27.01	Hemoglobin electrophoresis
83021		$37.89	Hemoglobin chromotography

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
83026		$6.82	Hemoglobin copper sulfate
83030		$18.26	Fetal hemoglobin chemical
83033		$13.60	Fetal hemoglobin assay qual
83036		$20.38	Glycosylated hemoglobin test
83036	QW	$20.38	Glycosylated hemoglobin test
83037		$20.38	Glycosylated hb home device
83037	QW	$20.38	Glycosylated hb home device
83045		$11.03	Blood methemoglobin test
83050		$15.39	Blood methemoglobin assay
83051		$15.35	Assay of plasma hemoglobin
83060		$17.36	Blood sulfhemoglobin assay
83065		$15.30	Assay of hemoglobin heat
83068		$17.77	Hemoglobin stability screen
83069		$8.30	Assay of urine hemoglobin
83070		$9.96	Assay of hemosiderin qual
83080		$35.41	Assay of b hexosaminidase
83088		$61.98	Assay of histamine
83090		$35.41	Assay of homocystine
83150		$40.61	Assay of homovanillic acid
83491		$36.79	Assay of corticosteroids 17
83497		$27.06	Assay of 5-hiaa
83498		$57.02	Assay of progesterone 17-d
83500		$47.53	Assay free hydroxyproline
83505		$51.02	Assay total hydroxyproline
83516		$24.21	Immunoassay nonantibody
83516	QW	$24.21	Immunoassay nonantibody
83518		$17.80	Immunoassay dipstick
83518	QW	$17.80	Immunoassay dipstick
83519		$31.28	Ria nonantibody
83520		$29.36	Immunoassay quant nos nonab
83520	QW	$29.36	Immunoassay quant nos nonab
83525		$23.99	Assay of insulin
83527		$27.17	Assay of insulin

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
83528		$33.69	Assay of intrinsic factor
83540		$13.58	Assay of iron
83550		$18.34	Iron binding test
83570		$18.58	Assay of idh enzyme
83582		$29.75	Assay of ketogenic steroids
83586		$26.86	Assay 17- ketosteroids
83593		$55.20	Fractionation ketosteroids
83605		$22.42	Assay of lactic acid
83605	QW	$22.42	Assay of lactic acid
83615		$12.67	Lactate (ld) (ldh) enzyme
83625		$26.86	Assay of ldh enzymes
83630		$41.21	Lactoferrin fecal (qual)
83631		$41.21	Lactoferrin fecal (quant)
83632		$42.45	Placental lactogen
83633		$19.13	Test urine for lactose
83655		$25.42	Assay of lead
83655	QW	$25.42	Assay of lead
83661		$46.14	L/s ratio fetal lung
83662		$39.70	Foam stability fetal lung
83663		$39.70	Fluoro polarize fetal lung
83664		$39.70	Lamellar bdy fetal lung
83670		$19.23	Assay of lap enzyme
83690		$14.47	Assay of lipase
83695		$27.17	Assay of lipoprotein(a)
83698		$78.73	Assay lipoprotein pla2
83700		$23.63	Lipopro bld electrophoretic
83701		$57.56	Lipoprotein bld hr fraction
83704		$66.22	Lipoprotein bld quan part
83718		$17.20	Assay of lipoprotein
83718	QW	$17.20	Assay of lipoprotein
83719		$24.41	Assay of blood lipoprotein
83721		$20.03	Assay of blood lipoprotein
83721	QW	$20.03	Assay of blood lipoprotein

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
83727		$36.07	Assay of lrh hormone
83735		$14.06	Assay of magnesium
83775		$15.47	Assay malate dehydrogenase
83785		$51.63	Assay of manganese
83789		$40.99	Mass spectrometry qual/quan
83825		$34.12	Assay of mercury
83835		$35.56	Assay of metanephrines
83857		$22.54	Assay of methemalbumin
83861		$38.22	Microfluid analy tears
83861	QW	$38.22	Microfluid analy tears
83864		$48.45	Mucopolysaccharides
83872		$12.31	Assay synovial fluid mucin
83873		$36.11	Assay of csf protein
83874		$27.12	Assay of myoglobin
83876		$86.46	Assay myeloperoxidase
83880		$71.23	Assay of natriuretic peptide
83880	QW	$71.23	Assay of natriuretic peptide
83883		$28.54	Assay nephelometry not spec
83885		$51.44	Assay of nickel
83915		$23.41	Assay of nucleotidase
83916		$46.56	Oligoclonal bands
83918		$40.12	Organic acids total quant
83919		$34.53	Organic acids qual each
83921		$36.06	Organic acid single quant
83930		$13.87	Assay of blood osmolality
83935		$14.31	Assay of urine osmolality
83937		$62.65	Assay of osteocalcin
83945		$27.01	Assay of oxalate
83950		$135.18	Oncoprotein her-2/neu
83951		$135.18	Oncoprotein dcp
83970		$86.63	Assay of parathormone
83986		$7.51	Assay ph body fluid nos
83986	QW	$7.51	Assay ph body fluid nos

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
83987		$7.51	Exhaled breath condensate
83993		$41.21	Assay for calprotectin fecal
84030		$11.54	Assay of blood pku
84035		$7.68	Assay of phenylketones
84060		$15.50	Assay acid phosphatase
84066		$20.28	Assay prostate phosphatase
84075		$10.86	Assay alkaline phosphatase
84075	QW	$10.86	Assay alkaline phosphatase
84078		$15.32	Assay alkaline phosphatase
84080		$31.03	Assay alkaline phosphatases
84081		$34.66	Assay phosphatidylglycerol
84085		$19.82	Assay of rbc pg6d enzyme
84087		$21.66	Assay phosphohexose enzymes
84100		$9.95	Assay of phosphorus
84105		$10.86	Assay of urine phosphorus
84106		$9.89	Test for porphobilinogen
84110		$17.71	Assay of porphobilinogen
84112		$166.79	Eval amniotic fluid protein
84119		$22.71	Test urine for porphyrins
84120		$30.87	Assay of urine porphyrins
84126		$66.49	Assay of feces porphyrins
84132		$9.66	Assay of serum potassium
84132	QW	$9.66	Assay of serum potassium
84133		$9.04	Assay of urine potassium
84134		$30.62	Assay of prealbumin
84135		$40.17	Assay of pregnanediol
84138		$39.73	Assay of pregnanetriol
84140		$43.38	Assay of pregnenolone
84143		$47.87	Assay of 17-hydroxypregneno
84144		$43.79	Assay of progesterone
84145		$56.24	Procalcitonin (pct)
84146		$40.66	Assay of prolactin
84150		$71.01	Assay of prostaglandin

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
84152		$38.61	Assay of psa complexed
84153		$38.61	Assay of psa total
84154		$38.61	Assay of psa free
84155		$7.70	Assay of protein serum
84155	QW	$7.70	Assay of protein serum
84156		$7.70	Assay of protein urine
84157		$7.70	Assay of protein other
84157	QW	$7.70	Assay of protein other
84160		$10.86	Assay of protein any source
84163		$31.60	Pappa serum
84165		$22.54	Protein e-phoresis serum
84166		$37.42	Protein e-phoresis/urine/csf
84181		$35.73	Western blot test
84182		$49.66	Protein western blot test
84202		$30.11	Assay rbc protoporphyrin
84203		$18.07	Test rbc protoporphyrin
84206		$45.37	Assay of proinsulin
84207		$58.97	Assay of vitamin b-6
84210		$24.62	Assay of pyruvate
84220		$19.82	Assay of pyruvate kinase
84228		$24.41	Assay of quinine
84233		$149.40	Assay of estrogen
84234		$136.17	Assay of progesterone
84235		$121.09	Assay of endocrine hormone
84238		$76.74	Assay nonendocrine receptor
84244		$46.16	Assay of renin
84252		$42.47	Assay of vitamin b-2
84255		$53.58	Assay of selenium
84260		$65.03	Assay of serotonin
84270		$45.61	Assay of sex hormone globul
84275		$28.20	Assay of sialic acid
84285		$49.40	Assay of silica
84295		$10.10	Assay of serum sodium

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
84295	QW	$10.10	Assay of serum sodium
84300		$10.20	Assay of urine sodium
84302		$10.20	Assay of sweat sodium
84305		$44.63	Assay of somatomedin
84307		$38.35	Assay of somatostatin
84311		$14.67	Spectrophotometry
84315		$5.58	Body fluid specific gravity
84375		$66.30	Chromatogram assay sugars
84376		$11.54	Sugars single qual
84377		$11.54	Sugars multiple qual
84378		$24.19	Sugars single quant
84379		$24.19	Sugars multiple quant
84392		$9.96	Assay of urine sulfate
84402		$53.47	Assay of free testosterone
84403		$54.18	Assay of total testosterone
84410		$107.64	Testosterone bioavailable
84425		$44.56	Assay of vitamin b-1
84430		$24.41	Assay of thiocyanate
84431		$59.69	Thromboxane urine
84432		$33.71	Assay of thyroglobulin
84436		$14.42	Assay of total thyroxine
84437		$13.57	Assay of neonatal thyroxine
84439		$18.92	Assay of free thyroxine
84442		$31.03	Assay of thyroid activity
84443		$35.28	Assay thyroid stim hormone
84443	QW	$35.28	Assay thyroid stim hormone
84445		$106.73	Assay of tsi globulin
84446		$29.77	Assay of vitamin e
84449		$37.77	Assay of transcortin
84450		$10.86	Transferase (ast) (sgot)
84450	QW	$10.86	Transferase (ast) (sgot)
84460		$11.12	Alanine amino (alt) (sgpt)
84460	QW	$11.12	Alanine amino (alt) (sgpt)

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
84466		$26.79	Assay of transferrin
84478		$12.05	Assay of triglycerides
84478	QW	$12.05	Assay of triglycerides
84479		$13.57	Assay of thyroid (t3 or t4)
84480		$29.77	Assay triiodothyronine (t3)
84481		$35.56	Free assay (ft-3)
84482		$33.08	T3 reverse
84484		$21.20	Assay of troponin quant
84485		$15.11	Assay duodenal fluid trypsin
84488		$15.32	Test feces for trypsin
84490		$16.88	Assay of feces for trypsin
84510		$21.83	Assay of tyrosine
84512		$17.15	Assay of troponin qual
84520		$8.30	Assay of urea nitrogen
84520	QW	$8.30	Assay of urea nitrogen
84525		$8.72	Urea nitrogen semi-quant
84540		$9.96	Assay of urine/urea-n
84545		$13.87	Urea-n clearance test
84550		$9.49	Assay of blood/uric acid
84550	QW	$9.49	Assay of blood/uric acid
84560		$9.96	Assay of urine/uric acid
84577		$35.28	Assay of feces/urobilinogen
84578		$7.60	Test urine urobilinogen
84580		$17.14	Assay of urine urobilinogen
84583		$10.56	Assay of urine urobilinogen
84585		$32.52	Assay of urine vma
84586		$74.15	Assay of vip
84588		$71.23	Assay of vasopressin
84590		$24.36	Assay of vitamin a
84591		$29.00	Assay of nos vitamin
84597		$28.80	Assay of vitamin k
84600		$33.75	Assay of volatiles
84620		$24.87	Xylose tolerance test

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
84630		$23.90	Assay of zinc
84681		$43.69	Assay of c-peptide
84702		$31.60	Chorionic gonadotropin test
84703		$15.79	Chorionic gonadotropin assay
84703	QW	$15.79	Chorionic gonadotropin assay
84704		$31.60	Hcg free betachain test
84830		$21.59	Ovulation tests
85002		$9.47	Bleeding time test
85004		$13.57	Automated diff wbc count
85007		$7.21	Bl smear w/diff wbc count
85008		$7.21	Bl smear w/o diff wbc count
85009		$8.62	Manual diff wbc count b-coat
85013		$11.90	Spun microhematocrit
85014		$4.98	Hematocrit
85014	QW	$4.98	Hematocrit
85018		$4.98	Hemoglobin
85018	QW	$4.98	Hemoglobin
85025		$16.30	Complete cbc w/auto diff wbc
85025	QW	$16.30	Complete cbc w/auto diff wbc
85027		$13.57	Complete cbc automated
85032		$9.04	Manual cell count each
85041		$6.34	Automated rbc count
85044		$9.04	Manual reticulocyte count
85045		$8.38	Automated reticulocyte count
85046		$11.70	Reticyte/hgb concentrate
85048		$5.32	Automated leukocyte count
85049		$9.40	Automated platelet count
85055		$60.76	Reticulated platelet assay
85130		$24.96	Chromogenic substrate assay
85170		$27.71	Blood clot retraction
85175		$34.63	Blood clot lysis time
85210		$27.25	Clot factor ii prothrom spec
85220		$37.04	Blooc clot factor v test

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
85230		$37.57	Clot factor vii proconvertin
85240		$37.57	Clot factor viii ahg 1 stage
85244		$42.86	Clot factor viii reltd antgn
85245		$48.14	Clot factor viii vw ristoctn
85246		$48.14	Clot factor viii vw antigen
85247		$48.14	Clot factor viii multimetric
85250		$39.97	Clot factor ix ptc/chrstmas
85260		$37.57	Clot factor x stuart-power
85270		$37.57	Clot factor xi pta
85280		$40.61	Clot factor xii hageman
85290		$34.29	Clot factor xiii fibrin stab
85291		$18.67	Clot factor xiii fibrin scrn
85292		$39.73	Clot factor fletcher fact
85293		$39.73	Clot factor wght kininogen
85300		$24.87	Antithrombin iii activity
85301		$22.70	Antithrombin iii antigen
85302		$25.21	Clot inhibit prot c antigen
85303		$29.04	Clot inhibit prot c activity
85305		$24.36	Clot inhibit prot s total
85306		$32.16	Clot inhibit prot s free
85307		$32.16	Assay activated protein c
85335		$27.01	Factor inhibitor test
85337		$29.36	Thrombomodulin
85345		$9.04	Coagulation time lee & white
85347		$8.94	Coagulation time activated
85348		$7.82	Coagulation time otr method
85360		$17.65	Euglobulin lysis
85362		$14.47	Fibrin degradation products
85366		$136.78	Fibrinogen test
85370		$23.83	Fibrinogen test
85378		$16.52	Fibrin degrade semiquant
85379		$21.35	Fibrin degradation quant
85380		$21.35	Fibrin degradj d-dimer

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
85384		$17.83	Fibrinogen activity
85385		$24.58	Fibrinogen antigen
85390		$26.32	Fibrinolysins screen i&r
85397		$52.46	Clotting funct activity
85400		$16.17	Fibrinolytic plasmin
85410		$16.17	Fibrinolytic antiplasmin
85415		$36.07	Fibrinolytic plasminogen
85420		$13.70	Fibrinolytic plasminogen
85421		$21.37	Fibrinolytic plasminogen
85441		$8.81	Heinz bodies direct
85445		$14.31	Heinz bodies induced
85460		$16.24	Hemoglobin fetal
85461		$15.91	Hemoglobin fetal
85475		$18.62	Hemolysin acid
85520		$27.47	Heparin assay
85525		$24.85	Heparin neutralization
85530		$27.47	Heparin-protamine tolerance
85536		$13.57	Iron stain peripheral blood
85540		$18.05	Wbc alkaline phosphatase
85547		$18.05	Rbc mechanical fragility
85549		$39.36	Muramidase
85555		$14.03	Rbc osmotic fragility
85557		$28.03	Rbc osmotic fragility
85576		$45.08	Blood platelet aggregation
85576	QW	$45.08	Blood platelet aggregation
85597		$37.72	Phospholipid pltlt neutraliz
85598		$37.72	Hexagnal phosph pltlt neutrl
85610		$8.25	Prothrombin time
85610	QW	$8.25	Prothrombin time
85611		$8.28	Prothrombin test
85612		$29.73	Viper venom prothrombin time
85613		$20.11	Russell viper venom diluted
85635		$20.67	Reptilase test

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
85651		$7.45	Rbc sed rate nonautomated
85652		$5.66	Rbc sed rate automated
85660		$11.56	Rbc sickle cell test
85670		$12.10	Thrombin time plasma
85675		$14.37	Thrombin time titer
85705		$20.21	Thromboplastin inhibition
85730		$12.61	Thromboplastin time partial
85732		$13.57	Thromboplastin time partial
85810		$24.50	Blood viscosity examination
86000		$14.65	Agglutinins febrile antigen
86001		$13.29	Allergen specific igg
86003		$10.95	Allg spec ige crude xtrc ea
86005		$16.73	Allg spec ige multiallg scr
86008		$37.64	Allg spec ige recomb ea
86021		$31.60	Wbc antibody identification
86022		$38.56	Platelet antibodies
86023		$26.15	Immunoglobulin assay
86038		$25.36	Antinuclear antibodies
86039		$23.43	Antinuclear antibodies (ana)
86060		$15.32	Antistreptolysin o titer
86063		$12.10	Antistreptolysin o screen
86140		$10.86	C-reactive protein
86141		$27.17	C-reactive protein hs
86146		$53.41	Beta-2 glycoprotein antibody
86147		$53.41	Cardiolipin antibody ea ig
86148		$33.73	Anti-phospholipid antibody
86152		$515.68	Cell enumeration & id
86155		$33.56	Chemotaxis assay
86156		$14.06	Cold agglutinin screen
86157		$16.92	Cold agglutinin titer
86160		$25.18	Complement antigen
86161		$25.18	Complement/function activity
86162		$42.65	Complement total (ch50)

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
86171		$21.01	Complement fixation each
86200		$27.17	Ccp antibody
86215		$27.80	Deoxyribonuclease antibody
86225		$28.85	Dna antibody native
86226		$25.42	Dna antibody single strand
86235		$37.64	Nuclear antigen antibody
86255		$25.30	Fluorescent antibody screen
86256		$25.30	Fluorescent antibody titer
86277		$33.03	Growth hormone antibody
86280		$17.20	Hemagglutination inhibition
86294		$43.47	Immunoassay tumor qual
86294	QW	$43.47	Immunoassay tumor qual
86300		$43.69	Immunoassay tumor ca 15-3
86301		$43.69	Immunoassay tumor ca 19-9
86304		$43.69	Immunoassay tumor ca 125
86305		$43.69	Human epididymis protein 4
86308		$10.86	Heterophile antibody screen
86308	QW	$10.86	Heterophile antibody screen
86309		$13.57	Heterophile antibody titer
86310		$15.47	Heterophile antibody absrbj
86316		$43.69	Immunoassay tumor other
86317		$31.45	Immunoassay infectious agent
86318		$30.75	Immunoassay infectious agent
86318	QW	$30.75	Immunoassay infectious agent
86320		$50.86	Serum immunoelectrophoresis
86325		$46.94	Other immunoelectrophoresis
86327		$50.86	Immunoelectrophoresis assay
86329		$29.48	Immunodiffusion nes
86331		$25.14	Immunodiffusion ouchterlony
86332		$51.15	Immune complex assay
86334		$46.90	Immunofix e-phoresis serum
86335		$61.59	Immunfix e-phorsis/urine/csf
86336		$32.71	Inhibin a

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
86337		$44.93	Insulin antibodies
86340		$31.64	Intrinsic factor antibody
86341		$41.53	Islet cell antibody
86343		$26.15	Leukocyte histamine release
86344		$17.66	Leukocyte phagocytosis
86352		$285.14	Cell function assay w/stim
86353		$102.90	Lymphocyte transformation
86355		$79.19	B cells total count
86356		$56.20	Mononuclear cell antigen
86357		$79.19	Nk cells total count
86359		$79.19	T cells total count
86360		$98.62	T cell absolute count/ratio
86361		$56.20	T cell absolute count
86367		$132.23	Stem cells total count
86376		$30.53	Microsomal antibody each
86382		$35.50	Neutralization test viral
86384		$23.90	Nitroblue tetrazolium dye
86386		$37.03	Nuclear matrix protein 22
86386	QW	$37.03	Nuclear matrix protein 22
86403		$21.39	Particle agglut antbdy scrn
86406		$22.32	Particle agglut antbdy titr
86430		$11.90	Rheumatoid factor test qual
86431		$11.90	Rheumatoid factor quant
86480		$130.08	Tb test cell immun measure
86481		$170.00	Tb ag response t-cell susp
86590		$23.19	Streptokinase antibody
86592		$8.96	Syphilis test non-trep qual
86593		$9.25	Syphilis test non-trep quant
86602		$21.35	Antinomyces antibody
86603		$27.01	Adenovirus antibody
86606		$31.60	Aspergillus antibody
86609		$27.03	Bacterium antibody
86611		$21.35	Bartonella antibody

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
86612		$27.08	Blastomyces antibody
86615		$27.68	Bordetella antibody
86617		$32.52	Lyme disease antibody
86618		$35.73	Lyme disease antibody
86618	QW	$35.73	Lyme disease antibody
86619		$28.08	Borrelia antibody
86622		$18.75	Brucella antibody
86625		$27.54	Campylobacter antibody
86628		$25.19	Candida antibody
86631		$24.82	Chlamydia antibody
86632		$26.62	Chlamydia igm antibody
86635		$24.09	Coccidioides antibody
86638		$25.45	Q fever antibody
86641		$30.24	Cryptococcus antibody
86644		$30.21	Cmv antibody
86645		$35.36	Cmv antibody igm
86648		$31.91	Diphtheria antibody
86651		$27.68	Encephalitis californ antbdy
86652		$27.68	Encephaltis east eqne anbdy
86653		$27.68	Encephaltis st louis antbody
86654		$27.68	Encephaltis west eqne antbdy
86658		$27.34	Enterovirus antibody
86663		$27.54	Epstein-barr antibody
86664		$32.10	Epstein-barr nuclear antigen
86665		$38.08	Epstein-barr capsid vca
86666		$21.35	Ehrlichia antibody
86668		$24.07	Francisella tularensis
86671		$25.72	Fungus nes antibody
86674		$30.89	Giardia lamblia antibody
86677		$30.45	Helicobacter pylori antibody
86682		$27.30	Helminth antibody
86684		$33.25	Hemophilus influenza antibdy
86687		$17.61	Htlv-i antibody

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
86688		$29.39	Htlv-ii antibody
86689		$40.63	Htlv/hiv confirmj antibody
86692		$36.02	Hepatitis delta agent antbdy
86694		$30.21	Herpes simplex nes antbdy
86695		$27.68	Herpes simplex type 1 test
86696		$40.63	Herpes simplex type 2 test
86698		$26.23	Histoplasma antibody
86701		$18.65	Hiv-1antibody
86701	QW	$18.65	Hiv-1antibody
86702		$28.37	Hiv-2 antibody
86703		$28.76	Hiv-1/hiv-2 1 result antbdy
86704		$25.30	Hep b core antibody total
86705		$24.72	Hep b core antibody igm
86706		$22.54	Hep b surface antibody
86707		$24.28	Hepatitis be antibody
86708		$25.99	Hepatitis a antibody
86709		$23.63	Hepatitis a igm antibody
86710		$28.44	Influenza virus antibody
86711		$30.21	John cunningham antibody
86713		$32.11	Legionella antibody
86717		$25.70	Leishmania antibody
86720		$27.68	Leptospira antibody
86723		$27.68	Listeria monocytogenes
86727		$27.01	Lymph choriomeningitis ab
86732		$27.68	Mucormycosis antibody
86735		$27.39	Mumps antibody
86738		$27.78	Mycoplasma antibody
86741		$27.68	Neisseria meningitidis
86744		$27.68	Nocardia antibody
86747		$31.55	Parvovirus antibody
86750		$27.68	Malaria antibody
86753		$25.99	Protozoa antibody nos
86756		$27.05	Respiratory virus antibody

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
86757		$40.63	Rickettsia antibody
86759		$30.99	Rotavirus antibody
86762		$30.21	Rubella antibody
86765		$27.03	Rubeola antibody
86768		$27.68	Salmonella antibody
86771		$41.62	Shigella antibody
86774		$31.06	Tetanus antibody
86777		$30.21	Toxoplasma antibody
86778		$30.23	Toxoplasma antibody igm
86780		$27.78	Treponema pallidum
86780	QW	$27.78	Treponema pallidum
86784		$26.37	Trichinella antibody
86787		$27.03	Varicella-zoster antibody
86788		$35.36	West nile virus ab igm
86789		$30.21	West nile virus antibody
86790		$27.03	Virus antibody nos
86793		$27.68	Yersinia antibody
86794		$35.36	Zika virus igm antibody
86800		$33.39	Thyroglobulin antibody
86803		$29.94	Hepatitis c ab test
86803	QW	$29.94	Hepatitis c ab test
86804		$32.52	Hep c ab test confirm
86805		$322.17	Lymphocytotoxicity assay
86806		$99.88	Lymphocytotoxicity assay
86807		$133.71	Cytotoxic antibody screening
86808		$62.29	Cytotoxic antibody screening
86812		$54.16	Hla typing a b or c
86813		$121.72	Hla typing a b or c
86816		$58.46	Hla typing dr/dq
86817		$180.44	Hla typing dr/dq
86821		$76.74	Lymphocyte culture mixed
86825		$186.13	Hla x-math non-cytotoxic
86826		$62.10	Hla x-match noncytotoxc addl

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
86828		$109.12	Hla class i&ii antibody qual
86829		$109.12	Hla class i/ii antibody qual
86830		$169.46	Hla class i phenotype qual
86831		$145.25	Hla class ii phenotype qual
86832		$550.38	Hla class i high defin qual
86833		$553.86	Hla class ii high defin qual
86834		$750.43	Hla class i semiquant panel
86835		$677.82	Hla class ii semiquant panel
86850		$16.61	Rbc antibody screen
86880		$11.31	Coombs test direct
86885		$12.02	Coombs test indirect qual
86886		$10.86	Coombs test indirect titer
86900		$6.27	Blood typing serologic abo
86901		$6.27	Blood typing serologic rh(d)
86902		$10.80	Blood type antigen donor ea
86904		$27.78	Blood typing patient serum
86905		$8.04	Blood typing rbc antigens
86906		$16.27	Bld typing serologic rh phnt
86940		$17.22	Hemolysins/agglutinins auto
86941		$25.42	Hemolysins/agglutinins
87003		$35.34	Small animal inoculation
87015		$14.01	Specimen infect agnt concntj
87040		$21.66	Blood culture for bacteria
87045		$19.82	Feces culture aerobic bact
87046		$19.82	Stool cultr aerobic bact ea
87070		$18.09	Culture othr specimn aerobic
87071		$19.82	Culture aerobic quant other
87073		$19.82	Culture bacteria anaerobic
87075		$19.87	Cultr bacteria except blood
87076		$16.95	Culture anaerobe ident each
87077		$16.95	Culture aerobic identify
87077	QW	$16.95	Culture aerobic identify
87081		$13.91	Culture screen only

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
87084		$46.02	Culture of specimen by kit
87086		$16.93	Urine culture/colony count
87088		$16.98	Urine bacteria culture
87101		$16.17	Skin fungi culture
87102		$17.65	Fungus isolation culture
87103		$34.78	Blood fungus culture
87106		$21.66	Fungi identification yeast
87107		$21.66	Fungi identification mold
87109		$32.30	Mycoplasma
87110		$41.12	Chlamydia culture
87116		$22.68	Mycobacteria culture
87118		$24.84	Mycobacteric identification
87140		$11.70	Culture type immunofluoresc
87143		$26.28	Culture typing glc/hplc
87147		$10.86	Culture type immunologic
87149		$42.09	Dna/rna direct probe
87150		$73.66	Dna/rna amplified probe
87152		$13.16	Culture type pulse field gel
87153		$242.11	Dna/rna sequencing
87158		$13.16	Culture typing added method
87164		$22.54	Dark field examination
87166		$23.72	Dark field examination
87168		$8.96	Macroscopic exam arthropod
87169		$8.96	Macroscopic exam parasite
87172		$8.96	Pinworm exam
87176		$12.34	Tissue homogenization cultr
87177		$18.68	Ova and parasites smears
87181		$9.96	Microbe susceptible diffuse
87184		$14.47	Microbe susceptible disk
87185		$9.96	Microbe susceptible enzyme
87186		$18.14	Microbe susceptible mic
87187		$68.29	Microbe susceptible mlc
87188		$13.94	Microbe suscept macrobroth

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
87190		$12.43	Microbe suscept mycobacteri
87197		$31.54	Bactericidal level serum
87205		$8.96	Smear gram stain
87206		$11.31	Smear fluorescent/acid stai
87207		$12.58	Smear special stain
87209		$37.72	Smear complex stain
87210		$9.89	Smear wet mount saline/ink
87210	QW	$9.89	Smear wet mount saline/ink
87220		$8.96	Tissue exam for fungi
87230		$41.43	Assay toxin or antitoxin
87250		$41.06	Virus inoculate eggs/animal
87252		$54.71	Virus inoculation tissue
87253		$42.40	Virus inoculate tissue addl
87254		$41.06	Virus inoculation shell via
87255		$71.08	Genet virus isolate hsv
87260		$25.16	Adenovirus ag if
87265		$25.16	Pertussis ag if
87267		$25.16	Enterovirus antibody dfa
87269		$25.16	Giardia ag if
87270		$25.16	Chlamydia trachomatis ag if
87271		$25.16	Cytomegalovirus dfa
87272		$25.16	Cryptosporidium ag if
87273		$25.16	Herpes simplex 2 ag if
87274		$25.16	Herpes simplex 1 ag if
87275		$25.16	Influenza b ag if
87276		$27.32	Influenza a ag if
87278		$26.52	Legion pneumophilia ag if
87279		$27.93	Parainfluenza ag if
87280		$25.16	Respiratory syncytial ag if
87281		$25.16	Pneumocystis carinii ag if
87283		$103.36	Rubeola ag if
87285		$25.16	Treponema pallidum ag if
87290		$25.16	Varicella zoster ag if

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
87299		$27.37	Antibody detection nos if
87300		$25.16	Ag detection polyval if
87301		$25.16	Adenovirus ag ia
87305		$25.16	Aspergillus ag ia
87320		$25.50	Chylmd trach ag ia
87324		$25.16	Clostridium ag ia
87327		$25.16	Cryptococcus neoform ag ia
87328		$25.16	Cryptosporidium ag ia
87329		$25.16	Giardia ag ia
87332		$25.16	Cytomegalovirus ag ia
87335		$25.16	E coli 0157 ag ia
87336		$27.20	Entamoeb hist dispr ag ia
87337		$25.16	Entamoeb hist group ag ia
87338		$30.19	Hpylori stool ia
87338	QW	$30.19	Hpylori stool ia
87339		$27.20	H pylori ag ia
87340		$21.68	Hepatitis b surface ag ia
87341		$21.68	Hepatitis b surface ag ia
87350		$24.19	Hepatitis be ag ia
87380		$34.44	Hepatitis delta ag ia
87385		$25.16	Histoplasma capsul ag ia
87389		$50.54	Hiv-1 ag w/hiv-1 & hiv-2 ab
87389	QW	$50.54	Hiv-1 ag w/hiv-1 & hiv-2 ab
87390		$40.90	Hiv-1 ag ia
87391		$37.23	Hiv-2 ag ia
87400		$25.16	Influenza a/b ag ia
87420		$25.16	Resp syncytial ag ia
87425		$25.16	Rotavirus ag ia
87427		$25.16	Shiga-like toxin ag ia
87430		$28.58	Strep a ag ia
87449		$25.16	Ag detect nos ia mult
87449	QW	$25.16	Ag detect nos ia mult
87450		$20.13	Ag detect nos ia single

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
87451		$20.13	Ag detect polyval ia mult
87471		$73.66	Bartonella dna amp probe
87472		$89.90	Bartonella dna quant
87475		$42.09	Lyme dis dna dir probe
87476		$73.66	Lyme dis dna amp probe
87480		$42.09	Candida dna dir probe
87481		$73.66	Candida dna amp probe
87482		$94.76	Candida dna quant
87483		$874.74	Cns dna amp probe type 12-25
87485		$42.09	Chylmd pneum dna dir probe
87486		$73.66	Chylmd pneum dna amp probe
87487		$89.90	Chylmd pneum dna quant
87490		$42.09	Chylmd trach dna dir probe
87491		$73.66	Chylmd trach dna amp probe
87492		$90.90	Chylmd trach dna quant
87493		$73.66	C diff amplified probe
87495		$51.05	Cytomeg dna dir probe
87496		$73.66	Cytomeg dna amp probe
87497		$89.90	Cytomeg dna quant
87498		$73.66	Enterovirus probe&revrs trns
87500		$73.66	Vanomycin dna amp probe
87501		$107.70	Influenza dna amp prob 1+
87502		$178.60	Influenza dna amp probe
87502	QW	$178.60	Influenza dna amp probe
87503		$49.67	Influenza dna amp prob addl
87505		$269.25	Nfct agent detection gi
87506		$447.93	Iadna-dna/rna probe tq 6-11
87507		$874.74	Iadna-dna/rna probe tq 12-25
87510		$42.09	Gardner vag dna dir probe
87511		$73.66	Gardner vag dna amp probe
87512		$87.64	Gardner vag dna quant
87516		$73.66	Hepatitis b dna amp probe
87517		$89.90	Hepatitis b dna quant

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
87520		$53.07	Hepatitis c rna dir probe
87521		$73.66	Hepatitis c probe&rvrs trnsc
87522		$89.90	Hepatitis c revrs trnscrpj
87525		$50.66	Hepatitis g dna dir probe
87526		$73.66	Hepatitis g dna amp probe
87527		$87.64	Hepatitis g dna quant
87528		$42.09	Hsv dna dir probe
87529		$73.66	Hsv dna amp probe
87530		$89.90	Hsv dna quant
87531		$98.60	Hhv-6 dna dir probe
87532		$73.66	Hhv-6 dna amp probe
87533		$87.64	Hhv-6 dna quant
87534		$42.09	Hiv-1 dna dir probe
87535		$73.66	Hiv-1 probe&reverse trnscrpj
87536		$178.60	Hiv-1 quant&revrse trnscrpj
87537		$42.09	Hiv-2 dna dir probe
87538		$73.66	Hiv-2 probe&revrse trnscripj
87539		$99.65	Hiv-2 quant&revrse trnscripj
87540		$42.09	Legion pneumo dna dir prob
87541		$73.66	Legion pneumo dna amp prob
87542		$87.64	Legion pneumo dna quant
87550		$42.09	Mycobacteria dna dir probe
87551		$82.01	Mycobacteria dna amp probe
87552		$89.90	Mycobacteria dna quant
87555		$45.70	M.tuberculo dna dir probe
87556		$73.66	M.tuberculo dna amp probe
87557		$89.90	M.tuberculo dna quant
87560		$46.39	M.avium-intra dna dir prob
87561		$73.66	M.avium-intra dna amp prob
87562		$89.90	M.avium-intra dna quant
87580		$42.09	M.pneumon dna dir probe
87581		$73.66	M.pneumon dna amp probe
87582		$514.45	M.pneumon dna quant

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
87590		$45.70	N.gonorrhoeae dna dir prob
87591		$73.66	N.gonorrhoeae dna amp prob
87592		$89.90	N.gonorrhoeae dna quant
87623		$73.66	Hpv low-risk types
87624		$73.66	Hpv high-risk types
87625		$73.66	Hpv types 16 & 18 only
87631		$269.25	Resp virus 3-5 targets
87631	QW	$269.25	Resp virus 3-5 targets
87632		$447.93	Resp virus 6-11 targets
87633		$874.74	Resp virus 12-25 targets
87633	QW	$874.74	Resp virus 12-25 targets
87634		$147.32	Rsv dna/rna amp probe
87640		$73.66	Staph a dna amp probe
87641		$73.66	Mr-staph dna amp probe
87650		$42.09	Strep a dna dir probe
87650	QW	$42.09	Strep a dna dir probe
87651		$73.66	Strep a dna amp probe
87651	QW	$73.66	Strep a dna amp probe
87652		$87.64	Strep a dna quant
87653		$73.66	Strep b dna amp probe
87660		$42.09	Trichomonas vagin dir probe
87661		$73.66	Trichomonas vaginalis amplif
87662		$107.70	Zika virus dna/rna amp probe
87797		$51.05	Detect agent nos dna dir
87798		$73.66	Detect agent nos dna amp
87799		$89.90	Detect agent nos dna quant
87800		$84.20	Detect agnt mult dna direc
87801		$147.32	Detect agnt mult dna ampli
87801	QW	$147.32	Detect agnt mult dna ampli
87802		$25.16	Strep b assay w/optic
87803		$27.20	Clostridium toxin a w/optic
87804		$28.14	Influenza assay w/optic
87804	QW	$28.14	Influenza assay w/optic

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
87806		$55.71	Hiv antigen w/hiv antibodies
87806	QW	$55.71	Hiv antigen w/hiv antibodies
87807		$25.16	Rsv assay w/optic
87807	QW	$25.16	Rsv assay w/optic
87808		$25.99	Trichomonas assay w/optic
87808	QW	$25.99	Trichomonas assay w/optic
87809		$36.99	Adenovirus assay w/optic
87809	QW	$36.99	Adenovirus assay w/optic
87810		$59.99	Chylmd trach assay w/optic
87850		$41.75	N. gonorrhoeae assay w/optic
87880		$28.10	Strep a assay w/optic
87880	QW	$28.10	Strep a assay w/optic
87899		$27.32	Agent nos assay w/optic
87899	QW	$27.32	Agent nos assay w/optic
87900		$273.56	Phenotype infect agent drug
87901		$540.33	Genotype dna hiv reverse t
87902		$540.33	Genotype dna/rna hep c
87903		$1,025.58	Phenotype dna hiv w/culture
87904		$54.71	Phenotype dna hiv w/clt add
87905		$25.64	Sialidase enzyme assay
87905	QW	$25.64	Sialidase enzyme assay
87906		$270.16	Genotype dna/rna hiv
87910		$540.33	Genotype cytomegalovirus
87912		$540.33	Genotype dna hepatitis b
88130		$37.72	Sex chromatin identification
88140		$16.76	Sex chromatin identification
88142		$42.52	Cytopath c/v thin layer
88143		$42.52	Cytopath c/v thin layer redo
88147		$85.95	Cytopath c/v automated
88148		$31.89	Cytopath c/v auto rescreen
88150		$24.91	Cytopath c/v manual
88152		$46.99	Cytopath c/v auto redo
88153		$40.85	Cytopath c/v redo

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
88155		$24.91	Cytopath c/v index add-on
88164		$24.91	Cytopath tbs c/v manual
88165		$71.77	Cytopath tbs c/v redo
88166		$24.91	Cytopath tbs c/v auto redo
88167		$24.91	Cytopath tbs c/v select
88174		$44.85	Cytopath c/v auto in fluid
88175		$55.61	Cytopath c/v auto fluid redo
88230		$244.49	Tissue culture lymphocyte
88233		$295.36	Tissue culture skin/biopsy
88235		$309.08	Tissue culture placenta
88237		$265.08	Tissue culture bone marrow
88239		$309.60	Tissue culture tumor
88240		$22.22	Cell cryopreserve/storage
88241		$21.20	Frozen cell preparation
88245		$363.46	Chromosome analysis 20-25
88248		$363.46	Chromosome analysis 50-100
88249		$363.46	Chromosome analysis 100
88261		$449.38	Chromosome analysis 5
88262		$261.60	Chromosome analysis 15-20
88263		$315.42	Chromosome analysis 45
88264		$261.60	Chromosome analysis 20-25
88267		$377.32	Chromosome analys placenta
88269		$349.08	Chromosome analys amniotic
88271		$44.95	Cytogenetics dna probe
88272		$69.19	Cytogenetics 3-5
88273		$67.42	Cytogenetics 10-30
88274		$73.07	Cytogenetics 25-99
88275		$87.02	Cytogenetics 100-300
88280		$56.90	Chromosome karyotype study
88283		$143.97	Chromosome banding study
88285		$45.75	Chromosome count additional
88289		$72.27	Chromosome study additional
88371		$46.65	Protein western blot tissue

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
88372		$47.74	Protein analysis w/probe
88720		$10.52	Bilirubin total transcut
88738		$10.52	Hgb quant transcutaneous
88740		$15.93	Transcutaneous carboxyhb
88741		$15.93	Transcutaneous methb
89050		$9.91	Body fluid cell count
89051		$11.56	Body fluid cell count
89055		$8.96	Leukocyte assessment fecal
89060		$15.01	Exam synovial fluid crystals
89125		$10.00	Specimen fat stain
89160		$8.25	Exam feces for meat fibers
89190		$9.96	Nasal smear for eosinophils
89300		$18.75	Semen analysis w/huhner
89300	QW	$18.75	Semen analysis w/huhner
89310		$18.07	Semen analysis w/count
89320		$25.30	Semen anal vol/count/mot
89321		$25.30	Semen anal sperm detection
89321	QW	$25.30	Semen anal sperm detection
89322		$32.52	Semen anal strict criteria
89325		$22.41	Sperm antibody test
89329		$41.11	Sperm evaluation test
89330		$20.76	Evaluation cervical mucus
89331		$41.11	Retrograde ejaculation anal
0001M		$122.72	Infectious dis hcv 6 assays
0001U		$ -	Rbc dna hea 35 ag 11 bld grp
0002M		$855.78	Liver dis 10 assays w/ash
0002U		$ -	Onc clrct 3 ur metab alg plp
0003M		$855.78	Liver dis 10 assays w/nash
0003U		$1,615.00	Onc ovar 5 prtn ser alg scor
0004M		$ -	Scoliosis dna alys
0005U		$1,292.00	Onco prst8 3 gene ur alg
0006M		$ -	Onc hep gene risk classifier
0006U		$419.76	Rx mntr 120+ drugs & sbsts

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
0007M		$ -	Onc gastro 51 gene nomogram
0007U		$194.53	Rx test prsmv ur w/def conf
0008U		$1,016.45	Hpylori detcj abx rstnc dna
0009M		$ -	Fetal aneuploidy trisom risk
0009U		$ -	Onc brst ca erbb2 amp/nonamp
0010U		$ -	Nfct ds strn typ whl gen seq
0011U		$194.53	Rx mntr lc-ms/ms oral fluid
0012U		$ -	Germln do gene reargmt detcj
0013U		$ -	Onc sld org neo gene reargmt
0014U		$ -	Hem hmtlmf neo gene reargmt
0016U		$344.11	Onc hmtlmf neo rna bcr/abl1
0017U		$192.39	Onc hmtlmf neo jak2 mut dna
G0027		$13.65	Semen analysis
G0103		$38.61	Psa screening
G0123		$42.52	Screen cerv/vag thin layer
G0143		$45.99	Scr c/v cyto,thinlayer,rescr
G0144		$74.75	Scr c/v cyto,thinlayer,rescr
G0145		$55.61	Scr c/v cyto,thinlayer,rescr
G0147		$24.91	Scr c/v cyto, automated sys
G0148		$54.30	Scr c/v cyto, autosys, rescr
G0306		$16.30	Cbc/diffwbc w/o platelet
G0307		$13.57	Cbc without platelet
G0328		$33.39	Fecal blood scrn immunoassay
G0328	QW	$33.39	Fecal blood scrn immunoassay
G0432		$33.27	Eia hiv-1/hiv-2 screen
G0433		$31.09	Elisa hiv-1/hiv-2 screen
G0433	QW	$31.09	Elisa hiv-1/hiv-2 screen
G0435		$25.16	Oral hiv-1/hiv-2 screen
G0471		$8.50	Ven blood coll snf/hha
G0472		$78.80	Hep c screen high risk/other
G0472	QW	$78.80	Hep c screen high risk/other
G0475		$50.54	Hiv combination assay
G0475	QW	$50.54	Hiv combination assay

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	MOD	MAXIMUM FEES	SHORTDESC
G0476		$73.66	Hpv combo assay ca screen
G0480		$194.53	Drug test def 1-7 classes
G0481		$266.20	Drug test def 8-14 classes
G0482		$337.86	Drug test def 15-21 classes
G0483		$419.76	Drug test def 22+ classes
G0499		$59.33	Hepb screen high risk indiv
G0659		$122.11	Drug test def simple all cl
G9143		$253.35	Warfarin respon genetic test
P2028		$10.39	Cephalin floculation test
P2029		$10.39	Congo red blood test
P2031		$10.39	Hair analysis
P2033		$10.39	Blood thymol turbidity
P2038		$10.39	Blood mucoprotein
P3000		$24.91	Screen pap by tech w md supv
P9612		$5.10	Catheterize for urine spec
P9615		$5.10	Urine specimen collect mult
Q0111		$24.91	Wet mounts/ w preparations
Q0112		$9.91	Potassium hydroxide preps
Q0113		$8.96	Pinworm examinations
Q0114		$16.56	Fern test
Q0115		$42.50	Post-coital mucous exam

Final Exhibit #9									
RVU Values and Division Z-Codes									
effective 1/1/2019									
CPT®, HCPCS, or DoWC Z-Code	Modifier	Conversion Factor or Fee Category	Rate	Non-Facility RVU	Facility RVU	Billing Increments	Indicator	Description	Rule 18 reference
90791		Medicine		9.91	9.60				18-5(G)(6)(b)
90792		Medicine		11.12	10.80				18-5(G)(6)(b)
90889		Medicine		1.40	1.40				18-5(G)(6)(c)
90901		Medicine		2.14	1.14				18-5(G)(3)
90911		Medicine		4.76	2.48				18-5(G)(3)
96101		Medicine		3.00	2.91				18-5(G)(6)(c)
96102		Medicine		1.79	0.65				18-5(G)(6)(c)
96103		Medicine		1.36	1.33				18-5(G)(6)(c)
96116		Medicine		3.40	3.16				18-5(G)(6)(c)
96118		Medicine		4.11	3.31				18-5(G)(6)(c)
96119		Medicine		2.51	0.74				18-5(G)(6)(c)
96120		Medicine		2.30	1.24				18-5(G)(6)(c)
96150		Medicine		0.80	0.79				18-5(G)(6)(c)
96151		Medicine		0.78	0.77				18-5(G)(6)(c)
96152		Medicine		0.74	0.73				18-5(G)(6)(c)
96153		Medicine		0.18	0.17				18-5(G)(6)(c)
96154		Medicine		0.74	0.73				18-5(G)(6)(c)
96155		Medicine		0.73	0.73				18-5(G)(6)(c)
97035		PM&R		0.36	0.00				18-5(H)(7)
97039		PM&R		0.36	0.00				18-5(H)(7)
97139		PM&R		0.92	0.92				18-5(H)(6)
97161		PM&R		1.66	1.66				18-5(H)(8)(b)

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Final Exhibit #9									
RVU Values and Division Z-Codes									
effective 1/1/2019									
CPT®, HCPCS, or DoWC Z-Code	Modifier	Conversion Factor or Fee Category	Rate	Non-Facility RVU	Facility RVU	Billing Increments	Indicator	Description	Rule 18 reference
97162		PM&R		2.48	2.48				18-5(H)(8)(b)
97163		PM&R		3.71	3.71				18-5(H)(8)(b)
97164		PM&R		1.60	1.60				18-5(H)(8)(b)
97165		PM&R		1.66	1.66				18-5(H)(8)(b)
97166		PM&R		2.48	2.48				18-5(H)(8)(b)
97167		PM&R		3.71	3.71				18-5(H)(8)(b)
97168		PM&R		1.60	1.60				18-5(H)(8)(b)
97169		PM&R		1.41	1.41				18-5(H)(8)(b)
97170		PM&R		2.10	2.10				18-5(H)(8)(b)
97171		PM&R		3.10	3.10				18-5(H)(8)(b)
97172		PM&R		1.36	1.36				18-5(H)(8)(b)
97545		PM&R		3.40	3.40				18-5(H)(14)(d)
97546		PM&R		1.70	1.70				18-5(H)(14)(d)
98940		Medicine		1.00	0.79				18-5(G)(5)
99000		Division	$ 25.00	1.00	1.00				18-5(G)(14)(a)
99001		Division	$ 25.00	1.00	1.00				18-5(G)(14)(a)
99002		Division	$ 13.00	1.00	1.00				18-5(G)(14)(a)
99100		Anesthesia		1.00	1.00				18-5(C)(5)
99116		Anesthesia		5.00	5.00				18-5(C)(5)

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RVU Values and Division Z-Codes									
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CPT®, HCPCS, or DoWC Z-Code	Modifier	Conversion Factor or Fee Category	Rate	Non-Facility RVU	Facility RVU	Billing Increments	Indicator	Description	Rule 18 reference
99135		Anesthesia		5.00	5.00				18-5(C)(5)
99140		Anesthesia		2.00	2.00				18-5(C)(5)
99231		E&M			2.21				18-5(I)(6)(c)
99232		E&M			3.15				18-5(I)(6)(c)
99233		E&M			4.22				18-5(I)(6)(c)
99241		E&M		2.57	2.15				18-5(I)(6)(c)
99242		E&M		3.77	3.18				18-5(I)(6)(c)
99243		E&M		4.71	3.96				18-5(I)(6)(c)
99244		E&M		6.39	5.57				18-5(I)(6)(c)
99245		E&M		8.15	7.23				18-5(I)(6)(c)
99251		E&M			2.79				18-5(I)(6)(c)
99252		E&M			3.83				18-5(I)(6)(c)
99253		E&M			4.95				18-5(I)(6)(c)
99254		E&M			6.39				18-5(I)(6)(c)
99255		E&M			8.47				18-5(I)(6)(c)
0232T		Surgery	$ 269.50		1.00				18-5(D)(8)(c)
A0425		Transportation	$ 18.11	1.00		per Urban mile		Urban	18-6(R)(3)
A0425		Transportation	$ 18.28	1.00		per Rural mile	R	Rural	18-6(R)(3)

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RVU Values and Division Z-Codes									
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CPT®, HCPCS, or DoWC Z-Code	Modifier	Conversion Factor or Fee Category	Rate	Non-Facility RVU	Facility RVU	Billing Increments	Indicator	Description	Rule 18 reference
A0425		Transportation	$ 18.28	1.00		per Super Rural mile	B	Super Rural	18-6(R)(3)
A0426		Transportation	$ 680.67					Urban	18-6(R)(3)
A0426		Transportation	$ 687.34				R	Rural	18-6(R)(3)
A0426		Transportation	$ 842.68				B	Super Rural	18-6(R)(3)
A0427		Transportation	$ 1,077.72					Urban	18-6(R)(3)
A0427		Transportation	$ 1,088.29				R	Rural	18-6(R)(3)
A0427		Transportation	$ 1,334.24				B	Super Rural	18-6(R)(3)
A0428		Transportation	$ 567.22					Urban	18-6(R)(3)
A0428		Transportation	$ 572.28				R	Rural	18-6(R)(3)
A0428		Transportation	$ 702.23				B	Super Rural	18-6(R)(3)
A0429		Transportation	$ 907.55					Urban	18-6(R)(3)

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CPT®, HCPCS, or DoWC Z-Code	Modifier	Conversion Factor or Fee Category	Rate	Non-Facility RVU	Facility RVU	Billing Increments	Indicator	Description	Rule 18 reference
A0429		Transportation	$ 916.45				R	Rural	18-6(R)(3)
A0429		Transportation	$ 1,123.57				B	Super Rural	18-6(R)(3)
A0432		Transportation	$ 992.64					Urban	18-6(R)(3)
A0432		Transportation	$ 1,002.37				R	Rural	18-6(R)(3)
A0432		Transportation	$ 1,002.37				B	Super Rural	18-6(R)(3)
A0433		Transportation	$ 1,559.86					Urban	18-6(R)(3)
A0433		Transportation	$ 1,575.15				R	Rural	18-6(R)(3)
A0433		Transportation	$ 1,931.14				B	Super Rural	18-6(R)(3)
A0434		Transportation	$ 1,843.47					Urban	18-6(R)(3)
A0434		Transportation	$ 1,861.54				R	Rural	18-6(R)(3)
A0434		Transportation	$ 2,282.25				B	Super Rural	18-6(R)(3)

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RVU Values and Division Z-Codes									
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CPT®, HCPCS, or DoWC Z-Code	Modifier	Conversion Factor or Fee Category	Rate	Non-Facility RVU	Facility RVU	Billing Increments	Indicator	Description	Rule 18 reference
A0888		Transportation	$ -						18-6(R)(3)
A0998		Transportation	$ -						18-6(R)(3)
A0999		Transportation	$ -						18-6(R)(3)
G0378		Facility Only	$ 45.00	0.00	1.00	per hour			18-6(L)(2)(d)
Q3014		Division	$ 35.00			per 15 min			18-5(J)(4)(c)
S9088		Urgent Care Facility Fee	$ 75.00	1.00	1.00	per episode			18-6(L)(2)(b)
S9122		Home Health	$ 45.00	1.00		per hour			18-6(M)(2)(b)
S9123		Home Health	$ 111.00	1.00		per hour			18-6(M)(2)(a)
S9124		Home Health	$ 89.00	1.00		per hour			18-6(M)(2)(a)
S9326		Home Health	$ 79.00	1.00		Per day			18-6(M)(1)(e)

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RVU Values and Division Z-Codes									
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CPT®, HCPCS, or DoWC Z-Code	Modifier	Conversion Factor or Fee Category	Rate	Non-Facility RVU	Facility RVU	Billing Increments	Indicator	Description	Rule 18 reference
S9327		Home Health	$ 103.00	1.00		Per day			18-6(M)(1)(e)
S9328		Home Health	$ 116.00	1.00		Per day			18-6(M)(1)(e)
S9329		Home Health	$ -	1.00		Per day			18-6(M)(1)(c)
S9330		Home Health	$ 91.00	1.00		Per day			18-6(M)(1)(c)
S9331		Home Health	$ 103.00	1.00		Per day			18-6(M)(1)(c)
S9341		Home Health	$ 44.09	1.00		Per day			18-6(M)(1)(d)
S9342		Home Health	$ 24.23	1.00		Per day			18-6(M)(1)(d)
S9343		Home Health	$ 24.23	1.00		Per day			18-6(M)(1)(d)
S9364		Home Health	$ 160.00	1.00		Per day			18-6(M)(1)(a)
S9365		Home Health	$ 174.00	1.00		Per day			18-6(M)(1)(a)
S9366		Home Health	$ 200.00	1.00		Per day			18-6(M)(1)(a)

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RVU Values and Division Z-Codes									
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CPT®, HCPCS, or DoWC Z-Code	Modifier	Conversion Factor or Fee Category	Rate	Non-Facility RVU	Facility RVU	Billing Increments	Indicator	Description	Rule 18 reference
S9367		Home Health	$ 227.00	1.00		Per day			18-6(M)(1)(a)
S9368		Home Health	$ 254.00	1.00		Per day			18-6(M)(1)(a)
S9373		Home Health	$ 61.00	1.00		Per day			18-6(M)(1)(f)
S9374		Home Health	$ 85.00	1.00		Per day			18-6(M)(1)(f)
S9375		Home Health	$ 85.00	1.00		Per day			18-6(M)(1)(f)
S9376		Home Health	$ 85.00	1.00		Per day			18-6(M)(1)(f)
S9377		Home Health	$ 85.00	1.00		Per day			18-6(M)(1)(f)
S9494		Home Health	$ 158.00	1.00		Per day			18-6(M)(1)(b)
S9497		Home Health	$ 152.00	1.00		Per day			18-6(M)(1)(b)
S9500		Home Health	$ 97.00	1.00		Per day			18-6(M)(1)(b)
S9501		Home Health	$ 110.00	1.00		Per day			18-6(M)(1)(b)

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RVU Values and Division Z-Codes									
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CPT®, HCPCS, or DoWC Z-Code	Modifier	Conversion Factor or Fee Category	Rate	Non-Facility RVU	Facility RVU	Billing Increments	Indicator	Description	Rule 18 reference
S9502		Home Health	$ 122.00	1.00		Per day			18-6(M)(1)(b)
S9503		Home Health	$ 134.00	1.00		Per day			18-6(M)(1)(b)
S9504		Home Health	$ 146.00	1.00		Per day			18-6(M)(1)(b)
Z0200		Division	$ 980.00					Upper body w/Autonomic Stress Testing	18-5(E)(3)(d)
Z0201		Division	$ 980.00					Lower Body w/autonomic Stress Testing	18-5(E)(3)(d)
Z0401		Division	$ 1,066.00			once per WC claim		QSART	18-5(G)(8)(b)
Z0500		Division	negotiated			per program		Interdisciplinary Rehabilitation Programs	18-5(H)(5)
Z0501		PM&R		1.30	0.77	per 15 min		Single or multiple needles - dry needling	18-5(H)(6)

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CPT®, HCPCS, or DoWC Z-Code	Modifier	Conversion Factor or Fee Category	Rate	Non-Facility RVU	Facility RVU	Billing Increments	Indicator	Description	Rule 18 reference
Z0502		PM&R		0.77	0.72	per 15 min		Each add'l 15 minutes of dry needling	18-5(H)(6)
Z0503		PM&R		0.93	0.93	per 15 min		Computer Enhanced Evaluation	18-5(H)(9)(a)(v)
Z0504		PM&R		0.93	0.93	per 15 min		Work Tolerance Screening	18-5(H)(9)(a)(vi)
Z0505		PM&R		0.23		per day		Unattended Treatment	18-6(H)(11)
Z0601		Division	$ 74.00			per 15 min		Face-to-face or telephonic meeting	18-6(A)(2)
Z0602		Division	$ 74.00			per 15 min		Peer-to-peer review by a treating physician with a medical reviewer	18-6(A)(4)

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CPT®, HCPCS, or DoWC Z-Code	Modifier	Conversion Factor or Fee Category	Rate	Non-Facility RVU	Facility RVU	Billing Increments	Indicator	Description	Rule 18 reference
Z0701		Division	$ 42.50			per 8 min		Face-to-face or telephone meeting treating with employee (SAMS)	18-6(A)(1)(c)
Z0720		Division	$ 180.00					Cancellation Fee 1/2 usual fee or rate whichever is less	18-6(B)(1)
Z0721		Division	$ 18.53			first 10 or fewer paper page(s)		Copying Fee for first 10 or fewer paper page(s)	18-6(C)
Z0722		Division	negotiated					Interpreter	18-6(Q)
Z0723		Division	$ 0.53			per mile		Mileage for Injured Worker	18-6(E)

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CPT®, HCPCS, or DoWC Z-Code	Modifier	Conversion Factor or Fee Category	Rate	Non-Facility RVU	Facility RVU	Billing Increments	Indicator	Description	Rule 18 reference
Z0724		Division	actual paid					Other Travel Expenses for Injured Worker	18-6(E)
Z0725		Division	$ 0.85			per paper page next 11-40 paper page(s)		Copying Fee per paper page for the next 11-40 paper page(s)	18-6(C)
Z0726		Division	$ 0.57			per paper page for remaining paper		Copying Fee per paper page for remaining paper page(s)	18-6(C)
Z0727		Division	$ 1.50			per microfilm		Copying Fee per microfilm page	18-6(C)
Z0728		Division	$ 14.00			per computer disc or as agreed		Copying Fee per computer disc or as agreed	18-6(C)

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CPT®, HCPCS, or DoWC Z-Code	Modifier	Conversion Factor or Fee Category	Rate	Non-Facility RVU	Facility RVU	Billing Increments	Indicator	Description	Rule 18 reference
Z0729		Division	$ 0.10			per electronic page or as agreed		Copying Fee per electronic page or as agreed	18-6(C)
Z0730		Division	$ 183.50			per 30 min		Prep Time Deposition and Testimony by Physician or Psychologist	18-6(D)(2)
Z0731		Division	$ 183.50			per 30 min		Deposition cancellation 7+ business days	18-6(D)(3)
Z0732		Division	$ 183.50			per 30 min		Deposition cancellation >5 but <7 business days	18-6(D)(3)
Z0733		Division	$ 183.50			per 30 min		Deposition cancellation <5 business days	18-6(D)(3)

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CPT®, HCPCS, or DoWC Z-Code	Modifier	Conversion Factor or Fee Category	Rate	Non-Facility RVU	Facility RVU	Billing Increments	Indicator	Description	Rule 18 reference
Z0734		Division	$ 183.50			per 30 min		Deposition fee per hr	18-6(D)(3)
Z0735		Division	$ 254.00			per 30 min		Testimony cancellation 7+ business days	18-6(D)(4)
Z0736		Division	$ 254.00			per 30 min		Testimony cancellation >5 but <7 business days	18-6(D)(4)
Z0737		Division	$ 254.00			per 30 min		Testimony cancellation <5 business days	18-6(D)(4)
Z0738		Division	$ 254.00			per 30 min		Testimony Fee	18-6(D)(4)
Z0750		Division	$ 49.00					Initial WC 164	18-6(G)(2)(e)
Z0751		Division	$ 49.00					Progress Report	18-6(G)(2)(e)
Z0752		Division	$ 49.00					Closing Report	18-6(G)(2)(e)
Z0753		Division	$ 49.00					Initial and Closing on same report	18-6(G)(2)(e)

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CPT®, HCPCS, or DoWC Z-Code	Modifier	Conversion Factor or Fee Category	Rate	Non-Facility RVU	Facility RVU	Billing Increments	Indicator	Description	Rule 18 reference
Z0754		Division	$ 49.00					Completion add'l forms	18-6(G)(3)
Z0755		Division	$ 91.75			per 15 min		Special Report - Written Report only	18-6(G)(4)
Z0756		Division	$ 91.75			per 15 min		Respondent requested IME (RIME)/Report with patient exam	18-6(G)(4)
Z0757		Division	$ 91.75			per 15 min		Special Report - Lengthy Form Completion	18-6(G)(4)
Z0758		Division	$ 91.75			per 15 min		18-5(I)(8) Meeting & Report with Non-treating Physician	18-6(G)(4)

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CPT®, HCPCS, or DoWC Z-Code	Modifier	Conversion Factor or Fee Category	Rate	Non-Facility RVU	Facility RVU	Billing Increments	Indicator	Description	Rule 18 reference
Z0759		Division	$ 575.00			per exam		Impairment Rating Treating Physician	18-6(F)(4)(b)(i)
Z0760		Division	$ 775.00			per exam		Impairment Rating Referral	18-6(F)(4)(b)(ii)
Z0761		Division	$ 91.75			per 15 min		Special Report - cancellation not requiring patient exam	18-6(G)(4)
Z0762		Division	$ 91.75			per 15 min		Special Report - IME/Report W Patient Exam Cancellation +7 business days	18-6(G)(4)

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CPT®, HCPCS, or DoWC Z-Code	Modifier	Conversion Factor or Fee Category	Rate	Non-Facility RVU	Facility RVU	Billing Increments	Indicator	Description	Rule 18 reference
Z0763		Division	$ 91.75			per 15 min		Special Report - IME/Report W Patient Exam Cancellation >5 but <7 business days	18-6(G)(4)
Z0764		Division	$ 91.75			per 15 min		Special Report - IME/Report W Patient Exam Cancellation <5 business days	18-6(G)(4)
Z0765		Division	$ 84.00			per 15 min		Chronic Opioid Management	18-8(B)(2)(f)
Z0766		Division	$ 34.00			per exam		CRS 8-43-404 IME Audio Recording	18-6(G)(4)

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CPT®, HCPCS, or DoWC Z-Code	Modifier	Conversion Factor or Fee Category	Rate	Non-Facility RVU	Facility RVU	Billing Increments	Indicator	Description	Rule 18 reference
Z0767		Division	$ 23.00			per copy		CRS 8-43-404 IME Audio Copying Fee	18-6(G)(4)
Z0768		Division	$ 1,000.00					Division Independent Medical Examination (DIME)/Report with patient exam	18-6(G)(4)
Z0769		Division	$ 1,400.00					DIME/Report with patient exam > 2 years or 3 regions	18-6(G)(4)
Z0770		Division	$ 91.75			per 15 min		Claimant requested IME (CIME)/Report with patient exam	18-6(G)(4)
Z0771		Division	$ 50.00			per report		Acute Opioid Management	18-8(A)(4)

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CPT®, HCPCS, or DoWC Z-Code	Modifier	Conversion Factor or Fee Category	Rate	Non-Facility RVU	Facility RVU	Billing Increments	Indicator	Description	Rule 18 reference
Z0772		Division	$ 0.53			per mile		Mileage for provider of Home Care	18-6(M)(4)
Z0773		Division	$ 34.00			per hr		Travel Time for provider of Home Care	18-6(M)(5)
Z0790		Division	$ 80.00			per 30 day supply		Category I Compounded Drugs	18-6(N)(6)
Z0791		Division	$ 160.00			per 30 day supply		Category II Compounded Drugs	18-6(N)(6)
Z0792		Division	$ 265.00			per 30 day supply		Category III Compounded Drugs	18-6(N)(6)
Z0793		Division	$ 370.00			per 30 day supply		Category IV Compounded Drugs	18-6(N)(6)
Z0794		Division	$ 30.00			per 30 day supply		Any topical OTC drug except patches	18-6(7)(b)

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CPT®, HCPCS, or DoWC Z-Code	Modifier	Conversion Factor or Fee Category	Rate	Non-Facility RVU	Facility RVU	Billing Increments	Indicator	Description	Rule 18 reference
Z0795		Division	$ 70.00			per 30 day supply		OTC patches	18-6(7)(b)
Z0800		Division	$ 99.80			per visit		LAc new patient	18-6(P)(3)(b)(ii)
Z0801		Division	$ 67.60			per visit		LAc established patient	18-6(P)(3)(b)(iii)
Z0802		Division	actual paid			per invoice		Postage	18-6(C)
Z0811		Division	$ 62.00			per episode		Initial functional assessment of pre-injection care	18-8(C)(2)
Z0812		Division	$ 33.00			per episode		Subsequent visit of therapeutic post-injection care	18-8(C)(2)

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Final Exhibit #9									
RVU Values and Division Z-Codes									
effective 1/1/2019									
CPT®, HCPCS, or DoWC Z-Code	Modifier	Conversion Factor or Fee Category	Rate	Non-Facility RVU	Facility RVU	Billing Increments	Indicator	Description	Rule 18 reference
Z0813		Division	$ 744.00					Platelet Rich Plasma injection in an office setting	18-5(D)(8)(b)
Z0814		Division	$ 33.00			per episode		Post-diagnostic injection care	18-8(C)(2)
Z0815		Division	$ 80.00			per episode		QPOP Initial Assessment	18-8(D)(1)(c)
Z0816		Division	$ 40.00			per visit		QPOP subsequent visit	18-8(D)(1)(c)
Z0817		Division	$ 15.00			per form		Rehabilitation Communication Form (WC196)	18-5(H)(8)(c)
Z9999		Division	$ -					Providers reporting Z9999 certify accreditation status	18-5(E)(2)(a)

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RVU Values and Division Z-Codes									
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CPT®, HCPCS, or DoWC Z-Code	Modifier	Conversion Factor or Fee Category	Rate	Non-Facility RVU	Facility RVU	Billing Increments	Indicator	Description	Rule 18 reference
	50	Division			1.50			Bi-Lateral Payment Adjustment	18-5(B)(3)(o)
	51	Division			0.50			Multiple Procedure Modifier	18-5(B)(3)(n)
	62	Division			1.25			Co-Surgeon; distinct procedure	18-5(D)(5)
	73	Division			0.50			Discontinued service prior to Anesthesia	18-6(J)(6)(f)(iv)
	74	Division			1.00			Discontinued service after Anesthesia	18-6(J)(6)(f)(iv)
	80	Division			0.20			Max allowance, Asst Surgeon	18-5(D)(c)

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RVU Values and Division Z-Codes									
effective 1/1/2019									
CPT®, HCPCS, or DoWC Z-Code	Modifier	Conversion Factor or Fee Category	Rate	Non-Facility RVU	Facility RVU	Billing Increments	Indicator	Description	Rule 18 reference
	81	Division			0.10			Max allowance, Clinical Nurse Specialist and Registered Surgical Asst	18-5(D)(e)
	82	Division			0.20			Max allowance, Qualified Resident Surgeon	18-5(D)(d)
	95	Division	$ 5.00	1.00	1.00	per visit		Telehealth add-on	18-5(J)(4)(b)
	AA	Anesthesia			1.00				18-5(C)(3)

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RVU Values and Division Z-Codes									
effective 1/1/2019									
CPT®, HCPCS, or DoWC Z-Code	Modifier	Conversion Factor or Fee Category	Rate	Non-Facility RVU	Facility RVU	Billing Increments	Indicator	Description	Rule 18 reference
	AD	Anesthesia				Maximum allowance: three (3) base anesthesia units for each case, regardless of the number of base anesthesia units assigned to each specific anesthesia episode of care.			18-5(C)(3)
	AS	Division			0.10			Max allowance, AS performed by NP or PA	18-5(D)(e)
	FX	Division			0.80			Film X-Ray	18-5(E)(2)(f)
	P1	Anesthesia			0.00				18-5(C)(4)

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Final Exhibit #9									
RVU Values and Division Z-Codes									
effective 1/1/2019									
CPT®, HCPCS, or DoWC Z-Code	Modifier	Conversion Factor or Fee Category	Rate	Non-Facility RVU	Facility RVU	Billing Increments	Indicator	Description	Rule 18 reference
	P2	Anesthesia			0.00				18-5(C)(4)
	P3	Anesthesia			1.00				18-5(C)(4)
	P4	Anesthesia			2.00				18-5(C)(4)
	P5	Anesthesia			3.00				18-5(C)(4)
	P6	Anesthesia			0.00				18-5(C)(4)
	QK	Anesthesia			0.50				18-5(C)(3)
	QX	Anesthesia			0.50				18-5(C)(3)
	QY	Anesthesia			0.50				18-5(C)(3)
	QZ	Anesthesia			0.90				18-5(C)(3)

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