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Introduction

The *Colorado Register* is published pursuant to C.R.S. 24-4-103(11) and is the sole official publication for state agency notices of rule-making, proposed rules, attorney general's opinions relating to such rules, and adopted rules. The register may also include other public notices including annual departmental regulatory agendas submitted by principal departments to the secretary of state.

"Rule" means the whole or any part of every agency statement of general applicability and future effect implementing, interpreting, or declaring law or policy or setting forth the procedure or practice requirements of any agency. "Rule" includes "regulation". C.R.S. 24-4-102(15). Adopted rules are effective twenty days after the publication date of this issue unless otherwise specified.

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Notice of Proposed Rulemaking

Tracking number

2019-00613

Department

200 - Department of Revenue

Agency

204 - Division of Motor Vehicles

CCR number

1 CCR 204-10

Rule title

VEHICLE SERVICES SECTION

Rulemaking Hearing

Date

11/18/2019

Time

01:30 PM

Location

1881 Pierce Street, Lakewood, CO 80214 Room 110

Subjects and issues involved

Purpose: The purpose of this rule is to establish criteria for the issuance of a Temporary Registration Permit or an Analog Temporary Registration Permit by Licensed Colorado Motor Vehicle Dealers.

Statutory authority

The statutory bases for this rule are sections 2-4-108(2), 42-1-204 and 42-3-203(3)(b), C.R.S.

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DEPARTMENT OF REVENUE

Division of Motor Vehicles –Vehicle Services Section

1 CCR 204-10

RULE 34. DEALER ISSUED TEMPORARY REGISTRATION PERMITS

Basis: The statutory bases for this rule are sections 2-4-108(2), 42-1-204 and 42-3-203(3)(b), C.R.S.

Purpose: The purpose of this rule is to establish criteria for the issuance of a Temporary Registration Permit or an Analog Temporary Registration Permit by Licensed Colorado Motor Vehicle Dealers.

1.0 Definitions

1.1 "After Department Business Hours" means 5:00 p.m. – 8:00 a.m. Monday – Friday, or on a weekend, or a State holiday.

1.2 "Analog Temporary Registration Permit" means the Department approved form that is issued by a Licensed Colorado Motor Vehicle Dealer as a substitute to the Temporary Registration Permit.

1.3 "Approved System" means the Department approved web-based portal and its infrastructure allowing a Dealer to perform Temporary Registration Permit transactions.

1.4 "Licensed Colorado Motor Vehicle Dealer" or "Dealer" means the same as defined in section 42-6-102(2), C.R.S.

1.5 "Mounting Boards" means the Department approved device that a printed Temporary Registration Permit is affixed to. "Mounting Boards" includes both Mounting Boards that are passenger vehicle license plate size and motorcycle license plate size.

1.6 "Secure and Verifiable Identification" or "SVID" means an identification document issued by a state or federal jurisdiction or recognized by the United States Government and that is verifiable by federal or state law enforcement, intelligence, or homeland security agencies.

1.7 "System Outage" means the Approved System is not operational at the time the Dealer is attempting to issue a Temporary Registration Permit. "System Outage" does not include situations where the Dealer's system is not operational or when the Approved System is operational but the Dealer is unable to complete the Temporary Registration Permit transaction due to other factors (e.g., Dealer's password problems, Dealer system network issues etc.).

1.8 "Temporary Registration Permit" means the Department approved form that is printed when performing a Temporary Registration Permit issuance transaction on the Approved System that when affixed to a Mounting Board and mounted to a vehicle provides evidence that the vehicle has been issued a temporary registration.

2.0 Requirements

2.1 Dealer issued Temporary Registration Permits must be processed and issued through the Approved System. A Dealer must register its dealership and each individual authorized

user in the Approved System. A Dealer must not issue Temporary Registration Permits unless registered in the Approved System.

2.2 A Dealer whose license is inactive, suspended, or revoked must not issue Temporary Registration Permits.

2.3 A Temporary Registration Permit is only valid if issued through the Approved System and affixed to a Mounting Board.

a. A Temporary Registration Permit issued to a motorcycle defined in section 42-1-102(55), C.R.S., will be printed to simulate a motorcycle size license plate and must be affixed to the motorcycle size Mounting Board.

b. A Temporary Registration Permit issued to all other vehicle types will be printed to simulate a passenger size license plate and must be affixed to the passenger size Mounting Board.

2.4 Dealers must purchase Mounting Boards directly from a Department authorized Mounting Board vendor(s). A Dealer must only use Department approved Mounting Boards for affixing Temporary Registration Permits.

2.5 Upon the sale of a vehicle, the Dealer must:

a. Perform the Temporary Registration Permit issuance transaction in the Approved System;

b. Print the Temporary Registration Permit generated by the Approved System;

c. Print the Colorado registration receipt generated by the Approved System ;

d. Affix the printed Temporary Registration Permit to a Mounting Board;

e. Affix the Mounting Board with the Temporary Registration Permit to the vehicle according to statute; and

f. Provide the printed Colorado registration receipt to the vehicle purchaser.

2.6 A Dealer must verify the purchaser(s) SVID prior to the issuance of a Temporary Registration Permit.

2.7 If the Temporary Registration Permit and/or Mounting Board are damaged during issuance, the Dealer may issue a corrected Temporary Registration Permit through the Approved System. The Dealer must destroy the original Temporary Registration Permit and Mounting Board to render it unreadable and unusable.

2.8 A Temporary Registration Permit is valid for up to sixty (60) days from the date of sale/issuance. A Temporary Registration Permit cannot not expire on a Saturday, Sunday, or legal holiday. If the sixtieth day falls on a Saturday, Sunday, or legal holiday, the Temporary Registration Permit will expire on the ~~first~~ next weekday ~~prior to the~~ which is not a Saturday, Sunday, or legal holiday.

2.9 A Temporary Registration Permit is not renewable, but when circumstances outlined in section 42-3-203(3)(e), C.R.S., are met, the Dealer may issue a second Temporary Registration Permit pursuant to the requirements in this rule.

2.10 A Dealer must not place hand written markings, stickers, items, decorations, decals, or other markings on the printed Temporary Registration Permit and/or Mounting Board. Mounting frames must not obstruct any portion of or otherwise render the Temporary Registration Permit unreadable pursuant to in section 42-3-202(2), C.R.S.

2.11 A Dealer must not alter the printing of the Temporary Registration Permit by resizing it, rotating it, or by any other alteration. Altering the printing of the Temporary Registration Permit will render it invalid.

2.12 A Temporary Registration Permit must not be issued to vehicles sold as "Tow Away" or to vehicles that are not roadworthy. A Temporary Registration Permit must not be used to demonstrate, transport, or deliver vehicles.

2.13 Dealers must ensure that the Approved System is secure and accessible only by authorized users. Dealers must meet all training and system requirements to use the Approved System.

2.14 Mounting Boards must be kept in a secure location. Dealers must file a police report with local law enforcement within twenty-four (24) hours of discovering that a Mounting Board(s) has been lost or stolen. A copy of the police report must be supplied to the Department.

2.15 All Mounting Boards must be surrendered immediately to the Department of Revenue, Enforcement Business Group, Auto Industry Division, when a Dealer's license has been suspended or revoked.

2.16 After notice and hearing conducted pursuant to 24-4-104 and 24-4-105, C.R.S., a Dealer found to have violated this rule may have its privilege of issuing Temporary Registration Permits suspended or revoked.

3.0 Analog Temporary Registration Permit Issuance

3.1 In the event of a System Outage occurring After Department Business Hours, Dealers may issue an Analog Temporary Registration Permit in lieu of the Temporary Registration Permit.

a. In the event of a System Outage occurring during Department Business Hours, Dealers may issue an Analog Temporary Registration Permit in lieu of the Temporary Registration Permit upon receiving notice from the Department that authorization to issue them is granted for the period of time that the System Outage occurred during Department Business Hours.

3.2 An Analog Temporary Registration Permit is valid for thirty-six (36) hours from the date of issuance during an Approved System outage.

3.3 An Analog Temporary Registration Permit shall be completed on forms provided by the Department and must contain:

a. The Dealer's dealer number, (preceded by zeros if less than six digits) and the last three numbers of the vehicle identification number (VIN). This will be the Analog Temporary Registration Permit serial number.

b. Month, Day and Year of issuance.

c. Time of issuance.

d. Vehicle VIN, color, model year, make, and body.

3.4 Dealer must affix the Analog Temporary Registration Permit to a Mounting Board as required in 2.3 above.

3.5 Dealer must provide the vehicle owner the completed Analog Temporary Registration Permit affixed to a Mounting Board, and a letter on the dealership letterhead that includes the date, time, VIN, color, model year, make, body, owner name and contact information, and Dealer's contact information.

3.6 Dealer must retain a copy of the Analog Temporary Registration Permit and dealership letter and send an image of the Analog Temporary Registration Permit and dealership letter to the Department via email to dor_comcenter@state.co.us and dor_vehicleportal@state.co.us or by fax to (303)205-5802.

3.7 Within thirty-six (36) hours from the date of issuance of the Analog Temporary Registration Permit, the Dealer must complete the issuance of a sixty-day (60) Temporary Registration Permit on the Approved System, as required in section 2.0, and provide it to the owner.

3.8 A Dealer that issues an Analog Temporary Registration Permit that does not coincide with an Approved System outage, or coincides with a Department approval notification, or fails to complete the requirements of this rule upon issuance of an Analog Temporary Registration Permit will be reported to the Department's Auto Industry Division.

Notice of Proposed Rulemaking

Tracking number

2019-00622

Department

200 - Department of Revenue

Agency

207 - Division of Gaming - Rules promulgated by Gaming Commission

CCR number

1 CCR 207-1

Rule title

GAMING REGULATIONS

Rulemaking Hearing

Date

11/21/2019

Time

09:15 AM

Location

17301 W Colfax Ave, Suite 135, Golden CO 80401

Subjects and issues involved

Amendments to Gaming Rule 1 General Rules and Regulations, and Rule 12 Gaming Devices and Equipment, as a result of mandatory rule review. The changes are being made for consistency and clarification and to allow for the use of new gaming technology.

Statutory authority

Sections 44-30-102 C.R.S., 44-30-103, C.R.S., 44-30-104, C.R.S., 44-30-201, C.R.S., 44-30-203, C.R.S., 44-30-302, C.R.S., and 44-30-806, C.R.S.

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BASIS AND PURPOSE FOR RULE 1

The purpose of Rule 1 is to present definitions of various terms used throughout the rules of the Colorado Limited Gaming Control Commission so that the rules can be uniformly applied and understood. The statutory basis for Rule 1 is found in sections 44-30-102 C.R.S., 44-30-103, C.R.S., 44-30-104, C.R.S., 44-30-201, C.R.S., 44-30-203, C.R.S., and 44-30-302, C.R.S. *Amended 2/14/14, Amended 1/14/15*

RULE 1 GENERAL RULES AND REGULATIONS

30-101 Purpose and statutory authority.

These Rules and Regulations are adopted by the Colorado Limited Gaming Control Commission governing the establishment and operation of limited gaming in Colorado pursuant to the authority provided by article 30, title 44, C.R.S. The Commission will, from time to time, promulgate, amend and repeal such regulations, consistent with the policy, objects and purposes of the Colorado Limited Gaming Act (THE ACT), as it may deem necessary or desirable in carrying out the policy and provisions of that Act. *Amended 1/14/15*

30-104 Authorized games.

Limited gaming permitted pursuant to article 30 of title 44, C.R.S., shall include only the following games: blackjack (21); poker; slot machines; craps; and roulette. All such games shall be conducted by licensees only in accordance with rules and regulations promulgated by the Commission.

30-105 Unauthorized gambling.

(1) No licensee shall conduct or permit on its licensed premises any wagering or gambling, except limited gaming ~~which~~THAT is conducted according to all the rules and regulations promulgated by the Commission and except other wagering activities licensed or approved by an agency of the State of Colorado.

(2) No person shall make any unauthorized wager or conduct any gambling activity on licensed premises unless in accordance with the Aact, the rules and regulations promulgated by the Commission, or the laws and regulations governing other wagering activities which are licensed or approved by an agency of the State of Colorado.

30-106 Definitions.

The following definitions of terms, in addition to those set forth in section 44-30-103, C.R.S., shall apply to all rules and regulations promulgated pursuant to article 30 of title 44, of the Colorado Revised Statutes:

(3) “Background investigation” means the INQUIRY INTO THE personal history, character, reputation, associations, PERSONAL AND PROFESSIONAL record, criminal history, CIVIL LITIGATION HISTORY, and financial ~~check~~HISTORY AND ACTIVITIES of an applicant for a license to establish the suitability of such applicant to become a licensee. *Amended 1/14/15*

(6) "Chip" means a nonmetal or partly metal representative of value issued and/or sold by a licensee for use ~~at~~IN LIMITED gaming. *Amended 11/30/2012*

(8) "Costs" means sums of money to be paid to the Commission. *Amended 1/14/15*

(~~8.59~~) *note to publisher: remove this space and move the following paragraphs up.*

~~(a)~~ "Credit" means allowing any person any length of time in which to make payment or otherwise honor a financial obligation, whether express or implied and includes lending of cash or cash equivalent. *Amended 11/30/2012, Amended 1/14/15*

~~(b)~~ CREDIT INSTRUMENTS INCLUDE ~~M~~Markers, promissory notes, IOUs or similar transactions or instruments constituting a memorandum of debt accepted for purposes of participating in limited gaming, ~~which are not~~EXCLUDING checks. ~~are credit instruments.~~ *Amended 11/30/2012*

(~~c~~A) "Credit" does not include:

(~~8.7~~10) "Dice" means small cubes, each with a different number of spots (1-6) on each side, used in games of chance to generate random numbers.

(~~9~~11) "Drop" means the total amount of money, chips, tickets, coupons, Mobile ATM Receipts and tokens removed from the drop boxes. *Amended 7/1/13*

(~~10~~2) "Drop box" means: (1) a locked container permanently marked with the game and a number corresponding to a permanent number on the table for blackjack, poker, craps, and roulette tables; OR (2) for slot machines, a container in a locked portion of the machine or its cabinet used to collect the money and tokens retained by the machine that is not used to make automatic payouts from the machine.

(~~11~~6) "Financial institution" means a bank, savings and loan association, credit union, trust company, or other similar entity chartered by the United States, a state, or a territory or commonwealth of the United States.

(~~12~~7) [Free play - Repealed eff. 05/15/2014]

(~~13~~8) "Gaming contract" means an agreement in which a person does business with or on the premises of an entity licensed under article 30 of title 44, C.R.S.~~:~~;

(~~13.5~~9) "Gaming device" or "gaming equipment" includes, in addition to the definition set forth in section 44-30-103(13), C.R.S., any progressive system, slot monitoring or control system, ticket redemption kiosk, or cashless system, and also includes any "physical or electronic versions," pursuant to section 44-30-103(13), (~~19~~22), C.R.S., to the extent such physical or electronic versions function in the manner of: *Eff 04/30/2007, Amended 2/14/14*

(~~14~~20) "Gaming employee" means, in addition to the definition set forth in section 44-30-103(14):

(2~~14.5~~)"House banked" means a game in which players with winning hands are paid by the dealer with money from the chip bank on the poker table and/or by hand with money belonging to the retail licensee. In a house banked game, player's wagers will not be pulled into a common pot, nor will such a pot be awarded to players with winning hands.

(~~15~~22) "Imprest bank" means a predetermined dollar amount of chips, tokens, or cash kept by the licensee.

(~~16~~23) "Jackpot verification mode" means the period of time between the progressive jackpot activation of a progressive slot machine and the resetting of the device which caused its activation.

(~~17~~24) "Lammer" or "lammer button" means a chip-like implement with a numeral.

(~~18~~25) “Licensee” means a person holding any license issued by the Commission, and an employee, agent, or representative of any such person.

(~~19~~27) “Link” means one or more progressive slot machines that are connected to a progressive controller and that may be played in order to achieve the stated progressive amount.

(~~20~~8) “Matched play” means the use of a coupon at table games that is issued to a patron by an establishment for play that must be accompanied by a bet. *Eff 11/30/2006*

(~~21~~30) “Moral turpitude” means an act done contrary to honesty and good morals; it is an act of baseness, vileness, or depravity in the private and social duties which a person owes to ~~a~~AN ~~fellowperson~~INDIVIDUAL or to society in general.

(~~22~~31) “Normal mode” means the mode of a progressive slot machine at all times other than when it is in the jackpot verification mode.

(~~22.~~32) “Physical skill” means an individual’s physical coordination, agility, or nimbleness, or lack thereof. *Eff 11/30/2007*

(~~22.5~~33)“Player banked” means a game in which players with winning hands are awarded all or part of a pot which consists of pooled antes, blinds, and wagers made by players playing in the hand. In a player banked game, the bankroll of the retail licensee is not at risk and is not used to pay winning wagers. The licensee will maintain only an imprest bank at the table.

(~~23~~4) “Progressive controller” means the hardware and software that controls all communications among the slot machines within a progressive slot machine link and its associated progressive meter, or among the gaming tables which offer a metered progressive jackpot within a progressive table game link and its associated progressive meter.

(~~24~~35) “Proposition player” means a person in a poker game paid a fixed sum by the licensee for the specific purpose of playing in a card game, who uses personal funds and who retains the winnings and absorbs the losses.

(~~24.5~~36)“Side Bet” means an unauthorized wager between or among a player and one or more other persons which is apart from, or independent of, wagers permitted by the rules of any approved game or wagering activity.

(~~24.~~37) “Slot Coupon” means an encoded credit certificate which, when inserted into a slot machine, is validated by a computerized system which causes redeemable credits on the face amount to be placed on the machine. A slot coupon has no value unless inserted into a slot machine or redeemed by the casino in another approved manner.

(~~25~~38) “Strategy card” means a small, hand-held card imprinted with information which analyzes or suggests the strategy for playing or betting to be used in any authorized casino game. The card may have a movable dial or slide, but it may not have any electronic computing or electronic display capability.

(~~26~~39) “Substantial interest” means the lesser of: as large an interest in a corporation, partnership, or association as that of any other shareholder, partner, or principal; or any financial or equity interest equal to or greater than five percent.

(~~27~~40) “Support licensee” means a gaming employee licensed by the Commission, but does not include licensed key employees.

(~~27.2~~41)"Table Games Mobile ATM" means a mobile payment processing device and service that allows ATM transactions at a table game. *Eff 7/1/13*_

(~~27.3~~42)"Ticket" means an encoded credit ticket produced by a slot machine ticket printer system when cashing out redeemable credits. (PREVIOUSLY "HOPPER TICKET"106 (8.3) added perm. 10/30/99; RENUMBERED AND AMENDED TO 106 (27.3) "TICKET" IN SEPTEMBER 2005)

(~~27.5~~44)"Tournament chip" means a chip issued by a licensee for use solely in tournaments and promotions at a licensed retail location.

(~~28~~45) "Token" means a metal or other approved material representative of value, redeemable for cash, issued and sold by a licensee for use in gaming. (30-106(28) amended perm. 10/30/99) *Eff 11/30/2006, Amended 11/30/2012*

(~~29~~46) "Wager" means a sum of money, electronic promotional credits or thing of value risked on an uncertain occurrence. Credit and debit cards cannot be used to place a wager in a limited gaming activity. *Eff 11/30/2006, Amended 1/14/2012, Amended 7/1/13*

(~~30~~47) "Wireless" means a wireless handheld validation unit used with a supporting Wireless Local Area Network (WLAN) as part of an approved gaming system. *Amended 1/14/15*

(~~31~~3) "Electronic Chips" means an electronic facsimile of chip representative of value, redeemable for cash, issued and sold by a licensee when using electronic betting terminals (EBTs). *Eff 03/01/2012*

(~~32~~14) "Electronic Dice" means an electronic facsimile of small cubes, each with a different number of spots (1-6) on each side in games of chance to generate random numbers when using electronic betting terminals. *Eff 03/01/2012*

(~~33~~15) "Electronic betting terminal" or EBT means an electronic betting terminal or interface used on a table game that allows a patron to exchange cash for electronic chips, and make wagers utilizing those electronic chips. *Eff 03/01/2012*

(~~34~~29) "Mobile ATM Receipt" means a receipt generated by a Table Games Mobile ATM in exchange for an authorized debit or credit card transaction. A Mobile ATM Receipt may be exchanged at a table game for physical or electronic chips. *Eff 7/1/13*

(4~~35~~) "Tip Storage Device" means a tip storage device, commonly referred to as a toke tube, used for the purpose of temporarily securing chips received by dealers as tips. Use of a tip storage device, must be exclusively for temporarily holding said chips, prior to exchanging lower denomination chips for higher denomination chips to place into the lockbox. The placement of tips into a tip storage device prior to exchanging shall be deemed to comply with C.R.S. 44.-30-820, as it applies to immediately dropping tips. *Eff 7/1/13*

(~~3~~26) "Linger in a gaming area of a casino" as used in C.R.S. 44-30-809(1)(a)(I) and (3)(a)(I), means that a person under twenty-one years of age remains, for a period of thirty consecutive minutes or more, within a casino's licensed premises, as defined by C.R.S. 44-30-103(19), which licensed premises are diagrammed on a retail floor plan, pursuant to C.R.S. 44-30-508, and outlined in red, in compliance with Rule 30-313(2). *Effective 12/15/18*

BASIS AND PURPOSE FOR RULE 12

The purpose of Rule 12 is to establish a procedure for the testing and approval by the Commission of gaming devices and equipment, to establish requirements for the gaming devices and equipment to be

used in limited gaming in Colorado, and to establish procedures for the storage of gaming devices and equipment in compliance with section 44-30-302 (2), C.R.S. The statutory basis for Rule 12 is found in sections 44-30-201, C.R.S., 44-30-203, C.R.S., 44-30-302, C.R.S., and 44-30-806, C.R.S.

RULE 12 GAMING DEVICES AND EQUIPMENT

30-1201 Device and equipment approval.

(1) No slot machine, ~~note acceptor~~BILL VALIDATOR, token acceptor, coin acceptor, hopper, ticketing (TITO) system, progressive controller, gaming system, table game with electronic or electromechanical components, mechanical or electronic shuffling device, chips, tokens, or other gaming equipment may be used for limited gaming purposes by any licensee without prior written approval of the Division. The approval must describe with particularity the equipment or device approved. (amend. perm. 03/30/02, amend. perm. 01/30/04) *Amended 11/30/14*

(2) Each individual slot machine, ~~component part and~~ table game (ELECTRONIC OR PHYSICAL), AND ALL ASSOCIATED EQUIPMENT must be inspected for proper settings/optioning/rule text (as applicable) by the offering retailer or operator before it is used for limited gaming. This shall include inspection of all required documentation on Division approved forms for proper completion. Each licensed manufacturer, distributor, associated equipment supplier, operator or retailer must ensure that all component parts, media storage devices and slot machines shipped and offered for play in the State's limited gaming areas are approved for use in the State of Colorado. (amend. perm. 03/30/02) *Amended 2/14/14, Amended 11/30/14*

30-1202 Gaming device and gaming system testing.

(5) All GAMING devices, including slot machines, equipment and gaming systems required to be tested under this section shall be tested to the standards established by this Rule 12 at the time the device is tested. Amendments to this Rule 12 shall not be retroactively applied to any device tested and approved before the effective date of the amendment unless the device is required to be retested at the independent laboratory after the effective date as the result of any modification, alteration or upgrade. A retest shall be performed to the new standards unless the manufacturer or associated equipment supplier can demonstrate to the Division that the new standards would hinder the design of the device or would otherwise pose a hardship due to capacity limitations in the device's originally approved platform. *Eff 03/02/2007, Amended 2/14/14, Amended 11/30/14*

30-1205 Cards – receipt and storage.

When decks of cards are received AT THE LICENSED ESTABLISHMENT, for use in a licensed establishment, they must be inventoried and PLACED FOR STORAGE IN A PRIMARY OR SECONDARY SECURE STORAGE AREA~~stored in a locked cabinet. The cabinet must be located in a secure location. The location must be approved by the Division. A secondary storage area must be located in a secure area approved by the Division~~. (amended perm. 03/30/03)

APPROVAL MUST BE OBTAINED FROM THE DIVISION BEFORE A LICENSEE MAY STORE DECKS OF CARDS AT A SECONDARY NON-LICENSED STORAGE AREA OFFSITE.

30-1206 Cards – inspection and removal from use.

~~(4) A label must be attached to an envelope or container which identifies the date and time and which must be signed or initialed by a pit supervisor.~~

(~~5~~4) Where a licensee has no reason to believe that damaged or flawed cards in a sealed envelope or container were so damaged or flawed as a result of an unlawful act, motive, or scheme, the

licensee may dispose of such cards after 30 days in any manner designed to prevent their future use in limited gaming. (amended perm. 09/30/03)

30-1221 Definitions for slot machines.

The following definitions apply to all slot machine hardware and software requirements: *Eff 03/02/2007*

(3) "Par sheet" means documentation which depicts the possible outcomes from the play of a slot machine, the probability of occurrence ~~of each~~ FOR THE ADVERTISED AWARDS, and the contribution of each winning outcome to the payback percentage of a slot machine. The documentation must also list the applicable game and personality program version(s), as well as the paytable identification numbers (as identified in the machine's configuration menus and/or display) of the media operating within the slot machine. THE DIVISION MAY APPROVE VARIATIONS TO THE SPECIFIC PAR SHEET REQUIREMENTS, PROVIDED THE SLOT MACHINE MANUFACTURER'S DOCUMENTATION SATISFIES THE OBJECTIVES OF THIS REGULATION. *Eff 03/02/2007, Amended 11/30/14*

30-1222 Control program requirements.

(2) The program residing in the slot machine must be contained in a media storage device which is not alterable through any use of the circuitry or programming of the slot machine itself. Hard disk, CD ROM, and other media storage devices in lieu of EPROMs may be acceptable; however, the media storage device must be approved by the Division. Non-volatile memory chips (e.g., a flash EPROM) may be used for the ~~note acceptor~~BILL VALIDATOR, ticket printer, sound and graphic programs if the procedure used to send information to the flash EPROM is secure from unauthorized tampering and the procedure has been approved by the Division. Flash EPROMs must not contain any information related to the security, operation, or metering of the game except as directly related to the operation of the ~~note acceptor~~BILL VALIDATOR, ticket printer, sound and graphics routines. *Eff 03/02/2007, Amended 11/30/14*

(4) All slot machines must have the capacity to display a complete play history for the last ten games. Retention of play history for additional prior games is encouraged. The display must indicate the game outcome (or a representative equivalent), intermediate play steps (such as a hold and draw sequence or a double-down sequence), credits available, bets placed, credits or coins paid, and credits cashed out. Slot machines offering games with a variable number of intermediate play steps per game may satisfy this requirement by providing the capability to display the last 50 play steps. Slot machines interfaced to any bonusing event or system must display a complete transaction history for the most recent transaction and the previous ~~thirty-four~~34 transactions prior to the most recent transaction that incremented any of the meters. Last game recall must also be time and date stamped, to allow for determination of credit meter incrementation (i.e., coins, ~~notes~~BILLS, tickets, slot coupons, or won credits). If a game incorporates take-or-risk bonus play, then last game recall must recall all award values presented or offered, and the ordering and outcome of the risk events.

(7) Slot machines equipped with ~~note acceptors~~ BILL VALIDATORS must maintain an audit log that records, at a minimum, the last five ~~notes~~BILLS accepted. Upon ~~note~~BILL acceptance, the log shall properly update with the ~~note~~BILL information, including the date and time of acceptance, and the ~~note~~BILL value. This log must not be cleared upon removal of the stacker. *Eff 03/02/2007, Amended 11/30/14*

(8) The slot machine must clearly display all game program and version identification numbers on demand, including peripheral devices such as the ~~note acceptor~~BILL VALIDATOR and the ticket printer installed in the game. The game program and version identification numbers displayed must ~~agree~~CORRESPOND with the contracted test laboratory's certification reports. *Effective 11/30/14*

30-1229 Coin and ~~note acceptors~~ BILL VALIDATORS.

(1) An electronic coin or token acceptor, or a ~~note acceptor~~BILL VALIDATOR, may be installed in a slot machine. Coin, token, and ~~note acceptors~~BILL VALIDATORS must be approved by the Division to indicate that they meet the requirements of this section. All programmable coin acceptors with multiple programmable channels must be secured in a manner so that only one channel can be programmed unless more than one channel is required to accept different mints of the same type, value, and otherwise identical tokens of the same licensee; multiple channels must not be enabled for any other reason. Coin, token, and ~~note acceptors~~BILL VALIDATORS must be designed to accept designated coin, tokens, tickets, or ~~notes~~BILLS and reject others on the basis of metal composition, size, composite makeup, or equivalent security. *Eff 03/02/2007*

(2) Coin Acceptors. *Eff 03/02/2007*

(a) Licensees must ensure their coin acceptors do not accept and credit other consideration, such as another licensee's tokens. *Eff 03/02/2007*

(b) The coin acceptor, and the slot machine's related parts, must be capable of handling and accurately accounting for all accepted coins. *Eff 03/02/2007*

(3) ~~Note Acceptors~~BILL VALIDATORS. *Eff 03/02/2007*

(a) The gaming device shall not credit the ~~note~~BILL or ticket received until the ~~note acceptor~~ BILL VALIDATOR confirms it has successfully received and stacked the ~~note~~BILL/ticket. *Eff 03/02/2007, Amended 11/30/14*

(b) The ~~note acceptor~~BILL VALIDATOR and its related parts shall be designed to be secure from unauthorized access, tampering, and ~~note~~BILL/ticket removal. *Eff 03/02/2007, Amended 11/30/14*

(c) If the ~~note acceptor~~BILL VALIDATOR stacker is full, the gaming device must disable the ~~note acceptor~~BILL VALIDATOR and refuse to accept ~~notes~~BILLS/tickets. The gaming device may generate an error message and hard tilt the ~~note acceptor~~BILL VALIDATOR. *Eff 03/02/2007, Amended 11/30/14*

(d) If a power loss or any door open condition occurs when accepting a ~~note~~BILL/ticket into the ~~note~~BILL stacker, and no credits have been vended to the game for this ~~note~~ BILL/ticket, the ~~note~~BILL/ticket should either be returned to the patron, or the appropriate credits should be vended to the game with the ~~note~~BILL/ticket being stacked in the ~~note acceptor~~BILL VALIDATOR after the error condition is cleared. *Eff 03/02/2007, Amended 11/30/14*

30-1233 Rules of play.

(1) The rules of play for a slot machine game must be displayable on the slot machine face, glass or video screen. Rules of play must have approval of the Division. The Division may ~~reject the rules~~ IMMEDIATELY DISABLE A SLOT MACHINE GAME FROM PATRON PLAY if ~~they~~THE RULES OF PLAY are UNAVAILABLE, incomplete, confusing, or misleading. *Amended 11/30/14*

(~~d~~7) The ~~bonus play~~SLOT MACHINE may ~~include~~OFFER ~~physical~~ skill based components, FEATURES, OR GAME PLAY which affect the return to the player if the following conditions are met: *Eff 11/30/2007*

(i) The difference between the minimum and the maximum pay for all ~~physical~~ skill based outcomes or awards may not exceed THE THEORETICAL PAY OUT REQUIREMENTS SET FORTH IN 30-1242 FOR~~a four percent contribution to~~ the overall return to the player of the gaming device. *Eff 11/30/2007, Amended 11/30/14*

(ii) Information explaining the ~~physical~~ skill based functionality must be prominently displayed on the award glass or video display. This information ~~should~~MUST include that there is a ~~physical~~ skill based advantage. *Eff 11/30/2007*

(~~7~~8) A player must be able to cash out his/her credits from a game, regardless of the amount. If the game utilizes a residual credit gamble feature, this feature shall have a theoretical return to the player of 100 percent. This requirement does not apply to non-cashable electronic promotional credits downloaded onto a slot machine.

30-1234 Multi-game and multi-denomination slot machines.

(3) A multi-game slot machine must have a last game recall that can display the last ten games, including any bonus occurrences which result in awards, and any other significant events such as tilts, credit cash outs, ~~note~~BILL acceptor transactions, or jackpots. Last game recall must also be time and date stamped, to allow for determination of credit meter (i.e. coins, ~~notes~~BILLS, electronic, or won credits). *Eff 03/02/2007*

30-1236 Error conditions-automatic reset.

Slot machines must be capable of detecting and displaying the following conditions, which must be automatically cleared by the slot machine upon initiation of a new play sequence:

(2) If a power loss or any door open condition occurs when accepting and escrowing a ticket while awaiting validation confirmation, the ticket should either maintain a valid status in the TITO system and be returned to the patron, or the appropriate automatic payment should be vended with the ticket being stacked in the ~~note acceptor~~BILL VALIDATOR and redeemed through the system after the error condition is cleared. *Amended 1/14/2012*

30-1237 Error conditions-cleared by attendant.

Slot machines must be capable of detecting and displaying the following error conditions, which an attendant must clear: *Eff 03/02/2007*

(7) Reverse coin in and ~~note~~BILL-in (coin or ~~note~~BILL/ticket traveling the wrong way through acceptor); *Eff 03/02/2007, Amended 11/30/14*

30-1240 Number and value of credits wagered. ***Amended 11/30/14***

Redeemable credits and wagers must be accumulated from wins or from coin, token, tickets, or ~~notes~~ BILLS. A slot machine may not offer or allow any wagers, which violate the $100 maximum wager restriction for any wagered game played. Any configuration setting that would allow a wager to exceed the $100 maximum wager and/or that can be altered in any way must be maintained behind a secure means. An attendant key switch may not be used to satisfy this requirement.

A double up feature may reside within the game media, provided it is capable of being disabled via a secure means.

30-1242 Software requirements for percentage payout.

The slot machine must meet the following maximum and minimum theoretical pay out during the expected lifetime of the slot machine:

(1) The slot machine game program must theoretically pay out at least 80 percent and no more than 100 percent of the amount wagered. The theoretical payout percentage is determined using standard methods of probability theory. When applied to games whose outcome is determined in

whole or in part by skill, WHETHER BY MEANS OF STRATEGY, DEXTERITY, AGILITY OR ANY OTHER ABILITY OR EXPERTISE RELEVANT TO GAME PLAY, the 100 percent theoretical pay out shall be computed using the optimum play strategy for compliance of the given game tested and the 80 percent theoretical payout will be computed using the lowest ~~manufacturer's expected~~ return for the game program. TO ENSURE COMPLIANCE WITH THE MINIMUM THEORETICAL PAYBACK PERCENTAGE, COUNTER OPTIMAL PLAY ON SIMULATED LIVE CARD GAME THEMES (E.G., POKER, BLACKJACK, ETC.) SHALL NOT APPLY.

30-1244 Progressive slot machine games defined.

(12) Discontinuance of progressive slot machine games.

No licensee may discontinue a progressive slot machine game until all of the advertised progressive amounts or prizes or both have been awarded, or the advertised progressive amount, minus the normal non-progressive award for the combination that would have awarded the progressive amount, is moved to another progressive link within the licensed establishment or this amount is disbursed in another method approved by the Division, such as an additional payout.

(Paragraph 30-1244 (12)(b) was relocated and renumbered to 30-1244 (15)(s), effective 12/15/2014; REGULATION 30-1244 (15)(S) WAS RELOCATED TO 30-1244.25 (1)(S), EFFECTIVE 2/14/19)

(14) Requirements apply to single machine games found within a single Colorado licensed retail establishment. The requirements of this rule are intended to apply equally to one progressive slot machine game linked to a progressive controller as well as several progressive slot machine games linked to one progressive controller. The Division may grant waivers in order that both single slot machine games and multiple slot machine games linked to a progressive controller may meet the requirements of this rule.(30-1244 perm. 5/30/93)(30-1244 perm. 9/30/97) *Amended 11/30/14*

(REGULATIONS 30-1244 (15) AND (16) WERE RELOCATED TO 30-1244.25 (1) AND (2), EFFECTIVE 2/14/19

30-1244.25 Multi-Link / Wide Area Progressive (WAP) Systems.

(1) Multi-link systems are the collection of hardware, software, and associated equipment used to link and monitor progressive slot machine games across telecommunication lines between two or more Colorado licensed retail establishments. In addition to the above requirements for linked progressive slot machine games, multi-link systems must comply with the following: *Effective 11/30/14; Amended 2/14/19*

(r) Mixed maximum bet progressive link. If all gaming devices connected to a multi-link system do not offer the same maximum bet value, all such gaming devices must equalize the expected value of winning the progressive jackpot by setting the odds of winning the progressive jackpot in proportion to the amount wagered on each device, or by requiring the same wager value on each device to win the progressive jackpot. A variance of no greater than .005% from the median odds for all games on a link will be acceptable. The method of equalizing the expected value of winning the progressive jackpot shall be conspicuously displayed on each device connected to the system. THE MULTI_LINK SYSTEM MANUFACTURER MUST NOTIFY THE DIVISION AT LEAST 30 DAYS PRIOR TO ADDING OR CONVERTING ANY SLOT MACHINES. THE NOTIFICATION MUST INCLUDE A COPY OF THE COLORADO APPROVED INDEPENDENT TESTING LABORATORY'S CERTIFICATION LETTER, AND DOCUMENTATION VERIFYING THE NEW OR CONVERTED SLOT MACHINES COMPLY WITH THE ODDS VARIANCE AS STATED ABOVE. (amended perm. 03/30/03) *Amended 11/30/14*

30-1254 Progressive table games defined.

(6) ~~Each progressive controller linking one or more progressive tables must be housed in a dual keyed compartment or secured in a manner approved by the Division.~~ The licensee offering the progressive must establish key control procedures TO PREVENT UNAUTHORIZED ACCESS TO THE PROGRESSIVE CONTROLLER ~~that ensure no one person may have access to a controller's configuration data. There must be a progressive entry authorization log within each controller and the log must be completed by any person gaining entrance to the controller. The log must be entered on a form provided by the Division~~. If the progressive controller is integrated with a personal computer software system, logical access over the personal computer software components must be designed to prevent unauthorized access to the software. *Amended 11/30/14*

30-1259 Incidental repairs.

A licensed MANUFACTURER OR DISTRIBUTOR, operator, ~~or~~ retailer, OR ASSOCIATED EQUIPMENT SUPPLIER may perform incidental repairs on its ~~slot machines~~GAMING DEVICES AND ASSOCIATED EQUIPMENT. All persons actually performing THE internal service or repairs ~~on slot machines~~ must display a CURRENT Colorado gaming license. The license~~d operator~~ is responsible for ensuring that all service WORK,~~and repairs on its slot machines,~~ including the installation or repairs of component parts and associated equipment such as bill ~~acceptors~~VALIDATORS, ticket printers, gaming systems, KIOSKS or other parts which would significantly alter the current or subsequent operation of the ~~slot machine~~GAMING DEVICES OR ASSOCIATED EQUIPMENT, are done correctly and are in compliance with Division requirements. (30-1259 perm: 9/30/97) *Amended 11/30/14*

30.1262 Use of slot coupons.

(2) The slot machines must have ~~note acceptors~~BILL VALIDATORS in order to accept slot coupons. The ~~note acceptors~~BILL VALIDATORS accepting slot coupons must communicate with the slot machines' microprocessors. The gaming system must validate all slot coupons before redeeming and stacking the slot coupons. Only after redeeming the slot coupons can credits be issued to the slot machine, through the gaming system. The gaming system must maintain a record of each slot coupon accepted, validated and redeemed by the system. Once a slot coupon is accepted, validated and redeemed, that coupon shall not be redeemed again. *Amended 11/30/14*

30-1281 Dice – receipt, storage, inspections, and removal from use.

(1) When dice are received AT THE LICENSED ESTABLISHMENT, for use in a licensed ~~premises~~ESTABLISHMENT, they must be inventoried and the boxes shall be placed for storage in a primary or secondary SECURE storage area ~~located in a secure location approved by the Division~~.

(A) APPROVAL MUST BE OBTAINED FROM THE DIVISION BEFORE A LICENSEE MAY STORE DICE AT A SECONDARY NON-LICENSED STORAGE AREA OFFSITE.

(B) Dice maintained in secondary storage areas shall be transferred to the primary storage area before being distributed to the pits or tables.

Notice of Proposed Rulemaking

Tracking number

2019-00620

Department

400 - Department of Natural Resources

Agency

404 - Oil and Gas Conservation Commission

CCR number

2 CCR 404-1

Rule title

PRACTICE AND PROCEDURE

Rulemaking Hearing

Date

11/19/2019

Time

04:30 PM

Location

University of Northern Colorado, University Center Ball Room, 2101 10th Avenue Greeley, CO 80631

Subjects and issues involved

The Oil and Gas Conservation Commission of the State of Colorado (Commission), on its own motion, will consider additions and amendments to Commission Rules of Practice and Procedure, 2 C.C.R. 404-1 (Rules),100-Series definitions; 215; 216; 316; 326; 333; 610; 711; 712; 713; 906; and the 1100-Series, as part of its rulemaking to adopt the 2019 Flowline Rules.

On April 16, 2019, Governor Polis signed SB 19-181, which modified §34-60-106(19)(a),(b), C.R.S. These statutory changes provide that the Commission shall review and amend its flowline and inactive, temporarily abandoned and shut-in well rules to protect and minimize adverse impacts to the public health, safety, and welfare and the environment by, at a minimum, 1) allowing for the public disclosure of flowline information; 2) evaluating and determining the process for inspecting deactivated flowlines prior to reactivation; and 3) evaluating and determining when inactive, temporarily abandoned and shut-in wells must be inspected prior to being placed back into production. The purpose of the rulemaking is to make necessary changes to Commission Rules to implement these provisions of SB 19-181 and make conforming changes. The rulemaking to adopt the 2019 Flowline Rules is not the only rulemaking contemplated by SB 19-181. Additional SB 19-181 rulemakings will be noticed and conducted at a later date.

Statutory authority

Section 34-60-105(1), C.R.S.
Section 34-60-106(2), C.R.S.
Section 34-60-106(2.5)(a), C.R.S.
Section 34-60-107, C.R.S.
34-60-108, C.R.S.

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APPENDIX A

FLOWLINE REGULATIONS (1100 Series)

1101. REGISTRATION REQUIREMENTS

1101.a. Flowline and Crude Oil Transfer Line Statuses.

(1) Pre-Commissioned Status means a constructed pipeline that:

A. Has not been connected or opened to sources of hazardous liquid, produced water, or natural or other gas;

B. Is isolated from active status assets;

C. Does not contain hazardous liquid, produced water, or natural or other gas; and

D. Is OOSLAT.

(2) Active Status means a pipeline that is engaged in or available for normal operations and is connected or open to sources of hazardous liquid, produced water, or natural or other gas or contains these products. This status includes pipelines that

A. Are undergoing repair or maintenance and are locked out/tagged out in accordance with OSHA requirements; and

B. Are shut-in, meaning that the line contains fluids associated with oil and gas operations, but the pipeline is not flowing fluids. If an off-location flowline or a crude oil transfer line has been shut-in for more than 90 days, the operator must apply tag out devices to the risers.

(3) Out-of-Service Status means a pipeline that the operator has ceased normal operations by

A. Isolating or disconnecting it from sources of hazardous liquid, produced water, or natural or other gas;

B. Purging it of combustibles and produced water; and

C. applying OOSLAT.

(4) Abandoned Status means a pipeline that has been permanently removed from service in accordance with Rule 1105.

1101.b. Off-Location Flowline Registration.

(1) An operator must register an off-location flowline ~~constructed on or after May 1, 2018,~~ by submitting a Flowline Report, Form 44, to the Director within 90 days after the flowline is placed in active status~~placed into service. An off-location flowline in existence prior to May 1, 2018, must be registered by October 31, 2019~~. An off-location flowline registered as part of a produced water transfer system or as part of a flowline system is not subject to this requirement.

(2) Registration Requirements. For off-location flowlines registered pursuant to this section, operators must include the following information:

~~A. For off-location flowlines constructed on or after May 1, 2018, operators must include the following information:~~

~~B.~~A. A geodatabase containing the pipeline alignment in the North American Datum of 1983 (NAD 83) with the following attributes: fluid type, pipe material type and pipe size in a format approved by the Director;

~~C.~~

~~D.~~B. Bedding materials used in construction;

C. Pipe material;

D. Maximum flowline diameter;

E. Fluids that will be transferred;

F. The maximum anticipated operating pressure, testing pressure, test date and chart of successful pressure test;

~~A layout drawing sufficient to identify the alignment of the flowline, associated oil and gas locations, and existing and proposed pipelines related to the oil and gas locations; and~~

G. Identify and describe the starting and ending oil and gas locations;

H. Description of corrosion protection; and

I. Description of the integrity management system utilized in accordance with 1104.f.

(3) For off-location flowlines in existence prior to May 1, 2018, and already registered with the Commission, operators must submit, on or before December 1, 2020, a geodatabase containing the pipeline alignment in the North American Datum of 1983 (NAD 83) with the following attributes: fluid type, pipe material type, and pipe size in a format approved by the Director~~, to the extent such information is or becomes known by the operator or can be acquired from such relevant records in the possession of the operator or its immediate predecessor in interest include in their registration:~~.

~~i.the information set forth in 2.(A)i-viii above, and~~

~~ii.the latitude and longitude of the risers.~~

(5) Within ~~30~~ 90 days of modifying the alignment of a registered off-location flowline, the operator must report the change to the Director by submitting a Flowline Report, Form 44.

(6) If a document is executed after May 1, 2018, that grants a right of access or easement to locate an off-location flowline on lands, then either the document itself or a memorandum or notice of such document must be recorded by the operator in the office of the county clerk and recorder of the county where the lands are located. If the document contains a legal description or map of the access or easement, then the memorandum or notice must include the legal description or map. Upon the surface owner's request, the operator shall provide a copy of the recorded document to the surface owner.

1101.c. **Flowline System Registration**

(1) An operator may register a flowline system, in lieu of registering the individual off-location flowlines or registering the individual produced water flowlines as part of a produced water transfer system, by submitting a Flowline Report, Form 44, to the Director within 90 days after the flowline system is placed into ~~service.~~active status

(2) Registration Requirements: Operators must include the following information:

A. A geodatabase containing the pipeline alignment(s) in the North American Datum of 1983

(NAD 83) with the following attributes: fluid type, pipe material type, and pipe size in a format approved by the Director;

B. Bedding materials used in construction;

C. Description of corrosion protection;

D. Description of the integrity management system utilized in accordance with 1104.f.; and

E. Description of the construction method used for public by-ways, road crossings, sensitive wildlife habitats, sensitive areas, and natural and manmade watercourses (i.e., open trench, bored and cased, or bored only).

(3) Within 90 days of modifying the alignment of a registered off-location flowline, the operator must report the change to the Director by submitting a Flowline Report, Form 44.

1101.d. **Domestic Tap Registration.**

(1) Within ~~30~~90-days of installation or discovery of a domestic tap connected to the operator's flowline, an operator must submit a Flowline Report, Form 44, to the Director to register the tap. ~~Operators must register known domestic taps that were installed prior to May 1, 2018, by submitting a Flowline Report, Form 44, to the Director on or before October 31, 2019.~~ The registration must include the latitude and longitude of the flowline or wellhead connection for the domestic tap and the street address or the latitude and longitude of the point of delivery.

(2) For domestic taps installed after May 1, 2018, an operator must register the domestic tap pursuant to subpart (1) and notify the domestic tap owner in writing that the domestic tap must:

A. Be locatable by a tracer line or location device placed adjacent to or in the trench of the domestic tap to facilitate locating it, and a tracer wire or metallic device for locating must be resistant to corrosion damage;

B. Be installed by a licensed plumber:

C. Have properly-sized regulators at the point the tap connects to the operator's flowline and at the point the tap delivers gas to the dwelling or structure where the gas is utilized;

D. Include all necessary piping to accommodate appropriate odorization, and gas utilization metering equipment;

E. Be installed using materials designed for gas service and appropriate cover and bedding material in accordance with industry standards; and

F. Have markers that are installed and maintained at the point the domestic tap connects to the operator's flowline and at the point it delivers gas to the dwelling or structure where the gas is utilized consistent with 1102.g.

(3) An operator must supply odorant to the domestic tap owner at the time of installation until abandonment of the domestic tap.

(4) Within 30 days of realigning, abandoning, ~~or~~ discovering, or receiving notification that a registered domestic tap has been re-aligned or abandoned, the operator must report the change to the Director by submitting a Flowline Report, Form 44.

1101.~~ce~~. **Crude Oil Transfer Line and Produced Water Transfer System Registration.**

(1) **Registration.** At least 10 days before beginning construction of a crude oil transfer line or

produced water transfer system, an operator must register it by submitting a Flowline Report, Form 44, to the Director. A produced water transfer system registered as part of a flowline system is not subject to this requirement. ~~The submittal must include a layout drawing sufficient to show its route, its crossings of public by-ways, road crossings, sensitive wildlife habitats, sensitive areas and natural and manmade watercourses and the surrounding topography.~~

For a crude oil transfer line or produced water transfer system constructed before May 1, 2018, and already registered with the Commission, operators must submit:

A. A geodatabase as required by (2)A., below, on or before December 1, 2020; and

B. Update any information required by (2)B., below, ~~the operator must register it by submitting a Flowline Report, Form 44, to the Director by October 31, 2019. The submittal must include the information specified in section (2) below,~~ to the extent such information ~~is or~~ becomes known by the operator or can be acquired from such relevant records in the possession of the operator or its immediate predecessor in interest.

(2) **As-built Specifications.** For a crude oil transfer line or produced water transfer system ~~placed into service after May 1, 2018~~, the operator must submit a Flowline Report, Form 44, within ~~30~~ 90 days of placing it into ~~service~~ active status to include the following information:

~~A. A layout drawing of the facility that sufficiently shows the surrounding topography, location of all associated above-ground equipment and the pipeline centerline from the point of origin to the termination point;~~

~~B.~~A. A geodatabase containing the pipeline alignment and isolation valves in the North American Datum of 1983 (NAD 83) with the following attributes: fluid type, pipe material type and pipe size in a format approved by the Director;

~~C.~~B. Specifications:

i. Bedding materials used in construction;

ii. Fluids that will be transferred;

iii. The maximum anticipated operating pressure, testing pressure, test date, and chart of successful pressure test;

iv. The pipe description (i.e., maximum size, grade, wall thickness, coating, standard dimension ratio, and material);

v. The burial depth of the crude oil transfer line or produced water transfer system;

vi. Description of corrosion protection;

vii. Description of the integrity management system utilized in accordance with 1104.f.;

viii. Description of the construction method used for public by-ways, road crossings, sensitive wildlife habitats, sensitive areas and natural and manmade watercourses (i.e., open trench, bored and cased, or bored only); and

ix. Copy of the operator's crude oil leak protection and monitoring plan prepared in accordance with 1104.g. If an operator has previously filed with the Commission a current copy of its leak protection and monitoring plan it may cross reference the oil and gas facility or location for which the leak protection and monitoring plan was previously filed with reference to the API, facility identification number, or COGCC document number.

~~D~~C. An affidavit of completion stating the operator designed and installed the crude oil transfer line or produced water transfer system in compliance with the 1100 Series rules.

(3) Within ~~30~~ 90 days of modifying the alignment of a registered crude oil transfer line, the operator must report the change to the Director by submitting a Flowline Report, Form 44.

(4) For produced water transfer systems that have had system alignment changes during the preceding year, an operator must submit a Flowline Report, Form 44, by May 1st of each year to report the new alignment.

(5) If a document is executed after May 1, 2018, that grants a right of access or easement to locate a crude oil transfer line or produced water system on lands, then either the document itself or a memorandum or notice of such document must be recorded by the operator in the office of the county clerk and recorder of the county where the lands are located. If the document contains a legal description or map of the access or easement, then the memorandum or notice must include the legal description or map. Upon the surface owner's request, the operator shall provide a copy of the recorded document to the surface owner.

1101.~~d~~f. **Disclosure of ~~Confidential~~ Form 44 Data ~~to Local Governments~~.**

(1) The Director will make Form 44 geodatabase information for off-location flowlines, crude oil transfer lines, and produced water transfer systems available on the Commission's publicly accessible online map.

(2) Upon request from a local governmental designee(s) of the jurisdiction(s) through which the flowline passes , and subject to executing a confidentiality agreement and the provisions of the Colorado Open Records Act, the Commission will provide to the local governmental designee(s) the geodatabase information submitted with a Form 44, and any periodic updates received, for all off-location flowlines, crude oil transfer lines and produced water transfer systems within that local government's jurisdiction. The sole purpose for providing the geodatabase information is to assist local governments with their emergency management, ~~and~~ planning, and development. The Commission will keep all such geodatabase information confidential to the extent allowed by the Colorado Open Records Act.

1102. FLOWLINE AND CRUDE OIL TRANSFER LINE REQUIREMENTS

1102.a. **Material.** Materials for pipe and pipe components must be:

(1) Able to maintain the structural integrity of the flowline or crude oil transfer line under anticipated operating temperature, pressure, and other operating conditions; and

(2) Compatible with the substances to be transported.

1102.b. **Applicable Technical Standards.** Each component of a flowline or crude oil transfer line installed or repaired ~~on or after May 1, 2018,~~ must meet one of the following standards appropriate for the component:

(1) American Society of Mechanical Engineers, Pipeline Transportation Systems for Liquids and Slurries, 2016 Edition (ASME B31.4-2016), and no later editions of the standard. ASME B31.4-2016 is available for public inspection during normal business hours from the Public Room Administrator at the office of the Commission, 1120 Lincoln Street, Suite 801, Denver, Colorado 80203. Additionally, ASME B31.4-2016 may be examined at any state publications depository library and is available to purchase from the ASME. The ASME can be contacted at Two Park Avenue, New York, NY 10016-5990, 1-800-843-2763;

(2) ASME Gas Transmission and Distribution Piping Systems, 2016 Edition (ASME B31.8-2016), and no later editions of the standard. ASME B31.8-2016 is available for public inspection during normal business hours from the Public Room Administrator at the office of the Commission, 1120

Lincoln Street, Suite 801, Denver, Colorado 80203. Additionally, ASME B31.8-2016 may be examined at any state publications depository library and is available to purchase from the ASME. The ASME can be contacted at Two Park Avenue, New York, NY 10016-5990, 1-800-843-2763;

(3) ASME Process Piping, 2016 Edition (ASME 31.3-2016), and no later editions of the standard. ASME 31.3-2016 is available for public inspection during normal business hours from the Public Room Administrator at the office of the Commission, 1120 Lincoln Street, Suite 801, Denver, Colorado 80203. Additionally, ASME 31.3-2016 may be examined at any state publications depository library and is available to purchase from the ASME. The ASME can be contacted at Two Park Avenue, New York, NY 10016-5990, 1-800-843-2763;

(4) API Specification 15S, Spoolable Reinforced Plastic Line Pipe, Second Edition, March 2016 (API Specification 15S), and no later editions of the standard. API Specification 15S is available for public inspection during normal business hours from the Public Room Administrator at the office of the Commission, 1120 Lincoln Street, Suite 801, Denver, Colorado 80203. In addition, API Specification 15S may be examined at any state publications depository library and is available from API at 1220 L Street, NW Washington, DC 20005-4070, 1-202-682-8000;

(5) API RP 15TL4 (R2018) Recommended Practice for Care and Use of Fiberglass Tubulars, Second Edition. March 1999 together with API Specification 15HR, High-pressure Fiberglass Line Pipe, Fourth Edition, February 2016 (API Specification 15HR), and no later editions of the standards. API RP 15TL4 and API Specification 15HR ~~is~~ are available for public inspection during normal business hours from the Public Room Administrator at the office of the Commission, 1120 Lincoln Street, Suite 801, Denver, Colorado 80203. In addition, API RP 15TL4 and API Specification 15HR may be examined at any state publications depository library and ~~is~~ are available from API at 1220 L Street, NW Washington, DC 20005-4070, 1-202-682-8000; or

(6) API RP 15TL4 (R2018) Recommended Practice for Care and Use of Fiberglass Tubulars, Second Edition, March 1999, together with API Specification 15LR (R2013), Low Pressure Fiberglass Line Pipe and Fittings, Seventh Edition, August 2001(API Specification 15LR), and no later editions of the standards. API RP 15TL4 and API Specification 15LR ~~is~~ are available for public inspection during normal business hours from the Public Room Administrator at the office of the Commission, 1120 Lincoln Street, Suite 801, Denver, Colorado 80203. In addition, API RP 15TL4 and API Specification 15LR may be examined at any state publications depository library and ~~is~~ are available from API at 1220 L Street, NW Washington, DC 20005-4070, 1-202-682-8000.

1102.c. **Design.** Each component of a flowline or crude oil transfer line must be designed to:

(1) Prevent failure by minimizing internal or external corrosion and the effects of transported fluids;

(2) Withstand maximum anticipated operating pressures and other internal loadings without impairment;

(3) Withstand anticipated external pressures and loads that will be imposed on the pipe after installation;

(4) Allow for line maintenance, periodic line cleaning, and integrity testing; and

(5) Have adequate controls and protective equipment to prevent it from operating above the maximum operating pressure.

1102.d. **Installation.**

(1) Installation crews must be trained in flowline or crude oil transfer line installation practices for which they are tasked to perform.

(2) All workers performing welding on steel lines in pressure service, must be certified in accordance with:

A. API Standard 1104, Welding of Pipelines and Related Facilities, Twenty First Edition, September 2013 and no later editions of the standard. API Standard 1104 is available for public inspection during normal business hours from the Public Room Administrator at the office of the Commission, 1120 Lincoln Street, Suite 801, Denver, Colorado 80203. In addition, API Standard 1104 ~~15S~~ may be examined at any state publications depository library and is available from API at 1220 L Street, NW Washington, DC 20005-4070, 1-202-682-8000; or~~.~~

B. ASME BPV Code 2017 Section IX - Welding, Brazing and Fusing Qualification and no later editions of the code. The Section is available for public inspection during normal business hours from the Public Room Administrator at the office of the Commission, 1120 Lincoln Street, Suite 801, Denver, Colorado 80203. In addition, the ASME BPV Code may be examined at any state publications depository library The ASME BPV Code is available to purchase from the ASME at Two Park Avenue, New York, NY 10016-5990, 1-800-843-2763.

(3) Non-destructive testing of welds for newly constructed steel off-location flowlines or steel crude oil transfer lines must be done in accordance with one of the following:

A. Those standards established by the U.S. Department of Transportation Pipeline and Hazardous Materials Safety Administration pursuant to 49 C.F.R. § 192.243 and 49 C.F.R. § 195.234, in existence as of the date of this regulation, and no later amendments. 49 C.F.R. § 192.243 and 49 C.F.R. § 195.234 are available for public inspection during normal business hours from the Public Room Administrator at the office of the Commission, 1120 Lincoln Street, Suite 801, Denver, Colorado 80203. Additionally, 49 C.F.R. § 192.243 and 49 C.F.R. § 195.234 may be found at https://www.phmsa.dot.gov; or~~.~~

B. One of the standards set forth in Section 1102.b. or 1102.d (2)A. and B. above.

(4) Non-destructive testing is not required for repairs of existing steel off-location flowlines or steel crude oil transfer lines.

(5) No pipe or other component may be installed unless it has been visually inspected at the site of installation to ensure that it is not damaged.

(6) Pipes must be locatable by a tracer line or location device placed adjacent to or in the trench of a buried nonmetallic flowline or crude oil transfer line. Any installed tracer wire or metallic device for locating must be resistant to corrosion damage. Caution tape must be placed in the trench one foot above the buried pipe.

(7) Flowlines or crude oil transfer lines must be installed in a manner that minimizes interference with agriculture, road and utility construction, wildlife resources, the introduction of secondary stresses, and the possibility of damage to the pipe.

(8) The pipe must be handled in a manner that minimizes stress and avoids physical damage to the pipe during stringing, joining, or lowering in. During the lowering in process the pipe string must be properly supported so as not to induce excess stresses on the pipe or the pipe joints or cause weakening or damage to the outer surface of the pipe.

(9) Flowlines or crude oil transfer lines that cross a municipality, county, or state graded road must be bored unless the responsible governing agency specifically permits the operator to open cut the road.

(10) Flowlines and crude oil transfer lines must be installed pursuant to the manufacturer's ~~procedures and practices~~specifications. In the absence of applicable manufacturer's ~~procedures~~specifications, the following requirements apply:

A. Pipeline trenches must be constructed to allow the pipeline to rest on undisturbed native soil and provide continuous support along the length of the pipe;

B. Trench bottoms must be free of rocks greater than two inches in diameter, debris, trash, and other foreign material not required for pipeline installation; and

C. Over excavated trench bottoms must be backfilled with appropriate material and compacted prior to installation of the pipe to provide continuous support along the length of the pipe.

(11) The width of the trench must provide adequate clearance on each side of the pipe. Trench walls must be excavated to ensure minimal ~~sluffing~~ sloughing of sidewall material into the trench. Subsoil from the excavated trench must be stockpiled separately from previously stripped topsoil.

(12) A flowline or crude oil transfer line trench must be backfilled in a manner that provides firm support under the pipe and prevents damage to the pipe and pipe coating from equipment or from the backfill material. Sufficient backfill material must be placed in the pipe springline to provide long-term support for the pipe. Backfill material that will be within two feet of the pipe must be free of rocks greater than two inches in diameter and foreign debris. Backfilling material must be compacted as appropriate during placement in a manner that provides support for the pipe and reduces the potential for damage to the pipe and pipe joints.

(13) Flowlines and crude oil transfer lines that traverse sensitive wildlife habitats or sensitive areas, such as wetlands, streams, or other surface waterbodies, must be installed in a manner that minimizes impacts to these areas.

1102.e. **Cover for Subsurface Flowlines and Crude Oil Transfer Lines.**

(1) All installed flowlines and crude oil transfer lines must have cover sufficient to protect them from damage. On cropland, all flowlines must have a minimum cover of three (3) feet.

(2) Where an underground structure, geologic, or other uncontrollable condition prevents a flowline or crude oil transfer line from being installed with minimum cover, or when there is a written agreement between the surface owner and the operator specifying flowline cover depth of less than minimum cover, it may be installed with less than minimum cover or above-ground, if:

A. The exposed pipe and components are designed to withstand anticipated conditions;

B. The operator installs it in compliance with manufacturer's specifications; and

C. The operator installs it in a manner to withstand anticipated external loads.

~~(2)~~(3) Operators must protect above-ground flowlines or crude oil transfer lines from vehicular traffic by installing the lines a safe distance from public roads or installing barricades.

1102.f. **Top Soil Management and Reclamation.**

(1) Site preparation and stabilization must be performed in accordance with Rule 1002 for trenches greater than twelve inches in width.~~When flowlines or crude oil transfer lines cross croplands, unless waived by the surface owner, the operator must segregate topsoil while trenching, and backfill trenches so that the soils must be returned to their original relative positions and contour.~~ This requirement to segregate and backfill topsoil does not apply to trenches which are twelve ~~(12)~~ inches or less in width. Operator must make reasonable efforts to install flowlines or crude oil transfer lines parallel to crop irrigation rows on flood irrigated land.

(2) All trenches must be maintained in order to correct subsidence and reasonably minimize erosion.

(3) Interim and final reclamation, including revegetation, must be performed in accordance with the applicable 1000 Series rules.

1102.g. **Marking.**

(1) ~~In Designated Setback Locations, and w~~Where crossing public rights-of-way or utility easement crossings, an operator must install and maintain markers that identify the location of flowlines or crude oil transfer lines. These markers must be placed in a manner to reduce the possibility of damage or interference with surface use but need not be placed where impracticable or if the landowner does not grant permission.

(2) Operators must install a marker consistent with 49 C.F.R. § 195.410 in existence as of the date of this regulation and does not include later amendments or ~~The~~ the marker must include the following language:

"Warning", "Caution" or "Danger" followed by the words "gas or petroleum (or name of gas or fluid transported) in the flowline (or crude oil transfer line)" along with the name of the operator and the telephone number where the operator can be reached at all times. The letters must be legible, written on a background of sharply contrasting color and on each side with at least one (1) inch high with one-quarter (¼) inch stroke.

49 C.F.R. § 195.410 is available for public inspection during normal business hours from the Public Room Administrator at the office of the Commission, 1120 Lincoln Street, Suite 801, Denver, Colorado 80203. Additionally, the regulation may be examined at any state publications depository library or found at https://www.phmsa.dot.gov.

1102.h. **Inspection.** A crude oil transfer line ~~constructed after May 1, 2018,~~ must be inspected by a third-party inspector who is a Professional Engineer registered with the State of Colorado or who is working under the supervision of a Professional Engineer registered with the State of Colorado before being placed into ~~service~~active status. The third-party inspector must be trained in the installation of crude oil transfer lines. The operator must maintain inspection records, including at a minimum:

(1) The third-party inspector's certification that the crude oil transfer line was installed as prescribed by the manufacturer's specifications and in accordance with the requirements of the 1100 Series rules; and

(2) The third-party inspector's training qualifications.

1102.i. **Maintenance.**

(1) Each operator must take reasonable ~~precautions~~ actions to prevent failures and leakage, and minimize corrosion of flowlines and crude oil transfer lines.

(2) Whenever an operator discovers any condition that could adversely affect the safe and proper operation of a flowline or crude oil transfer line, the operator must correct the condition as soon as possible. However, if the condition presents an immediate hazard to persons or property, the operator may not operate the affected segment until the operator has corrected the condition.

(3) If the flowline or crude oil transfer line lacks integrity, the operator must immediately investigate, report, and remediate any Spills or Releases in accordance with the 900 Series rules.

(4) Any flowline or crude oil transfer line undergoing maintenance must be locked out and tagged out in accordance with OSHA requirements. ~~not actively in use must have isolation valves locked and tagged out.~~

1102.j. **Repair.**

(1) Each operator must make repairs in a safe manner that prevents injury to persons and damage to equipment and property.

(2) An operator may not use any pipe, valve, or fitting to repair a flowline or crude oil transfer line unless the component meets the installation requirements of the 1100 Series rules for the repaired

segment. For a flowline or crude oil transfer line installed prior to May 1, 2018 that undergoes a major modification or change in ~~service~~ status after May 1, 2018, the segment repaired must satisfy all applicable requirements of the 1100 Series rules before an operator can return the flowline or crude oil transfer line active status~~to service~~.

(3) An operator may not ~~use~~ install or operate any pipe, valve, or fitting for replacement or repair of a flowline or crude oil transfer line unless it is designed to the maximum anticipated operating pressure.

(4) An operator must verify the integrity of any replaced or repaired segment of flowline or crude oil transfer line before returning it to ~~service~~use.

(5) An operator must conduct a repair in accordance with the manufacturer's specifications or ASME "Repair of Pressure Equipment and Piping" (ASME PCC-2-2018) and no later editions of the standard. The ASME standard is available for public inspection during normal business hours from the Public Room Administrator at the office of the Commission, 1120 Lincoln Street, Suite 801, Denver, Colorado 80203. Additionally, the standard may be examined at any state publications depository library. The ASME standard is available to purchase from ASME at Two Park Avenue, New York, NY 10016-5990, 1-800-843-2763.

(6) Each segment of pipe, valve, or fitting that becomes unsafe must be replaced or repaired before returning it to service.

~~(4)~~(7) Any flowline or crude oil transfer line undergoing repair must be locked out and tagged out in accordance with OSHA requirements.

1102.k. **Operating requirements.**

(1) No flowline or crude oil transfer line may be in active status and operated until it has demonstrated compliance with Rule 1104, Integrity Management.

(2) The maximum operating pressure for a flowline or crude oil transfer line may not exceed the manufacturer's specifications of the pipe or the manufacturer's specifications of any other component of it, whichever is less.

1102.l. **Corrosion control.**

(1) All coated pipe for underground service must be electronically inspected prior to installation using coating deficiency (i.e. scratch, bubble, and "holiday") detectors to check for any faults not observable by visual examination. The detector must operate in accordance with manufacturer's specifications ~~instructions~~ and at a voltage level appropriate for the electrical characteristics of the pipeline being tested. During installation all joints, fittings, and tie-ins must be coated with materials compatible with the coatings on the pipe. Coating materials must:

A. Be designed to mitigate corrosion of the buried pipe;

B. Have sufficient adhesion to the metal surface to prevent ~~under~~ under-film migration of moisture;

C. Be sufficiently ductile to resist cracking;

D. Have enough strength to resist damage due to handling and soil stress;

E. Support any supplemental cathodic protection; and

F. If the coating is an insulating type, have low moisture absorption and provide high electrical resistance.

(2) Cathodic protection systems must meet or exceed the minimum criteria set forth in the National Association of Corrosion Engineers (NACE) standard practice SP0169-2007 (formerly RP0169), Control of External Corrosion on Underground or Submerged Metallic Piping Systems, 2007 Edition (NACE SP0169-2007), and no later editions of the standard. NACE SP0169-2007 is available for public inspection during normal business hours from the Public Room Administrator at the office of the Commission, 1120 Lincoln Street, Suite 801, Denver, Colorado 80203. Additionally, NACE SP0169-2007 may be examined at any state publications depository library and is available to purchase from the NACE. The NACE can be contacted at 15835 Park Ten Place, Houston, Texas 77084, 1-281-228-6200.

(3) An operator must take prompt remedial action to correct any abnormal internal corrosion. Remedial action may include increased pigging, using corrosion inhibitors, coating the internal pipeline (e.g. an epoxy paint or other plastic liner), or a combination of these actions.

1102.m. **Record Keeping.** An operator must maintain records of flowline or crude oil transfer line size, route, materials, maximum anticipated operating pressure, pressure or other integrity test results, inspections, repairs, and integrity management documentation for the life of the flowline. If an operator relies upon manufacturer's specifications, it is the operator's responsibility to ensure the appropriate specifications are available upon request by the Commission. These records are to be transferred with a change of operator.

1102.n. **One Call participation.** Every operator with underground facilities, as defined in §9-1.5-102(7), C.R.S., including wells and below-ground flowlines and crude oil transfer lines, must become a Tier One member of the Utility Notification Center of Colorado (~~UNCC~~CO 811) and participate in Colorado's One Call notification system, the requirements of which are established by §9-1.5-101., C.R.S. et seq.

(1) An operator with underground facilities must confirm ~~include~~ its CO 811~~UNCC~~ membership ~~code~~ when submitting an Operator Registration, Form 1, Change of Operator, Form 10, Gas Facility Registration, Form 12, or Flowline Report, Form 44, by checking the One Call box.

(2) An operator that does not have underground facilities should check the N/A box for One Call on the appropriate form.

(2) Within 30 days of completing an asset purchase, a transfer, construction or relocation of a flowline or crude oil transfer line, an operator must update the operator's location information with ~~the~~ ~~UNCC~~CO 811.

(3) An operator's registration with the Commission grants the Director permission to access information the operator submits to ~~UNCC~~ CO 811 about its oil and gas facilities.

1102.o. **~~Notification of~~ Requirements for shut-in or out of service off-location flowline or crude oil transfer line for inspection~~not in service~~.**

(1) For an active status off-location flowline or crude oil transfer line that has been shut-in for more than 90 days, the operator must:

A. Within 120 days of installing tag out devices, submit a Flowline Report, Form 44, to the Director identifying the off-location or crude oil transfer line or segment thereof that has been locked out and tagged out, the integrity management program that applies, and the outcome of the most recent integrity management test;

B. Continue to comply with the integrity management requirements of Rule 1104; and

C. Pressure test the off-location flowline or crude oil transfer line in accordance with Rule 1104.h. before returning the line to operation; and

D. Not less than 48 hours prior to pressure testing, submit notice with a Field Operations Notice,

Form 42, to the Director of the scheduled date the pressure test to allow the Commission to inspect during the pressure test.

(2) For an off-location flowline or a crude oil transfer line that has been out of service for more than 90 days, the operator must:

A. Within 120 days of applying OOSLAT, ~~The operator of an off-location flowline or crude oil transfer line must~~ submit a Flowline Report, Form 44, to the Director identifying the off-location flowline or crude oil transfer line or segment thereof that has been taken out of service~~removed from service~~ and the outcome of the most recent integrity management test. ~~for more than one year. The Form 44 must be submitted within 30 days after the one-year anniversary of the operator removing the line from service.~~

B. Pressure test the off-location flowline or crude oil transfer line in accordance with Rule 1104.h. before returning the line to active status; and

C. Not less than 48 hours prior to pressure testing, submit notice with a Field Operations Notice, Form 42, to the Director of the scheduled date for the pressure test to allow the Commission to inspect during the pressure test.

1103. FLOWLINE AND CRUDE OIL TRANSFER LINE VALVES

1103.a. Isolation valve repair and maintenance. ~~Operators must annually conduct of one of the following maintenance operations on all isolation valves:~~

(1) Operators must annually conduct one of the following maintenance operations on all isolation valves:

A. Perform a function test, or

B. Maintain the isolation valve in accordance with its manufacturer's specifications.

(2) Operators must repair or replace isolation valves that are not fully operable.

(3) On-location manifold, peripheral and process piping flowlines are exempt from the annual maintenance operations set forth in this section 1103.a.(1).

1103.b. Any valve, flange, fitting or other component ~~installed after May 1, 2018~~ that is connected to a flowline or crude oil transfer line must have a manufacturer's specification rating that is equal to or greater than the maximum anticipated operating pressure.

1103.c. For all flowlines or crude oil transfer lines constructed after May 1, 2018, an isolation valve must be installed at each of the following locations before ~~operation~~being placed into active status:

(1) On the suction end and the discharge end of a pump station in a manner that permits isolation of the pump station equipment in the event of an emergency;

(2) On each flowline or crude oil transfer line entering or leaving a breakout tank in a manner that permits isolation of the breakout tank from other facilities;

(3) At locations along a flowline or crude oil transfer line that will minimize damage or pollution from accidental discharge of hydrocarbons or E&P Waste, as appropriate for the terrain in open country or for populated areas;

(4) On each side of a flowline or crude oil transfer line crossing a Rule 317B Public Water System

defined water supply or a waterbody that is more than 100 feet (30 meters) wide from high-water mark to high-water mark; and

(5) On each side of a flowline or crude oil transfer line crossing a reservoir storing water for human consumption.

1103.d. Flowlines and crude oil transfer lines constructed before May 1, 2018, must be retrofitted with isolation valves at each of the locations identified in c.(1)-(5) by October 31, 2019. On-location manifold, peripheral and process piping flowlines are exempt from the retrofit provisions set forth in this section 1103.d.

1103.e. Check Valve Installation Requirements.

(1) Where an operator produces two or more wells through a common flowline, separator, or manifold, the operator must equip each flowline leading from a well to the common flowline, crude oil transfer line, separator, or manifold with a check valve or other comparable reverse flow prevention mechanism.

(2) The check valve or other comparable reverse flow prevention mechanism must be installed to permit fluids to move from the well to the common flowline, crude oil transfer line, separator, or manifold and to prevent any fluid from entering the well through the flowline.

(3) The operator must keep all check valves or other comparable reverse flow mechanisms in good working order.

(4) Upon the Director's request, operators must test the operation of the check valve or other comparable reverse flow mechanism.

(5) The requirements set forth in subsection (1) and (2) above, apply only to those check valves or comparable reverse flow mechanisms installed after May 1, 2018. Existing check valves or comparable reverse flow mechanisms must comply with subsection (3) and (4) above.

1104. INTEGRITY MANAGEMENT

1104.a. **Initial Pressure Testing Requirements.** Within 90 days ~~P~~prior to ~~operating~~ placing any newly installed segment of flowline or crude oil transfer line into active status, an operator must test the line to at least maximum anticipated operating pressure and demonstrate integrity. In conducting tests, each operator must ensure that reasonable precautions are taken to protect its employees and the general public. The operator may use a hydrostatic test or conduct the test using inert gas or wellhead pressure sources and well bore fluids, including gas, in accordance with one of the applicable standards set forth in Section 1104.h.(1) below.

1104.b. **Testing upon request.** An operator will conduct an integrity test of any segment of flowline or crude oil transfer line at any time upon request of the Director.

1104.c. **Integrity Management for Active Status Below-ground Dump Lines.** An operator must verify integrity of below-ground dump lines by performing an annual static-head test and a monthly audio, visual, olfactory (AVO) detection survey of the entire line.

1104.d. **Integrity Management for Active Status Above-ground On-location Flowlines.** An operator must verify the integrity of above-ground on-location flowlines by performing a monthly audio, visual, olfactory (AVO) detection survey of the entire line.

1104.e. **Integrity Management for Active Status Below-Ground On-location Flowlines.**

(1) For any below-ground on-location flowlines not subject to c. or d. above an operator must adhere to one of the following integrity management programs:

A. A pressure test to maximum anticipated operating pressure every three years;

B. Smart pigging conducted every three years;

C. Continuous pressure monitoring; or

D. Annual instrument monitoring conducted pursuant to Rule 1104.j.(2).

(2) If an operator elects to use smart pigging to comply with this section, the smart pig must be able to measure flowline wall thickness, and measure for flowline defects that could affect integrity, including measurement of metal loss. If no geodatabase file of the flowline exists, the smart pig will have GPS capabilities to the extent such capabilities do not materially compromise the ability of the smart pig to conduct the integrity testing required by this section.

1104.f. **Integrity Management for Active Status Off-Location Flowlines and Crude Oil Transfer Lines.**

(1) For ~~all~~ active status off-location flowlines and crude oil transfer lines, but not including off-location produced water flowlines, operators must adhere to one of the following integrity management programs:

A. An annual pressure test to maximum anticipated operating pressure;

B. Continuous pressure monitoring;

C. Smart pigging conducted every three years; or

D. Annual instrument monitoring conducted pursuant to Rule 1104.j.(2).

(2) For active status off-location ~~below~~ below-ground produced water flowlines, operators must adhere to one of the following integrity management programs:

A. An annual pressure test to maximum anticipated operating pressure;

B. Continuous pressure monitoring; or

C. Smart pigging conducted every three years.

(3) For active status ~~above~~ above-ground off-location produced water flowlines, operators may use any of the options listed in 1104.f.(2), or monthly AVO inspections.

(4) If an operator elects to use smart pigging to comply with this section, the smart pig must be able to measure flowline wall thickness, and measure for flowline defects that could affect integrity, including measurement of metal loss. If no geodatabase file of the flowline exists, the smart pig will have GPS capabilities to the extent such capabilities do not materially compromise the ability of the smart pig to conduct the integrity testing required by this section.

1104.g. **Leak protection, detection, and monitoring.**

(1) All crude oil transfer line operators must prepare and file with the Director a leak protection and monitoring plan with their registration.

(2) All crude oil transfer line operators must develop and maintain a plan to coordinate the assessment of all inflow and outflow data. The plan must provide for the assessment of inflow and outflow data between the production facility operator, the crude oil transfer line operator, and the operator at the point or points of disposal, storage, or sale. Upon discovery of a material data discrepancy, the discovering party is to notify all other appropriate parties and take action to determine the cause. The crude oil transfer line operator is to retain a record of all material data

discrepancies.

1104.h. **Pressure Test Requirements.**

(1) Initial Pressure Test.

A. ~~For~~ Before putting a flowline~~s and~~ or Crude Oil Transfer Line into active status~~s installed after May 1, 2018~~, the initial pressure test must be conducted for a minimum of four hours or in compliance with the manufacturer's specifications and in accordance with the provisions of one of the following applicable standards

i. American Society of Mechanical Engineers (ASME), Process Piping, 2016 Edition (ASME 31.3-2016) and no later edition;

ii. ASME Pipeline Transportation Systems for Liquids and Slurries, 2016 Edition (ASME B31.4-2016) and no later edition;

iii. ASME Gas Transmission and Distribution Piping Systems, 2016 Edition (ASME B31.8-2016) and no later edition;

iv. API Specification 15S, Spoolable Reinforced Plastic Line Pipe, Second Edition, March 2016 (API Specification 15S) and no later edition;

v. API RP 15TL4 (R2018) Recommended Practice for Care and Use of Fiberglass Tubulars, Second Edition, March 1999, together with API Specification 15HR, High-pressure Fiberglass Line Pipe, Fourth Edition, February 2016 (API Specification 15HR), and no later editions~~API Specification 15LR (R2013), Low Pressure Fiberglass Line Pipe and Fittings, Seventh Edition, August 2001(API Specification 15LR) and no later edition~~;

vi. API RP 1110, Recommended Practice for the Pressure Testing of Steel Pipelines for the Transportation of Gas, Petroleum Gas, Hazardous Liquids, Highly Volatile Liquids or Carbon Dioxide (6th Ed., February 1, 2013) (API RP 1110) and no later edition, or

vii. ASTM F2164-13, Standard Practice for Field Leak Testing of Polyethylene (PE) and Crosslinked Polyethylene (PEX) Pressure Piping Systems Using Hydrostatic Pressure, and no later edition, or manufacturer's specifications ~~recommendations~~ and must test the line to at least maximum anticipated operating pressure.

B. The ASME, API and ASTM standards identified in A. above are available for public inspection during normal business hours from the Public Room Administrator at the office of the Commission, 1120 Lincoln Street, Suite 801, Denver, Colorado 80203. Additionally, the standards may be examined at any state publications depository library. The ASME standards are available to purchase from the ASME at Two Park Avenue, New York, NY 10016-5990, 1-800-843-2763. The API standard is available to purchase from the API at 1220 L Street, NW Washington, DC 20005-4070, 1-202-682-8000. The ASTM standard is available to purchase from the ASTM at ASTM International, West Conshohocken, PA, 19428-2959, 1-877-909-2786.

C. The test can be hydrostatic or the test fluid can be the produced fluids of oil, produced water or natural gas or inert gas in accordance with the applicable sections of the above-mentioned standards.

D. A successful test must demonstrate that the line does not leak.

(2) **Annual and Triennial Pressure Testing Requirements.** For annual or triennial pressure tests conducted to meet the requirements of Sections 1104.e and 1104.f:

A. A pressure test must test to at least the maximum operating pressure and run for at least 30 minutes once the fluid pressure has stabilized.

B. The test can be hydrostatic or the test fluid can be the produced fluids of oil, produced water or natural gas.

C. A successful test will demonstrate the line does not leak, that pressure loss does not exceed 10%, and the fluid pressure is stable for the last five minutes of the pressure test.

1104.i. **Continuous Pressure Monitoring Requirements.** An operator's continuous pressure monitoring program must meet API RP 1175 "Pipeline Leak detection Program Management (2017), and no later editions of the standard, and ensure:

(1) Pressure data are monitored continuously, i.e., 24 hours per day and 7 days a week, and the monitoring is sufficiently sophisticated to identify flowline or crude oil transfer line integrity or pressure anomalies;

(2) Systems are capable of being shut-in for repairs immediately upon discovery of a suspected leak, either through automation or a documented, manual process; and

(3) The operator documents the continuous monitoring program, including suspected or identified integrity failures and how the operator will maintain and repair flowlines or crude oil transfer lines.

~~(3)~~(4) The API RP 1175 is available for public inspection during normal business hours from the Public Room Administrator at the office of the Commission, 1120 Lincoln Street, Suite 801, Denver, Colorado 80203. In addition, API RP 1175 may be examined at any state publications depository library and is available from API at 1220 L Street NW, Washington, DO 20005-4070, 1-202-682-8000.

1104.j. **Audio, Visual and Olfactory (AVO) Detection Survey or Alternative Survey Requirements.**

(1) When performing an AVO detection survey, an operator must survey the entire flowline length using audio, visual and olfactory techniques to detect integrity failures, leaks, spills, or releases, or signs of a leak, spill, or release like stressed vegetation or soil discoloration.

(2) Instrument Monitoring Method (IMM). Where the regulations permit, an operator also may conduct a survey using an instrument monitoring method capable of detecting integrity failures, leaks, spills or releases, or signs of a leak, spill or release.

(3) For either survey method, an operator must document the date and time of the survey, the detection methodology and technology, if any, used and the name of the employee who conducted the survey.

1104.k. ~~**Gas Leak Reporting**~~**Integrity Failure Investigation.**

(1) If the integrity management program indicates that a flowline or crude oil transfer line has or has had an integrity failure, the operator must investigate the cause of the failure, investigate whether the failure resulted in a spill or release of liquids, produced water, or gas, and repair any failure as required by Rule 1102.j.

(2) If the failure resulted in a spill or release of liquids, produced water or gas, the operator must comply with the 900 Series Rules.

1105. ABANDONMENT

1105.a. A flowline or crude oil transfer line remains subject to all of the requirements in Rules 1101 through 1104 until the operator completes all abandonment requirements set forth below.

APPENDIX A

1105.b. Upon removing a flowline or crude oil transfer line from ~~service~~use, an operator must immediately apply~~lockout or tag out~~ OOSLAT to the risers while the operator is in the process of abandoning the pipeline. ~~Lockout and tagout devices~~OOSLAT must stay in place at all times during the process of abandoning the flowline or crude oil transfer line until the operator removes the riser.

1105.c. Notice of Abandonment of off-location flowline or crude oil transfer line for inspection.

(1) If the off-location flowline or crude oil transfer line will be removed, the operator must submit notice to the Director with a Field Operations Notice, Form 42 – Abandonment of Flowlines, of the scheduled date for commencing abandonment. The operator must submit the Field Operations Notice no less than forty-eight (48) hours before the operator will commence abandonment.

(2) If the operator plans to abandon the off-location flowline or crude oil transfer line in place, the operator must submit notice to the Director with a Field Operations Notice, Form 42 – Abandonment of Flowlines, of the scheduled date for commencing abandonment. The operator must submit the Field Operations Notice no less than twenty (20) days before the operator will commence abandonment and include documentation supporting the applicable reason for abandonment in place consistent with Rule 1105.e(1). The Director may review the Field Operations Notice prior to the commencement of abandonment procedures to determine whether abandonment in place is appropriate. The Director may approve, deny, request additional information, or impose additional Conditions of Approval.

1105.d. Isolation. ~~For abandonment, o~~Operators must permanently remove a flowline or crude oil transfer line from ~~service~~ operation by physically separating it from all sources of fluids or pressure within the time frame set forth in Section 1004.a. ~~Abandonment must also comply with one of the following:~~

1105.e. Abandonment. Operators must remove the flowline or crude oil transfer line and its risers, the riser associated with cathodic protection, and above-ground equipment, unless one of the below exceptions applies allowing abandonment in place.

(1) Reasons for abandoning in place:

A. Surface owner agreement.

B. Successful revegetation has occurred or is in process and removal of the line would harm revegetation and the line is in a sensitive area for wildlife or plants.

C. The federal government directs abandonment in place.

D. Removal of a segment of the line requires damaging a public road, railroad, bike path, or public right of way.

E. Removal requires removal from under a body of water.

F. The flowline or crude oil transfer line is co-located with other active utilities or is in a recorded right of way.

~~(1)~~(2) ~~**Abandonment in place.**~~ For a flowline or crude oil transfer line abandoned in place, ~~The~~ the operator must:

A. Purge the flowline or crude oil transfer line of any liquids or fluids transported by the line;

B. Deplete the flowline or crude oil transfer line to atmospheric pressure;

C. Cut the flowline's or crude oil transfer line's risers to three (3) feet below grade or to the depth of the flowline or crude oil transfer line, whichever is shallower;

D. Seal the ends of the flowline or crude oil transfer line below grade; ~~and~~

E. Remove above-ground cathodic protection and equipment associated with the riser; and

F. Submit pressure test results conducted in the prior 12 months as well as identification of any associated document numbers for a COGCC Spill/Release Report, Form 19.

~~(2) **Removal.** The operator must remove the flowline or crude oil transfer line and its risers, the riser associated with cathodic protection, and above-ground equipment.~~

1105.~~e~~f. Within ~~30~~ 90 days of an operator completing abandonment requirements for a flowline or crude oil transfer line, an operator must submit:

(1) A Field Operations Notice, Form 42 – Abandonment of Flowlines, to the Director for an on-location flowline. If the operator conducted a pressure test as part of the abandonment as part of the abandonment, a copy of the pressure test shall be submitted with the Report of Abandonment, Form 6 – Subsequent.

(2) A Flowline Report, Form 44, to the Director for an off-location flowline or crude oil transfer line ~~the operator must submit a Flowline Report, Form 44, to the Director.~~ , which must include:

A. A geodatabase for the flowline, if~~If~~ the operator abandons an off-location flowline and a geodatabase for the flowline has not submitted ~~latitude and longitude for the flowline's risers, the Flowline Report, Form 44, must include this information~~.

B. An account of the manner in which the abandonment work was performed.

C. Copies of any pressure test results run as part of the abandonment shall be submitted with Form 44 for off-location flowlines and crude oil transfer lines.

1105.~~d~~Eg. The Director will provide a Field Operations Notice, Form 42 – Abandonment of Flowlines, for an on-location flowline or a Flowline Report, Form 44, for an off-location flowline or crude oil transfer line abandonment to the appropriate Local Governmental Designee and ~~UNCC~~CO 811.

DEFINITIONS (100 Series)

FLOWLINE SYSTEM means a network of off-location flowlines.

GRADE 1 GAS LEAK means a gas leak that ignites or represents an existing or probable hazard to persons or property and requires immediate repair or continuous action until the conditions are no longer hazardous.

OUT OF SERVICE LOCKS AND TAGS (OOSLAT) means locks and tags that an operator applies when equipment is in pre-commissioned status, is placed in an out of service status, or is in the process of abandonment. Out of service locks and tags must be visibly different from lock out and tag out devices and may not be used during repair or maintenance of the equipment.

PRODUCED WATER TRANSFER SYSTEM means a system of off-location flowlines that transports produced water generated at more than one well site or production facility or a single, off-location flowline carrying produced water that is greater than one-mile in length.

TAGOUT DEVICE means a prominent warning device, such as a tag, that will not deteriorate or become illegible with exposure to weather conditions or wet and damp locations. The tagout device must: include an instruction to not operate the equipment; the date of the last successful integrity test; and the reason for tagging out the equipment~~; and be color coded per ASME Scheme for the Identification of Piping Systems, 2015 Edition (A13.1- 2015), and no later editions of the standard. ASME A13.1- 2015 is available for public~~

~~inspection during normal business hours from the Public Room Administrator at the office of the Commission, 1120 Lincoln Street, Suite 801, Denver, Colorado 80203. Additionally, ASME A13.1- 2015 may be examined at any state publications depository library and is available to purchase from the ASME. The ASME can be contacted at Two Park Avenue, New York, NY 10016-5990, 1-800-843-2763~~.

GENERAL RULES (200 Series)

215. GLOBAL POSITIONING SYSTEMS

Global Positioning Systems (GPS) may be used to locate facilities used in oil and gas operations provided they meet the following minimum standards of the Commission:

a. Instruments rated as Differential Global Positioning System (DGPS) shall be used.

b. Instruments shall be capable of one (1) meter accuracy after differential correction.

c. ~~All GPS data shall be differentially corrected by post processing prior to data submission~~Submission position accuracy value in meters shall be reported with location data. If unavailable, a position dilution of precision (PDOP) value less than six (6) is acceptable. GPS data shall be differently corrected by post-processing to meet accuracy requirements, if necessary.

~~d. Position dilution of precision (PDOP) values shall not be higher than six (6) and shall be included with location data.~~

~~e~~d. Elevation mask (lowest acceptable height above the horizon) shall be no less than fifteen degrees (15o)

~~f~~e. Latitude and longitude coordinates shall be provided in decimal degrees with an accuracy and precision of five (5) decimals of a degree using the North American Datum (NAD) of 1983 (e.g.; latitude 37.12345 N, longitude 104.45632 W).

~~g~~f. Raw and corrected data files shall be held for a period of three (3) years.

~~h~~g. Measurements shall be made by a trained GPS operator familiar with the theory of GPS, the use of GPS instrumentation, and typical constraints encountered during field activities.

216. COMPREHENSIVE DRILLING PLANS

c. **Information requirements.** Operators are encouraged to submit the most detailed information practicable about the future activities in the geographic area covered by the Comprehensive Drilling Plan. Detailed information is more likely to lead to identification of specific impacts and agreement regarding measures to minimize adverse impacts. The information included in the Comprehensive Drilling Plan shall be decided upon by the operator, in consultation with other participants. Information provided by operators to federal agencies to obtain approvals for surface disturbing activities on federal land may be submitted in support of a Comprehensive Drilling Plan. The following information may be included as part of a Comprehensive Drilling Plan, depending on the circumstances:

(1) A U.S. Geological Survey 1:24,000 topographic map showing the proposed oil and gas locations, including proposed access roads and gathering systems reasonably known to the operator(s);

(2) A current aerial photo showing the proposed oil and gas locations displayed at the same scale as the topographic map to facilitate use as an overlay;

(3) Overlay maps showing the proposed oil and gas locations, including all proposed access roads, crude oil transfer lines, produced water transfer systems, ~~and~~ gathering systems, drainages and

stream crossings, and existing and proposed buildings, roads, utility lines, pipelines, known mines, oil or gas wells, water wells known to the operator(s) and those registered with the State Engineer's Office, and riparian areas;

(4) A list of all proposed oil and gas facilities, including crude oil transfer lines and produced water transfer systems, to be installed within the area covered by the Comprehensive Drilling Plan over the time of the Plan and the anticipated timing of the installation;

(5) A plan for the management of exploration and production waste and a plan for the management of other fluids;

[no other changes proposed to the remaining subparts]

DRILLING, DEVELOPMENT, PRODUCTION AND ABANDONMENT (300 Series)

326. MECHANICAL INTEGRITY TESTING

326.b. **Shut-in Wells** - All shut-in wells shall pass a mechanical integrity test.

(1) A mechanical integrity test shall be performed on each shut-in well within two years of the initial shut-in date.

(2) Subsequently, a mechanical integrity test shall be performed on each shut-in well on 5 year intervals from the date the initial mechanical integrity test was performed, as long as the well remains shut-in .

(3) The mechanical integrity test for a shut-in well shall be performed after: isolating the wellbore with a bridge plug or similar approved isolating device set 100 feet or less above the highest open perforation. The pressure test shall be with liquid or gas at an initial, stabilized surface pressure of not less than 300 psi surface pressure or any equivalent test or combination of tests approved by the Director.

(4) Not less than 48 hours prior returning an inactive, shut-in well to production or injection, an operator must submit a Field Operations Notice, Form 42, to the Director of the scheduled date for returning the well to production or injection to allow the Commission to inspect.

326c. **Temporarily Abandoned Wells** – All temporarily abandoned wells shall pass a mechanical integrity test.

(1) A mechanical integrity test shall be performed on each temporarily abandoned well within 30 days of temporarily abandoning the well.

(2) Subsequently, a mechanical integrity test shall be performed on each temporarily abandoned well on five year intervals from the date of the initial mechanical integrity test was performed, as long as the well remained temporarily abandoned.

(3) The mechanical integrity test for a temporarily abandoned well shall be performed after isolating the wellbore with a bridge plug or similar approved isolating device set 100 feet or less above the highest open perforation. The pressure test shall be liquid or gas at an initial, stabilized surface pressure of not less than 300 psi surface pressure or any equivalent test or combination of tests approved by the Director.

(4) Not less than 48 hours prior returning an inactive, temporarily abandoned well to production or injection, an operator must submit a Field Operations Notice, Form 42, to the Director of the scheduled date for returning the well to production or injection to allow the Commission to inspect

the installation of equipment or conduct of the mechanical intervention.

[no other changes proposed to the remaining subparts]

333. SEISMIC OPERATIONS

333.c.(3) Prior to any shothole drilling, the operator shall contact the Utility Notification Center of Colorado (CO 811)~~at 1-800-922-1987~~.

[no other changes proposed to the remaining subparts]

SAFETY REGULATIONS (600 Series)

610. GRADE 1 GAS LEAK REPORTING

An operator must initially report a Grade 1 Gas Leak from a flowline to the Director in accordance with Rule 906 and must submit the COGCC Spill/Release Report, Form 19, document number on a Flowline Report, Form 44 for the Grade 1 Gas Leak.

FINANCIAL ASSURANCE AND OIL AND GAS CONSERVATION AND ENVIORNMENTAL RESPONSE FUND (700 Series)

711. ~~Produced water transfer systems, G~~gas gathering, gas processing and underground gas storage facilities.

Operators of ~~produced water transfer systems,~~ gas gathering, gas processing, or underground gas storage facilities must provide statewide blanket financial assurance to ensure compliance with the 900 Series rules in the amount of fifty thousand dollars ($50,000), or in an amount voluntarily agreed to with the Director, or in an amount determined by order of the Commission. Operators of small systems gathering or processing less than five (5) MMSCFD ~~or seven hundred (700) barrels of water~~ per day may provide individual financial assurance in the amount of five thousand dollars ($5,000).

712. Produced water transfer systems.

Operators of produced water transfer systems of a mile length or greater must provide statewide blanket financial assurance to ensure compliance with the 900 Series rules in the amount of fifty thousand dollars ($50,000), or in an amount voluntarily agreed to with the Director, or in an amount determined by order of the Commission. Operators of small systems transferring less than seven hundred (700) barrels of water per day may provide individual financial assurance in the amount of five thousand dollars ($5,000).

713. Surface facilities and structures appurtenant to Class II Commercial Underground Injection Control wells.

Operators of Class II commercial Underground Injection Control (UIC) wells shall be required to provide financial assurance to ensure compliance with the 900-Series Rules in the amount of fifty-thousand dollars ($50,000) for each facility, or in an amount voluntarily agreed to with the Director, or in an amount to be determined by order of the Commission. The financial assurance required by this Rule 712 shall apply to the surface facilities and structures appurtenant to the Class II commercial injection well and used prior to the disposal of E&P wastes into such well and shall be in place by July 1, 2009. The financial assurance requirements for the plugging and abandonment of Class II commercial UIC wells are specified in Rule 706.

APPENDIX A

E&P WASTE MANAGEMENT (900 Series)

906. SPILLS AND RELEASES

a. General. Operators shall, immediately upon discovery, control and contain all spills/releases of E&P waste, gas, or produced fluids to protect the environment, public health, safety, and welfare, and wildlife resources. Operators shall investigate, clean up, and document impacts resulting from spills/releases as soon as practicable. The Director may require additional activities to prevent or mitigate threatened or actual significant adverse environmental impacts on any air, water, soil or biological resource, or to the extent necessary to ensure compliance with the concentration levels in Table 910-1, with consideration to WQCC ground water standards and classifications.

b. Reporting spills or releases of E&P Waste, gas, or produced fluids.

(1) Report to the Director. Operators shall report a spill or release of E&P Waste, gas, or produced fluids that meet any of the following criteria to the Director verbally or in writing as soon as practicable, but no more than twenty-four (24) hours after discovery for A.-C., below, or no more than six (6) hours after discovery for D., below (the "Initial Report").

A. A spills/release of any size that impacts or threatens to impact any waters of the state, a residence or occupied structure, livestock, or public byway;

B. A spill/release in which one (1) barrel or more of E&P Waste or produced fluids is spilled or released outside of berms or other secondary containment;

C. A spill/release of five (5) barrels or more regardless of whether the spill/release is completely contained within berms or other secondary containment ~~.~~; or

D. A Grade 1 Gas Leak. The operator also must submit the COGCC Spill/Release Report, Form 19, document number on a Flowline Report, Form 44 for the Grade 1 Gas Leak.

(2) The Initial Report to the Director shall include, at a minimum,

A. ~~the~~ The location of the spill/release;

B. Documentation that the operator provided additional party notifications as required by (6)-(9);

C. A description of any threat to waters of the state, residences or occupied structures, livestock, or public byway from the spill/release; and

D. ~~any~~ Any information available to the Operator about the type and volume of fluid or waste involved, including whether it is controlled or uncontrolled at the time of submitting the Initial Report.

(3) If the Initial Report was not made by submitting a COGCC Spill/Release Report, Form 19 the Operator must submit a Form 19 with the Initial Report information as soon as practicable but not later than 72 hours after discovery of the spill/release unless extended by the Director.

(4) In addition to the Initial Report to the Director, the Operator shall make a supplemental report on Form 19 not more than 10 calendar days after the spill/release is discovered that includes an 8 1/2 x 11 inch topographic map showing the governmental section and location of the spill or an aerial photograph showing the location of the spill; all pertinent information about the spill/release known to the Operator that has not been reported previously; and information relating to the initial mitigation, site investigation, and remediation measures conducted by the Operator.

(5) The Director may require further supplemental reports or additional information.

(~~2~~6) Notification to the local government. In addition to the Initial Report to the Director, as soon as practicable, but not more than 24 hours after discovery of a spill/release of E & P Waste, gas, or produced fluids reportable under Rule 906.b.(1)A or B, above, an Operator shall provide verbal or written notification to the entity with jurisdiction over emergency response within the local municipality if the spill/release occurred within a municipality or the local county if the spill/release did not occur within a municipality. The notification shall include, at a minimum, the information provided in the Initial Report to the Director.

(~~3~~7) Notification to the Surface Owner. In addition to the Initial Report to the Director, within 24 hours after discovery of a spill/release of E & P Waste, gas, or produced fluids reportable under Rule 906.b.(1)A or B, an Operator shall provide verbal notification to the affected Surface Owner or the Surface Owner's appointed tenant. If the Surface Owner cannot be reached within 24 hours, the Operator shall continue good faith efforts to notify the Surface Owner until notice has been provided. The verbal notification shall include, at a minimum, the information.

(~~4~~8) Report to Environmental Release/Incident Report Hotline. A spill/release of any size which impact or threaten to impact any surface water supply area shall be reported to the Director and to the Environmental Release/Incident Report Hotline (1-877-518-5608). Spills and releases that impact or threaten a surface water intake shall be verbally reported to the emergency contact for that facility immediately after discovery.

(~~5~~9) Reporting chemical spills or releases. Chemical spills and releases shall be reported in accordance with applicable state and federal laws, including the Emergency Planning and Community Right-to-Know Act, the Comprehensive Environmental Response, Compensation, and Liability Act, the Oil Pollution Act, and the Clean Water Act, as applicable.

[no changes proposed for other subparts of Rule 906]

Effective Date: These amendments will become effective, per § 24-4-103, C.R.S., twenty days after publication in the Colorado Register.

APPENDIX B

Statement of Basis, Specific Statutory Authority, and Purpose
New Rules and Amendments to Current Rules of the Colorado Oil and Gas Conservation Commission, 2 CCR 404-1

Cause No. 1R Docket No. 191100692
2019 Flowline Rulemaking

This statement sets forth the basis, specific statutory authority, and purpose for amendments ("2019 Flowline Rules") to the Colorado Oil and Gas Conservation Commission ("Commission") Rules of Practice and Procedure, 2 CCR 404-1 ("Rules"). In adopting amendments to the Rules, the Commission will rely upon the entire administrative record for this Rulemaking proceeding, which formally began on October 8, 2019, when the Commission submitted its Notice of Rulemaking to the Colorado Secretary of State.

Background

On April 16, 2019, Governor Polis signed Senate Bill 19-181 into law. Senate Bill 19-181 ensures that oil and gas development and operations in Colorado are regulated in a manner that protects public health, safety, welfare, the environment, and wildlife resources. Senate Bill 19-181's amendments to the Oil and Gas Conservation Act ("Act"), §§ 34-60-101 - 131, C.R.S., are effective as of April 16, 2019, the date the Governor signed the bill into law. Senate Bill 19-181 amends, among other provisions of the Act, §§ 34-60-106(19), C.R.S., directing:

> The commission shall review and amend its flowline and inactive, temporarily abandoned, and shut-in well rules to the extent necessary to ensure that the rules protect and minimize adverse impacts to public health, safety, and welfare and the environment, including by:
>
> (a) Allowing public disclosure of flowline information and evaluating and determining when a deactivated flowline must be inspected before being reactivated; and
>
> (b) Evaluating and determining when inactive, temporarily abandoned, and shut-in wells must be inspected before being put into production or used for injection.

Stakeholder and Public Participation

On August 1, 2019, the Commission announced it would undertake the rulemaking for the 2019 Flowline Rules in November of 2019. On September 5, 2019, the Commission hosted its first stakeholder meeting for the 2019 Flowline Rules. On October 8, 2019, it issued a draft of the proposed rules with its Notice of Rulemaking and hosted a stakeholder meeting the following day, October 9, 2019, to explain the proposed rules and solicit stakeholder comments. The Commission invited stakeholders to participate formally as parties or informally by submitting oral or written comments in the Notice. In addition, the

Commission created online portals through which anyone could submit written comments regarding the 2019 Flowline Rules.

Statutory Authority

In addition to the specific language quoted above from Section 34-60-106(19), C.R.S., the Commission's authority to promulgate amendments to the Rules is derived from the following sections of the Act:

- Section 34-60-105(1), C.R.S. (Commission has the power to make and enforce rules necessary to enforce the Act);
- Section 34-60-106(2), C.R.S. (Commission may regulate the drilling, production, and pugging of wells and all other operations for the production of oil or gas);
- Section 34-60-106(2.5)(a), C.R.S. (Commission will regulate oil and gas operations in a reasonable manner to protect and minimize adverse impacts to public health, safety, and welfare, the environment, and wildlife resources and protect against adverse environmental impacts on any air, water, soil, or biological resource resulting from oil and gas operations);
- Section 34-60-107, C.R.S. (Commission has duty to regulate oil and gas operations so as to prevent waste of oil and gas); and
- 34-60-108, C.R.S. (Commission has authority to prescribe rules and procedure to adopt rules).

Identification of New and Amended Rules

Consistent with its statutory authority and its legislative mandates, and in accord with the administrative record, the Commission added or amended the following Rules:

- 100 Series Rules (Flowline System, Grade 1 Gas Leak, Out of Service Locks and Tags (OOSLAT), Produced Water Transfer System, and Tagout Device);
- Rules 215 and 216;
- Rules 326 and 333;
- Rule 610;
- Rules 711, 712, and 713;
- Rule 906; and
- 1100 Series Rules.

Overview of Purpose and Intent

The Commission implemented Senate Bill 19-181's directives regarding public disclosure of flowlines and evaluating and determining when a deactivated flowline, inactive, temporarily abandoned, or inactive shut-in well must be inspected before being returned to active use. The three fundamental changes to the existing flowline and inactive well rules that implement these provisions are:

(1) Requiring geodatabase information for all off-location flowlines and crude oil transfer lines and making that geodatabase information accessible to the public from COGCC's map; and

(2) Enabling COGCC staff to conduct inspections when an operator takes action to return an inactive flowline, temporarily abandoned well, or shut-in well to active status by requiring notice 48 hours prior to returning the line or well to service.

In addition to these critical changes, the Commission identified areas to improve protection of public health, safety, welfare, and the environment in making some changes to the flowline and other rules.

The amendments adopted as part of the 2019 Flowline Rules build upon the Commission's work during the Flowline Rulemaking in 2018 to build a more complete database of information regarding flowlines and crude oil transfer lines – from beginning to end. The Commission will have complete geodatabase information for all off-location flowlines and crude oil transfer lines, an understanding of each line's integrity management program with regular integrity verifications, investigation into integrity failures to better protect the environment from a spill or release, and, upon abandonment, a repository of information regarding the life-cycle of the flowline or crude oil transfer line.

Amendments and Additions to Rules

Rule 1101.a.

In a new section 1101.a., the Commission adopted rules to create different statuses for flowlines and crude oil transfer lines. These statuses are consistent with the federal Pipeline and Hazardous Materials Safety Administration (PHMSA) statuses, which should create seamless regulation between the two agencies. Importantly, the rules require any flowline or crude oil transfer line to be Out of Service Locked and Tagged (also a new defined term, discussed below) unless it is in Active Status. This carries forward the requirement to ensure that upon accessing a site, anyone can discern what lines are active and available for use. The Rule contemplates three scenarios for an Active Status line: (1) transporting fluids; (2) undergoing repair or maintenance and locked out and tagged out in accordance with the requirements of the federal Occupational Safety and Health Administration; and (3) holding fluid, but not transporting it, which is shut-in. For shut-in lines, the Commission requires the operator to apply a tag out device – again, to ensure that anyone on-site knows

precisely the status of each line on an oil and gas location. Clarifying changes were made throughout the rules to use consistent terms for these statuses.

Rule 1101.b.

The Commission moved the previous requirements in 1101.a. regarding registration of off-location flowlines into 1101.b. The most important change to this section is the requirement for operators to submit a geodatabase all off-location flowline to the Director. The Director will then make information about flowlines publicly viewable on the Commission's map. As of October 31, 2019, every off-location flowline was required to be registered with the Commission. Therefore, for off-location flowlines that an operator has already-registered, but has not submitted a geodatabase for it, the Commission established a deadline of December 1, 2020, for operators to submit the geodatabase. Because all lines must have a geodatabase, the Commission also removed the requirement to submit a layout drawing, which would be duplicative.

To make information submittals consistent for off-location flowlines regardless of the registration path, the Commission also now requires information about the off-location flowline's corrosion protection and integrity management system. For lines that an operator has already registered, the operator must submit this information with their next Flowline Report, Form 44, filed for the line.

The Commission, in this section and throughout the 1100-Series rules, changed the reporting timeline from a 30 day requirement to 90 days. The Commission expects operators to transition to quarterly reporting on flowline and crude oil transfer lines, which is a more efficient submittal process and also increases the efficiency for the Commission to review and audit operator submittals.

Last, the Commission deleted the previous version's references to the May 1, 2018 and October 31, 2019 deadlines, and related requirements. As of adoption of these rules, all actions required by the dates has passed, and therefore, the dates are now obsolete. The Commission also deleted other reference to these dates where the action deadlines have expired. In other scenarios, the Commission left the May 1, 2018 date in the rules if it continues to establish a date that – going forward – is an on-going requirement for operators.

Rule 1101.c.

In Rule 1101.c., the Commission created a new path for operators to register off-location flowlines – as a flowline system. Importantly, an operator must register every off-location flowline; though the rules create options for the registration, the Commission expects the same information regardless of the registration option. For off-location flowlines that DO NOT transport produced water, the operator may register the flowline:

(1) individually pursuant to 1101.b.; or

(2) as part of a flowline system pursuant to 1101.c.

For an off location flowline that transports produced water, the operator may register the flowline:

(1) individually pursuant to 1101.b.;

(2) as part of a flowline system pursuant to 1101.c.; or

(3) if the lines transport produced water generated at more than one well site or production facility, as part of a produced water transfer system pursuant to 1101.e.

The flowline system allows operators to register all or a subset of their off-location flowlines in a single submittal, i.e., a bulk upload. The bulk upload provides efficiencies for operators and the Commission's review and monitor the operator's off-location flowlines. The Commission will work with operators who have previously registered some or all off-locations lines through a different path if the operator prefers submitting information about the flowlines as a flowline system.

Rule 1101.d.

The Commission moved its domestic tap registration requirements to 1101.d. and deleted the now-obsolete date references. The Commission also established its expectation that tracer wire or other metallic devices used to locate subsurface lines must be resistant to corrosion damage. To comply with this, the Commission expects operators to use coated copper wire or other co-equal means. The Commission also added this reference in other sections of the rule requiring tracer wires or location devices.

Rule 1101.e.

The Commission's registration requirements for crude oil transfer lines and produced water transfer systems moved to Rule 1101.e. with a couple of changes, which have been discussed above, as the changes are similar to those made in other registration rule requirements. Again, the Commission established the requirement to submit a geodatabase by December 1, 2020, if an operator has previously registered a crude oil transfer line or produced water transfer system, but did not include a geodatabase of the location.

1101.f.

The Commission moved previously existing requirements for local governments to execute a confidentiality agreement before obtaining the underlying geodatabase information received by the Commission for off-location flowlines and crude oil transfer lines to a new section and included a modification. The Commission believes this provision continues to balance the need of local governments for information with safety concerns associated with publicly distributing geodatabase information. The modification clarifies that local governments can use the information for emergency planning as well as development and planning purposes. The Commission believes it should support the role of Utility Notification Center of Colorado (CO 811) as the primary source of information about subsurface facilities, including those related to oil and gas. However, the Commission included in this section a specific requirement that it will use geodatabase information to create a publicly accessible map of flowlines in Colorado. This accomplishes an important

directive of Senate Bill 19-181. The rule leaves discretion to the Director to determine at what scale the map displays flowline and crude oil transfer line locations to the public.

Rule 1102

The Commission updated and or clarified a number of standards throughout the Rule, and other 1100-Series rules.

Rule 1102.d.

In Rule 1102.d., the Commission's amendments better protect and minimize adverse impacts to public health, safety, and welfare and the environment from flowlines as required by Section 34-60-106(19). First, in subpart (6), the Commission requires operators going forward to install caution tape one foot above newly installed pipe. This measure is designed to prevent damage to the pipe during excavation. The Commission also included language about corrosion protection for tracer wire or metallic locating devices discussed above.

Second, in subpart (7), the Commission now requires operators to minimize impacts to wildlife resources when installing flowlines. Some stakeholders raised the issue of wildlife resource impacts during the siting or installation of flowlines or crude oil transfer lines as something the Commission should address during this rulemaking. The Commission agrees that during installation operators should minimize impacts to wildlife resources and, therefore made the change to subpart (7). The Commission, however, will take up the question of siting flowlines to be part of the Mission Change Rulemaking's broader conversation regarding permitting of oil and gas locations and facilities.

Third, the Commission changed references to manufacturer's procedures and practices to manufacturer's specifications in Subpart (10). The Commission made conforming changes throughout the 1100-Series to ensure that the rules use a consistent, single term – manufacturer's specifications – when an operator may rely upon manufacturer's directives, whether in the form of guidelines, instructions, policies, procedures or specifications.

1102.e.

The Commission revised subpart (2) to be more protective of public health, safety, welfare, and the environment by ensuring that pipes buried with less than three feet of cover are intended to be exposed, and are designed and installed to withstand exposure to the elements. The Commission also included the requirement for operators to – as is reasonable and necessary under the circumstances – install barricades to protect above-ground flowline and crude oil transfer line infrastructure from vehicular impacts.

1102.f.

The Commission adjusted the top soil management requirements to eliminate redundancy – and perhaps potential conflicts – between the 1100-Series and 1000-Series regarding top soil management.

1102.g.

The Commission updated its marking requirements to clarify that operators installing a marker that complies with the federal requirements also meets the Commission's requirements. In addition, the Commission removed confusing language about "in designated setback locations," to clarify that markers are required when flowlines or crude oil transfer lines cross public rights-of-way or utility easement crossings.

1102.h.

The Commission updated 1102.h. to require, going forward, that all third-party inspectors of crude oil transfer lines are either Professional Engineers or working under the supervision of a Professional Engineer.

1102.i. and 1102.j.

To conform with OSHA requirements, the Commission clarified its expectations while operators are performing maintenance or repairing flowlines or crude oil transfer lines. The rules now require an operator to apply lock out or tagg out devices when performing maintenance or repair in conformity with OSHA's requirements. The Commission also added a standard for repair and its expectation that unsafe equipment is repaired or removed.

1102.m.

Given the importance of manufacturer's specifications throughout the rules, the Commission believes it important for public health, safety, welfare, the environment, and wildlife reasons to have access to the manufacturer's specifications an operator uses when designing, operating, or installing flowlines or crude oil transfer lines. The change to 1102.m. establishes that it is the operator's responsibility to maintain a copy of or access to (e.g., online) manufacturer's specifications that the operator uses and ensures the specification is available for evaluation if a question arises regarding the operator's compliance with the specification.

1102.n.

Changes to the section clarify the Commission's expectations regarding compliance with the Utility Notification Center of Colorado (CO 811) requirements. The changes also acknowledge that some operators registered with the Commission may not have underground facilities – e.g., financial assurance providers and transporters – and that these operators are exempt from the section's requirements.

1102.o.

The Commission adopted increased requirements in Rule 1102.o. to implement Senate Bill 19-181's directive for the Commission to inspect inactive flowlines before the operator returns the line to active status. In sum, any off-location flowline or crude oil transfer line that has been inactive – meaning Out of Service or shut in – for more than ninety days, the operator must pressure test the line before returning it to use and must notify the

Commission at least 48 hours before the pressure test. This notice allows the Commission staff to conduct an inspection during the pressure test and observe the operator when returning the inactive line to use.

In addition, the rule clarifies that shut-in off-location flowlines and crude oil transfer lines, which are still in Active Status, must continue with their integrity management regimes while shut-in. In contrast, Out of Service off-location flowlines and crude oil transfer lines are not subject to integrity management because those lines are locked out and tagged out, disconnected from any source of fluids, and purged of any fluids.

Rule 1104

In Rule 1104, the Commission made clarifying changes throughout regarding the status of a line, updating standards, and timing.

Rule 1104.k.

The Commission included an important regulatory step to create a uniform process for operators to, first, evaluate whether a spill or release of fluids resulted from an integrity management failure, and second, turn to Rule 906 to report and investigate the spill or release, if necessary. This ensures investigation and reporting (via an existing process) for all spills or releases, irrespective of the source.

Rule 1105.

The Commission's changes to the abandonment process focus on (1) expecting that abandoned infrastructure is removed, unless certain conditions are met; (2) establishing notice procedures to allow the Commission staff to inspect during abandonment; and (3) clarifying the reporting requirements for abandonment. Importantly, while abandonment of a flowline is underway, but risers have not been removed, operators must apply OOSLAT.

Rule 1105.c.

Given the Commission's presumption that flowlines will be removed, the Commission now requires 20-days notice if an operator believes an exception to the requirement applies. This time gives the Director the opportunity to review the documentation supporting the exception and approve, deny, request information, or apply conditions of approval, if reasonable and necessary to protect public health, safety, welfare, the environment, or wildlife from adverse impacts. An example of a condition of approval would be to flow fill the line abandoned in place.

For flowlines that will be abandoned and removed, operators must submit notice to the Director forty-eight hours, or more, before commencing abandonment. This allows the Commission to inspect and observe abandonment processes.

Rule 1105.e.

The Commission's amendments to the abandonment process make clear that the presumption is abandonment of a flowline or crude oil transfer line means removal. However, the Commission understands there are some circumstances that warrant abandoning a flowline in place. For example, removing a flowline from an existing right-of-way in which the flowline is co-located with other active lines creates safety risks. For flowlines abandoned in place, the Commission's previously existing requirements, including cutting risers below grade, continue to apply. The Commission also requires including information about the line's most recent pressure test to ensure any environmental impacts have been identified and are cleaned up or are in the process of being cleaned up.

Rule 1105.f.

The Commission's changes to flowline abandonment notifications for off-location flowlines or crude oil transfer lines establish information required to be submitted to the Commission for abandonment – and this information will create a complete repository of the line's life cycle.

The changes also establish by rule what is occurring for on-location flowlines. Receiving the Field Operations Notice, Form 42 – Abandonment of Flowlines for an on-location flowline allows staff to verify the operator has completed abandonment of all facilities when staff evaluates the operator's submittals for well abandonment. In addition, the Form can be automatically sent to the relevant Local Government Designee. Conforming changes were made to Rule 1105.g.

Rule 326.

The Commission's changes to Rule 326 implement Senate Bill 19-181's directive for the Commission to inspect an inactive, temporarily abandoned or inactive, shut-in well before the operator returns the well to production or injection. Operators are now required to provide notice at least 48 hours prior to returning an inactive, shut-in well to production or injection or to conducting the work necessary or installing equipment necessary to return an inactive, temporarily abandoned well to production or injection. This notice allows the Commission staff to conduct an inspection and observe the operator's work when returning the well to production or injection.

Rule 610.

The Commission included language in a new rule – Rule 610 – to ensure operators reviewing the safety rules and who may consider a Grade 1 Gas Leak a safety (not E&P Waste) issue understand the responsibility to report a gas spill or release through the 900 Series. To ensure the agency captures the data, operators also must report the document number for the Form 19 associated with the Leak on the appropriate Form 44.

Rule 906.

Consistent with previous changes discussed, the Commission updated Rule 906 to create a clear process for operators to also report Grade 1 Gas Leaks as well as any other flowline integrity failure that causes a reportable spill or release pursuant to Rule 906.b.(1). The Commission also clarified what information should be submitted as part of an Initial Spill Report and numbered previously unnumbered paragraphs for clarity. In addition, the inclusion of "gas" in the language of 906 ensures clarity that spill or release contemplates a spill or release of gas, in addition to a spill or release of liquids or produced water.

Conforming Changes

Definitions -- 100 Series Rules.

The Commission created two new definitions: Flowline System and Out of Service Lcks and Tags (OOSLAT). The definition of Flowline Systems allows operators to bulk upload off-location flowline information more efficiently and staff to review those uploads more effectively. The definition of OOSLAT is necessary to harmonize Commission rules with those of PHMSA and OSHA. It is critically important to keep out of service flowlines and crude oil transfer lines from being connected to active sources of fluids or pressure; however, the Commission's existing definition of lock out and tag out devices may only be used when an operator is locking out and tagging out equipment for repairs or maintenance according to OSHA. Therefore, the Commission developed the OOSLAT definition to create a separate lock out/tag out process for out of service lines—enabling operators to comply with federal and state requirements.

In addition, the Commission clarified the definition of a produced water transfer system to conform with the 700 Series and removed unnecessary language from the definition of tagout device.

Rule 215.

The Commission updated Rule 215 to reflect changes in the technology used to determine GPS or geodatabase information. This is a critical definitional change given the importance of obtaining accurate geodatabase information for mapping of off-location flowlines and crude oil transfer lines.

Rule 216.

The Commission clarified its expectations that an operator include information about its plans to convey fluids, including liquids, gas, and produced water, in a Comprehensive Drilling Plan (CDP) submittal. This information assists the Commission in understanding

the scope of impacts to public health, safety, welfare, the environment, and wildlife from a proposed CDP.

Rule 333.

This rule clarification makes consistent the reference to the Utility Notification Center of Colorado as updated in the 1100 Series rules.

Rules 711, 712, and 713.

When the Commission updated its rules in 2018, it included produced water transfer systems as a type of facility for which the Commission would collect financial assurance to ensure compliance with the 900 Series rules. Including it in this section led to confusion as some operators thought a single blanket bond would cover both produced water transfer systems as well as any other facility listed in Rule 711. The Commission, therefore, moved the financial assurance requirements for produced water transfer systems into Rule 712 to provide clarity that the Commission requires a separate financial assurance dedicated for an operator's produced water transfer system. The previous Rule 712 was renumbered to Rule 713.

Effective Date

The Commission will adopt proposed amendments at its hearing on November 20-21, 2019. These amendments will become effective, per § 24-4-103, C.R.S., twenty days after publication in the Colorado Register.

Notice of Proposed Rulemaking

Tracking number

2019-00621

Department

1000 - Department of Public Health and Environment

Agency

1003 - Water and Wastewater Facility Operators Certification Board (1003 Series)

CCR number

5 CCR 1003-2

Rule title

REGULATION NO. 100 - WATER AND WASTEWATER FACILITY OPERATORS CERTIFICATION REQUIREMENTS

Rulemaking Hearing

Date

11/26/2019

Time

09:00 AM

Location

CDPHE - 4300 Cherry Creek Drive South Denver, CO 80246 - Sabin Conference Room

Subjects and issues involved

In response to feedback from the Office of Legislative Legal Services concerning satisfaction of incorporation by reference requirements to add the date and citation of the Colorado Certified Water Professionals Code of Conduct.

Statutory authority

Section 25-9-104, C.R.S.

Contact information

Name

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COLORADO
Water & Wastewater Facility
Operators Certification Board
Department of Public Health & Environment

NOTICE OF PUBLIC RULEMAKING HEARING
BEFORE THE
WATER AND WASTEWATER FACILITY OPERATORS CERTIFICATION BOARD

SUBJECT:

For consideration of proposed revisions to Regulation No. 100, "Water and Wastewater Facility Operators Certification Requirements" (5 CCR 1003-2). The revisions to Regulation No. 100 proposed by the Water Quality Control Division, along with proposed Statement of Basis, Statutory Authority and Purpose, are attached to this notice as Exhibit 1. Proposed new language is shown with underlining and proposed deletions are shown with ~~strikeouts~~.

HEARING SCHEDULE:

DATE:	Tuesday, November 26, 2019
TIME:	9:00 a.m.
PLACE:	Sabin Conference Room Colorado Department of Public Health and Environment 4300 Cherry Creek Drive South Denver, CO 80246

WRITTEN AND ORAL COMMENTS:

The Operators Certification Board encourages all interested persons to provide their opinions or recommendations regarding the matters to be addressed in this rulemaking hearing. The board will only accept written comments on these proposed changes. Due to the limited nature of the proposed changes, oral comments will not be heard.

Written comments must be received by November 14, 2019. Anyone providing written comments should deliver an electronic copy to cdphe.wwfocb@state.co.us. All written comments will be available to the public on the board's website.

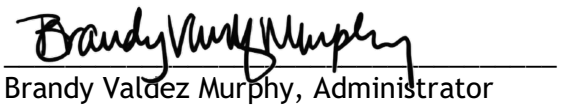
SPECIFIC STATUTORY AUTHORITY:

The provisions of C.R.S. 25-9-101 through 25-9-110 provide the specific statutory authority for consideration of the regulatory provisions proposed by this notice. The purpose of the proposed amendments are to incorporate feedback from the Office of Legislative Legal Services concerning incorporation by reference requirements pursuant to C.R.S. 24-4-103, to add the proper date and citation to references to the Colorado Certified Water Professionals Code of Conduct. Should the Operators Certification Board adopt the regulatory language as proposed in this notice or alternative provisions, it will also adopt, in compliance with section

24-4-103(4) C.R.S., an appropriate Statement of Basis, Specific Statutory Authority, and Purpose.

Dated this 10th day of October 2019 at Denver, Colorado.

WATER AND WASTEWATER FACILITY OPERATORS CERTIFICATION BOARD



Brandy Valdez Murphy, Administrator

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Water And Wastewater Facility Operators Certification Board

REGULATION NO. 100 - WATER AND WASTEWATER FACILITY OPERATORS CERTIFICATION REQUIREMENTS

5 CCR 1003-2

. . . .

100.13 DISCIPLINARY PROCEEDINGS

. . . .

100.13.2 Certified Operators – In accordance with the procedures in sections 24-4-104 and 105, C.R.S., the Board may reprimand a certified operator, and/or suspend or revoke the certificate of any certified operator who violates the requirements of this regulation, including, but not limited to the following:

. . . .

(j) when acting in the capacity of a certified operator, behaving in a threatening, intimidating, demeaning or similar manner in verbal or written communications or in interactions with the public, the regulated community or regulators; or

(k) failure to follow the Colorado Certified Water Professionals Code of Conduct (June 2018), available online at https://drive.google.com/file/d/1CzfHNNhvgHhT8gISEYxtqOgsildWky5k/view and available for public inspection during normal business hours from the Water and Wastewater Operators Certification Board, 4300 Cherry Creek Drive South, Denver, CO 80246.

. . . .

100.14 CERTIFICATION QUALIFICATIONS, EDUCATION, EXPERIENCE AND SUBSTITUTIONS

100.14.1 A person desiring to be certified shall apply for certification with the Board or its contractor. Applicants shall affirm agreement with the Colorado Certified Water Professionals Code of Conduct (June 2018), available online at https://drive.google.com/file/d/1CzfHNNhvgHhT8gISEYxtqOgsildWky5k/view and available for public inspection during normal business hours from the Water and Wastewater Operators Certification Board, 4300 Cherry Creek Drive South, Denver, CO. ~~and~~ Applicants shall also provide the following:

. . . .

100.58 STATEMENT OF BASIS, SPECIFIC STATUTORY AUTHORITY AND PURPOSE; NOVEMBER 26, 2019 RULEMAKING; EFFECTIVE JANUARY 31, 2020

Provisions of section 25-9-104, C.R.S., provide the specific statutory authority for the adoption of these amendments to the established regulatory provisions of Regulation 100 governing the requirements for

water and wastewater facility operators (5 CCR 1003-2). The Board hereby adopts, in compliance with section 24-4-103(4), C.R.S., the following statement of basis and purpose.

BASIS AND PURPOSE

In response to feedback from the Office of Legislative Legal Services concerning satisfaction of incorporation by reference requirements in the State Administrative Procedure Act, the board conducted a written comment rulemaking to add date and citation information for the Colorado Certified Water Professionals Code of Conduct.

Notice of Proposed Rulemaking

Tracking number

2019-00618

Department

1505 - Department of State

Agency

1505 - Secretary of State

CCR number

8 CCR 1505-8

Rule title

RULES CONCERNING LOBBYIST REGULATION

Rulemaking Hearing

Date

11/15/2019

Time

01:00 PM

Location

Blue Spruce Conference Room on the 2nd floor of the Secretary of States Office at 1700 Broadway, Denver, Colorado 80290

Subjects and issues involved

The Secretary is considering amendments and recodification of the rules to improve the administration and enforcement of Colorado laws regarding lobbyist regulation. Specifically, the Secretary is considering rule revisions necessary to ensure proper administration of additional legislation recently passed by the Colorado General Assembly; eliminate obsolete provisions; organize existing rules for clarity; simplify the language of existing rules; remove language that is duplicative of statute or constitutional provisions; and ensure consistency with Department rulemaking standards. The Secretary may consider additional rule amendments. Please see the attached Notice of Rulemaking (includes a draft statement of basis and preliminary draft proposed rules).

Statutory authority

Sections 24-6-303(6.3)(a) and 24-6-305(2)(b), C.R.S., (2019)

Contact information

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Title

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Preliminary Draft of Proposed Rules

Office of the Colorado Secretary of State
Rules Concerning Lobbyist Regulation
8 CCR 1505-8

October 4, 2019

Disclaimer:

In accordance with the State Administrative Procedure Act, this draft is filed with the Secretary of State and submitted to the Department of Regulatory Agencies.[1]

This is a preliminary draft of the proposed rules that may be revised before the November 15, 2019 rulemaking hearing. If changes are made, a revised copy of the proposed rules will be available to the public and a copy will be posted on the Department of State's website no later than November 8, 2019.[2]

Please note the following formatting key:

Font effect	Meaning
Sentence case	Retained/modified current rule language
SMALL CAPS	New language
~~Strikethrough~~	Deletions
Italic blue font text	Annotations

Amendments to 8 CCR 1505-8 follow:

Rule 1. Definitions

~~1.1 "Client" means a person or entity who initially hires, engages, or otherwise pays or contributes money to a professional lobbyist for lobbying services. "Client" does not include a lobbying firm that employs a professional lobbyist or a professional lobbyist who is, on a subcontract basis, working for another professional lobbyist.~~[3]

~~1.2 "Covered official" means the governor, lieutenant governor, a member of the general assembly, any member of legislative council staff, a member of a rulemaking board or commission, or a rulemaking official of a state agency who has jurisdiction over the subject matter of a rule, standard, or rate.~~[4]

~~1.3 "Lobbying:"~~

~~1.3.1 Means communicating directly, or soliciting others to communicate, with a covered official for the purpose of aiding or influencing:~~

1 Sections 24-4-103(2.5) and (3)(a), C.R.S. (2019). A draft must be submitted to the Department at the time that a notice of proposed rulemaking is filed with the Secretary of State.
2 Section 24-4-103(4)(a), C.R.S. (2019). "[A]ny proposed rule or revised proposed rule by an agency which is to be considered at the public hearing…shall be made available to any person at least five days prior to said hearing."
~~3 Section 24-6-301 (1), C.R.S.~~
~~4 Section 24-6-301 (1.7), C.R.S.~~

(a) The drafting, introduction, sponsorship, consideration, debate, amendment, passage, defeat, approval, or veto on any:

(1) Bill, resolution, amendment, nomination, appointment, or report, whether or not in writing, pending or proposed for consideration by the general assembly, whether or not the general assembly is in session;

(2) Any other matter pending or proposed in writing by a covered official, whether or not the general assembly is in session;

(b) The preparation of an initial fiscal impact statement for an initiated measure to be considered by the title setting board;

(c) The convening of a special session of the general assembly or the specification of business to be transacted during the special session; or

(d) The drafting, consideration, amendment adoption, or defeat of any rule, standard, or rate of any state agency that has rulemaking authority.[5]

1.3.2 Does not include:

(a) Communications required by a statute, rule, regulation, or order;[6]

(b) Appearing before a committee of the general assembly or a rulemaking board or commission if the committee, board, or commission issued a mandatory order or subpoena commanding appearance and testimony or commanding a person to appear as a respondent;[7]

(c) Appearing before a committee of the general assembly or a rulemaking board or commission at the request of public official or employees. This exemption applies only to a person who is not already registered as a lobbyist, and the person must clearly identify themselves and the interest for whom they are testifying.[8]

(d) Communications made by an attorney at law on behalf of a client that constitute the practice of law if the client is clearly identified.[9] This exemption applies only to an attorney who is representing his or her client's legal rights before a tribunal or adjudicative body that contains covered officials. Examples include, but are not limited to, the state title setting board, administrative licensure hearings, and legislative ethics panels This exemption does not extend to an attorney who is merely lobbying, as defined above, on behalf of a client.

(e) Appearance as a witness in a rule, standard, or rate-making proceeding;[10]

(f) A political committee, volunteer, lobbyist, or citizen who lobbies on his or her own behalf, a state official acting in his or her official capacity, or a public official acting in his or her official capacity.[11]

[Current Rule 1.3.2(g) is relocated and recodified as New Rule 2.2.2(a)]

5 Section 24-6-301 (3.5), C.R.S.
6 Section 24-6-301 (3.5) (c), C.R.S.
7 Section 24-6-301 (3.5) (d), C.R.S.
8 Section 24-6-301 (3.5) (d), C.R.S.
9 Section 24-6-301 (3.5) (e), C.R.S.
10 Section 24-6-303 (5), C.R.S.
11 Section 24-6-303 (6), C.R.S.

~~1.4 "Lobbying firm" means a person or entity who employs a professional lobbyist on behalf of a client that is not the person or entity. "Lobbying firm" includes a self-employed professional lobbyist.[12]~~

1.1 "CONTRIBUTION" MEANS A GIFT, SUBSCRIPTION, LOAN, ADVANCE, OR DEPOSIT OF MONEY OR ANYTHING OF VALUE AND INCLUDES A CONTRACT, PROMISE, OR AGREEMENT, WHETHER OR NOT LEGALLY ENFORCEABLE, TO MAKE A CONTRIBUTION. "CONTRIBUTION" ALSO INCLUDES THE COMPENSATION AND REIMBURSEMENT FOR EXPENSES OF A PERSON REQUIRED TO FILE A DISCLOSURE STATEMENT UNDER SECTION 24-6-302, C.R.S.

1.2 "DIVISION" MEANS THE DIVISION WITHIN THE OFFICE OF THE SECRETARY OF STATE RESPONSIBLE FOR ADMINISTERING THE STATE'S LAWS GOVERNING LOBBYING.

1.3 "FISCAL YEAR" MEANS THE PERIOD BEGINNING JULY 1 OF A CALENDAR YEAR AND ENDING JUNE 30 OF THE FOLLOWING CALENDAR YEAR.

1.4 "LEGISLATION" MEANS ANY BILL, RESOLUTION, AMENDMENT, NOMINATION, REPORT, OR ANY OTHER MATTER WHETHER OR NOT IN WRITING, PENDING, OR PROPOSED FOR CONSIDERATION BY EITHER HOUSE OR COMMITTEE OF THE GENERAL ASSEMBLY, WHETHER OR NOT THE GENERAL ASSEMBLY IS IN SESSION.

1.5 "Monitoring" status means that a registered lobbyist is not currently communicating support or opposition, or influencing or attempting to influence a covered official on the drafting, introduction, sponsorship, consideration, debate, amendment, passage, defeat, approval, or veto of any bill, resolution, amendment, nomination, appointment, or report, pending or proposed.

1.6 "Professional lobbyist" means a person, a business entity, including a sole proprietorship, or an employee of a client, who is compensated by a client, another professional lobbyist, or lobbying firm for lobbying services.[13]

1.7 "Rate" means a ratio of valuation, percentage, percentage change, annual adjustment, or an amount charged for a good or service, adopted by a state agency having rulemaking authority.

1.8 "RESPONDENT" MEANS THE PERSON OR ENTITY AGAINST WHOM A COMPLAINT IS FILED.

1.9 "SESSION" MEANS A REGULAR OR SPECIAL SESSION OF THE GENERAL ASSEMBLY, AND, WHERE APPLICABLE, WHEN ANY MEASURE ADOPTED BY THE GENERAL ASSEMBLY IN REGULAR SESSION IS PENDING BEFORE THE GOVERNOR FOR APPROVAL OR DISAPPROVAL.

~~1.8~~ 1.10 "Standard" means a criterion measuring acceptability, quality, accuracy, weight, or an amount, or a threshold for agency jurisdiction adopted by a state agency having rulemaking authority.

~~1.9~~ 1.11 "State Liaison" means the one person designated by each principal department of state government who is responsible for any lobbying by a state official or employee on behalf of the principal department.[14]

~~1.10 "Volunteer lobbyist" means a person who engages in lobbying but whose only receipt of money for doing so consists of nothing more than reimbursement for actual and reasonable expenses such as meals, travel, lodging and parking.[15]~~

Rule 2. Professional Lobbyists

2.1 Registration

~~12 Section 24-6-301 (3.6), C.R.S.~~
~~13 Section 24-6-301 (6), C.R.S~~
~~14 Section 24-6-303.5 (1) (a), C.R.S.~~
~~15 Section 24-6-301 (7), C.R.S.~~

2.1.1 A professional lobbyist must register electronically via the Secretary of State's website before lobbying. The statement must contain:

(a) The professional lobbyist's full name, business address, and business telephone number;

(b) The name, address, and telephone number of the lobbying firm or any other person or entity that employs the professional lobbyist;

(c) The name, address, and telephone number of all clients that engage the professional lobbyist;

(d) The name, address, and telephone number of any other professional lobbyist for whom the professional lobbyist is lobbying on a subcontract basis.[16]

2.1.2 The fee for filing a professional lobbyist registration statement is $40.00.

(a) Upon request, the Secretary of State may waive the registration fee for a professional lobbyist who is lobbying for a nonprofit organization if the professional lobbyist's only compensation is from the nonprofit organization. To receive a waiver, the professional lobbyist must submit a written request to the Secretary of State along with a copy of the nonprofit organization's most recent IRS form 990, 990EZ, or 990-N showing gross annual revenue of $50,000 or less.[17]

2.1.3 A professional lobbyist must file an updated registration statement on or before July 15 each year.[18]

2.2 EXCEPTIONS TO REGISTRATION WITH THE SECRETARY OF STATE'S OFFICE

2.2.1 VOLUNTEER LOBBYIST

(A) A VOLUNTEER LOBBYIST, AS DEFINED IN SECTION 24-6-301(7), C.R.S., IS NOT REQUIRED TO REGISTER WITH THE SECRETARY OF STATE, BUT MUST REGISTER WITH THE GENERAL ASSEMBLY.

2.2.2 GRASS ROOTS LOBBYING

~~1.3.2(g)~~ (A) ~~Activity~~ IF AN ACTIVITY that could otherwise be considered lobbying ~~if that activity~~ is performed by an employee ~~of an organization, and the activity occurs~~ ONLY once a year, ~~or less~~ and the employee is not paid solely to lobby, THEN THAT ACTIVITY IS NOT CONSIDERED LOBBYING. This exclusion from lobbying covers "grassroots" lobbying by employees of an organization who contact members of the organization in response to a piece of legislation or rule.

2.3 TERMINATION OF REGISTRATION

2.3.1 A PROFESSIONAL LOBBYIST MAY TERMINATE THEIR REGISTRATION AT ANY TIME IF THE PROFESSIONAL LOBBYIST:

(A) WILL NOT LOBBY OR RECEIVE LOBBYING INCOME FOR THE REMAINDER OF THE FISCAL YEAR;

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16 Section 24-6-303 (1), C.R.S.
17 Section 24-6-303 (1.3) (a), C.R.S.
18 Section 24-6-303 (1.5), C.R.S.

(B) INDICATES ON THE NEXT MONTHLY DISCLOSURE STATEMENT THAT THE PROFESSIONAL LOBBYIST IS TERMINATING THEIR PROFESSIONAL LOBBYIST REGISTRATION; AND

(C) FILES THEIR ANNUAL DISCLOSURE STATEMENT REQUIRED BY SECTION 24-6-302(3)(B), C.R.S.

2.4 REVOCATION OF REGISTRATION

2.4.1 THE DIVISION WILL REVOKE A PROFESSIONAL LOBBYIST'S REGISTRATION CERTIFICATE IF THE LOBBYIST:

(A) IS CONVICTED OF VIOLATING ANY PROVISION OF PART 3 OF ARTICLE 6 OF TITLE 24, C.R.S.; OR

(B) HAS BEEN SUSPENDED FROM LOBBYING BY THE GENERAL ASSEMBLY.

2.4.2 THE DIVISION MAY REVOKE A PROFESSIONAL LOBBYIST'S REGISTRATION CERTIFICATE UNDER THE PROVISIONS OF SECTION 24-6-305 (2), C.R.S.

~~2.2~~ 2.5 ~~Disclosure~~ MONTHLY DISCLOSURE STATEMENTS

~~2.2.1~~ 2.5.1 A professional lobbyist must file a monthly disclosure statement electronically via the Secretary of State's website on or before the 15th day of the month following the month in which the professional lobbyist began lobbying, and monthly thereafter. The statement must contain:[19]

(a) The name and address of each client or other professional lobbyist who ~~paid~~ CONTRIBUTED $100 OR MORE TO the professional lobbyist for lobbying, and the amount paid by the client or other professional lobbyist since the previous disclosure statement;[20]

(1) If the client or other professional lobbyist is an individual, THE STATEMENT MUST INCLUDE a description of the INDIVIDUAL'S business. ~~activity in which the individual is engaged;~~

(2) If the client or other professional lobbyist is a business entity, THE STATEMENT MUST INCLUDE a description of the ENTITY'S business, ~~in which the entity is engaged~~ and the names of any chief executive officer, partners, or other designated contact person.~~; or~~

(3) If the client or other professional lobbyist is an industry, trade, organization~~,~~ or group of persons, or professional association, THE STATEMENT MUST INCLUDE a description of the industry, trade, organization~~,~~ or group of persons, or professional association.[21]

(b) The total ~~amount of money paid to or for~~ SUM OF CONTRIBUTIONS the professional lobbyist RECEIVED FOR LOBBYING ACTIVITIES since the previous disclosure statement and during the fiscal year;~~;~~[22]

(C) THE LEGISLATION, STANDARDS, RULES, OR RATES, ABOUT WHICH THE PROFESSIONAL LOBBYIST IS LOBBYING, INCLUDING:

19 ~~Section 24-6-302 (2.5), C.R.S.~~

20 ~~Section 24-6-301 (1.9) (a) (1), C.R.S.~~

21 ~~Section 24-6-301 (1.9) (a) (XI), C.R.S.~~

22 ~~Section 24-6-301 (1.9) (a) (II), (III), and (VIII), C.R.S.~~

(1) THE OFFICIAL NUMBER OR OTHER DESIGNATION OF EACH LEGISLATIVE BILL, STANDARD, RULE, OR RATE, IF AVAILABLE. IF A NUMBER OR DESIGNATION IS NOT AVAILABLE, THE LOBBYIST MUST DESCRIBE THE NATURE AND SUBJECT MATTER OF THE LEGISLATION, STANDARDS, RULES OR RATES;

(2) THE TITLE OR SUBJECT MATTER OF THE ACTIVITY MENTIONED ABOVE; AND

(3) WHETHER THE LOBBYIST IS SUPPORTING, OPPOSING, AMENDING, OR MONITORING THE ACTIVITY MENTIONED ABOVE, INCLUDING ALL UP-TO-DATE AND CURRENT POSITIONS.

~~(c)~~ (E) If the professional lobbyist has made an expenditure that exceeds the current dollar gift limit, as established by the Independent Ethics Commission and posted on the Secretary of State website, on behalf of a covered official for gift or entertainment purposes, whether or not the professional lobbyist was reimbursed, AND:

(1) The name of the covered official; and

(2) The amount, date, and principal purpose of the gift or entertainment;[23]

~~(d)~~ (F) The total amount of expenditures made by or on behalf of the professional lobbyist in connection with lobbying, other than for gift or entertainment purposes;[24]

~~(e)~~ (G) If the professional lobbyist has made an expenditure or given a contribution to a paper, periodical, magazine, radio or TV station, or other media of mass communication:

(1) The name of the entity; and

(2) The amount given to the entity;[25]

~~(f) The specific legislation, standards, rules, or rates for which the professional lobbyist is lobbying or, if not known, the nature of the legislation, standards, rules, or rates, including:~~

~~(1) The bill number of the legislation; and~~

~~(2) Whether the lobbyist is supporting, opposing, amending, or monitoring the legislation.~~[26]

~~(g)~~ (H) Any direct business association the professional lobbyist has with any pending legislation, measure, or question.[27]

2.6 ANNUAL CUMULATIVE DISCLOSURE STATEMENT

~~2.2.2~~ 2.6.1 ~~In addition to the monthly disclosure statement described in Rule 2.2.1, a~~ A professional lobbyist must file an annual disclosure statement for the entire fiscal year no later than July 15. The annual disclosure statement must include:

~~23 Section 24-6-301 (1.9) (a) (1) (IV), C.R.S.~~
~~24 Section 24-6-301 (1.9) (a) (1) (V) and (VII), C.R.S.~~
~~25 Section 24-6-301 (1.9) (a) (1) (IX), C.R.S.~~
~~26 Section 24-6-301 (1.9) (a) (1) (X), C.R.S.~~
~~27 Section 24-6-301 (1.9) (a) (1) (XII), C.R.S.~~

(A) ~~the~~ THE name of ~~and~~ THE CLIENT OR OTHER PROFESSIONAL LOBBYIST FOR WHOM THE PROFESSIONAL LOBBYIST IS LOBBYING;

(B) THE total gross income the professional lobbyist has received from each client or other professional lobbyist~~.~~; AND

(C) If a subcontract relationship exists between two professional lobbyists, both lobbyists must disclose the amount of money paid and received on the annual disclosure statement.~~[28]~~

2.7 NEW CLIENT DISCLOSURE

~~2.2.3~~ 2.7.1 NEW CLIENT NOT DURING SESSION

(A) ~~In addition to the monthly and annual disclosure statements described in Rules 2.2.1 and 2.2.2, when~~ WHEN a professional lobbyist enters into a new oral or written agreement with a client or other professional lobbyist for lobbying ~~that isn't disclosed in the registration statement described in Rule 2.1.1, the professional lobbyist must notify the Secretary of State.~~ WHILE THE GENERAL ASSEMBLY IS NOT IN SESSION, THE PROFESSIONAL LOBBYIST MUST NOTIFY THE SECRETARY OF STATE BY UPDATING THEIR REGISTRATION STATEMENT WITHIN FIVE BUSINESS DAYS OF THE ORAL OR WRITTEN AGREEMENT TO LOBBY.

2.7.2 NEW CLIENT DURING SESSION

(A) IF A PROFESSIONAL LOBBYIST ENTERS INTO A NEW ORAL OR WRITTEN AGREEMENT WITH A CLIENT OR OTHER PROFESSIONAL LOBBYIST FOR LOBBYING WHILE THE GENERAL ASSEMBLY IS IN SESSION, THE PROFESSIONAL LOBBYIST MUST NOTIFY THE SECRETARY OF STATE BY UPDATING THEIR REGISTRATION STATEMENT WITHIN 24 HOURS IN ACCORDANCE WITH SECTION 24-6-302(6)(A), C.R.S. THE PROFESSIONAL LOBBYIST MUST UPDATE THEIR REGISTRATION BY PROVIDING:

(1) THE NAME OF THE CLIENT;

(2) THE ADDRESS OF THE CLIENT; AND

(3) A SUMMARY OF THE TERMS OF THE AGREEMENT INCLUDING:

(A) THE CLIENT'S CONTACT INFORMATION;

(B) THE DATE THE LOBBYIST WAS HIRED;

(C) THE DATE THE LOBBYIST'S EMPLOYMENT WILL END, IF KNOWN; AND

(D) IF THE CLIENT IS A BUSINESS:

(I) THE ORGANIZATION'S NAME;

(II) THE BUSINESS TYPE;

(III) THE INDUSTRY/TRADE TYPE; AND

(IV) THE NAMES OF THE ENTITY'S CHIEF EXECUTIVE OFFICER OR PARTNERS.

~~28 Section 24-6-302 (3), C.R.S.~~

~~(a) If the new engagement occurs while the general assembly is not in session the professional lobbyist must notify the Secretary within five working days.~~

~~(b) If the new engagement occurs while the general assembly is in session the professional lobbyist must notify the Secretary within 24 hours, except that, if the agreement is oral, the notification must occur within 24 hours after the date of the subsequent written agreement.~~

~~(c) In addition to the notification, the professional lobbyist must:~~

~~(1) File, concurrently with the next disclosure statement, a signed written statement that contains the name and address of the new client and a summary of the terms of the agreement including:~~

~~(A) Client contact information;~~

~~(B) If client is a business, the organization name, business type, industry/trade type, and the name(s) of the entity's chief executive officer or partners;~~

~~(C) Date the lobbyist was hired; and~~

~~(D) Date the lobbyist's employment will end, if known.~~

~~(2) Update the professional lobbyist's registration statement within 24 hours.~~[29]

~~2.2.4 Effective January 1, 2019, a professional lobbyist must log by date all position changes (monitoring, oppose, and support) on a bill and file the log covering the preceding month with the monthly disclosure statement required by Rule 2.2.1.~~

2.8 Additional required disclosure during session

2.8.1 Lobbying disclosure during session for new client

(a) If a professional lobbyist agrees to lobby for a new client or other professional lobbyist during session, the professional lobbyist must disclose:

(1) The identity of the new client or other professional lobbyist in accordance with Rule 2.7.2 within 24 hours; and

(2) The legislation, standards, rules, or rates, on which the professional lobbyist is lobbying for that client or other professional lobbyist, in accordance with Rule 2.5.1(d), within 72 hours.

2.8.2 Lobbying disclosure during session for existing client or other professional lobbyist

(a) New legislation, standards, rules, or rates.

(1) If a professional lobbyist agrees to lobby for an existing client during session in connection with new legislation, standards, rules, or rates, the professional lobbyist must disclose the lobbying activity, in accordance with Rule 2.5.1(d), within 72 hours.

29 Section 24-6-302 (6) (b), C.R.S.

(2) NEW LEGISLATION INCLUDES AN ENGAGEMENT TO LOBBY FOR AN EXISTING CLIENT ON LOBBYING ACTIVITIES THAT WERE NOT PREVIOUSLY DISCLOSED.

(B) CHANGE OF POSITION ON LEGISLATION, STANDARDS, RULES, OR RATES

(1) IF A PROFESSIONAL LOBBYIST TAKES A NEW POSITION ON LEGISLATION, STANDARDS, RULES, OR RATES FOR AN EXISTING CLIENT DURING SESSION, THE PROFESSIONAL LOBBYIST MUST DISCLOSE THE POSITION CHANGE, IN ACCORDANCE WITH RULE 2.5.1(D), WITHIN 72 HOURS.

2.8.3 DISCLOSURES MADE IN ACCORDANCE WITH THIS RULE 2.8 ARE PROPER WHEN THE PROFESSIONAL LOBBYIST UPLOADS THE NEW LEGISLATION, CHANGE OF POSITION, OR OTHER LOBBYING ACTIVITY TO THE ELECTRONIC FILING SYSTEM.

Rule 3. Lobbying Firms

3.1 Registration

3.1.1 There is no registration requirement for a lobbying firm, but a ~~lobby~~ LOBBYING firm must file disclosure statements in accordance with statute and as described in Rule 3.2 below.

3.2 ~~Disclosure~~ MONTHLY DISCLOSURE STATEMENTS FOR LOBBYING FIRMS

3.2.1 Except as specified in paragraph (a) below, a lobbying firm must file a monthly disclosure statement electronically via the Secretary of State's website on or before the 15th day of the month following the month in which the lobbying firm began lobbying, and monthly thereafter.[30]

(a) A single-member lobbying firm that consists solely of one professional lobbyist need not file a lobbying-firm disclosure statement if the professional lobbyist's disclosure statement contains the name of both the professional lobbyist and the single-member firm that employs the professional lobbyist.[31]

3.2.2 The statement must contain:[32]

(a) The name and address of each client or other professional lobbyist who has ~~paid~~ CONTRIBUTED $100 OR MORE TO the lobbying firm for lobbying and the amount CONTRIBUTED by the client or other professional lobbyist since the previous disclosure statement;[33]

(1) If the client or other professional lobbyist is an individual, THE STATEMENT MUST INCLUDE a description of the INDIVIDUAL'S business activity;

(2) If the client or other professional lobbyist is a business entity, THE STATEMENT MUST INCLUDE a description of the ENTITY'S business, and the names of any chief executive officer, partners, or other designated contact person; or

(3) If the client or other professional lobbyist is an industry, trade, organization, or group of persons, or professional association, THE STATEMENT MUST INCLUDE a description of the industry, trade, organization~~,~~

30 ~~Section 24-6-302 (2.5) (a), C.R.S.~~
31 ~~Section 24-6-302 (2.5) (a), C.R.S.~~
32 ~~Section 24-6-302 (2.5), C.R.S.~~
33 ~~Section 24-6-301 (1.9) (a) (1), C.R.S.~~

or group of persons, or professional association.[34]

(b) The total ~~amount of money paid~~ SUM OF CONTRIBUTIONS to ~~or for~~ the lobbying firm RECEIVED FOR LOBBYING ACTIVITIES since the previous disclosure statement and during the fiscal year;[35]

(c) THE LEGISLATION, STANDARDS, RULES, OR RATES, ON WHICH THE LOBBYING FIRM IS LOBBYING, WHICH INCLUDES:

(1) THE OFFICIAL NUMBER OR OTHER DESIGNATION CORRESPONDING WITH THE ACTIVITY MENTIONED ABOVE, IF AVAILABLE. IF THE OFFICIAL NUMBER OR DESIGNATION IS NOT AVAILABLE, THE LOBBYING FIRM MUST DESCRIBE THE NATURE AND SUBJECT MATTER OF THE LEGISLATION, STANDARDS, RULES OR RATES;

(2) THE TITLE OR SUBJECT MATTER OF THE ACTIVITY MENTIONED ABOVE; AND

(3) WHETHER THE LOBBYING FIRM IS SUPPORTING, OPPOSING, AMENDING, OR MONITORING THE ACTIVITY MENTIONED ABOVE.

~~(c)~~ (D) If the lobbying firm has made an expenditure that exceeds the current dollar gift limit, as established by the Independent Ethics Commission and posted on the Secretary of State website, on behalf of a covered official for gift or entertainment purposes, whether or not the professional lobbyist was reimbursed:

(1) The name of the covered official; and

(2) The amount, date, and principal purpose of the gift or entertainment;[36]

~~(d)~~ (E) The total amount of expenditures made by or on behalf of the lobbying firm in connection with lobbying, other than for gift or entertainment purposes;[37]

~~(e)~~ (F) If the lobbying firm has made an expenditure or given a contribution to a paper, periodical, magazine, radio or TV station, or other media of mass communication:

(1) The name of the entity; and

(2) The amount given to the entity;[38]

~~(f) The specific legislation, standards, rules, or rates for which the lobbying firm is lobbying or, if not known, the nature of the legislation, standards, rules, or rates, including:~~

~~(1) The bill number of the legislation; and~~

~~(2) Whether the lobbying firm is supporting, opposing, amending, or monitoring the legislation.~~[39]

(g) Any direct business association the lobbying firm has with any pending

~~34 Section 24-6-301 (1.9) (a) (XI), C.R.S.~~
~~35 Section 24-6-301 (1.9) (a) (II), (III), and (VIII), C.R.S.~~
~~36 Section 24-6-301 (1.9) (a) (1) (IV), C.R.S.~~
~~37 Section 24-6-301 (1.9) (a) (1) (V) and (VII), C.R.S.~~
~~38 Section 24-6-301 (1.9) (a) (1) (IX), C.R.S.~~
~~39 Section 24-6-301 (1.9) (a) (1) (X), C.R.S.~~

legislation, measure, or question.[40]

Rule 4. Complaints and Enforcement

4.1 FILING A COMPLAINT

4.1.1 Any person who believes that a PROFESSIONAL lobbyist or ~~lobbyist~~ LOBBYING firm is not complying with the Colorado Lobbyist Regulation laws or these rules, may file a complaint with the Secretary of State.[41]

~~4.1.1~~ 4.1.2 A PERSON MAY FILE A written complaint ~~filed~~ with the Secretary of State, ON THE SECRETARY OF STATE'S APPROVED FORM. AT A MINIMUM, THE COMPLAINT must ~~be verified and, notarized, and~~ contain the following information:

(a) The complainant's name;

(b) The complainant's ~~residential address and mailing~~ address ~~(if different from residence),~~ AND ELECTRONIC MAIL ADDRESS, IF APPLICABLE;

(c) The alleged violation, which may include a reference to the specific statute or rule;

(d) The lobbyist or firm name;

(e) The date and location of the alleged violation, if known; and

(f) Other applicable or relevant information OR DOCUMENTATION.

~~4.1.2 The Secretary of State will review all properly submitted complaints and investigate as appropriate. If the Secretary determines that a violation occurred, the Secretary will take appropriate action under section 24-6-305, C.R.S.~~

4.2 NOTICE OF COMPLAINT

~~4.1.3~~ 4.2.1 Upon receipt of a ~~properly submitted~~ complaint, the ~~Secretary of State~~ DIVISION will:

(a) Notify ~~the person against whom~~ AND PROVIDE A COPY OF THE COMPLAINT TO THE RESPONDENT ~~the complaint is filed~~ by ~~certified~~ mail OR BY ELECTRONIC MAIL IF ELECTRONIC MAIL IS AVAILABLE; and

(b) In the case of a state liaison, notify the head of the principal department in writing;

(c) In the case of a state official or employee lobbying on behalf of a principal department, notify the state liaison in writing; or

(d) In the case of a state official or employee lobbying on behalf of an institution or governing board of higher education, notify the institution or governing board in writing.

~~4.1.4 Notification of a complaint in accordance with Rule 4.1.3 will include:~~

~~40 Section 24-6-301 (1.9) (a) (1) (XII), C.R.S.~~
~~41 Section 24-6-305 (2) (c), C.R.S.~~

~~(a) The date and factual basis of each act alleged;~~

~~(b) The particular provision of the statute that the lobbyist or firm allegedly violated;~~

~~(c) The action the Secretary of State plans to take; and~~

~~(d) Other relevant information.~~

4.3 Initial review

4.3.1 After receiving a complaint, the division will conduct an initial review within 15 business days. The division will determine whether the lobbyist complaint:

(a) Specifically identifies one or more violations of section 24-6-301 et seq. C.R.S. and

(b) Alleges sufficient facts to support a basis for the violations of law alleged in the complaint.

4.3.2 Upon initial review, the division will take at least one of the actions below:

(a) Dismiss the complaint if the complainant failed to specifically identify one or more violations of section 24-6-301 et seq. C.R.S., or allege sufficient facts to support a factual and legal basis for the violations of law alleged in the complaint;

(b) Conduct an investigation.

4.4 Response to a complaint filed against lobbyist or lobbying firm

4.4.1 During the division's initial review, the respondent may respond to the allegations and provide other relevant information or documentation. The division may extend this time period to allow for clarification and further information gathering.

4.5 Division investigation

4.5.1 The division may conduct an investigation of the alleged violation.

4.5.2 If the division conducts an investigation, it will do so within 30 days from the date it receives a response or within 30 days from the response-submission deadline, whichever is sooner. The division may extend this time period at its discretion.

4.6 Enforcement

4.6.1 If, after its investigation, the division has reasonable grounds to believe that a violation of section 24-6-301 et seq. C.R.S., has occurred, the division may recommend, at a hearing conducting under section 24-4-105, C.R.S., that the Secretary of State or their designee take any one or more of the following actions:

(a) Impose penalties;

(b) Suspend, revoke, or bar a person or entity from registration;

(c) Refer the matter to the general assembly;

(D) PROVIDE NOTICE TO THE GENERAL ASSEMBLY WHEN A SUBSTANTIAL VIOLATION HAS OCCURRED;

(E) APPLY TO THE DISTRICT COURT FOR THE ISSUANCE OF AN ORDER IN ACCORDANCE WITH SECTION 24-6-309(2), C.R.S.; OR

(F) DETERMINE ANOTHER REMEDY IN ACCORDANCE WITH SECTION 24-6-301 ET SEQ. C.R.S.

~~4.2 Penalty waiver process~~

~~4.2.1 A registered professional lobbyist or lobbyist firm may ask the Secretary of State to excuse or reduce an imposed fine by submitting a written request by mail, email, fax, or hand-delivery within 30 days of the imposition of fine. The request must include:~~

~~(a) The professional lobbyist's name;~~

~~(b) The request date;~~

~~(c) The due date of the delinquently filed disclosure statement;~~

~~(d) The filing date the professional lobbyist actually filed the disclosure statement;~~

~~(e) Any measures the professional lobbyist or firm has instituted or will institute to avoid future delinquencies, if applicable; and~~

~~(f) A brief summary of the reason, circumstance, or other justification of the bona fide personal emergency;~~

~~(1) A Bona fide personal emergency, includes:~~

~~(A) A medical emergency involving the individual responsible for filing or the individual's immediate family. The medical emergency can include but is not limited to incapacitation, hospitalization, death, or debilitating illness or injury.~~

~~(B) A practical emergency, including extraordinary obstacles beyond the control of the professional lobbyist or lobbyist firm, that precludes timely disclosure. For example:~~

~~(i) The loss or unavailability of records, or a computer due to fire, flood, or theft;~~

~~(ii) A web site error that made it impossible to file a required registration document; or~~

~~(iii) Other compelling reasons beyond the professional lobbyist's or lobbyist firm's control.~~

~~(2) The following are not bona fide personal emergencies:~~

~~(A) Failure to timely file registration documents due to failure to plan;~~

~~(B) Misunderstandings of applicable disclosure requirements and deadlines;~~

~~(C) Mistakes in electronic filing submissions, including incomplete filings;~~

~~(D) Lack of access to the internet or personal computer; or~~

~~(E) Lack of credit card or other means of making online payments.~~

~~4.2.2 The Secretary of State may take into account all appropriate facts and circumstances when granting or rejecting a waiver request or in reducing an imposed fine. The Secretary may also consider the frequency of the requests to excuse or reduce a fine within a two-year period, efforts to mitigate or remedy the failure to register or file, and the registrant's demonstrated commitment to meet the requirements of Colorado's laws concerning professional lobbyist regulation.~~

~~4.3 The Secretary of State will investigate, provide notice of hearings, and hold hearings for a violation of Part 3 of Article 6 of Title 24, C.R.S., in accordance with the State Administrative Procedure Act (Article 4 of Title 24, C.R.S.).~~

~~4.4 In accordance with section 24-6-305, C.R.S., the Secretary of State:~~

~~4.4.1 May suspend, revoke, or bar from registration any lobbyist who fails to:~~

~~(a) File disclosure statements under section 24-6-303, C.R.S.;~~

~~(b) Upon request of the Secretary of State, provide books and records for the Secretary of State's examination under section 24-6-304.5, C.R.S.; or~~

~~(c) Pay penalties in full under section 24-6-302(7), C.R.S.~~

~~4.4.2 Will revoke the registration certificate of an individual who:~~

~~(a) Is convicted in district court of violating any provision of Part 3 of Article 6 of Title 24, C.R.S.; or~~

~~(b) Has been suspended from lobbying by the General Assembly.~~

~~4.5 If the Secretary of State deems any of the violations contained in Rule 4.4 to be substantial violations, the Secretary of State will notify the president of the senate and speaker of the house. In determining whether the violation is substantial, the Secretary of State will consider:~~

~~4.5.1 The extent of noncompliance;~~

~~4.5.2 The purpose of the applicable provision and whether that purpose is substantially achieved despite the alleged noncompliance; and~~

~~4.5.3 Whether there was a good-faith effort to comply or whether noncompliance is based on a conscious decision to lobby covered officials without registering or filing disclosure statements.~~

Rule 5. ~~Electronic Filing Hardship Exemption~~ REQUESTS FOR WAIVER OR REDUCTION OF PENALTIES.

5.1 A PROFESSIONAL LOBBYIST OR A LOBBYING FIRM MAY ASK THE DIVISION TO WAIVE OR REDUCE A PENALTY AUTOMATICALLY IMPOSED IN THE ELECTRONIC FILING SYSTEM BY SUBMITTING A WRITTEN REQUEST, ON THE SECRETARY OF STATE'S APPROVED FORM, BY ELECTRONIC MAIL OR MAIL WITHIN 30 DAYS OF THE IMPOSITION OF A PENALTY. THE REQUEST MUST INCLUDE:

5.1.1 THE PROFESSIONAL LOBBYIST'S OR LOBBYING FIRM'S NAME;

5.1.2 THE REQUEST DATE;

5.1.3 THE SPECIFIC DISCLOSURE STATEMENT THAT THE LOBBYIST OR LOBBYING FIRM IS REQUESTING A WAIVER OR REDUCTION OF A PENALTY FROM; AND

5.1.4 A BRIEF SUMMARY OF THE REASON, CIRCUMSTANCES, OR OTHER JUSTIFICATION OF THE BONA FIDE PERSONAL EMERGENCY.

5.2 BONA FIDE PERSONAL EMERGENCY

5.2.1 THE DIVISION WILL GRANT A WAIVER UPON EVIDENCE OF A BONA FIDE PERSONAL EMERGENCY.

5.2.2 A BONA FIDE PERSONAL EMERGENCY INCLUDES:

(A) A MEDICAL EMERGENCY INVOLVING THE INDIVIDUAL RESPONSIBLE FOR FILING THE REQUIRED DISCLOSURE REPORT OR THE INDIVIDUAL'S FAMILY.

(B) AN NONMEDICAL EMERGENCY THAT MADE THE TIMELY FILING OF A DISCLOSURE STATEMENT AN IMPRACTICABILITY.

5.3 THE DIVISION MAY CONSIDER ALL APPROPRIATE FACTS AND CIRCUMSTANCES WHEN GRANTING OR REJECTING A WAIVER REQUEST OR REDUCING AN IMPOSED PENALTY. THE DIVISION MAY ALSO CONSIDER:

5.3.1 THE FREQUENCY OF REQUESTS TO WAIVE OR REDUCE A PENALTY WITHIN A TWO-YEAR PERIOD;

5.3.2 EFFORTS TO MITIGATE OR REMEDY THE FAILURE TO FILE;

5.3.3 WHETHER THE DELINQUENT FILER WAS REQUIRED TO REGISTER AS A PROFESSIONAL LOBBYIST; AND

5.3.4 WHETHER THE PROFESSIONAL LOBBYIST OR LOBBYING FIRM DEMONSTRATED A COMMITMENT TO MEET THE REQUIREMENTS OF COLORADO'S LOBBYING LAWS.

5.4 THE DIVISION WILL NOT CONSIDER A WAIVER REQUEST AFTER A PENALTY HAS BEEN PAID.

5.5 A PROFESSIONAL LOBBYIST OR LOBBYING FIRM MAY REQUEST THAT THE DIVISION RECONSIDER A REQUEST FOR WAIVER OR REDUCTION OF LOBBYING PENALTIES.

5.6 WHEN REDUCING A PENALTY, THE DIVISION WILL ROUND TO THE HIGHEST $20. THE DIVISION WILL NOT REDUCE A PENALTY TO AN AMOUNT LESS THAN $20, UNLESS IT GRANTS A FULL WAIVER.

~~5.1~~ 5.7 The ~~Secretary of State~~ DIVISION may grant an exception to the electronic filing requirement based on hardship or good cause shown.

~~5.1.1~~ 5.7.1 All applications for an exception must include a brief statement of the hardship or good cause for the requested exception.

~~5.1.2~~ 5.7.2 A PROFESSIONAL lobbyist OR LOBBYING FIRM must submit WRITTEN DOCUMENTATION ON THE SECRETARY OF STATE'S APPROVED FORM ~~an application~~ to the ~~Secretary of State~~ DIVISION at least 15 calendar days before the first applicable filing deadline, unless the exception is based on emergency circumstances arising after the deadline, in which case the PROFESSIONAL lobbyist OR LOBBYING FIRM must describe the nature of the emergency in the application.

~~5.1.3~~ 5.7.3 Filing the application for exception based on emergency circumstances does not delay any reporting deadlines. If, however, a penalty is imposed for failure to file a disclosure statement on the due date, the ~~Secretary of State~~ DIVISION may reduce or ~~set the penalty aside~~ WAIVE THE PENALTY in accordance with section 24-6-302(7), C.R.S.

Rule 6. ~~Contributions to members of the general assembly or elected members of the executive branch during consideration of legislation~~ MISCELLANEOUS PROHIBITIONS APPLICABLE TO PROFESSIONAL LOBBYING.

6.1 PROFESSIONAL LOBBYISTS ARE PROHIBITED FROM MAKING CERTAIN CONTRIBUTIONS, AS OUTLINED IN SECTION 1-45-105.5, C.R.S.

6.2 PROFESSIONAL LOBBYISTS MAY NOT GIVE ANY GIFT OR THING OF VALUE TO ANY PUBLIC OFFICER, MEMBER OF THE GENERAL ASSEMBLY, GOVERNMENT EMPLOYEE, OR TO A MEMBER OF SUCH PERSON'S IMMEDIATE FAMILY, AS OUTLINED IN ARTICLE XXIX, SECTION 3 (4) OF THE COLORADO CONSTITUTION.

~~6.1 No professional lobbyist, volunteer lobbyist, or principal of a professional lobbyist or volunteer lobbyist may make or promise to make a contribution to, or solicit or promise to solicit a contribution for:[42]~~

~~6.1.1 A member of the general assembly or candidate for the general assembly, when the general assembly is in regular session;[43]~~

~~6.1.2 The governor or a candidate for governor when the general assembly is in regular session or when any measure adopted by the general assembly in a regular session is pending before the governor for approval or disapproval;[44] or~~

~~6.1.3 The lieutenant governor, the secretary of state, the state treasurer, the attorney general, or a candidate for any of such offices when the general assembly is in regular session.[45]~~

~~6.2 As used in this rule, "Principal" means any person that employs, retains, engages, or uses, with or without compensation, a professional or volunteer lobbyist. A person serving as an officer, employee, member, shareholder, or partner of an organization or business entity that employs, retains, engages, or uses a lobbyist is not considered a principal.[46]~~

~~42 Section 1-45-105.5 (1) (a), C.R.S.~~
~~43 Section 1-45-105.5 (1) (a) (I), C.R.S.~~
~~44 Section 1-45-105.5 (1) (a) (II) (A), C.R.S.~~
~~45 Section 1-45-105.5 (1) (a) (II) (B), C.R.S.~~
~~46 Section 1-45-105.5 (1) (b) (I), C.R.S.~~

STATE OF COLORADO
Department of State
1700 Broadway
Suite 200
Denver, CO 80290

Jena Griswold
Secretary of State

Jenny Flanagan
Deputy Secretary of State

Notice of Proposed Rulemaking

Office of the Secretary of State
Rules Concerning Lobbyist Regulation
8 CCR 1505-8

October 4, 2019

I. Hearing Notice

As required by the State Administrative Procedure Act,[1] the Secretary of State gives notice of proposed rulemaking. The hearing is scheduled for **November 15, 2019 at 1:00 p.m.** in the Blue Spruce Conference Room on the 2nd floor of the Secretary of State's Office at 1700 Broadway, Denver, Colorado 80290.

II. Subject

The Secretary is considering amendments and recodification of the rules concerning lobbyist regulation[2] to improve the administration and enforcement of Colorado laws regarding lobbyist regulation.[3]

Specifically, the Secretary is considering rule revisions necessary to ensure proper administration of additional legislation recently passed by the Colorado General Assembly; eliminate obsolete provisions; organize existing rules for clarity; simplify the language of existing rules; remove language that is duplicative of statute or constitutional provisions; and ensure consistency with Department rulemaking standards. The Secretary may consider additional rule amendments.

A detailed Statement of Basis, Purpose, and Specific Statutory Authority follows this notice and is incorporated by reference.

In a separate effort, the Secretary of State's Lobbyist Program is developing a policy manual to help lobbyists understand and comply with those legal requirements set out in the constitution, statute, and rule. Our office will provide more details and make the manual available to stakeholders online as soon as possible upon conclusion of this rulemaking proceeding.

III. Statutory authority

[1] Section 24-4-103(3)(a), C.R.S. (2019).
[2] 8 CCR 1505-8.
[3] Part 3 of Article 6 of Title 24, C.R.S. (2019).

The Secretary proposes the rule revisions and amendments in accordance with the following statutory provisions:

- Section 24-6-303(6.3)(a), C.R.S., (2019), which authorizes the Secretary of State to adopt rules concerning the manner in which reports filed by lobbyists may be filed electronically, including but not limited to the information to be contained in such reports, the procedure for amending such reports, and public access to the electronic filing system.

- Section 24-6-305(2)(b), C.R.S., (2019), which authorizes the Secretary of State to adopt rules and regulations to define, interpret, implement, and enforce the provisions of and to prevent the evasion of the requirements of the Colorado lobbyist regulation law (Part 3, Article 6, Title 24 of the Colorado Revised Statutes).

IV. Copies of draft rules

A preliminary draft of the proposed rules is posted on the Secretary of State's rules and notices of rulemaking website at:
www.sos.state.co.us/pubs/rule_making/hearings/2019/LobbyistRulesHearing20191115.html.

You may also contact our office to request a paper or editable electronic copy of the draft rules.

As required by the State Administrative Procedures Act,[4] if changes are made before the hearing, revised proposed draft rules will be available to the public and posted on the website by November 8, 2019.

V. Opportunity to testify and submit written comments

The Secretary values your feedback in our rulemaking process and we would very much like to hear your thoughts on the proposed amendments. Please review and consider the attached proposed draft rules.

Everyone will have the opportunity to testify and provide written comment concerning the rule amendments. To ensure that the hearing is prompt and efficient, oral testimony may be time-limited.

You may submit written comments by mail, email, or in person to our office any time before the hearing. If you attend the hearing, you may submit written comments to the hearing panel as well. Additional opportunity to comment in writing may be announced at the conclusion of the hearing.

All written comments will be posted online at the Secretary of State website:
www.sos.state.co.us/pubs/rule_making/hearings/2019/LobbyistRulesHearing20191115.html.

[4] Section 24-4-103(3)(a), C.R.S. (2019). "Any proposed rule or revised proposed rule by an agency which is to be considered at the public hearing…shall be made available to any person at least five days prior to said hearing."

We will redact contact information, including home address, email address, and telephone number(s), from submissions before posting the information online, unless otherwise directed by the contributor.

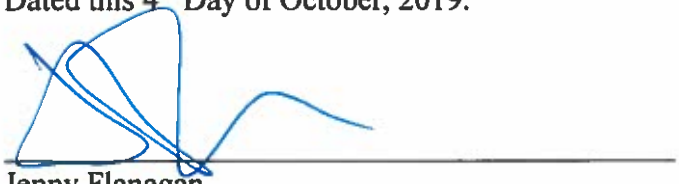
VI. Broadcast and audio recording of hearing

If you are unable to attend the hearing, you may listen to the live broadcast from the Blue Spruce Conference Room online at www.sos.state.co.us/pubs/info_center/audioBroadcasts.html. After the hearing, visit the same website and click on "archived recordings" to access an audio recording of the hearing.

VII. Office contact

If you have any questions or would like to submit written comments, please contact Andrea Gyger with the Administration Division at SoS.Rulemaking@sos.state.co.us or (303) 894-2200 ext. 6329.

Dated this 4th Day of October, 2019.



Jenny Flanagan
Deputy Secretary of State

For

Jena Griswold
Colorado Secretary of State

STATE OF COLORADO
Department of State
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Draft Statement of Basis, Purpose, and Specific Statutory Authority

Office of the Secretary of State
Rules Concerning Lobbyist Regulation
8 CCR 1505-8

October 4, 2019

I. Basis and Purpose

This statement explains proposed amendments and recodification of the Colorado Secretary of State rules concerning lobbyist regulation.[1] The rules are intended to ensure uniform and proper administration, implementation, and enforcement of Colorado laws regarding lobbyist regulation[2] as follows:

In general, rules duplicative of statute have been repealed to match departmental rulemaking standards. Footnotes have also been repealed to match departmental rulemaking standards. Those rules remaining have in some cases been re-ordered to better clarify what is required by rule.

Specific proposed changes include:

- Repeal of current Rules 1.1 through 1.3. These rules are duplicative of statute and do not match departmental rulemaking standards.
- Relocation of current Rule 1.3.2(g) to New Rule 2.2.2(a) to better clarify what is required by rule.
- Repeal of current Rule 1.4. This rule is duplicative of statute and does not match departmental rulemaking standards
- New Rules 1.1 through 1.4 to ensure uniform and proper administration of lobbyist regulation law in Colorado.
- New Rules 1.8 through 1.9 to ensure uniform and proper administration of lobbyist regulation law in Colorado.
- Repeal of Rule 1.10. This rule is duplicative of statute and does not match departmental rulemaking standards.

[1] 8 CCR 1505-8.
[2] Part 3 of Article 6 of Title 24, C.R.S. (2019).

- New Rules 2.2 through 2.3 to prescribe the proper use of the electronic filing system maintained by the Secretary of State.

- New Rule 2.4 to better enforce lobbyist regulation law in Colorado.

- Amendments to renumbered Rules 2.5 and 2.6 (formerly Rules 2.2 and 2.2.2) to better prescribe the proper use of the electronic filing system maintained by the Secretary of State and to remove duplicative references to statute to better match departmental rulemaking standards.

- Amendments to renumbered Rules 2.7 and 2.8 (formerly Rules 2.2.3 and 2.2.4) concerning new client disclosure and disclosure requirements during the session, to ensure uniform and proper administration of lobbyist regulation law in Colorado, to implement changes required by HB 19-1248, and to remove duplicative references to statute to better match departmental rulemaking standards.

- Amendments to Rule 3.2.2 to better prescribe the proper use of the electronic filing system maintained by the Secretary of State and to remove duplicative references to statute to better match departmental rulemaking standards.

- Amendments to Rule 4 to better prescribe the enforcement process the department will take when enforcing lobbyist regulation law in Colorado.

- Amendments to Rule 4.1 to remove duplicative references to statute to better match departmental rulemaking standards.

- Repeal of current Rule 4.2. The waiver process has been restated and moved to Rule 5.

- Repeal of current Rules 4.3 through 4.5. The entire enforcement process has been restated and reordered in Rule 4.

- Amendments to Rule 5 to better prescribe the enforcement process the department will take when enforcing lobbyist regulation law in Colorado, and more specifically, prescribing the process by which the department may grant waivers or reduction of penalties associated with enforcing lobbyist regulation law in Colorado.

- Repeal of current Rule 6. This rule is duplicative of statute and does not match departmental rulemaking standards.

- New Rule 6 to ensure uniform and proper administration of lobbyist regulation law in Colorado.

Other changes to rules not specifically listed are non-substantive and necessary for consistency with Department rulemaking format and style. Cross-references in rules are also corrected or updated.

In a separate effort, the Secretary of State's Lobbyist Program is developing a policy manual to help lobbyists understand and comply with those legal requirements set out in the constitution, statute,

and rule. Our office will provide more details and make the manual available to stakeholders online as soon as possible upon conclusion of this rulemaking proceeding.

II. Rulemaking Authority

The statutory and constitutional authority is as follows:

- Section 24-6-303(6.3)(a), C.R.S., (2019), which authorizes the Secretary of State to adopt rules concerning the manner in which reports filed by lobbyists may be filed electronically, including but not limited to the information to be contained in such reports, the procedure for amending such reports, and public access to the electronic filing system.

- Section 24-6-305(2)(b), C.R.S., (2019), which authorizes the Secretary of State to adopt rules and regulations to define, interpret, implement, and enforce the provisions of and to prevent the evasion of the requirements of the Colorado lobbyist regulation law (Part 3, Article 6, Title 24 of the Colorado Revised Statutes).

Notice of Proposed Rulemaking

Tracking number

2019-00619

Department

2505,1305 - Department of Health Care Policy and Financing

Agency

2505 - Executive Director of Health Care Policy and Financing

CCR number

10 CCR 2505-5

Rule title

EXECUTIVE DIRECTOR OF HEALTH CARE POLICY AND FINANCING RULES

Rulemaking Hearing

Date

11/22/2019

Time

10:00 AM

Location

303 East 17th Avenue, 11th Floor, Denver, CO 80203

Subjects and issues involved

See attachment

Statutory authority

Section 25.5-1-108, C.R.S. (2018)

Contact information

Name

Chris Sykes

Title

Medical Services Board Coordinator

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COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

NOTICE OF PROPOSED RULES

The Executive Director of the Colorado Department of Health Care Policy and Financing will hold a public meeting on Friday, November 22, 2019, beginning at 10:00 a.m., in the eleventh floor conference room at 303 East 17th Avenue, Denver, CO 80203. Reasonable accommodations will be provided upon request for persons with disabilities. Please notify the Rules Administrator at 303- 866-4416 or chris.sykes@state.co.us or the 504/ADA Coordinator hcpf504ada@state.co.us at least one week prior to the meeting.

A copy of the full text of these proposed rule changes is available for review from the Rules Administration Office, 1570 Grant Street, Denver, Colorado 80203, tel. (303) 866-4416, fax (303) 866-4411. Written comments may be submitted to the Rules Administration Office on or before close of business the Thursday prior to the meeting. Additionally, the full text of all proposed changes will be available approximately one week prior to the meeting on the internet at the Executive Director Administrative Rules Hearing Schedule page.

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ED 19-10-07-A, Revision to the Executive Director of the Department of Health Care Policy and Financing Rule Concerning All-Payers Claims Database. 10 CCR 2505-5, Sections 1.200.1, 1.200.2 A

Executive Director. This rule changes makes multiple amendments.
As the Colorado All Payer Claims Database (CO APCD) Administrator, CIVHC began conversations with the submitters regarding the rule change in the summer of 2019. The goals of the proposed updates to the data submissions guide are outline below:

- Improve the quality of the submitted data by modifying the data element definition, field type or field length. For example, change the field type for Employer Tax ID from 'varchar' to 'integer' to prevent submitters from entering an employer name in this field.

- Improve the completeness of the data by changing data elements that are important for measurement of health care cost, utilization and quality from being optional to being required. For example, the data element for Discharge Status, which is important for analyzing transitions of care for patients discharged from a hospital setting.

- DSG v11 includes changes to the APCD files recommended by submitters, data recipients and updated data items that are required for data quality. The updates also move CIVHC toward adoption of national standards by redefining existing DSG data elements to be consistent with definitions in the APCD Council Common Data Layout or by adding useful data elements to the DSG that are currently included in the CDL.

CIVHC sent the proposed Rule language and revised Data Submission Guide (DSG) to all data submitters on August 21 2019. CIVHC hosted a webinar that same day and presented the proposed changes to DSG v11. Representatives from 35 data submitters attended the webinar and had opportunity to ask questions and discuss the proposed changes with CIVHC. The concern was raised that some of the payers would not have the ability to submit required fields, and that CIVHC would need to include a default for Race and Ethnicity requirements. (A transcription of this webinar and an attendee list are included in the Stakeholder Summary document.) CIVHC requested payer feedback on the proposed changes by September 6, 2019. CIVHC received feedback from nine payers. (Summaries are included in the stakeholder summary document.)

The statutory authority for this rule change is contained in 25.5-1-108, C.R.S. (2018).

Permanent Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - Board of Chiropractic Examiners

CCR number

3 CCR 707-1

Rule title

3 CCR 707-1 COLORADO STATE BOARD OF CHIROPRACTIC EXAMINERS RULES AND REGULATIONS 1 - eff 11/14/2019

Effective date

11/14/2019

DEPARTMENT OF REGULATORY AGENCIES

Board of Chiropractic Examiners

COLORADO STATE BOARD OF CHIROPRACTIC EXAMINERS RULES AND REGULATIONS

3 CCR 707-1

[Editor's Notes follow the text of the rules at the end of this CCR Document.]

1.6 Electrotherapy Authority

A. Electrotherapy/Physiotherapy certification is required prior to any licensee practicing electrotherapy/physiotherapy. Physiotherapy as used in these rules includes the theory, principles, and use of standard recognized physiotherapy equipment and procedures.

…

1.7 Scope of Practice

A. Practices that are not within the scope of chiropractic practice and invoke the duty to refer provision in section 12-215-115(1)(aa), C.R.S., include, but are not limited to:

1. Treatment of the disease cancer. This does not preclude screening and diagnostic procedures for the prevention and early detection of cancer or the chiropractic treatment of other concomitant conditions that the patient may have. In addition, a qualified chiropractor may collaboratively treat cancer in conjunction with, but not replacing, drugs, surgery, or chemotherapy.

2. Obstetrics.

3. Surgery.

4. Administration of anesthetics, with the exception of topical or over-the-counter anesthetics.

5. Prescription of drugs not referenced in Rule 1.7(C).

6. Hypnosis unless used as a procedure to augment the treatment of the neuromusculoskeletal system and unless the practitioner presents evidence to the Board of having obtained education in hypnosis from an accredited college or Board approved program.

B. A chiropractor must have the knowledge, skill, ability, and documented competency to perform an act that is within the chiropractic scope of practice. Procedures with specific clinical, didactic requirements and qualifications include, but are not limited to:

1. Paraspinal Surface Electromyography

a. Ten hours of initial training with demonstrated competency.

b. Procedures may be delegated to a qualified technician and must be supervised and interpreted by an on-site qualified and licensed doctor of chiropractic.

c. Procedures must be performed in a manner consistent with generally accepted parameters, including any relevant standards of the Center for Communicable Diseases and meet safe and professional standards.

2. Surface Electromyography excluding paraspinal, Nerve Conduction Velocity (NCV) and Needle Electromyography

a. One hundred and twenty hours of initial clinical and didactic training with demonstrated competency in electromyography (paraspinal surface electromyography excluded).

b. Procedures may not be delegated to a technician and must be directly performed by a qualified and licensed doctor of chiropractic.

c. Procedures must be performed in a manner consistent with generally accepted parameters, including clean needle techniques, and standards of the Center for Communicable Diseases and meet safe and professional standards.

3. Electrocardiography (EKG/ECG)

a. One hundred and twenty hours of initial and related clinical with didactic training and demonstrated competency in cardiac medicine.

b. Procedures may not be delegated to a technician and must be directly performed by a qualified and licensed doctor of chiropractic.

c. Procedures must be performed in a manner consistent with generally accepted parameters, including any relevant standards of the Center for Communicable Diseases and meet safe and professional standards.

4. Manipulation Under Anesthesia (MUA)

a. Thirty-six hours of didactic and clinical training, successful completion of a competency examination, and nationally recognized certification.

b. Professional liability insurance coverage to specifically include MUA.

c. Procedures must be performed in a manner consistent with generally accepted parameters and standards of practice.

d. Procedures shall be performed at either an ambulatory surgical center or outpatient hospital facility.

e. The role of the chiropractor shall be limited to the scope of chiropractic practice as defined in section 12-215-103(4), C.R.S.

5. Intramuscular stimulation/Dry Needling.

a. Dry needling is a physical intervention that uses a filiform needle to stimulate trigger points, diagnose and treat neuromuscular pain and functional movement deficits; requires an examination and diagnosis, and treats specific anatomic entities selected according to physical signs. Dry needling does not include the stimulation of auricular or distal points and cannot be presented as acupuncture.

b. Dry needling as defined pursuant to this rule is within the scope of practice of chiropractic.

c. A chiropractor must have an electrotherapy certification, knowledge, skill, ability and documented competency to perform an act that is within the chiropractor's scope of practice.

d. To be deemed competent to perform dry needling, a chiropractor holding electrotherapy certification and acupuncture certification must meet the following requirements:

(1) Document successful completion of a dry needling course of study including a minimum of twenty-four hours of face-to-face IMS/dry needling course study; online study is not considered appropriate training.

(2) Practiced acupuncture as a licensed chiropractor for at least two years prior to using the dry needling technique.

e. To be deemed competent to perform dry needling a chiropractor with electrotherapy certification but without acupuncture certification must meet the following requirements:

(1) Document successful completion of a dry needling course of study including a minimum of forty-six hours of face-to-face IMS/dry needling course study; online study is not considered appropriate training.

(2) Practiced as a licensed chiropractor for at least two years prior to using the dry needling technique.

f. A provider of a dry needling course of study must meet the educational and clinical requirements in dry needling of a body recognized by the US Department of Education or similar agency of a foreign country and demonstrate a minimum of two years of dry needling practice techniques. The provider is not required to be a chiropractor.

g. A chiropractor performing dry needling must have written, informed consent for each patient where this technique is used. The patient must sign and be given a copy of the informed consent form. The form must, clearly state the risks and benefits of dry needling.

h. Any dry needling performed must be clearly documented in the procedure notes, which must indicate how the patient tolerated the technique and the outcome after the procedure.

i. Dry needling shall not be delegated and must be directly performed by a qualified, licensed chiropractor with electrotherapy certification who meets the standards in this rule.

C. Nutritional Remedial Measures as referenced in section 12-215-103(4), C.R.S., means that a doctor of chiropractic may administer, prescribe, recommend, compound, sell and distribute homeopathic and botanical medicines, vitamins, minerals, phytonutrients, antioxidants, enzymes, glandular extracts, non-prescription drugs, durable and non-durable medical goods and devices.

D. Physical Remedial Measures as referenced in section 12-215-103(4), C.R.S., includes but is not limited to:

1. Tests (physical, functional, mechanical, computerized).
2. Exercise therapeutics (instruction, passive, active, resistive, cardiovascular).
3. Work hardening.
4. Gait/locomotion training.
5. Manual therapies (massage, mobilization, manipulation).
6. Traction.
7. Postural drainage.
8. Biofeedback (when done to facilitate chiropractic care).
9. Functional activities with or without assistive devices.
10. Postural re-education.
11. Physiotherapy.

E. Patient assessment may include, but is not limited to the following:

1. Physical examination.
2. Neurologic testing.
3. Orthopedic testing (provocative/ functional testing).
4. Chiropractic testing.
5. Range of motion examination.
6. Strength testing (manual, mechanical, computerized).
7. Postural examination.
8. Gait/movement analysis.
9. Activities of daily living.
10. Psychometric questionnaires.
11. Nocioception.
12. Cardiac, pulmonary, and vascular examination.
13. Fitness examination.
14. Work site assessment.

15. Home assessment.

16. Photosensitivity testing.

17. Impairment or disability ratings.

18. Functional capacity evaluation.

19. Radiography and other diagnostic imaging

…

1.11 Use of Credentials

A. Only those titles authorized by statute may be used.

B. Post-graduate degrees received from an institution accredited by the Council of Chiropractic Education or diplomate status may be used in conjunction with those titles authorized by statute.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

STATE OF COLORADO
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Office of the Attorney General

Tracking number: 2019-00409

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - Board of Chiropractic Examiners

on 09/19/2019

3 CCR 707-1

COLORADO STATE BOARD OF CHIROPRACTIC EXAMINERS RULES AND REGULATIONS

The above-referenced rules were submitted to this office on 09/20/2019 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

October 03, 2019 11:16:44

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Law

Agency

Administrator-Uniform Consumer Credit Code and Commission on Consumer Credit

CCR number

4 CCR 902-3

Rule title

4 CCR 902-3 Colorado Student Loan Servicers Act Rules 1 - eff 11/14/2019

Effective date

11/14/2019

DEPARTMENT OF LAW

Administrator – Uniform Consumer Credit Code

COLORADO STUDENT LOAN SERVICERS ACT RULES

4 CCR 902-3

Rule 1. Nonrefundable Initial and Annual Renewal License Fees for Student Loan Servicers

The amount of the initial license fee for a license commencing January 31, 2020 for a student loan servicer is $12,500. The amount of the annual renewal fee is $12,500. The amount of the initial license fee and the annual renewal fee may be reduced or increased periodically based upon the Administrator's determination of anticipated changes to the cost of administering the Student Loan Servicer Act.

Rule 2. Nonrefundable Investigation Fee

The investigation fee for a student loan servicer, applicant for licensure pursuant to section 5-20-106(2), C.R.S. is $500 and must be paid only at the time of and in conjunction with the initial license application.

Rule 3. Federal Contractor Exemption

A student loan servicer seeking licensure pursuant to section 5-20-106(1), C.R.S., shall document eligibility for the exemption by submitting at least one of the following documents:

A. The signed signature page to a currently operative contract showing that the servicer is a party to a contract awarded by the United States Secretary of Education under 20 U.S.C. § 1087f; or

B. Any other document that serves as the functional equivalent to (A), which will be judged in the Administrator's sole discretion.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

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Office of the Attorney General

Tracking number: 2019-00408

Opinion of the Attorney General rendered in connection with the rules adopted by the

Administrator-Uniform Consumer Credit Code and Commission on Consumer Credit

on 10/07/2019

4 CCR 902-3

Colorado Student Loan Servicers Act Rules

The above-referenced rules were submitted to this office on 10/07/2019 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

October 10, 2019 13:10:23

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Public Health and Environment

Agency

Center for Health and Environmental Data (1006, 1009 Series)

CCR number

5 CCR 1006-1

Rule title

5 CCR 1006-1 VITAL STATISTICS 1 - eff 01/01/2020

Effective date

01/01/2020

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Center for Health and Environmental Data

VITAL STATISTICS

5 CCR 1006-1

Adopted by the Board of Health on September 18, 2019; Effective January 1, 2020.

*****

Publication Instructions: Replace the current text in Section 4.1 with the following text.

SECTION 4 REGISTRATION OF BIRTH

SECTION 4.1 Sex Designation

The record and certificate may identify the sex designation as female or male at the time of birth and may be amended pursuant to Section 5.5 to identify the sex designation as female, male or "X".

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SECTION 5 AMENDING RECORD OR CERTIFICATES

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SECTION 5.1 General Requirements for Amending Certificates

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Publication Instructions: Replace the current text in Section 5.1 E. with the following text.

E. 1. Amended certificates shall only be amended to the extent necessary to modify the Information included in the report or court decree. The remainder of the information shown on the original certificate shall remain unchanged. The certificate will be identified as "amended" or "delayed" when required by law.

2. When a registrant's sex designation is amended pursuant to Section 5.5, a new certificate is issued. The new certificate will not be marked as amended or otherwise indicate that the gender designation or any name change accompanying the gender designation change, occurred.

*****

Publication Instructions: Replace the current text in Section 5.5 with the following text.

SECTION 5.5 Amendment of the Sex Designation

Before changing the sex designation on the birth certificate, the State Registrar must:

A. Confirm the registrant is eighteen years of age or older, or an emancipated minor, or, if the registrant is under the age of eighteen, confirm that the person requesting the amendment is a

parent on the birth record, a legal guardian, or an attorney or other authorized agent, as determined by the State Registrar.

B. Confirm the name on the birth certificate and the name of the individual for whom the amendment is requested match, or can be linked through the submitted documentation in instances such as where the registrant is changing their name and sex designation at the same time, and

C. 1. Receive: a certified copy of an order of a court of competent jurisdiction changing the sex of the applicant, or

2. a. A written request from the person, or from the person's parent, if the person is a minor, or from the person's guardian or legal representative, signed under penalty of law, to issue a new birth certificate with a gender designation that differs from the sex designated on the person's original birth certificate; and,

b. A statement, in a form or format designated by the State Registrar, from the person or from the person's parent, if the person is a minor, or from the person's guardian or legal representative, signed under penalty of law, confirming the sex designation on the person's birth certificate does not align with the person's gender identity; and,

c. If the person is a minor under the age of eighteen, a statement, in a form or format designated by the State Registrar, signed under penalty of law, from a professional medical or mental health care provider licensed in good standing in Colorado or an equivalent license in good standing from another jurisdiction, stating that:

I. The minor has undergone surgical, hormonal, or other treatment appropriate for that person for the purpose of gender transition, based on contemporary medical standards, and, in the provider's professional opinion, the minor's gender designation should be changed accordingly; or,

II. The minor has an intersex condition, and, in the provider's professional opinion, the minor's gender designation should be changed accordingly.

3. The State Registrar shall change the sex designation pursuant to a request made under Section 5.5(C)(2) only once during an individual's lifetime. Any further amendment to the sex designation on a birth record or certificate requires a court order pursuant to Section 5.5(C)(1).

4. Pursuant to Section 25-2-113.8(7), C.R.S., if a new birth certificate is issued pursuant to this Section 5.5, the certificate will also be amended to reflect any legal name change made before or simultaneous with the change in gender designation, as long as appropriate documentation of the name change is submitted.

*****

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

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Office of the Attorney General

Tracking number: 2019-00335

Opinion of the Attorney General rendered in connection with the rules adopted by the

Board of Health

on 09/18/2019

5 CCR 1006-1

VITAL STATISTICS

The above-referenced rules were submitted to this office on 09/20/2019 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

September 26, 2019 11:39:54

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Public Health and Environment

Agency

Center for Health and Environmental Data (1006, 1009 Series)

CCR number

5 CCR 1006-2

Rule title

5 CCR 1006-2 MEDICAL USE OF MARIJUANA 1 - eff 11/14/2019

Effective date

11/14/2019

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Center for Health and Environmental Data

MEDICAL USE OF MARIJUANA

5 CCR 1006-2

[Publication instructions: Remove the current adoption date and effective date in the title block and replace with the following.]

Adopted by the Board of Health on September 18 2019, effective November 14, 2019.

Regulation 1: Establishment and confidentiality of the registry for the medical use of marijuana

*****

[Publication Instructions: Replace current existing text in Regulation 1(A)(4) with the text below.]

4. Primary care-givers and potential primary care-givers may authorize the inclusion of their contact information in the voluntary caregiver registry maintained by the department to allow authorized department staff to release their contact information to new registry patients only in accordance with Regulation 9(C) below.

*****

[Publication Instructions: Replace all current existing text in Regulation 1(C) with the text below.]

C. Definitions

1. "Adult applicant" is defined as a patient eighteen years of age or older.

2. "Bona fide physician-patient relationship", for purposes of the medical marijuana program, means:

a. A physician and a patient have a treatment or counseling relationship, in the course of which the physician has completed a full assessment of the patient's medical history, including reviewing a previous diagnosis for a debilitating or disabling medical condition, and current medical condition, including an appropriate personal physical examination. "Appropriate personal physical examination" may not be performed by remote means, including telemedicine;

b. The physician has consulted with the patient and if the patient is a minor, with the patient's parents, with respect to the patient's debilitating or disabling medical condition and has explained the possible risks and benefits of use of medical marijuana to the patient, and each of the minor patient's parents residing in Colorado, before the patient applies for a registry identification card, and the physician has documented the consultation and explanation in the physician's records; and

c. The physician is available to or offers to provide follow-up care and treatment to the patient, including but not limited to patient examinations, to determine the efficacy of the use of medical marijuana as a treatment of the patient's debilitating or disabling medical condition.

3. “Council” means the medical marijuana scientific advisory council appointed by the executive director of the Colorado Department of Public Health and Environment per requirements established in § 25-1.5-106.5, C.R.S.

4. “Grant program” means the Colorado medical marijuana research grant program created in § 25-1.5-106.5, C.R.S. to fund research intended to ascertain the efficacy of administering marijuana and its component parts as part of medical treatment.

5. "In good standing” with respect to a physician’s or dentist or advanced practice practitioner license means:

    a. The physician holds a doctor of medicine or doctor of osteopathic medicine degree from an accredited medical school or the dentist or advanced practice practitioner holds a degree in a medical field within his or her scope of practice.

    b. The physician holds a valid license to practice medicine, or the dentist or advanced practice practitioner holds a valid license to practice within his or her scope of practice, in Colorado that does not contain a restriction or condition that prohibits the recommendation of medical marijuana or for a license issued prior to July 1, 2011, is valid, unrestricted and unconditioned; and

    c. The physician or dentist or advanced practice practitioner has a valid and unrestricted United States Department of Justice federal Drug Enforcement Administration controlled substances registration.

6. “Minor applicant” is defined as a patient less than eighteen years of age.

7. “Patient” means a person who has a debilitating medical condition or disabling medical condition, § 25-1.5-106(2)(d.3), C.R.S.

8. “Physician” means a doctor of medicine, including a doctor of osteopathic medicine, who maintains, in good standing, a license to practice medicine issued by the state of Colorado, Section (1)(e) of Section 14 of Article XVIII; however, when a physician is making a medical marijuana recommendation for a disabling medical condition, “physician” also includes a dentist or advanced practice practitioner with prescriptive authority (physician assistant, advanced nurse practitioner, podiatrist, or optometrist) who holds a valid license, and is in good standing. § 25-1.5-106.5 (2)(d.4), C.R.S.

9. “Primary care-giver” or “primary caregiver” means a person other than the patient and the patient’s physician, who is eighteen years of age or older and has significant responsibility for managing the well-being of a patient who has a debilitating or disabling medical condition. A primary caregiver may have one or more of the following relationships:

    a. A parent of a child as described by Section (6) (e) of Section 14 of Article XVIII of the Colorado Constitution or a parent of a child with a disabling medical condition and anyone who assists that parent with caregiver responsibilities, including cultivation and transportation;

    b. An advising caregiver who advises a patient on which medical marijuana products to use and how to dose them and does not possess, provide, cultivate, or transport marijuana on behalf of the patient;

    c. A transporting caregiver who purchases and transports marijuana to a patient who is homebound; or

d. A cultivating caregiver who grows marijuana for a patient.

10. "Significant responsibility for managing the well-being of a patient" means that the caregiver is involved in basic or instrumental activities of daily living. Cultivating or transporting marijuana and the act of advising a patient on which medical marijuana products to use and how to dose them constitutes a "significant responsibility."

Regulation 2: Application for a registry identification card

*****

[Publication instructions: Replace current existing text at Regulation 2(B)(2)(b) with the following text.]

b. For minor applicants with a disabling medical condition, written documentation from two physicians that have diagnosed the patient as having a disabling medical condition as defined at § 25-1.5-106(2)(a.7), C.R.S. If the recommending physician is not the patient's primary care physician, the recommending physician shall review the records of a diagnosing physician or a licensed mental health provider acting within his or her scope of practice;

*****

[Publication instructions: Replace current existing text at Regulation 2(B)(5) with the following text.]

5. Documentation that at least one of the physicians referred to in subsection B.2 of this Regulation 2 has concluded that the patient might benefit from the medical use of marijuana and has explained the possible risks and benefits of medical use of marijuana to the applicant, and each of the applicant's parents residing in Colorado if the applicant is a minor; and

*****

[Publication instructions: Replace current existing text at Regulation 2(H) with the following text.]

H. A patient who has been convicted of a criminal offense under Article 18 of Title 18, C.R.S. who is sentenced or ordered by a court to treatment for a substance use disorder or sentenced to the division of youth corrections shall be subject to immediate revocation of his/her registry identification card. Such patient may only reapply with a new physician recommendation from a physician with whom the patient has a bona fide physician-patient relationship.

1. The patient shall remit the registry card to the department within 24 hours of the conviction/sentence/court order.

2. The patient may complete and submit a renewal application for a registry card including a new recommendation from a physician with a bona fide physician-patient relationship.

*****

Regulation 3: Verification of medical information; issuance, denial, revocation, and form of registry identification cards

[Publication instructions: Replace current existing test at Regulation 3(A) through 3(C) with the following text.]

A. The department shall verify medical information contained in the patient's application within thirty days of receiving the application. Verification of medical information shall consist of determining

that there is documentation stating the applicant has a current diagnosis with a debilitating or disabling medical condition as defined in Regulation 6, by a physician who has a current active, unrestricted and unconditioned license to practice medicine issued by the State of Colorado, which license is in good standing, and who has a bona fide physician-patient relationship with the patient.

B. No more than five days after verifying medical information of the applicant, the department shall issue a serially numbered registry identification card to the patient. The card shall state the following:

1. The patient's name, address, date of birth, and social security number;

2. That the patient's name has been certified to the department as a person with a debilitating or disabling medical condition, whereby the person may address such condition with the medical use of marijuana;

3. The date of issuance of such card and the date of expiration.

   a. A registry identification card issued for treatment of a debilitating medical condition shall be valid for one year from the date of issuance, and

   b. A registry identification card issued for treatment of a disabling medical condition shall be valid for no less than 60 days and no more than one year as determined by the recommending physician;

4. The name and address of the patient's primary care-giver, if any is designated at the time of application;

5 How to notify the department of any change in name, address, medical status, physician, or primary care-giver.

C. Except for minor applicants with a debilitating medical condition, where the department fails within thirty-five days of receipt of application to issue a registry identification card or fails to issue verbal or written notice of denial of such application, the patient's application for such card will be deemed to have been approved. "Receipt" shall be deemed to have occurred upon delivery to the department or deposit in the United States mail.

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Regulation 6: Debilitating medical conditions and the process for adding new debilitating medical conditions

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[Publication instructions: Replace current existing text in regulation 6(D)(1) with text below.]

1. Petitioner requirements. Petitions must be filed by a patient residing in Colorado or a physician who is authorized under these rules to recommend medical marijuana for a debilitating medical condition. The petitioner must provide their name, address, email address, and telephone number.

*****

Regulation 8: Physician requirements; reasonable cause for referrals of physicians to the Colorado Medical Board; reasonable cause for department adverse action concerning physicians; appeal rights

[Publication instructions: Replace current existing text in Regulation 8(A) through 8(B) with text below.]

A. **Physician Requirements.** A physician who certifies a debilitating or disabling medical condition for an applicant to the medical marijuana program shall comply with all of the following requirements:

1. **Colorado license to practice.** The physician shall have a valid, unrestricted Colorado license to practice that is in good standing.

2. **Bona fide physician-patient relationship.** A physician who has a bona fide physician-patient relationship with a particular patient may certify to the state health agency that the patient has a debilitating or disabling medical condition and that the patient may benefit from the use of medical marijuana. If the physician certifies that the patient would benefit from the use of medical marijuana based on a chronic or debilitating disease or medical condition, or a disabling medical condition, the physician shall specify the chronic or debilitating disease or medical condition, or disabling medical condition, and, if known, the cause or source of the chronic or debilitating disease or medical condition, or disabling medical condition.

    a. A physician making medical marijuana recommendations for a debilitating or disabling medical condition shall comply with generally accepted standards of medical practice, the provisions of the medical practice act, § 12-36-101 et seq., C.R.S, and all Colorado Medical Board rules.

    b. When making medical marijuana recommendations for a disabling medical condition, if the physician is a dentist or advanced practice practitioner with prescriptive authority, the dentist or advance practice practitioner must act within the scope of his or her practice and hold a valid license in good standing.

3. **Medical records.** The physician shall maintain a record-keeping system for all patients for whom the physician has recommended the medical use of marijuana. Pursuant to an investigation initiated by the Colorado Medical Board, the physician shall produce such medical records to the Colorado Medical Board after redacting any patient or primary caregiver identifying information.

4. **Financial prohibitions.** A physician shall not:

    a. Accept, solicit, or offer any form of pecuniary remuneration from or to a primary caregiver, distributor, or any other provider of medical marijuana;

    b. Offer a discount or any other thing of value to a patient who uses or agrees to use a particular primary caregiver, distributor, or other provider of medical marijuana to procure medical marijuana;

    c. Examine a patient for purposes of diagnosing a debilitating or disabling medical condition at a location where medical marijuana is sold or distributed; or

    d. Hold an economic interest in an enterprise that provides or distributes medical marijuana if the physician certifies the debilitating or disabling medical condition of a patient for participation in the medical marijuana program.

B. **Reasonable cause for referral of a physician to the Colorado Medical Board.** For reasonable cause, the department may refer a physician who has certified a debilitating or disabling medical condition of an applicant to the medical marijuana registry to the Colorado Medical Board or a

dentist or advance practice practitioner with prescriptive authority to the applicable licensing authority, for potential violations of this rule.

*****

Regulation 9: Primary care-giver-patient relationship and primary care-giver rules

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[Publication instructions: Replace current existing text in Regulation 9(F) with text below.]

F. A patient may only have one primary care-giver at a time; except that, on or after December 1, 2020, a patient who is under eighteen years of age may have each parent or guardian to act as a primary caregiver or, if the patient is under the jurisdiction of the juvenile court, the judge presiding over the case may determine who is the primary caregiver.

*****

Regulation 12: Patient Responsibilities.

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[Publication instructions: Replace current existing text in Regulation 12(E) with the text below.]

E. A patient who is convicted of a criminal offense under Article 18 of Title 18, C.R.S. who is sentenced or ordered by a court to treatment for a substance use disorder or sentenced to the division of youth corrections, shall notify the department. The patient shall be subject to immediate revocation of his/her registry identification card. Such patient may only reapply with a new physician recommendation from a physician with whom the patient has a bona fide relationship.

*****

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Office of the Attorney General

Tracking number: 2019-00334

Opinion of the Attorney General rendered in connection with the rules adopted by the

Board of Health

on 09/18/2019

5 CCR 1006-2

MEDICAL USE OF MARIJUANA

The above-referenced rules were submitted to this office on 09/20/2019 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

September 26, 2019 11:38:49

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Labor and Employment

Agency

Division of Workers' Compensation

CCR number

7 CCR 1101-3

Rule title

7 CCR 1101-3 WORKERS' COMPENSATION RULES OF PROCEDURE WITH TREATMENT GUIDELINES 1 - eff 01/01/2020

Effective date

01/01/2020

DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation

7 CCR 1101-3

WORKERS' COMPENSATION RULES OF PROCEDURE

Rule 16 UTILIZATION STANDARDS

16-1 STATEMENT OF PURPOSE

In an effort to comply with the legislative charge to assure the quick and efficient delivery of medical benefits at a reasonable cost, the Director (Director) of the Division of Workers' Compensation (Division) has promulgated these utilization standards, effective January 1, 2020. This Rule defines the standard terminology, administrative procedures, and dispute resolution procedures required to implement the Division's Medical Treatment Guidelines and Medical Fee Schedule.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(W) 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.

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

16-3 RECOGNIZED HEALTH CARE PROVIDERS

(A) Physician and Non-Physician Providers

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

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

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

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

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

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

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

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

(iv) Athletic Trainers (ATC) –licensed by the Colorado Department of Regulatory Agencies;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) Referrals:

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

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

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

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

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

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

(A) Out-of-State Provider

(1) Relocated Injured Worker

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

(b) A change of provider must be made:

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

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

(2) Referred Injured Worker

In the event an injured worker has not relocated out-of-state but is referred to an out-of-state provider for treatment or services not available within Colorado, the

referring provider shall obtain prior authorization from the payer as set forth in section 16-6. The referring provider's written request for out-of-state treatment shall include the following information:

(a) Medical justification prepared by the referring provider;

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

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

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

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

16-4 REQUIRED USE OF THE MEDICAL TREATMENT GUIDELINES

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

16-5 NOTIFICATION

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

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

(1) Providers can accept verbal confirmation; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16-6 PRIOR AUTHORIZATION

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

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

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

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

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

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

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

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

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

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

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

(3) Final diagnosis.

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

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

16-7 DENIAL OF A REQUEST FOR PRIOR AUTHORIZATION

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

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

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

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

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

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

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

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

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

(C) Prior Authorization Appeals

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

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

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

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

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

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

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

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

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

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

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

16-8 REQUIRED USE OF THE FEE SCHEDULE

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

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

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

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

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

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

16-9 REQUIRED BILLING FORMS, CODES, AND PROCEDURES

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

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

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

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

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

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

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

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

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

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

(3) American Dental Association's Dental Claim Form, Version 2019 shall be used by all providers billing for dental services or procedures.

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

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

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

(B) International Classification of Diseases (ICD) Codes

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

(C) Providers must accurately report their services using applicable billing codes, modifiers, instructions, and parenthetical notes listed in the Medical Fee Schedule; the National Relative Value File, as published by Medicare in the April 2019 Resource Based Relative Value Scale (RBRVS); and the American Medical Association's Current Procedural Terminology (CPT®) 2019 edition. The provider may be subject to penalties for inaccurate billing when the provider knew or should have known that the services billed were inaccurate, as determined by the Director or an administrative law judge.

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

(E) Timely Filing

Providers shall submit their bills for services rendered within 120 days of the date of service or the bill may be denied unless extenuating circumstances exist. For claims submitted through electronic data interchange (EDI), providers may prove timely filing by

showing a payer acknowledgement (claim accepted). Rejected claims or clearinghouse acknowledgment reports are not proof of timely filing. For paper claims, providers may prove timely filing with a signed certificate of mailing listing the original date mailed and the payer's address; a fax acknowledgment report; or certified mail receipt showing the date the payer received the claim. All timely filing issues will be considered final 10 months from date of service unless extenuating circumstances exist.

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

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

16-10 REQUIRED MEDICAL RECORD DOCUMENTATION

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

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

(1) Patient's name;

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

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

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

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

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

(7) Pain diagrams, where applicable;

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

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

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

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

(1) The report type as "initial" when the injured worker has his or her initial visit with the authorized treating physician managing the total workers' compensation claim (generally the designated or selected physician). If applicable, the emergency department (ED) or urgent care authorized treating physician for this workers' compensation injury also may create a Form WC 164 initial report. Unless requested or preauthorized by the payer to a specific workers' compensation claim, no other authorized physician should complete and bill for the initial Form WC 164. See Rule 18 for required fields.

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

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

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

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

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

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

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

16-11 PAYMENT OF MEDICAL BENEFITS

(A) Payer Requirements for Processing Medical Service Bills

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

(a) Name of the injured worker;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) If the billing provider agrees with the payer, then the payer shall process the service with the agreed upon code and shall document on the EOB

the agreement with the provider. The EOB shall include the name of the person at the provider's office who made the agreement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(D) Process for Appealing Billed Service Denials

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts. The parties shall do so within 12 months of the date the original bill should have been processed in compliance with section 16-11, unless extenuating circumstances exist.

(E) Retroactive review of Medical Bills

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

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

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

(2) If the payer conducts a retroactive review to recover overpayments from a provider based on medical reasons, the payer shall have the bill and all supporting documentation reviewed by a "physician provider" as defined in section 16-3(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. The physician providers performing this review shall be Level I or Level II accredited. In addition, a clinical pharmacist (Pharm.D.) as defined by section

16-3(A)(1)(b)(xvi) may review billed services for medications without having received Level I or Level II accreditation. The payer shall send the billing party written notice that shall include all notice requirements set forth in section 16-11(A)(1) and also shall include:

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

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

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

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

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

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

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

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

(F) An injured worker shall never be required to directly pay for admitted or ordered medical benefits covered under the Workers' Compensation Act. In the event the injured worker has directly paid for medical services that are then admitted or ordered under the Workers' Compensation Act, the payer shall reimburse the injured worker for the amounts actually paid for authorized services within 30 days after receipt of the bill. If the actual costs exceed the maximum fee allowed by the Medical Fee Schedule, the payer may seek a refund from the medical provider for the difference between the amount charged to the injured worker and the maximum fee. Each request for a refund shall indicate the service provided and the date of service(s) involved.

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

(H) Onsite Review of Hospital or Other Medical Charges

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

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

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

(a) Name of the injured worker;

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

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

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

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

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

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

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

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

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

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

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

(b) Negotiate the starting date for the review;

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

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

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

16-12 DISPUTE RESOLUTION PROCESS

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

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

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

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

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

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

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

DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation

7 CCR 1101-3
WORKERS' COMPENSATION RULES OF PROCEDURE

Rule 18 MEDICAL FEE SCHEDULE

Contents

18-1 INTRODUCTION

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

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

18-2 INCORPORATION BY REFERENCE

The Director adopts and incorporates by reference the following materials:

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

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

(C) Medicare Severity Diagnosis Related Groups (MS-DRGs) Definitions Manual, Version 37 using MS-DRGs effective August 2019. The MS-DRGs Definitions Manual may be purchased from 3M Health Information Systems.

(D) Health Care Common Procedure Coding System (HCPCS) Level II Professional 2019, published by the AMA.

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

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

18-3 GENERAL POLICIES

(A) Billing Codes and Fee Schedule:

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

(2) The Division incorporates CPT®, HCPCS, and National Drug Code (NDC) codes and values, unless otherwise specified in Rule 18. The providers may use CPT® Category III codes listed in the RBRVS with payer agreement. Payment for the Category III codes shall comply with Rule 16 policy for services that are not identified or identified but without established value in the Medical Fee Schedule.

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

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

(B) Place of Service Codes:

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

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

(C) Correct Reporting and Payment Policies:

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

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

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

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

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

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

18-4 PROFESSIONAL FEES AND SERVICES

(A) GENERAL INSTRUCTIONS

(1) Conversion Factors (CFs):

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

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

(2) Maximum Allowance:

(a) Maximum allowance for most providers shall be 100% of the RBRVS value unless otherwise specified in this Rule.

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

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

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

(ii) The PA or NP is Level I Accredited.

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

allowance for services addressed in the fee schedule.

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

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

(b) Modifier;

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

(d) Status Code:

Code	**Meaning**
A	Separately Payable
B & P	Bundled Code
C	Payer-Priced
D, F & H	Deleted Code or Modifier
E, G, I, N, R, or X	Valid for CO WC
J	Anesthesia Code
M & Q	Measurement or Functional Information Codes - No Value
T	Paid When Only Payable Service, Otherwise Bundled

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

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

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

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

(i) Facility (F) Total RVUs;

(j) Professional Component/Technical Component Indicators:

Indicator	Meaning
0	Physician Service Codes – professional component/ technical component (PC/TC) distinction does not apply.
1	Diagnostic Radiology Tests - may be billed with or without modifiers 26 or TC.
2	Professional Component Only Codes – standalone professional service code (no modifier is appropriate because the code description dictates the service is professional only).
3	Technical Component Only Codes - standalone technical service code (no modifier is appropriate because the code description dictates the service is technical only.
4	Global Test Only Codes - modifiers 26 and TC cannot be used because the values equal to the sum of the total RVUs (work, practice expense and malpractice).
5	Incident To Codes - do not apply.
6	Laboratory Physician Interpretation Codes – separate payments may be made (these codes represent the professional component of a clinical laboratory service and cannot be billed with modifier TC).
7	Physical Therapy Service – not recognized.
8	Physician Interpretation Codes – separate payments may be made only if a physician interprets an abnormal smear for a hospital inpatient.
9	Concept of PC/TC distinction does not apply.

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

Indicator	Meaning
000	Endoscopies or some minor surgical procedures, typically a zero day post-operative period. E&M visits on the same day as procedures generally are included in the procedure, unless a separately identifiable service is reported with an appropriate modifier.
010	Other minor procedures, 10-day post-operative period. E&M visits on the same day as procedures and during the 10-day post-operative period generally are included

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

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

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

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

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

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

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

(o) Multiple-Procedure Modifier

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

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

(p) Bilateral Procedures

Indicator	Meaning
0	Not eligible for the bilateral payment adjustment. Either the procedure cannot be performed bilaterally due to the anatomical constraints or another code more adequately describes the procedure.
1	Eligible for bilateral payment adjustment and should be reported on one line with modifier 50 and “1” in the units box.

	Provider performing the same bilateral procedure during the same operative setting multiple times shall report the second and subsequent procedures with modifiers 50 and 59. Report on one line with one unit for each bilateral procedure performed. The maximum fee is increased to 150% of the fee schedule value. If provider performs bilateral procedures during the same setting, payer shall apply the bilateral payment adjustment rule first, and then apply other applicable payment adjustments (e.g., multiple surgery).
2	Not eligible for the bilateral payment adjustment. These procedure codes are already bilateral.
3	Not eligible for the bilateral payment adjustment. Report these codes on two lines with RT and LT modifiers. There is one payment per line. Indicator 3 codes are primarily diagnostic radiology and other diagnostic medicine procedures.
9	Not eligible for the bilateral payment adjustment because the concept does not apply.

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

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

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

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

(r) Co-Surgeons, Modifier 62

Indicator	**Meaning**

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

(s) Team Surgeons, Modifier 66

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

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

(u) All other fields are not recognized.

(B) EVALUATION AND MANAGEMENT (E&M)

(1) Evaluation and management codes may be billed by physician providers as defined in Rule 16, nurse practitioners (NP), and physician assistants (PA). To justify the billed level of E&M service, medical record documentation shall utilize the 2019 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.

(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.

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

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

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

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

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

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

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

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

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

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

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

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

Subsequent Hospital modified RVUs are:

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

Consultation modified RVUs are:

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

(7) Prolonged Services:

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

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

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

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

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

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

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

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

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

(C) ANESTHESIA

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

When a CRNA or AA administers anesthesia:

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

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

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

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

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

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

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

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

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

(a) Anesthesia complicated by extreme age (under 1 or over 70 years) 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) 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 2019 Anesthesia Base Values

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

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

(D) SURGERY

(1) Assistant Surgeons Payment Policies and Modifiers:

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

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

(b) Payment for more than one (1) assistant surgeon or minimum assistant surgeon requires prior authorization.

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

(d) Maximum allowance for a minimum assistant surgeon, reported by a non-physician, as indicated by modifiers AS and 81, is 10% of the surgeon's fees (the 85% adjustment in section 18-4(A)(2)(b) does not apply).

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

(f) See section 18-4(A)(3)(q) for additional payment policies applicable to assistant surgeons.

(2) Global Package

(a) All surgical procedures include the following:

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

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

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

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

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

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

(vii) typical post-operative follow-up care during the global period of the surgery that is related to recovery, see section 18-4(A)(3)(k).

(viii) supplies integral to an operative procedure. See section 18-6(A) to determine reimbursement for unrelated supplies or Durable Medical Equipment, Orthotics or Prosthetics (DMEPOS).

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

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

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

(b) Modifiers:

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

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

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

Modifier	Payment and billing policies	Applicability/Documentation
24	E&M services unrelated to the primary surgical procedure. The reasonableness and necessity for an E&M service that is separate and identifiable from the surgical global period shall be	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

	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.	treating physician for disability management. The definitions of disability counseling are located in Exhibit #7.
25	Initial or follow up visit that occurred on the same day/encounter as a minor surgical procedure.	E&M documentation must support the patient's condition. The visit must be significant and separately identifiable from the minor surgical procedure and the usual pre- and post-operative care required.
57	The surgeon's E&M visit that resulted in the decision for major surgery performed on either the same day or the day after the visit.	The E&M documentation must identify the medical necessity of the procedure and the discussion with the patient.

(3) General Surgical Payment Policies:

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

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

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

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

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

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

(4) Knee Arthroscopies

(a) Medial, lateral, and patella are the knee compartments recognized for purposes of separate payment of debridement and synovectomies.
(b) Chondroplasty is separately payable with another knee arthroscopy only if performed in a different knee compartment or to remove a loose/foreign body during a meniscectomy.
(c) Limited synovectomy involving one knee compartment is not separately payable with another arthroscopic procedure on the same knee.
(d) Payment for a major synovectomy procedure shall require a synovial diagnosis and two or more knee compartments without any other arthroscopic surgical procedures performed in the same compartment.

(5) Shoulder Arthroscopies

(a) Glenohumeral, acromioclavicular, and subacromial bursal space are the shoulder regions recognized for purposes of separate payment.
(b) Limited debridement performed with a shoulder arthroscopy is bundled into the arthroscopy and is not separately payable unless subsection (c) applies.
(c) Limited debridement performed in the glenohumeral region is separately payable if it is the only procedure performed in that region in the surgical encounter.
(d) Extensive debridement (debridement that takes place in more than one location or region) is separately payable if documented in the medical record.

(6) Spine and Nervous System

(a) Spinal manipulation is integral to spinal surgical procedures and is not separately payable.
(b) Surgeon performing a spinal procedure shall not report intra-operative neurophysiology monitoring/testing codes.
(c) If multiple procedures from the same CPT® code family are performed at contiguous vertebral levels, provider shall append modifier 51 to all lesser-valued primary codes. See sections 18-5(B)(6)(a) and 18-4(A)(3)(o) for applicable payment policies.
(d) Fluoroscopy is separately payable with spinal procedures only if indicated by a specific CPT® instruction.
(e) Lumbar laminotomies and laminectomies performed with arthrodesis at the same interspace are separately payable if the surgeon identifies the additional work performed to decompress the thecal sac and/or spinal nerve(s). If these procedures are performed at the same level, provider shall append modifier 51 to the lesser-valued procedure(s). If procedures are performed at different interspaces, provider shall append modifier 59 to the lesser-valued procedure(s). See sections 18-5(B)(6)(a) and 18-4(A)(3)(o) for applicable payment policies.
(f) Only one anterior or posterior instrumentation performed through a single skin incision is payable.
(g) Anterior instrumentation performed to anchor an inter-body biomechanical device to the intervertebral disc space is not separately payable.
(h) Anterior instrumentation unrelated to anchoring the device is separately payable with modifier 59 appended.

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

(8) Platelet Rich Plasma (PRP) Injections

Codes and professional fees:

DoWC Z0813	Office setting	$758.88
CPT® 0232T	Facility setting	$274.50

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

(E) RADIOLOGY

(1) General Policies

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

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

(2) Payments

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

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

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

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

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

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

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

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

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

(3) Thermography

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

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

(b) Thermography Billing Codes:

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

(c) The bill shall include a report that supplies the thermographic evaluation and complies with this section.

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

(F) PATHOLOGY

(1) General Policies

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

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

(2) Clinical Laboratory Improvement Amendments (CLIA)

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

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

(3) Payments

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

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

(a) physician blood bank services,
(b) cytopathology and cell marker study interpretations,
(c) cytogenics or molecular cytogenics interpretation and report,
(d) surgical pathology gross and microscopic and special stain groups 1 and 2 and histochemical stain, blood or bone marrow interpretations, and
(e) skin tests for unlisted antigen each, coccidoidomycosis, histoplasmosis, TB intradermal.

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

(4) Clinical Drug Screening/Testing Codes and Values:

(a) Clinical drug screening/testing evaluates whether:

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

(b) Billing requirements for clinical drug testing:

(i) the ordering physician shall document the medical necessity of the clinical drug test.
(ii) the ordering physician shall specify which drugs require definitive testing to meet the patient's medical needs.
(iii) quantification of illicit or non-prescribed drugs or drug classes requires a physician order.
(iv) Medicare codes used in the 2019 Medicare Fee Schedule shall be billed for presumptive and definitive urine drug tests.
(v) all recognized codes and maximum fee values are listed in Exhibit #8.

(c) Presumptive Tests

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

(d) Definitive qualitative or quantitative tests identify specific drug(s) and any associated metabolites, providing sensitive and specific results expressed as a concentration in ng/mL or as the identity of a specific drug.

- These tests may be billed using G0480-G0483.
- Providers may only bill one definitive HCPCS Level II code per day.

A physician must order definitive quantitative tests. The reasons for ordering a definitive quantification drug test may include:

- Unexpected positive presumptive or qualitative test results inadequately explained by the injured worker.
- Unexpected negative presumptive or qualitative test results and suspected medication diversion.
- Differentiate drug compliance:
  - Buprenorphine vs. norbuprenorphine
  - Oxycodone vs. oxymorphone and noroxycodone
- Need for quantitative levels to compare with established benchmarks for clinical decision-making, such as tetrahydrocannabinol quantitation to document discontinuation of a drug.
- Chronic opioid management:
  - Drug testing shall be done prior to the implementation of the initial long-term drug prescription and randomly repeated at least annually.
  - While the injured worker receives chronic opioid management, additional drug screens with documented justification may be conducted (see section 18-9(A) for examples).
- CPT® may be consulted for a definitive drug classes listing and examples of individual drugs within each class. Each class of drug can only be billed once per day.

(G) MEDICINE

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

(2) Biofeedback

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

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

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

The modified RVUs for biofeedback services are:

CPT® 90901, non-facility RVU is 2.14, facility RVU is 1.14
CPT® 90911, non-facility RVU is 4.76, facility RVU is 2.48

(3) Appendix J of 2019 CPT® identifies mixed, motor, and sensory nerve conduction studies and applicable billing requirements. Electromyography (EMG) and nerve conduction velocity 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 2019 CPT® for billing modifier 25 have been met.

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

(a) Prior authorization shall be obtained before billing for more than four body regions in one (1) visit. The provider's medical records shall reflect medical necessity and prior authorization if treatment exceeds these limitations.

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

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

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

CPT® 98940	Non-facility RVU is 1.0, facility RVU is 0.79
CPT® 98941	Non-facility RVU is 1.44, facility RVU is 1.22

(5) Psychiatric/Psychological Services:

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

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

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

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

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

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

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

The modified RVUs for psychological and neuropsychological services are:

CPT® 96116 = non-facility RVU is 3.4, facility RVU is 2.98
CPT® 96127 = non-facility and facility RVUs are 0.18
CPT® 96130 = non-facility RVU is 3.63, facility RVU is 3.4
CPT® 96131 = non-facility RVU is 2.92, facility RVU is 2.73
CPT® 96132 = non-facility RVU is 4.11, facility RVU is 3.2
CPT® 96133 = non-facility RVU is 3.11, facility RVU is 2.44
CPT® 96146 = non-facility and facility RVUs are 0.10
CPT® 90791 = non-facility RVU is 9.91, facility RVU is 9.6
CPT® 90792 = non-facility RVU is 11.12, facility RVU is 10.8
CPT® 96150 = non-facility RVU is 0.80, facility RVU is 0.79
CPT® 96151 = non-facility RVU is 0.78, facility RVU is 0.77
CPT® 96152 = non-facility RVU is 0.74, facility RVU is 0.73
CPT® 96153 = non-facility RVU is 0.18, facility RVU is 0.17
CPT® 96154 = non-facility RVU is 0.74, facility RVU is 0.73
CPT® 96155 = non-facility and facility RVUs are 0.73

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

Psychotherapy for work-related conditions continuing for more than three (3) months after the initiation of therapy requires prior authorization unless the Medical Treatment Guidelines recommend a longer duration.

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

(i) both services must be separately identifiable;

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

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

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

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

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

(g) Upon request of a party to a workers' compensation claim and pursuant to HIPAA regulations, a psychiatrist, psychologist or other qualified health care professional may generate a separate report and bill for that service as a special report.

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

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

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

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

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

(i) Resting Sweat Test;

(ii) Stimulated Sweat Test;

(iii) Resting Skin Temperature Test; and

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

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

(8) Intra-Operative Monitoring (IOM)

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

(a) Clinical Services for IOM: Technical and Professional

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

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

(ii) Professional/Supervisory /Interpretive

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

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

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

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

(b) Procedures and Time Reporting

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

(c) Billing Restrictions

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

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

The fee schedule value for CPT® 95941 is equal to the fee schedule value for CPT® 95940.

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

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

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

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

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

(12) Moderate (Conscious) Sedation

Providers billing for moderate sedation services shall comply with all applicable 2019 CPT® billing instructions. The Maximum Fee Schedule value is determined using the Medicine CF.

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

(1) General Policies:

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

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

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

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

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

(e) Unlisted services require a report.

(2) Medical nutrition therapy requires prior authorization.

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

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

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

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

If the individual interdisciplinary rehabilitation professionals bill separately for their participation in an interdisciplinary rehabilitation program, the applicable CPT® codes shall be used to bill for their services.

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

For Dry Needling of Trigger Points, single or multiple needles, use DoWC Z0501 or Z0502:

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

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

The modified RVU for an unlisted procedure, CPT® 97139, is 0.92, non-facility and facility.

(5) Modalities

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

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

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

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

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

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

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

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

(b) A PT or OT may utilize a Rehabilitation Communication Form (WC 196) in addition to a progress note no more than every two (2) weeks for the first six (6) weeks, and once every four (4) weeks thereafter.

The WC 196 form should not be used for an evaluation, re-evaluation or re-assessment.

The WC 196 form must be completed and include which validated functional tool was used for assessing the patient.

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

DoWC Z0817 $15.30.

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

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

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

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

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

(7) Special Tests

(a) The following are considered special tests:

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

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

(b) Billing Restrictions:

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

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

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

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

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

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

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

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

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

(10) Non-Medical Facility Fees

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

(11) Work Conditioning, Work Hardening, Work Simulation

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

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

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

(d) Treatment Plan:

(i) The provider shall submit a treatment plan including expected frequency and duration of treatment. If requested by the provider, the payer will prior authorize payment for the treatment plan services or shall identify any concerns including those based on the reasonableness or necessity of care.

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

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

(12) Wound Care

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

(13) Acupuncture

(a) Acupuncture may be performed with or without the electrical current on the needles at the acupuncture site.

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

(b) New or established patient evaluation services are payable if the medical record specifies the appropriate history, physical examination, treatment plan or evaluation of the treatment plan. Payers are only required to pay for evaluation services directly performed by a physician or an LAc. All evaluation notes or reports must be written and signed by the physician or the LAc.

LAc new patient visit: DOWC Z0800, $101.80

LAc established patient visit: DOWC Z0801, $68.95

(I) TELEMEDICINE

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

All healthcare services provided through 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 telemedicine services:

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

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

- The office of a physician or practitioner
- A hospital (inpatient or outpatient)
- A critical access hospital (CAH)
- A rural health clinic (RHC)
- A federally qualified health center (FQHC)
- A hospital based or critical access hospital based renal dialysis center (including satellites)
- A skilled nursing facility (SNF)
- A community mental health center (CMHC)

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

(c) Telemedicine:

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

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

(ii) Payment for 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.

(v) Medical providers shall bill codes G0425-G0427 for consultations, emergency department or initial inpatient visits.

(vi) Medical providers shall bill codes G0406-G0408 for follow up inpatient consultations.

18-5 FACILITY FEES

(A) INPATIENT HOSPITAL FACILITY FEES

(1) Billing:

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

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

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

(c) Exhibit #1 establishes the maximum length of stay (LOS) using the "arithmetic mean LOS". However, no additional allowance for exceeding this LOS, other than through the cost outlier criteria under subsection 2(e) is allowed.

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

(2) Reimbursement:

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

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

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

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

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

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

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

(c) Medicare Long Term Care Hospitals (MLTCH)

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

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

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

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

The "Maximum Fee Allowance" is determined by calculating:

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

(ii) For trauma center activation allowance, (revenue codes 680-685) see subsection (B)(6)(e)

(iii) For organ acquisition allowance, (revenue codes 810-819) see subsection (A)(2)(i).

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

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

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

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

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

(iv) If the “Difference” is greater than $26,994.00, additional reimbursement is warranted. The additional reimbursement is determined by the following equation:

“Difference” x .80 = additional fee allowance

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

(i) If an injured worker is admitted to the hospital, the ED reimbursement is included in the inpatient reimbursement under this section.

(ii) Trauma center activation fees and organ acquisition allowance are paid in addition to inpatient fees.

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

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

(i) The MS-DRG adjusted billed charges to the MS-DRG allowance (including any outlier allowance);
(ii) The trauma center activation billed charge to the trauma center activation allowance; and
(iii) The organ acquisition charges to the organ acquisition maximum fees.

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

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

(B) OUTPATIENT FACILITY FEES

(1) Provider Restrictions

(a) All non-emergency outpatient surgeries require prior authorization unless the Medical Treatment Guidelines recommend a surgery for the particular

condition. All outpatient surgical procedures performed in an ASC shall warrant performance at an ASC level.

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

(2) Types of Bills for Service:

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

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

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

(3) Outpatient Facility Reimbursement:

(a) The following types of outpatient facilities are reimbursed at 100% of billed outpatient charges, except for any associated professional fees:

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

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

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

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

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

To identify which APC grouper is aligned with an Exhibit #4 APC code number and dollar value, use Medicare's 2019 Addendum B.

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

CPT® 22558 = APC 5116
CPT® 22600, 22610, 22630, 22633, and 22857 = APC 5115
CPT® 22632 = APC 5092
CPT® 22634, 22800, and 22830= APC 5114
CPT® 22846 = APC 5192
CPT® 22849, 22850, 22852, and 22855 = APC 1571
CPT® 23472, 23474, 27130, 27132, 27134, 27137, 27138, 27447, and 27702 = APC 1575

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

Services and items included in the APC value:

(a) nursing, technician, and related services;
(b) use of the facility where the surgical procedure(s) was performed;
(c) drugs and biologicals for which separate payment is not allowed;
(d) medical and surgical supplies, durable medical equipment and orthotics not listed as a "pass through";
(e) surgical dressings;
(f) equipment;
(g) splints, casts and related devices;
(h) radiology services when not allowed under Exhibit #4;
(i) administrative, record keeping and housekeeping items and services;
(j) materials, including supplies and equipment for the administration and monitoring of anesthesia;
(k) supervision of the services of an anesthetist by the operating surgeon;
(l) post-operative pain blocks; and
(m) implanted items.

Packaged Services	
Rev Code	Description
0250	Pharmacy; General Classification
0251	Pharmacy; Generic Drugs
0252	Pharmacy; Non-Generic Drugs
0254	Pharmacy; Drugs Incident to Other Diagnostic Services
0255	Pharmacy; Drugs Incident to Radiology
0257	Pharmacy; Non-Prescription
0258	Pharmacy; IV Solutions
0259	Pharmacy; Other Pharmacy
0260	IV Therapy; General Classification
0261	IV Therapy; Infusion Pump
0262	IV Therapy; IV Therapy/Pharmacy Services
0263	IV Therapy; IV Therapy/Drug/Supply Delivery

Packaged Services	
Rev Code	Description
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),

Packaged Services	
Rev Code	Description
	Pulmonary Rehabilitation

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

Indicator	Meaning
A	Use another fee schedule instead of Exhibit #4, such as conversion factors listed in section 18-4, RBRVS RVUs, Ambulance Fee Schedule, or Exhibit #8.
B	Is not recognized by Medicare for Outpatient Hospital Services Part B bill type (12x and 130x) and therefore is not separately payable unless separate fees are applicable under another section of this Rule.
C	Recognized by Medicare as inpatient-only procedures. However, the Division recognizes these procedures on an outpatient basis with prior authorization. See subsection 18-5(B)(3)(d) for reimbursement of certain procedures with "C" status indicator.
D	Discontinued code.
E1 or E2	Not paid by Medicare when submitted on any outpatient bill type. However, services could still be reasonable and necessary, thus requiring hospital or ASC level of care. The billing party shall submit documentation to substantiate the billed service codes and any similar established codes with fees in Exhibit #4.
F	Corneal tissue acquisition and certain CRNA services and Hepatitis B vaccines are allowed at a reasonable cost to the facility. The facility must provide a separate invoice identifying its cost.
G	"Pass-Through Drugs and Biologicals" are separately payable under Exhibit #4 as an APC value.
H	A "Pass-Through Device" is separately payable based on cost to the facility.
J1 or J2	The services are paid through a "comprehensive APC" for Medicare. However, the DoWC has not adopted the "comprehensive APC." Therefore, an agreement between the payer and the provider is necessary.
K	A separately payable "Pass-Through Drug or Biological or Device" for therapeutic radiopharmaceuticals, brachytherapy sources, blood and blood products as listed under Exhibit #4 APC value.
L	Represents Influenza Vaccine/Pneumococcal Pneumonia Vaccine and therefore is generally considered to be unrelated to work injuries.

M	Not separately payable.
N	Service is bundled and is not separately payable.
P	Partial hospitalization paid based on observation fees outlined in this section.
R	Blood and blood products
Q	Any “Packaged Codes” with Q1, Q2, Q3, Q4 or STVX combinations are not recognized unless the parties make a prior agreement.
S or T	Multiple procedures, the highest-valued code allowed at 100% of the Exhibit #4 value and up to three (3) additional codes allowed at 50% of the Exhibit #4 value, per episode of care.
U	Brachytherapy source and is separately payable under Exhibit #4 APC value.
V	Represents a clinic or an ED visit and is separately payable for hospitals as specified in section 18-5(B)(6).
Y	Non-implantable Durable Medical Equipment paid pursuant to Medicare’s Durable Medical Equipment Regional Carrier fee schedule for Colorado.

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

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

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

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

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

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

(b) Other surgical payment policies are as follows:

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

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

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

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

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

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

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

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

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

(e) Trauma activation means a trauma team has been activated, not just alerted. Trauma activation is billed with 068X revenue codes. The level of trauma activation shall be determined by CDPHE’s assigned hospital

trauma level designation. Trauma activation fees are in addition to ED and inpatient fees and are not paid for alerts. APC 5045, Trauma Response with Critical Care, is not recognized for separate payment.

Trauma activation fees are as follows:

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

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

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

(h) Charges for observation status lasting longer than six (6) hours may be subject to retroactive review. Documentation should support the medical necessity for observation or convalescent care. Observation time begins when the patient is placed in a bed for the purpose of initiating observation care in accordance with the physician's order. Observation or daily outpatient convalescence time ends when the patient is actually discharged from the hospital or ASC or admitted into a licensed facility for an inpatient stay. Observation time would not include the time patients remain in the observation area after treatment is finished for reasons such as waiting for transportation home. Hospital or convalescence licensure is required for billing observation or convalescence time beyond 23 hours.

Billing Code is G0378, $45.90 per hour, round to the nearest hour.

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

(i) ambulance services (revenue rode 540), see section 18-6(E)
(ii) blood, blood plasma, platelets (revenue codes 380X)
(iii) physician or physician assistant services
(iv) nurse practitioner services
(v) licensed clinical psychologist
(vi) licensed social workers
(vii) rehabilitation services (PT, OT, respiratory or speech/language, revenue codes 420, 430,440)

(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(C).

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

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

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

(ii) Billing and Maximum Fees

- Clinics designated as rural health facilities and listed in Exhibit #5 may be reimbursed a single separate clinic fee at 80% of billed charges per date of service, regardless of whether the clinic has been designated by the employer, the urgency of the episode of care, or the time of day.
- CAHs listed in Exhibit #5 may be reimbursed a single separate clinic fee at 80% of billed charges per date of service.
- Any specialty care clinic (wound/infections) that requires drugs/supplies that are typically not provided in a physician's office may be allowed a separate clinic fee with prior approval from the payer, as outlined in Exhibit #4.
- No other clinic facility fees are payable except those listed in section 18-5
- Maximum fees for hospital urgent care facilities or services are covered under section (C). These are identified by either place of service code 20, as billed on a CMS-1500, or by revenue code(s) 516 or 526 on a UB-04.

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

(l) IV infusion therapy performed in an outpatient hospital facility is separately payable in accordance with this section.

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

(C) URGENT CARE FACILITIES

(1) Provider Restrictions

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

(2) Billing and Maximum Fees:

(a) Urgent Care Facility Fees:

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

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

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

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

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

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

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

18-6 ANCILLARY SERVICES

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

(1) Durable Medical Equipment (DME)

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

(a) Purchased Equipment/Capped Rental:

(i) Items that cost $100.00 or less may not be rented.
(ii) Rented items must be purchased or discontinued after 10 months of continuous use or once the total fee scheduled price has been reached.
(iii) The monthly rental rate cannot exceed 10% of the DMEPOS fee schedule, or if not available, the cost of the item to the provider or the supplier (after taking into account any discounts/rebates the

supplier or the provider may have received). When the item is purchased, all rental fees shall be deducted from the total fee scheduled price. If necessary, the parties should use an invoice to establish the purchase price.

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

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

(b) Take Home Exercise Equipment

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

(c) Electrical Stimulators

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

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

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

(iii) Replacement supplies are limited to once per month and are not eligible with a first month rental.
A4595 - electrical stimulator supplies, 2 leads.
A4557 - replacement leads.

(iv) Conductive Garments: E0731.

(d) Continuous Passive Motion Devices (CPMs):

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

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

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

(e) Intermittent Pneumatic Devices

These devices (including, but not limited to, Game Ready and cold compression) are bundled into facility fees and are not separately payable. The use of these devices after discharge requires prior authorization.

E0650-E0676 – Codes based on body part(s), segmental or not, gradient pressure and cycling of pressure and purpose of use; and

A4600 – Sleeve for intermittent limb compression device, replacement only, per each limb.

(2) Prosthesis and Orthotics

Maximum fees for any orthotic created using casting materials shall be billed using Medicare's Q codes and values listed under Medicare's DMEPOS fee schedule for Colorado. The therapist time necessary to create the orthotic shall be billed using CPT® 97760.

Payment for professional services associated with the fabrication and/or modification of orthotics, custom splints, adaptive equipment, and/or adaptation and programming of communication systems and devices shall be paid in accordance with the Colorado Medicare HCPCS Level II values.

(3) Supplies

Supplies necessary to perform a service or procedure are considered inclusive and not separately reimbursable. Only supplies that are not an integral part of a service or procedure are considered to be over and above those usually included in the service or procedure. Reimbursement of supplies to facilities shall comply with the appropriate section of this Rule.

(4) Reimbursement

Unless other limitations exist in this Rule, DMEPOS suppliers and medical providers shall be reimbursed using Medicare's HCPCS Level II codes, when one exists, as established in the January 2019 DMEPOS schedule for rural (R) or non-rural (NR) areas. The DMEPOS schedule can be found at https://www.cms.gov.

If no code or value exists, reimbursement shall be based on Colorado Medicaid's DME, Upper Payment Limit, January 2019 Interim Rate for rural or non-rural areas. See https://www.colorado.gov/hcpf/provider-rates-fee-schedule.

If no Medicaid fee schedule value exists, reimbursement shall be based on 120% of the cost of the item as indicated by invoice. Shipping and handling charges are not separately payable. Payers shall not recognize the KE modifier.

Auto-shipping of monthly DMEPOS is not allowed.

(5) Complex Rehabilitation Technology dispensed and billed by Non-Physician DMEPOS Suppliers

(a) Complex rehabilitation technology (CRT) items, including products such as complex rehabilitation power wheelchairs, highly configurable manual

wheelchairs, adaptive seating and positioning systems, and other specialized equipment, such as standing frames and gait trainers, enable individuals to maximize their function and minimize the extent and costs of their medical care.

(b) Complex Rehabilitation Technology products must be provided by suppliers who are specifically accredited by a Center for Medicare and Medicaid Services (CMS) deemed accreditation organization as a supplier of CRT and licensed as a DMEPOS Supplier with the Colorado Secretary of State.

(B) HOME CARE SERVICES

Prior authorization is required for all home care–services, unless otherwise specified. All skilled home care service providers shall be licensed by the Colorado Department of Public Health and Environment (CDPHE) as Type A or B providers. The payer and the home health entity should agree in writing on the type of care, the type and skill level of provider, frequency of care and duration of care at each visit, and any financial arrangements to prevent disputes.

(1) Home Infusion Therapy

The per day or refill rates for home infusion therapy shall include all reasonable and necessary products, equipment, IV administration sets, supplies, supply management, and delivery services necessary to perform the infusion therapy. Per diem rates are only payable when licensed professionals (RNs) are providing "reasonable and necessary" skilled assessment and evaluation services in the patient's home.

Skilled Nursing fees are separately payable when the nurse travels to the injured worker's home to perform initial and subsequent patient evaluation(s), education, and coordination of care.

(a) Parenteral Nutrition:

Code	**Quantity**	**Max Bill Frequency**	**Daily Rate**
S9364	<1 Liter	once per day	$160.00
S9365	1 liter	once per day	$174.00
S9366	1.1 - 2.0 liter	once per day	$200.00
S9367	2.1 - 3.0 liter	once per day	$227.00
S9368	> 3.0 liter	once per day	$254.00

The daily rate includes the standard total parenteral nutrition (TPN) formula. Lipids, specialty amino acid formulas, and drugs other than in standard formula are separately payable under section 18-6(C).

(b) Antibiotic Therapy per day rate by professional + drug cost at Medicare's Average Sale Price (ASP). If ASP is not available, use Average Wholesale Price (AWP) (see section 18-6(C)).

Code	Time	Max Bill Frequency	Daily Rate
S9494	hourly	once per day	$158.00
S9497	once every 3 hours	once per day	$152.00
S9500	every 24 hours	once per day	$97.00
S9501	once every 12 hours	once per day	$110.00
S9502	once every 8 hours	once per day	$122.00
S9503	once every 6 hours	once per day	$134.00
S9504	once every 4 hours	once per day	$146.00

(c) Chemotherapy per day rate + drug cost at ASP. If ASP is not available, use AWP.

Code	Description	Max Bill Frequency	Daily Rate
S9329	Administrative Services	once per day	$0.00
S9330	Continuous (24 hrs. or more) chemotherapy	once per day	$91.00
S9331	Intermittent (less than 24 hrs.)	once per day	$103.00

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

Code	Description	Max Bill Frequency	Daily Rate
S9341	Via Gravity	once per day	$44.09
S9342	Via Pump	once per day	$24.23
S9343	Via Bolus	once per day	$24.23

(e) Pain Management per day or refill + drug cost at ASP. If ASP is not available, use AWP.

Code	Description	Max Bill Frequency	Daily Rate
S9326	Continuous (24 hrs. or more)	once per day	$79.00
S9327	Intermittent (less than 24 hrs.)	once per day	$103.00
S9328	Implanted pump (no separate daily rate)	Per refill	$116.00/refill. No separate daily rate.

(f) Fluid Replacement per day rate + drug cost at ASP. If ASP is not available, use AWP.

Code	Quantity	Max Bill Frequency	Daily Rate
S9373	< 1 liter per day	once per day	$61.00
S9374	1 liter per day	once per day	$85.00
S9375	>1 but <2 liters per day	once per day	$85.00
S9376	>2 liters but <3 liters	once per day	$85.00
S9377	>3 liters per day	once per day	$85.00

(g) Multiple Therapies:

Highest cost per day or refill only + drug cost at ASP. If ASP is not available, use AWP.

(2) Nursing Services are limited to two (2) hours without prior authorization, unless otherwise indicated in the Medical Treatment Guidelines:

Code	Type of Nurse	Max Bill Frequency	Hourly Rate
S9123	RN	2 hrs	$111.00
S9124	LPN	2 hrs	$89.00
S9122	CNA	The amount of time spent with the injured worker must be specified in the medical records and on the bill.	$45.00

(3) Physical medicine procedures are payable at the rates listed in section 18-4(H).

(4) Mileage

The parties should agree upon travel allowances and the mileage rate should not exceed 53 cents per mile, portal to portal. DoWC Z0772.

(5) Travel Time

Travel is typically included in the fees listed. Travel time greater than one (1) hour one-way shall be reimbursed. The fee shall be agreed upon at the time of prior authorization and shall not exceed $34.68 per hour. DoWC Z0773.

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

As defined in section 18-6(A), any drugs/supplies/DME/Orthotics/Prosthetics considered integral to at-home professional's service are not separately payable.

The maximum fees for non-integral drugs/supplies/DME/Orthotics/Prosthetics used during a professional's home care visits are listed in section 18-6(A). All IV infusion supplies are included in the per diem or refill rates listed in this Rule.

(C) DRUGS AND MEDICATIONS

(1) All medications must be reasonably needed to cure and relieve the injured worker from the effects of the injury. Prior authorization is required for medications "not recommended" in the Medical Treatment Guidelines for a particular diagnosis or if Rules 16 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 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/scheduled controlled substances that are prescribed for treatment lasting longer than 3 days shall be provided through a pharmacy. The prescriber shall comply with applicable provisions of §§ 12-32-107.5, 12-35-114, 12-36-117.6, 12-38-111.6, 12-40-109.5, 12-42.5-404, and other statutes and rules.

(3) Billing

(a) Drugs (brand name or generic) shall be reported on bills using the applicable identifier from the National Drug Code (NDC) Directory as published by the Food and Drug Administration (FDA).

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

(i) CMS-1500 – dispensing provider shall bill by using the metric quantity (number of tablets, grams, or mls) in column 24.G and NDC number of the drug being dispensed or, if one does not exist, the RBRVS supply code. For repackaged drugs, dispensing provider shall list the "repackaged" and the "original" NDC numbers in field 24 of the CMS-1500. The dispensing provider shall list the "repackaged" NDC number of the actual dispensed medication first and the "original" NDC number second, with the prefix 'ORIG' appended. Billing providers shall include the units and days supply for all dispensed medications in field 19, example: '60UN/30DY.'

(ii) With the agreement of the payer, the National Council for Prescription Drug Programs (NCPDP) or ANSI ASC 837 (American National Standards Institute Accredited Standards Committee) electronic billing transaction containing the same information as in (1) or (2) in this sub-section may be used for billing. NCPDP Workers' Compensation/Property and Casualty (P&C) Universal Claim Form, version 1.1, for prescription drugs billed on paper shall be used by dispensing pharmacies and pharmacy benefit managers.

(c) Dispensing provider shall keep a signature on file indicating the injured worker or his/her authorized representative has received the prescription.

(4) Average Wholesale Price (AWP)

(a) AWP for brand name and generic pharmaceuticals may be determined through the use of such monthly publications as Red Book Online, or Medispan. In case of a dispute on AWP values for a specific NDC, the parties should take the lower of their referenced published values.

(b) If published AWP data becomes unavailable, substitute Wholesale Acquisition Cost (WAC) + 20% for AWP everywhere in this Rule.

(5) Reimbursement for Prescription Drugs & Medications

(a) For prescription medications, except topical compounds, reimbursement shall be AWP + $4.00. If drugs have been repackaged, use the original AWP and NDC that was assigned by the source of the repackaged drugs to determine reimbursement.

(b) The entity packaging two or more products together makes an implied claim that the products are safe and effective when used together and shall be billed as individual line items identified by their original AWP and NDC. This original AWP and NDC shall be used to determine reimbursement.

Supplies are considered integral to the package are not separately reimbursable.

(c) Reimbursement for an opiate antagonist prescribed or dispensed under §§ 12-36-117.7, 12-38-125.5, 12-42.5-120, 13-21-108.7, to an injured worker at risk of experiencing an opiate-related drug overdose event, or to a family member, friend, an employee or volunteer of a harm reduction organization, or other person in a position to assist the injured worker shall be AWP plus $4.00.

(d) Drugs administered in the course of the provider's direct care (injectables) shall be reimbursed at Medicare's Part B Drug Average Sale Price (ASP), unless the ASP value does not exist for the drug or the provider's actual cost exceeds the ASP. In this circumstance, provider may request reimbursement based on the actual cost, after taking into account any discounts/rebates the provider may have received.

(e) The provider may bill for the discarded portion of drug from a single use vial or a single use package, appending the JW modifier to the HCPCS Level II code. The provider shall bill for the discarded drug amount and the amount administered to the injured worker on two separate lines. The provider must document the discarded drug in the medical record.

(6) Prescription Strength Topical Compounds

In order to qualify as a compound under this section, the medication must require a prescription; the ingredients must be combined, mixed, or altered by a licensed pharmacist or a pharmacy technician being overseen by a licensed pharmacist, a licensed physician, or, in the case of an outsourcing facility, a person under the supervision of a licensed pharmacist; and it must create a medication tailored to the needs of an individual patient. All topical compounds shall be billed using the DoWC Z code corresponding with the applicable category as follows:

Category I Z0790, $81.60 per 30 day supply

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

Category II Z0791, $163.20 per 30 day supply

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

Category III Z0792, $270.30 per 30 day supply

Any single agent other than anti-inflammatory agent or local anesthetic, either alone, or in combination with anti-inflammatory or local anesthetic agents.

Category IV Z0793, $377.40 per 30 day supply

Two (2) or more agents that are not anti-inflammatory or local anesthetic agents, either alone or in combination with other anti-inflammatory or local anesthetic agents.

All ingredient materials must be listed by quantity used per prescription. If the Medical Treatment Guidelines approve some but not all of the active ingredients for a particular diagnosis, the insurer shall count only the number of the approved ingredients to determine the applicable category. In addition, initial prescription containing the approved ingredients shall be reimbursed without a medical review. Continued use (refills) may require documentation of effectiveness including functional improvement.

Category fees include materials, shipping and handling, and time. Regardless of how many ingredients or what type, compounded drugs cannot be reimbursed higher than the Category IV fee. The 30 day Maximum Fee Schedule value shall be fractioned down to the prescribed and dispensed amount given to the injured worker. Automatic refilling is not allowed.

(7) Over-the-Counter Medications

(a) Medications that are available for purchase by the general public without a prescription and listed as over-the-counter in publications such as RedBook Online, or Medispan, are reimbursed at NDC/AWP and are not eligible for dispensing fees. If drugs have been repackaged, use the original AWP and NDC that was assigned by the source of the repackaged drugs to determine reimbursement.

(b) The maximum reimbursement for any topical muscle relaxant, analgesic, anti-inflammatory and/or anti-neuritic medications containing only active ingredients available without a prescription shall be reimbursed at cost to the billing provider up to $30.00 per 30 day supply for any application (excludes patches). Maximum reimbursement for a patch is cost to the billing provider up to $70.00 per 30 day supply.

DoWC Z0794 per 30 day supply for any application (excludes patches).

DoWC Z0795 per 30 day supply for patches.

See subsection (6) for prescription-strength topicals and patches.

(8) Dietary Supplements, Vitamins and Herbal Medicines

Reimbursement for outpatient dietary supplements, vitamins and herbal medicines is authorized only by prior agreement of the payer or if specifically indicated in the Medical Treatment Guidelines. The reimbursement shall be at cost to the injured worker (see subsection (9) below).

(9) Injured Worker Reimbursement

In the event the injured worker has directly paid for authorized medications, the payer shall reimburse the injured worker for the amounts actually paid for authorized prescriptions or authorized over-the-counter drugs within 30 days after submission of the injured worker's receipt. See Rule 16.

(D) COMPLEMENTARY INTEGRATIVE MEDICINE

Complementary integrative medicine describes a broad range of treatment modalities, some of which are generally accepted in the medical community and others that remain

outside the accepted practice of conventional western medicine. Non-physician providers of complementary integrative medicine that are not listed in Rule 16 must have completed training in one (1) or more forms of therapy and certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in Chinese herbology.

(E) MEDICAL TRANSPORTATION

(1) Fee Schedule:

The fee schedule for medical transportation consists of a base rate and a payment for mileage. Both the transport of the injured worker to the nearest facility and all items and services associated with such transport are included in the base rate and mileage rate.

(2) General Claims Submission:

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

(b) Providers shall use HCPCS codes and origin/destination modifiers.

(c) Providers shall list their name, complete address and NPI number.

(d) Providers shall list the zip code for the origin (point of pickup) in Item 23 of the CMS-1500 or FL 39-41 of the UB-04 with an "AO" code. If billing for multiple trips and the zip code for each origin is the same, services can be submitted on the same claim. If the zip codes are different, a separate claim must be submitted for each trip.

(3) Ground Ambulance Services Billing Codes and Fees:

The selection of the base code is based upon the condition of the injured worker at the time of transport, not the vehicle used and includes services and supplies used during the transport.

HCPCS	Base Rate	URBAN BASE RATE/ URBAN MILEAGE	RURAL BASE RATE/ RURAL MILEAGE	RURAL BASE RATE/ LOWEST QUARTILE	RURAL GROUND MILES
A0425	$18.50	$18.88	$19.05	n/a	$28.58
A0426	$574.78	$712.40	$719.38	$881.95	n/a
A0427	$574.78	$1,127.95	$1,139.00	$1,396.43	n/a
A0428	$574.78	$593.65	$599.48	$734.95	n/a
A0429	$574.78	$949.85	$959.18	$1,175.95	n/a
A0432	$574.78	$1,038.90	$1,049.08	n/a	n/a
A0433	$574.78	$1,632.55	$1,648.58	$2,021.15	n/a
A0434	$574.78	$1,929.38	$1,948.30	$2,388.63	n/a

The "urban" base rate(s) and mileage rate(s) shall apply to all relevant/applicable ambulance services unless the zip code range area is "Rural" or "Super Rural." Medicare MSA zip code grouping is listed on Medicare's webpage with an "R" indicator for "Rural"

and “B” indicator for “Super Rural.” See Medicare’s Zip Code to Carrier Locality File, updated May 15, 2019, available at https://www.cms.gov.

(4) Non-Emergent Medical Transportation Billing Codes:

The payer shall reimburse for non-emergent medical transportation of the injured worker to and from reasonable and necessary medical services. The payment shall be for the least expensive means appropriate for the injured worker’s condition.

Billing Code	Billing Code Description	Unit
A0130	Wheelchair Van Base Rate	One Way Trip
S0209	Wheelchair Van Mileage	Per Mile
T2005	Stretcher Van Base Rate	One Way Trip
T2049	Stretcher Van Mileage	Per Mile
A0120	Mobility Van Base Rate	One Way Trip

(5) Modifiers

Modifiers identify place of origin and destination of the trip. The modifier is to be placed next to the HCPCS code billed. The following is a list of current modifiers. Each of the modifiers may be utilized to make up the first and/or second half of a two-letter modifier. The first letter must describe the origin of the transport, and the second letter must describe the destination (Example: if a patient is picked up at his/her home and transported to the hospital, the modifier to describe the origin and destination would be RH).

Code	**Description**
D	Diagnostic or therapeutic site other than “P” or “H”
E	Residential, domiciliary, custodial facility, nursing home other than a skilled nursing facility
G	Hospital-based dialysis facility (hospital or hospital-related) which includes: - Hospital administered/Hospital located - Non-Hospital administered/Hospital located
GM	Multiple patients on one ambulance trip
H	Hospital
I	Site of transfer (i.e., airport, ferry, or helicopter pad) between modes of ambulance transport

J	Non-hospital-based dialysis facility - Hospital administered/Hospital located - Non-Hospital administered/Hospital located
N	Skilled Nursing Facility
P	Physician's Office (includes non-hospital facility, clinic, etc.)
QL	Patient pronounced dead after ambulance called.
QM	Ambulance service under arrangement by a provider of service
QN	Ambulance service furnished directly by a provider of service.
R	Residence
S	Scene of Accident or Acute Event
X	Destination Code Only (Intermediate stop at physician's office en route to the hospital, includes non-hospital facility, clinic, etc.)

(6) Mileage

Charges for mileage must be based on loaded mileage only, i.e., from the pickup of a patient to his/her arrival at the destination. The miles billed must be in whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number.

18-7 DIVISION ESTABLISHED CODES AND VALUES

(A) FACE-TO-FACE OR TELEPHONIC MEETINGS

(1) Face-to-face or telephonic meeting by a treating physician (as defined by Rule 16 or a psychologist (PsyD, PhD, or EdD) with an employer, claim representative, or any attorney, and with or without the injured worker. Claim representatives include physicians or other qualified medical personnel performing payer-initiated medical treatment reviews, but this Rule does not apply to provider-initiated requests for prior authorization. The physician or psychologist may bill for the time spent attending the meeting and preparing the report (no travel time or mileage is separately payable). The fee includes the cost of the report for all parties, including the injured worker.

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

(a) Each meeting (including the time to document) shall be a minimum of 8 minutes.

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

(i) Who was present at the meeting and their role at the meeting;
(ii) Purpose of the meeting;

(iii) A brief statement of recommendations and actions at the conclusion of the meeting;
(iv) Documented time (both start and end times).

(c) DoWC Z0701, $43.35, is payable in 8-minute increments. The CPT® mid-point rule for attaining a unit of time does not apply to this code. The physician or psychologist may bill multiple units of this code per date of service.

(d) For reimbursement to qualified non-physician providers for coordination of care with medical professionals, see section 18-4(H).

(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.

DoWC Z0601, $75.48 per 15 minutes billed to the requesting party.

(3) Face-to-face or telephonic meeting by a non-treating physician with the employer, claim representatives or any attorney to provide a medical opinion on a specific workers' compensation case, which is accompanied by a report or written record, shall be billed as a special report (see section 18-6(G)(4)).

(4) Peer-to-peer review by a treating physician with a medical reviewer, following the treating physician's complete prior authorization request pursuant to Rule 16.

DoWC Z0602, $75.48 per 15 minutes billed to the requesting party.

(B) CANCELLATION FEES FOR PAYER-MADE APPOINTMENTS

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

The payer shall pay one-half of the usual fee for the scheduled services, or $183.60, whichever is less:

DoWC Z0720. The provider shall indicate the code corresponding to the service that has been cancelled in Box 19 of the CMS-1500 form or electronic billing equivalent.

For payer-made appointments scheduled for four (4) hours or longer, the payer shall pay one-half of the usual fee for the scheduled service.

DoWC Z0740. The provider shall indicate the code corresponding to the service that has been cancelled in Box 19 of the CMS-1500 form or electronic billing equivalent.

(2) Missed Appointments:

When claimants fail to keep scheduled appointments, the provider should contact the payer within two (2) business days. Upon reporting the missed appointment, the provider may inquire if the payer wishes to reschedule the appointment for the

claimant. If the claimant fails to keep the payer's rescheduled appointment, the provider may bill for a cancellation fee according to this section.

(C) COPYING FEES

The payer, payer's representative, injured worker and injured worker's representative shall pay a reasonable fee for the reproduction of the injured worker's medical record. If the requester and provider agree, the copy may be provided on a disc. If the requester and provider agree and appropriate security is in place, including, but not limited to, compatible encryption, the copies may be submitted electronically. Requester and provider should attempt to agree on a reasonable fee. Absent an agreement to the contrary, the fee shall be $0.10 per page. Copying charges do not apply for the initial submission of records that are part of the required documentation for billing.

Copying Fee Billing Codes and Maximum Fees:

DoWC Z0721, $18.53 for first 10 or fewer paper page(s), including faxed documents

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

DoWC Z0726, $0.57 per paper page for remaining paper page(s), including faxed documents

DoWC Z0727, $1.50 per microfilm page

DoWC Z0728, $14.00 per computer disc or as agreed

DoWC Z0729, $0.10 per electronic page or as agreed

DoWC Z0802 actual postage paid

(D) DEPOSITION AND TESTIMONY FEES

(1) When requesting deposition or testimony from physicians or any other type of provider, guidance should be obtained from the Interprofessional Code, prepared by the Colorado Bar Association, the Denver Bar Association, the Colorado Medical Society, and the Denver Medical Society. If the parties cannot agree upon lesser fees for the deposition or testimony services, or cancellation time periods and/or fees, the deposition and testimony rules and fees listed below shall be used.

If a party shows good cause to an Administrative Law Judge (ALJ) for exceeding the Maximum Fee Schedule, that ALJ may allow a greater fee.

(2) By prior agreement, the provider may charge for preparation time for a deposition or testimony, for reviewing and signing the deposition or for preparation time for testimony.

Preparation Time:

Treating or non-treating physician as defined by Rule 16 or psychologist (PsyD, PhD, or EdD):

DoWC Z0730, $187.00, billed in half-hour increments. Other providers shall be paid 85% of this fee.

(3) Deposition:

Payment for testimony at a deposition shall not exceed $187.00, billed in half-hour increments, for a treating or non-treating physician as defined by Rule 16 or a psychologist (PsyD, PhD, or EdD). DoWC Z0734, calculating the provider's time from "portal to portal." Other providers shall be paid 85% of this fee.

If requested, the provider is entitled to a full hour deposit in advance in order to schedule the deposition.

If the provider is notified of the cancellation of the deposition at least ten (10) days prior to the scheduled deposition, the provider shall be paid the number of hours s/he has reasonably spent in preparation, less any deposit paid by the deposing party. DoWC Z0731, $187.00, in half-hour increments.

If the provider is notified less than ten (10) days in advance of a cancellation or rescheduling, or the deposition is shorter than the time scheduled, the provider shall be paid the number of hours s/he has reasonably spent in preparation and has scheduled for the deposition. DoWC Z0733, $187.00, in half-hour increments.

(4) Testimony:

Treating or non-treating physician as defined by Rule 16 or psychologist (PsyD, PhD, or EdD):

DoWC Z0738, $259.00, billed in half-hour increments. Other providers shall be paid 85% of this fee.

Calculation of the provider's time shall be "portal to portal" (includes travel time and mileage in both directions).

For testifying at a hearing, if requested, the provider is entitled to a four (4) hour deposit in advance in order to schedule the testimony.

If the provider is notified of the cancellation of the testimony at least ten (10) days prior to the scheduled testimony, the provider shall be paid the number of hours s/he has reasonably spent in preparation, less any deposit paid by the requesting party. DoWC Z0735, $259.00, in half-hour increments.

If the provider is notified less than ten (10) days in advance of a cancellation or rescheduling, or the testimony is shorter than the time scheduled, the provider shall be paid the number of hours s/he has reasonably spent in preparation and has scheduled for the testimony. DoWC Z0737, $259.00, in half-hour increments.

(E) INJURED WORKER TRAVEL EXPENSES

The payer shall reimburse the injured worker for reasonable and necessary mileage expenses for travel to and from medical appointments. The injured worker shall submit a

request to the payer showing the date(s) of travel and mileage, and explain any other reasonable and necessary travel expenses incurred or anticipated. The number of miles shall be in whole numbers and calculated using the most direct route available on the date of service. If a trip has a fraction of a mile, round up to the nearest whole number.

Mileage Expense: DoWC Z0723, 53 cents per mile

Other Travel Expenses: DoWC Z0724, actual paid

(F) PERMANENT IMPAIRMENT RATING

(1) The payer is only required to pay for one (1) combined whole-person permanent impairment rating per claim, except as otherwise provided in the Workers' Compensation Rules of Procedures. Exceptions that may require payment for an additional impairment rating include, but are not limited to, reopened cases, as ordered by the Director or an Administrative Law Judge, or a subsequent request to review apportionment. The ATP is required to submit in writing all permanent restrictions and future maintenance care related to the injury or occupational disease.

(2) Provider Restrictions

The Level II accredited authorized treating physician (see Rule 5) shall determine the permanent impairment rating.

(3) Maximum Medical Improvement (MMI) Determined Without any Permanent Impairment

If a physician determines the injured worker is at MMI and has no permanent impairment, the physician should be reimbursed for the examination at the appropriate level of E&M service. The authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient should complete the Physician's Report of Workers' Compensation Injury (Closing Report), WC 164 (see section 18-6(G)(2)).

(4) MMI Determined with a Calculated Permanent Impairment Rating

(a) Calculated Impairment: The total fee includes the office visit, a complete physical examination, complete history, review of all medical records except when the amount of medical records is extensive (see below), determining MMI, completing all required measurements, referencing all tables used to determine the rating, using all report forms from the AMA's Guide to the Evaluation of Permanent Impairment, Third Edition (Revised), (AMA Guides), and completing the Physician's Report of Workers' Compensation Injury (Closing Report) WC 164.

Extensive medical records take longer than one (1) hour to review and a separate report is created. The separate report must document each record reviewed, specific details of the records reviewed and the dates represented by the records reviewed. The separate record review can be billed under special reports for written reports only and requires prior authorization and agreement from the payer for the separate record review fees.

(b) DoWC codes:

(i) DoWC Z0759, $586.00, for the Level II Accredited Authorized Treating Physician Providing Primary Care.
(ii) DoWC Z0760, $790.00, for the Referral, Level II Accredited Authorized Physician (the claimant is not a previously established patient to that physician for that workers' compensation injury).
(iii) A return visit for a range of motion (ROM) validation shall be billed with the appropriate code in the Medicine Section of CPT®.
(iv) Multiple Impairment Evaluation Requiring More Than One Level II Accredited Physician:

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

(G) REPORT PREPARATION

(1) Routine Reports

Providers shall submit routine reports free of charge as directed in Rule 16 and by statute. Requests for additional copies of routine reports and for reports not in Rule 16 or statute are reimbursable under the copying fee section of this Rule. Routine reports include:

(a) Diagnostic testing
(b) Procedure reports
(c) Progress notes
(d) Office notes
(e) Operative reports
(f) Supply invoices, if requested by the payer

(2) Completion of the Physician's Report of Workers' Compensation Injury

(a) Initial Report WC 164

The authorized treating physician (ATP) (generally the designated physician) or emergency department/urgent care physician when applicable shall complete the first report of injury. Items 1-7 and 11 must be complete, however item 2 may be omitted if not known by the provider. If completed by a PA or NP, the ATP must countersign the form.

DoWC Z0750 Initial Report $50.00

(b) Closing Report WC 164

The ATP managing the workers' compensation claim must complete the WC 164 closing report when the injured worker is at maximum medical improvement (MMI) for all covered injuries or diseases, with or without a permanent impairment. Items 1-5, 6 B-C, and 7-11 must be complete. If completed by a PA or NP, the ATP must countersign the form.

DoWC Z0752 Closing Report $50.00

If the injured worker has sustained a permanent impairment, the following additional information must be attached to the bill when MMI is determined:

(i) All necessary permanent impairment rating reports, medical reports and narrative relied upon by the ATP, when the ATP managing the workers' compensation claim of the patient is Level II Accredited; or
(ii) The name of the Level II Accredited Physician requested to perform the permanent impairment rating when a rating is necessary and the ATP managing the workers' compensation claim is not determining the permanent impairment rating.

(c) Initial and Closing Report WC 164 completed on the same form for the same date of service: DoWC Z0753 $50.00

(d) Progress Report WC 164

Any request from the payer or the employer for the information provided on this form is deemed authorization for payment. The provider shall document who requested the WC 164, complete items 1, 2, 4-7, and 11, and send it to all parties within three business days of the request. If completed by a PA or NP, the ATP must countersign the form.

DoWC Z0751 Progress Report $50.00

(3) Form Completion

The requesting party shall pay for its request for physician to complete additional forms requiring 15 minutes or less, including forms sent by a payer or an employer. This code also may be billed when completing the requirements outlined in § 8-43-404(10)(a) or Desk Aid 15 for a non-medical discharge.

DoWC Z0754 Form Completion $50.00

(4) Special Reports

The term special report includes any form, questionnaire, letter or report with variable content not otherwise addressed in Rules. Examples include:

(a) treating or non-treating medical reviewers or evaluators producing written reports pertaining to injured workers not otherwise addressed,

(b) meeting with and reviewing another provider's written record, and amending or signing that record.

Billable Hours: Because narrative reports may have variable content, the content and total payment shall be agreed upon by the provider and the report's requester before the provider begins the report.

Advance Payment: If requested, the provider is entitled to a two (2) hour deposit in advance in order to schedule a patient exam associated with a special report.

DoWC Z0755 Written Report, $93.50 billable in 15 minute increments

DoWC Z0757 Lengthy Form, $93.50 billable in 15 minute increments

DoWC Z0758 Meeting and Report with Non-treating Physician, $93.50 billable in 15 minute increments

In cases of cancellation for those special reports not requiring a scheduled patient exam, the provider shall be paid for the time s/he has reasonably spent in preparation up to the date of cancellation.

DoWC Z0761 Report Preparation with Cancelled Patient Exam, $93.50 billable in 15 minute increments

(5) Independent Medical Examinations:

RIME: Respondent-requested Independent Medical Examination

DoWC Z0756 RIME Report with patient exam, $93.50 billable in 15 minute increments

Section 8-43-404 requires RIMEs to be recorded in audio in their entirety and retained by the examining physician for 12 months and made available by request to any party to the case.

DoWC Z0766 RIME Audio Recording, $35.00 per exam

DoWC Z0767 RIME Audio Copying Fee, $24.00 per copy

CIME: Claimant-requested Independent Medical Examination, $93.50 billable in 15 minute increments to the injured worker, DoWC Code Z0770

DIME: Division Independent Medical Examination - see Rule 11

All IME reports must be served concurrently to all parties no later than 20 calendar days after the examination.

Cancellations:

In cases of a cancelled or rescheduled RIME or CIME, the provider shall be paid the following fees:

If the provider is notified of the cancellation of the RIME or CIME at least ten (10) business days prior to the scheduled examination, the provider shall be paid the number of hours s/he has reasonably spent in preparation, less any deposit paid by the requesting party. DoWC Z0762, $93.50 billable in 15 minute increments.

If the provider is notified less than ten (10) business days in advance of a cancelled or rescheduled RIME or CIME, the provider shall be paid the number of hours s/he has reasonably spent in preparation and has scheduled for the examination. DoWC Z0763, $93.50 billable in 15 minute increments.

(H) USE OF AN INTERPRETER

Payers shall reimburse for the services of a qualified interpreter in specified settings if the injured worker does not proficiently speak or understand the English language.

A qualified interpreter must be provided via video or audio remote interpreting service or on-site appearance at complex medical treatment appointments, at behavioral health

appointments and when otherwise requested by the provider or injured worker. Providers may, but are not required to use bi-lingual staff to provide third party interpretation when a qualified interpreter is not available.

Qualified interpreter is defined as:

- a Certified Medical Interpreter, if this certification is available for the injured worker's language; or
- for all other languages, is fluent in English and the necessary target language, has knowledge of basic medical and/or legal terminology, and knowledge of health care interpreting ethics and standards of practice.

Providers are prohibited from relying on minor children and should refrain from using adult family members, and friends as interpreters. The exceptions are unavailability of a qualified interpreter in the case of "other" languages and in an emergency involving an imminent threat to the safety or welfare of an individual or the public.

Rates and terms shall be negotiated. Prior authorization is required except for emergency treatment. Non-qualified interpreters are not eligible for reimbursement. DoWC Z0722.

18-8 DENTAL FEE SCHEDULE

The dental fee schedule is adopted using the American Dental Association's Current Dental Terminology, 2019 (CDT® 2019). However, surgical treatment for dental trauma and subsequent related procedures shall be billed using medical codes from the RBRVS. If billed using RBRVS, reimbursement shall be in accordance with the values listed in the Surgery/Anesthesia section and the corresponding CF. See Exhibit #6 for the listing and Maximum Fee Schedule value for CDT® 2019 dental codes.

Regarding prosthetic appliances, the provider may bill and be reimbursed for 50% of the allowed fee at the time the master casts are prepared for removable prosthodontics or the final impressions are taken for fixed prosthodontics. The remaining 50% may be billed on insertion of the final prosthesis.

18-9 QUALITY INITIATIVES

(A) OPIOID MANAGEMENT

(1) Codes and maximum fees are payable to the prescribing ATP for a written report with all the following opioid review services completed and documented:

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

(b) ordering and reviewing Colorado Prescription Drug Monitoring Program (PDMP) results;

(c) reviewing the medical records;

(d) reviewing the injured worker's current functional status;

(e) evaluating the risk of misuse and abuse initially and periodically; and

(f) determining what actions, if any, need to be taken.

In determining the prescribed levels of medications, the ATP shall review and integrate the drug screening results required for subacute and chronic opioid management, as appropriate; the PDMP and its results; an evaluation of compliance with treatment and risk for addiction or misuse; as well as the injured worker's past and current functional status. A written report also must document the treating physician's assessment of the patient's past and current functional status of work, leisure, and activities of daily living.

The patient should initially and periodically be evaluated for risk of misuse or addiction. The ATP may consider whether the injured worker experienced an opiate-related drug overdose event that resulted in an opiate antagonist being prescribed or dispensed pursuant to §§ 12-36-117.7, 12-38-125.5, 12-42.5-120, or 13-21-108.7. If the patient is deemed to be at risk for an opiate overdose, an opioid antagonist may be prescribed (see section 18-6(C)(5)(c)).

Opioid Management Billing Codes:

Acute Phase:	DoWC Z0771, $85.00, per 15 minutes, maximum of 30 minutes per report
Subacute/Chronic Phase:	DoWC Z0765, $85.00, per 15 minutes, maximum of 30 minutes per report

(2) Definitions:

(a) Acute opioid use refers to the prescription of opioid medications (single or multiple) for duration of 30 days or less for non-traumatic injuries, or 6 weeks or less for traumatic injuries or post-operatively.

(b) Subacute opioid use refers to the prescription of opioid medications for longer than 30 days for non-surgical cases and longer than 6 weeks for traumatic injuries or post-operatively.

(c) Chronic Opioid use refers to the prescription of opioid medications for longer than 90 days.

(3) Acute opioid prescriptions generally should be limited to three (3) to seven (7) days and 50 morphine milliequivalents (MMEs) per day. Providers considering repeat opioid refills at any time during treatment are encouraged to perform the actions in this section and bill accordingly.

(4) When the ATP prescribes long-term opioid treatment, s/he shall comply with the Division's Chronic Pain Disorder Medical Treatment Guideline (Rule 17, Exhibit #9), and review the Colorado Medical Board Policy #40-26, "Policy for Prescribing and Dispensing Opioids."

(5) Urine drug tests are required for subacute and chronic opioid management and shall employ testing methodologies that meet or exceed industry standards for sensitivity, specificity, and accuracy. The test methodology must be capable of identifying and quantifying the parent compound and relevant metabolites of the opioid prescribed. In-office screening tests designed to screen for drugs of abuse

are not appropriate for subacute or chronic opioid compliance monitoring. Refer to section 18-4(F)(4) for clinical drug screening testing codes and values.

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

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

(i) Concern regarding the functional status of the patient;
(ii) Abnormal results on previous testing;
(iii) Change in management of dosage or pain; and
(iv) Chronic daily opioid dosage above 50 MMEs.

(B) FUNCTIONAL ASSESSMENTS

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

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

(b) Pre-and post-injection procedure shall have at least three (3) objective, diagnostically appropriate, functional measures identified, measured and documented. These may include spinal range of motion; tolerance and time limits for sitting, walking and lifting; straight leg raises for herniated discs; a variety of provocative SI joint maneuvers such as Patrick's sign, Gaenslen, distraction or gapping and compression tests. Objective descriptions, preferably with measurements, shall be provided initially and post procedure at the appropriate time for medication effect, usually 30 minutes post procedure.

(c) There shall be a trained physician or trained non-physician health care professional detailed report with a pre- and post-procedure pain diagram, normally using a 0-10 point scale. The patient(s) should be instructed to keep a post-injection pain diary that details the patient's pain level for all pertinent body parts, including any affected limbs. The patient pain diary should be kept for at least eight (8) hours post injection and preferably up to seven (7) days. The patient should be encouraged to also report any changes in activity level post injection.

(2) If all three (3) elements are documented, the billing codes and maximum fees are as follows:

DOWC Z0811, $63.00, per episode for the initial functional assessment of pre-injection care, billed with the appropriate E&M code, related to spinal or SI joint injections.

DOWC Z0812, $34.60, for a subsequent visit of therapeutic post-injection care (preferably done by a non-injectionist and at least seven (7) days after the injection), billed along with the appropriate E&M code, related to follow-up care of

spinal or SI joint injections. The injured worker should provide post injection pain data, including a pain diary.

DOWC Z0814, $34.60, for post-diagnostic injection care (repeat functional assessment within the time period for the effective agent given).

(C) QUALITY PERFORMANCE AND OUTCOMES PAYMENTS (QPOP)

(1) Medical providers who are Level I or II accredited, or who have completed the Division-sponsored Level I or II accreditation program and have successfully completed the QPOP training may bill separately for documenting functional progress made by the injured worker. The medical providers must utilize both a Division-approved psychological screen and a Division-approved functional tool. The psychological screen and the functional tool are approved by the Division and are validated for the specific purpose for which they have been created. The medical provider also must document whether the injured worker's perception of function correlates with clinical findings. The documentation of functional progress should assist the provider in preparing a successful plan of care, including specific goals and expected time frames for completion, or for modifying a prior plan of care. The documentation must include:

(a) Specific testing that occurred, interpretation of testing results, and the weight given to these results in forming a reasonable and necessary plan of care;
(b) Explanation of how the testing goes beyond the evaluation and management (E&M) services typically provided by the provider;
(c) Meaningful discussion of actual or expected functional improvement between the provider and the injured worker.

(2) Billing codes and maximum fees:

DOWC Z0815, $81.60, for the initial assessment during which the injured worker provides functional data and completes the validated psychological screen, which the provider considers in preparing a plan of care. This code also may be used for the final assessment that includes review of the functional gains achieved during the course of treatment and documentation of MMI.

DOWC Z0816, $40.80, for subsequent visits during which the injured worker provides follow-up functional data that could alter the treatment plan. The provider may use this code if the analysis of the data causes him or her to modify the treatment plan. The provider should not bill this code more than once every two (2) to four (4) weeks.

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

(D) PILOT PROGRAMS

Payers may submit a proposal to conduct a pilot program(s) to the Director for approval. Pilot programs authorized by this Rule shall be designed to improve quality of care, determine the efficacy of clinic or payment models, and to provide a basis for future development and expansion of such models.

The proposal for a pilot program shall meet the minimum standards set forth in § 8-43-602 and shall include:

(1) beginning and end date for the pilot program.

(2) population to be managed (e.g. size, specific diagnosis codes).

(3) provider group(s) participating in the program.

(4) proposed codes and fees.

(5) process for evaluating the program's success.

Participating payers must submit data and other information as required by the Division to examine such issues as the financial implications for providers and patients, enrollment patterns, utilization patterns, impact on health outcomes, system effects and the need for future health planning.

18-10 INDIGENCE STANDARDS

(A) A person shall be found to be indigent for purposes of Rule 11-12 only if:

(1) income is at or below eligibility guidelines with liquid assets of $1,500 or less; or

(2) income is up to 25% above the eligibility guidelines, liquid assets equal $1,500 or less, and the claimant's monthly expenses equal or exceed monthly income; or,

(3) "extraordinary circumstances" exist which merit a determination of indigence.

(B) Income Eligibility Guidelines:

Family Size	Monthly income guidelines	Monthly income guideline plus 25%
1	$1,301	$1,626
2	$1,761	$2,202
3	$2,222	$2,777
4	$2,682	$3,353
5	$3,143	$3,928
6	$3,603	$4,504
7	$4,064	$5,079
8	$4,524	$5,655

*For family units with more than eight members, add $460 per month for "monthly income" or $5,525, per year for "yearly income" for each additional family member.

(1) Income is gross income from all members of the household who contribute monetarily to the common support of the household.

(2) Liquid assets include cash on hand or in accounts, stocks, bonds, certificates of deposit, equity and personal property or investments which could readily be converted into cash without jeopardizing the applicant's ability to maintain home and employment. "Liquid assets" exclude any equity in any vehicle which the injured worker or his/her family must use for essential transportation unless the ALJ makes an affirmative finding of fact that the worker is credit worthy, can borrow against the equity in this vehicle, and can afford to pay back a loan without compromising food, clothing, shelter, and transportation needs.

(3) Expenses for nonessential items such as cable television, club memberships, entertainment, dining out, alcohol, cigarettes, etc. shall not be included.

18-11 LIST OF EXHIBITS

Exhibit #1 – MS-DRG Relative Weights

Exhibit #2 - Hospital Base Rates and Cost to Charge Ratios (CCRs)

Exhibit #3 - Critical Access Hospitals

Exhibit #4 - Hospital and ASC APCs

Exhibit #5 - Rural Health Clinics

Exhibit #6 - Dental Fee Schedule

Exhibit #7 - Evaluation and Management (E&M)

Exhibit #8 - Clinical Lab

Exhibit #1						
List of Medicare Severity Diagnosis-Related Groups (MS-DRGS), Relative Weighting Factors, and Geometric and Arithmetic Mean Length of Stay						
Source: CMS-1694-F Table 5						
Effective 1/1/2020						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geo-metric mean LOS**	**Arith-metic mean LOS**
001	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W MCC	26.4106	29.1	37.5
002	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W/O MCC	13.4227	15.1	18.0
003	PRE	SURG	ECMO OR TRACH W MV >96 HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	18.2974	23.4	30.1
004	PRE	SURG	TRACH W MV >96 HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	11.4192	19.5	23.6
005	PRE	SURG	LIVER TRANSPLANT W MCC OR INTESTINAL TRANSPLANT	10.2545	14.6	20.0
006	PRE	SURG	LIVER TRANSPLANT W/O MCC	4.8655	7.9	8.6
007	PRE	SURG	LUNG TRANSPLANT	10.6510	16.7	20.2
008	PRE	SURG	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	5.2490	8.9	10.1
010	PRE	SURG	PANCREAS TRANSPLANT	4.5139	7.8	8.5
011	PRE	SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES OR LARYNGECTOMY W MCC	4.9124	10.9	13.4
012	PRE	SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES OR LARYNGECTOMY W CC	3.8137	8.7	9.8
013	PRE	SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES OR LARYNGECTOMY W/O CC/MCC	2.3265	5.9	6.7
014	PRE	SURG	ALLOGENEIC BONE MARROW TRANSPLANT	11.9503	24.1	27.4
016	PRE	SURG	AUTOLOGOUS BONE MARROW TRANSPLANT W CC/MCC OR T-CELL IMMUNOTHERAPY	6.5394	17.1	18.4

017	PRE	SURG	AUTOLOGOUS BONE MARROW TRANSPLANT W/O CC/MCC	4.3811	7.9	10.7
020	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W MCC	10.4253	13.6	16.5
021	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W CC	7.9056	12.1	13.7
022	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W/O CC/MCC	5.1575	6.3	8.1
023	01	SURG	CRANIOTOMY W MAJOR DEVICE IMPLANT OR ACUTE COMPLEX CNS PDX W MCC OR CHEMOTHERAPY IMPLANT OR EPILEPSY W NEUROSTIMULATOR	5.4601	7.3	10.2
024	01	SURG	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W/O MCC	3.9194	4.3	5.7
025	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W MCC	4.2775	6.7	8.8
026	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W CC	3.0157	4.3	5.7
027	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W/O CC/MCC	2.4057	2.1	2.7
028	01	SURG	SPINAL PROCEDURES W MCC	5.3748	9.0	11.8
029	01	SURG	SPINAL PROCEDURES W CC OR SPINAL NEUROSTIMULATORS	3.1557	4.4	5.8
030	01	SURG	SPINAL PROCEDURES W/O CC/MCC	2.1757	2.3	3.0
031	01	SURG	VENTRICULAR SHUNT PROCEDURES W MCC	4.1829	7.2	10.1
032	01	SURG	VENTRICULAR SHUNT PROCEDURES W CC	2.3021	3.3	4.8
033	01	SURG	VENTRICULAR SHUNT PROCEDURES W/O CC/MCC	1.6877	1.8	2.3
034	01	SURG	CAROTID ARTERY STENT PROCEDURE W MCC	3.5998	4.7	6.8
035	01	SURG	CAROTID ARTERY STENT PROCEDURE W CC	2.2203	2.1	3.0
036	01	SURG	CAROTID ARTERY STENT PROCEDURE W/O CC/MCC	1.7260	1.2	1.4
037	01	SURG	EXTRACRANIAL PROCEDURES W MCC	3.2098	5.1	7.4
038	01	SURG	EXTRACRANIAL PROCEDURES W CC	1.6717	2.2	3.1
039	01	SURG	EXTRACRANIAL PROCEDURES W/O CC/MCC	1.1324	1.3	1.5

040	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W MCC	3.9282	7.6	10.7
041	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W CC OR PERIPH NEUROSTIM	2.3584	4.2	5.3
042	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W/O CC/MCC	1.8715	2.5	3.1
052	01	MED	SPINAL DISORDERS & INJURIES W CC/MCC	1.7004	4.1	5.8
053	01	MED	SPINAL DISORDERS & INJURIES W/O CC/MCC	0.9141	2.7	3.3
054	01	MED	NERVOUS SYSTEM NEOPLASMS W MCC	1.3166	3.8	5.1
055	01	MED	NERVOUS SYSTEM NEOPLASMS W/O MCC	1.0472	3.1	4.4
056	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS W MCC	2.1245	5.5	8.1
057	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS W/O MCC	1.2089	3.9	5.6
058	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W MCC	1.7596	5.0	6.9
059	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W CC	1.0993	3.7	4.5
060	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W/O CC/MCC	0.8327	3.0	3.5
061	01	MED	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA W THROMBOLYTIC AGENT W MCC	2.8477	5.0	6.5
062	01	MED	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA W THROMBOLYTIC AGENT W CC	1.9437	3.4	4.0
063	01	MED	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA W THROMBOLYTIC AGENT W/O CC/MCC	1.6280	2.4	2.7
064	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	1.8692	4.4	6.1
065	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	1.0315	3.1	3.8
066	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W/O CC/MCC	0.7268	2.1	2.5
067	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W MCC	1.5014	3.6	4.8

068	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W/O MCC	0.8987	2.3	2.8
069	01	MED	TRANSIENT ISCHEMIA W/O THROMBOLYTIC	0.7655	2.1	2.5
070	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W MCC	1.6453	4.5	6.2
071	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	0.9858	3.3	4.3
072	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC/MCC	0.7420	2.4	2.9
073	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W MCC	1.4111	3.7	5.1
074	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O MCC	0.9739	2.9	3.7
075	01	MED	VIRAL MENINGITIS W CC/MCC	1.4816	4.8	6.0
076	01	MED	VIRAL MENINGITIS W/O CC/MCC	0.8248	2.8	3.3
077	01	MED	HYPERTENSIVE ENCEPHALOPATHY W MCC	1.5520	4.1	5.2
078	01	MED	HYPERTENSIVE ENCEPHALOPATHY W CC	0.9701	3.1	3.8
079	01	MED	HYPERTENSIVE ENCEPHALOPATHY W/O CC/MCC	0.7465	2.1	2.5
080	01	MED	NONTRAUMATIC STUPOR & COMA W MCC	1.8788	4.5	6.8
081	01	MED	NONTRAUMATIC STUPOR & COMA W/O MCC	0.8546	2.7	3.7
082	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W MCC	2.1586	3.8	6.0
083	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W CC	1.2950	3.2	4.2
084	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W/O CC/MCC	0.9233	2.2	2.7
085	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W MCC	2.1800	4.7	6.5
086	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W CC	1.2431	3.2	4.1
087	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W/O CC/MCC	0.8453	2.1	2.6
088	01	MED	CONCUSSION W MCC	1.4796	3.6	4.7
089	01	MED	CONCUSSION W CC	1.0675	2.7	3.5
090	01	MED	CONCUSSION W/O CC/MCC	0.7934	1.9	2.3
091	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W MCC	1.6120	4.2	5.7

092	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.9433	3.0	3.8
093	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC/MCC	0.7378	2.2	2.7
094	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W MCC	3.6779	8.0	11.0
095	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W CC	2.3809	5.7	7.1
096	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W/O CC/MCC	2.1110	4.4	5.2
097	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W MCC	3.5389	8.4	11.4
098	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W CC	1.8505	5.4	6.9
099	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W/O CC/MCC	1.2729	3.7	4.7
100	01	MED	SEIZURES W MCC	1.8124	4.3	5.9
101	01	MED	SEIZURES W/O MCC	0.8693	2.7	3.4
102	01	MED	HEADACHES W MCC	1.0765	3.0	4.0
103	01	MED	HEADACHES W/O MCC	0.7814	2.3	3.0
113	02	SURG	ORBITAL PROCEDURES W CC/MCC	2.3027	4.5	6.2
114	02	SURG	ORBITAL PROCEDURES W/O CC/MCC	1.2551	2.3	2.9
115	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT	1.3621	3.5	4.5
116	02	SURG	INTRAOCULAR PROCEDURES W CC/MCC	1.7080	4.0	5.8
117	02	SURG	INTRAOCULAR PROCEDURES W/O CC/MCC	1.0025	2.3	3.1
121	02	MED	ACUTE MAJOR EYE INFECTIONS W CC/MCC	1.0593	4.0	5.2
122	02	MED	ACUTE MAJOR EYE INFECTIONS W/O CC/MCC	0.7058	3.2	4.1
123	02	MED	NEUROLOGICAL EYE DISORDERS	0.7529	2.0	2.5
124	02	MED	OTHER DISORDERS OF THE EYE W MCC	1.3313	3.6	4.9
125	02	MED	OTHER DISORDERS OF THE EYE W/O MCC	0.8102	2.6	3.3
129	03	SURG	MAJOR HEAD & NECK PROCEDURES W CC/MCC OR MAJOR DEVICE	2.4310	3.7	5.5
130	03	SURG	MAJOR HEAD & NECK PROCEDURES W/O CC/MCC	1.4912	2.3	2.9

131	03	SURG	CRANIAL/FACIAL PROCEDURES W CC/MCC	2.6284	4.2	5.7
132	03	SURG	CRANIAL/FACIAL PROCEDURES W/O CC/MCC	1.5286	2.0	2.5
133	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W CC/MCC	2.0986	4.0	5.8
134	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W/O CC/MCC	1.1987	2.0	2.5
135	03	SURG	SINUS & MASTOID PROCEDURES W CC/MCC	2.2982	4.4	6.4
136	03	SURG	SINUS & MASTOID PROCEDURES W/O CC/MCC	1.2125	1.8	2.8
137	03	SURG	MOUTH PROCEDURES W CC/MCC	1.3771	3.6	4.8
138	03	SURG	MOUTH PROCEDURES W/O CC/MCC	0.8452	2.0	2.4
139	03	SURG	SALIVARY GLAND PROCEDURES	1.1604	2.1	2.8
146	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W MCC	1.9231	5.3	7.4
147	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W CC	1.2505	3.7	5.2
148	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W/O CC/MCC	0.7238	2.1	2.8
149	03	MED	DYSEQUILIBRIUM	0.7111	2.0	2.5
150	03	MED	EPISTAXIS W MCC	1.3275	3.5	4.8
151	03	MED	EPISTAXIS W/O MCC	0.7038	2.2	2.8
152	03	MED	OTITIS MEDIA & URI W MCC	1.0421	3.2	4.1
153	03	MED	OTITIS MEDIA & URI W/O MCC	0.7118	2.4	2.9
154	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W MCC	1.4465	4.0	5.3
155	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W CC	0.8833	2.9	3.7
156	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W/O CC/MCC	0.6599	2.2	2.7
157	03	MED	DENTAL & ORAL DISEASES W MCC	1.6730	4.4	6.1
158	03	MED	DENTAL & ORAL DISEASES W CC	0.8903	2.8	3.6
159	03	MED	DENTAL & ORAL DISEASES W/O CC/MCC	0.6784	2.1	2.6
163	04	SURG	MAJOR CHEST PROCEDURES W MCC	4.9193	9.7	12.1
164	04	SURG	MAJOR CHEST PROCEDURES W CC	2.5689	4.8	5.9
165	04	SURG	MAJOR CHEST PROCEDURES W/O CC/MCC	1.8524	2.9	3.5
166	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	3.4980	7.9	10.2
167	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	1.8976	4.3	5.6

168	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC/MCC	1.3416	2.4	3.0
175	04	MED	PULMONARY EMBOLISM W MCC	1.4649	4.3	5.3
176	04	MED	PULMONARY EMBOLISM W/O MCC	0.8990	2.8	3.4
177	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	1.8408	5.5	6.8
178	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W CC	1.2744	4.3	5.3
179	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W/O CC/MCC	0.9215	3.2	4.0
180	04	MED	RESPIRATORY NEOPLASMS W MCC	1.6960	4.9	6.5
181	04	MED	RESPIRATORY NEOPLASMS W CC	1.1409	3.4	4.5
182	04	MED	RESPIRATORY NEOPLASMS W/O CC/MCC	0.7951	2.2	2.8
183	04	MED	MAJOR CHEST TRAUMA W MCC	1.4909	4.4	5.5
184	04	MED	MAJOR CHEST TRAUMA W CC	1.0044	3.2	3.8
185	04	MED	MAJOR CHEST TRAUMA W/O CC/MCC	0.7323	2.4	2.8
186	04	MED	PLEURAL EFFUSION W MCC	1.5595	4.4	5.8
187	04	MED	PLEURAL EFFUSION W CC	1.0540	3.3	4.1
188	04	MED	PLEURAL EFFUSION W/O CC/MCC	0.7672	2.4	3.0
189	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.2353	3.8	4.8
190	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1.1907	3.8	4.7
191	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	0.9139	3.1	3.7
192	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	0.7241	2.5	3.0
193	04	MED	SIMPLE PNEUMONIA & PLEURISY W MCC	1.3167	4.2	5.2
194	04	MED	SIMPLE PNEUMONIA & PLEURISY W CC	0.9002	3.3	3.9
195	04	MED	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	0.6868	2.6	3.1
196	04	MED	INTERSTITIAL LUNG DISEASE W MCC	1.6381	4.8	6.2
197	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.0017	3.3	4.0
198	04	MED	INTERSTITIAL LUNG DISEASE W/O CC/MCC	0.7585	2.5	3.1
199	04	MED	PNEUMOTHORAX W MCC	1.7828	5.3	6.9
200	04	MED	PNEUMOTHORAX W CC	1.0748	3.4	4.3
201	04	MED	PNEUMOTHORAX W/O CC/MCC	0.6989	2.4	3.0
202	04	MED	BRONCHITIS & ASTHMA W CC/MCC	0.9401	3.0	3.7
203	04	MED	BRONCHITIS & ASTHMA W/O CC/MCC	0.6970	2.4	2.9
204	04	MED	RESPIRATORY SIGNS & SYMPTOMS	0.7676	2.2	2.8

205	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W MCC	1.5179	4.0	5.4
206	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O MCC	0.8635	2.5	3.1
207	04	MED	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT >96 HOURS OR PERIPHERAL EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)	5.5965	12.0	13.9
208	04	MED	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <=96 HOURS	2.4374	4.9	6.7
215	05	SURG	OTHER HEART ASSIST SYSTEM IMPLANT	12.8861	5.2	8.7
216	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W MCC	9.8209	12.5	15.3
217	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W CC	6.3628	7.3	8.8
218	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W/O CC/MCC	5.9053	4.1	5.5
219	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W MCC	7.6916	9.1	11.1
220	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W CC	5.2053	6.1	6.7
221	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W/O CC/MCC	4.6074	4.2	4.8
222	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W MCC	8.1372	9.2	11.1
223	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W/O MCC	6.3562	5.3	6.4
224	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W MCC	7.4247	7.7	9.6
225	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W/O MCC	5.7194	4.1	4.8
226	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W MCC	6.8182	6.5	8.4
227	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W/O MCC	5.3167	3.1	4.1
228	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W MCC	6.5762	6.7	9.7

229	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W/O MCC	4.6484	3.4	4.7
231	05	SURG	CORONARY BYPASS W PTCA W MCC	8.3989	10.3	12.0
232	05	SURG	CORONARY BYPASS W PTCA W/O MCC	6.1604	8.0	8.8
233	05	SURG	CORONARY BYPASS W CARDIAC CATH W MCC	7.6377	11.5	12.9
234	05	SURG	CORONARY BYPASS W CARDIAC CATH W/O MCC	5.1472	8.1	8.6
235	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W MCC	5.8099	8.8	10.1
236	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W/O MCC	3.9263	6.0	6.5
239	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W MCC	4.7093	10.2	13.0
240	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W CC	2.7449	7.0	8.5
241	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W/O CC/MCC	1.5960	4.4	5.2
242	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W MCC	3.7369	5.4	7.0
243	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W CC	2.5543	3.3	4.0
244	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W/O CC/MCC	2.1108	2.3	2.7
245	05	SURG	AICD GENERATOR PROCEDURES	5.0121	4.4	6.1
246	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W DRUG-ELUTING STENT W MCC OR 4+ ARTERIES OR STENTS	3.2388	4.1	5.4
247	05	SURG	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	2.0771	2.2	2.6
248	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W NON-DRUG-ELUTING STENT W MCC OR 4+ ARTERIES OR STENTS	3.1726	4.7	6.3
249	05	SURG	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MCC	1.9901	2.4	3.0
250	05	SURG	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W MCC	2.5868	3.9	5.3
251	05	SURG	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W/O MCC	1.6778	2.2	2.7
252	05	SURG	OTHER VASCULAR PROCEDURES W MCC	3.2598	5.3	7.6
253	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.5943	4.1	5.4
254	05	SURG	OTHER VASCULAR PROCEDURES W/O CC/MCC	1.8100	2.3	2.8

255	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W MCC	2.5403	6.5	8.1
256	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W CC	1.7487	5.2	6.2
257	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W/O CC/MCC	1.1261	3.5	4.3
258	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT W MCC	2.9888	5.0	6.4
259	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT W/O MCC	2.0970	2.7	3.4
260	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W MCC	3.6195	6.8	9.2
261	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W CC	1.9918	3.3	4.2
262	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W/O CC/MCC	1.6309	2.3	2.7
263	05	SURG	VEIN LIGATION & STRIPPING	2.3922	4.2	6.3
264	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	3.1586	6.5	9.2
265	05	SURG	AICD LEAD PROCEDURES	3.1167	3.7	5.1
266	05	SURG	ENDOVASCULAR CARDIAC VALVE REPLACEMENT W MCC	7.1915	4.0	6.1
267	05	SURG	ENDOVASCULAR CARDIAC VALVE REPLACEMENT W/O MCC	5.8481	2.3	2.9
268	05	SURG	AORTIC AND HEART ASSIST PROCEDURES EXCEPT PULSATION BALLOON W MCC	6.7037	6.4	9.5
269	05	SURG	AORTIC AND HEART ASSIST PROCEDURES EXCEPT PULSATION BALLOON W/O MCC	4.1509	1.7	2.4
270	05	SURG	OTHER MAJOR CARDIOVASCULAR PROCEDURES W MCC	5.0617	6.6	9.5
271	05	SURG	OTHER MAJOR CARDIOVASCULAR PROCEDURES W CC	3.4938	4.3	5.8
272	05	SURG	OTHER MAJOR CARDIOVASCULAR PROCEDURES W/O CC/MCC	2.6181	2.1	2.8
273	05	SURG	PERCUTANEOUS INTRACARDIAC PROCEDURES W MCC	3.6525	5.3	7.3
274	05	SURG	PERCUTANEOUS INTRACARDIAC PROCEDURES W/O MCC	2.9783	2.0	2.6
280	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC	1.6571	4.2	5.4

281	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W CC	0.9796	2.6	3.2
282	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W/O CC/MCC	0.7490	1.8	2.2
283	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W MCC	1.8047	3.0	4.8
284	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W CC	0.7666	1.7	2.3
285	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W/O CC/MCC	0.5964	1.3	1.6
286	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W MCC	2.1808	5.2	6.9
287	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O MCC	1.1389	2.4	3.0
288	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W MCC	2.6941	7.3	9.6
289	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W CC	1.7099	5.4	6.7
290	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W/O CC/MCC	1.0114	3.4	4.3
291	05	MED	HEART FAILURE & SHOCK W MCC OR PERIPHERAL EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)	1.3454	4.1	5.2
292	05	MED	HEART FAILURE & SHOCK W CC	0.9198	3.3	4.0
293	05	MED	HEART FAILURE & SHOCK W/O CC/MCC	0.6656	2.4	2.8
294	05	MED	DEEP VEIN THROMBOPHLEBITIS W CC/MCC	1.1608	3.4	4.4
295	05	MED	DEEP VEIN THROMBOPHLEBITIS W/O CC/MCC	0.5513	2.3	3.1
296	05	MED	CARDIAC ARREST, UNEXPLAINED W MCC OR PERIPHERAL EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)	1.5355	2.0	3.2
297	05	MED	CARDIAC ARREST, UNEXPLAINED W CC	0.6524	1.3	1.5
298	05	MED	CARDIAC ARREST, UNEXPLAINED W/O CC/MCC	0.4825	1.1	1.2
299	05	MED	PERIPHERAL VASCULAR DISORDERS W MCC	1.4504	3.9	5.2
300	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	1.0237	3.3	4.1
301	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC/MCC	0.7262	2.3	2.8
302	05	MED	ATHEROSCLEROSIS W MCC	1.0695	2.7	3.6
303	05	MED	ATHEROSCLEROSIS W/O MCC	0.6655	1.9	2.3

304	05	MED	HYPERTENSION W MCC	1.0811	3.0	3.9
305	05	MED	HYPERTENSION W/O MCC	0.7199	2.2	2.7
306	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS W MCC	1.4088	3.8	5.2
307	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS W/O MCC	0.8560	2.4	3.1
308	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W MCC	1.2036	3.6	4.6
309	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.7635	2.5	3.0
310	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC/MCC	0.5623	1.9	2.2
311	05	MED	ANGINA PECTORIS	0.6872	1.9	2.4
312	05	MED	SYNCOPE & COLLAPSE	0.8015	2.3	2.9
313	05	MED	CHEST PAIN	0.7073	1.7	2.1
314	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W MCC	2.0231	4.8	6.5
315	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.9559	2.8	3.6
316	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC/MCC	0.7513	2.0	2.4
326	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W MCC	5.2559	10.1	13.5
327	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W CC	2.4843	4.9	6.7
328	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W/O CC/MCC	1.5421	2.2	2.8
329	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W MCC	4.9927	10.8	13.4
330	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	2.5233	6.2	7.4
331	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1.6947	3.7	4.2
332	06	SURG	RECTAL RESECTION W MCC	3.3982	6.9	8.8
333	06	SURG	RECTAL RESECTION W CC	1.9278	4.4	5.4
334	06	SURG	RECTAL RESECTION W/O CC/MCC	1.3062	2.4	2.9
335	06	SURG	PERITONEAL ADHESIOLYSIS W MCC	4.0620	10.1	12.3
336	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.2982	6.3	7.7
337	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC/MCC	1.6033	3.9	4.8
338	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W MCC	2.8648	6.6	8.2
339	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	1.7406	4.3	5.2

340	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC/MCC	1.1878	2.4	2.9
341	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W MCC	2.2845	4.6	6.3
342	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.4188	2.7	3.5
343	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC/MCC	1.0853	1.7	2.0
344	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W MCC	2.9872	7.6	10.1
345	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.6376	4.6	5.7
346	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1.2366	3.2	3.8
347	06	SURG	ANAL & STOMAL PROCEDURES W MCC	2.4111	5.7	7.8
348	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.4000	3.6	4.7
349	06	SURG	ANAL & STOMAL PROCEDURES W/O CC/MCC	0.9497	2.1	2.6
350	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W MCC	2.4465	5.1	6.9
351	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W CC	1.5001	3.4	4.1
352	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W/O CC/MCC	1.0535	2.1	2.5
353	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W MCC	2.9659	6.0	7.8
354	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W CC	1.7310	3.8	4.7
355	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W/O CC/MCC	1.3548	2.5	3.0
356	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W MCC	3.9757	7.8	10.3
357	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.1367	4.7	5.9
358	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	1.3483	2.8	3.5
368	06	MED	MAJOR ESOPHAGEAL DISORDERS W MCC	1.9440	4.7	6.2
369	06	MED	MAJOR ESOPHAGEAL DISORDERS W CC	1.1088	3.2	3.9
370	06	MED	MAJOR ESOPHAGEAL DISORDERS W/O CC/MCC	0.7433	2.2	2.8
371	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W MCC	1.7388	5.4	7.0

372	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC	1.0384	4.0	4.9
373	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W/O CC/MCC	0.7576	3.1	3.7
374	06	MED	DIGESTIVE MALIGNANCY W MCC	2.0650	5.6	7.5
375	06	MED	DIGESTIVE MALIGNANCY W CC	1.2067	3.7	4.8
376	06	MED	DIGESTIVE MALIGNANCY W/O CC/MCC	0.9157	2.5	3.1
377	06	MED	G.I. HEMORRHAGE W MCC	1.7888	4.5	5.7
378	06	MED	G.I. HEMORRHAGE W CC	0.9903	3.0	3.6
379	06	MED	G.I. HEMORRHAGE W/O CC/MCC	0.6532	2.1	2.5
380	06	MED	COMPLICATED PEPTIC ULCER W MCC	1.9460	5.1	6.6
381	06	MED	COMPLICATED PEPTIC ULCER W CC	1.0950	3.3	4.0
382	06	MED	COMPLICATED PEPTIC ULCER W/O CC/MCC	0.7678	2.5	2.9
383	06	MED	UNCOMPLICATED PEPTIC ULCER W MCC	1.3510	4.0	5.0
384	06	MED	UNCOMPLICATED PEPTIC ULCER W/O MCC	0.8553	2.6	3.2
385	06	MED	INFLAMMATORY BOWEL DISEASE W MCC	1.6979	5.3	7.3
386	06	MED	INFLAMMATORY BOWEL DISEASE W CC	0.9801	3.5	4.4
387	06	MED	INFLAMMATORY BOWEL DISEASE W/O CC/MCC	0.6967	2.8	3.3
388	06	MED	G.I. OBSTRUCTION W MCC	1.5307	4.8	6.4
389	06	MED	G.I. OBSTRUCTION W CC	0.8432	3.3	4.0
390	06	MED	G.I. OBSTRUCTION W/O CC/MCC	0.5910	2.5	2.9
391	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W MCC	1.2215	3.7	4.9
392	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	0.7554	2.6	3.2
393	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W MCC	1.6326	4.4	6.1
394	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W CC	0.9411	3.1	4.0
395	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W/O CC/MCC	0.6765	2.3	2.8
405	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W MCC	5.3791	9.6	12.8
406	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	2.8326	5.6	7.0
407	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC/MCC	2.0068	3.8	4.5
408	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W MCC	4.0465	9.2	11.9

409	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	2.3227	5.6	6.9
410	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC/MCC	1.6526	3.7	4.5
411	07	SURG	CHOLECYSTECTOMY W C.D.E. W MCC	3.9981	8.3	11.1
412	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	2.3819	5.5	6.5
413	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC/MCC	1.6862	3.5	4.3
414	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W MCC	3.5772	8.0	9.8
415	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	2.0188	5.2	6.1
416	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC/MCC	1.3931	3.2	3.8
417	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W MCC	2.4234	5.4	6.7
418	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.6642	3.7	4.4
419	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC/MCC	1.3042	2.5	2.9
420	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W MCC	3.5176	7.7	10.5
421	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W CC	1.7791	4.1	5.4
422	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W/O CC/MCC	1.5076	2.8	3.4
423	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W MCC	3.9460	8.6	12.3
424	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W CC	2.1911	5.6	7.4
425	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W/O CC/MCC	1.4929	3.4	4.1
432	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W MCC	1.8260	4.7	6.4
433	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W CC	1.0279	3.3	4.2
434	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W/O CC/MCC	0.6511	2.3	2.8
435	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W MCC	1.6977	4.8	6.3
436	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W CC	1.1359	3.5	4.5

437	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W/O CC/MCC	0.8658	2.4	3.1
438	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W MCC	1.6382	4.6	6.3
439	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W CC	0.8623	3.2	4.0
440	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W/O CC/MCC	0.6213	2.5	2.9
441	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W MCC	1.8572	4.7	6.5
442	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	0.9389	3.2	4.1
443	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC/MCC	0.6958	2.5	3.0
444	07	MED	DISORDERS OF THE BILIARY TRACT W MCC	1.6109	4.4	5.7
445	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.0676	3.2	3.9
446	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC/MCC	0.7950	2.3	2.7
453	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W MCC	9.4969	7.6	9.7
454	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W CC	6.3368	4.0	4.7
455	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W/O CC/MCC	5.0000	2.6	3.0
456	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W MCC	9.1252	9.5	11.6
457	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W CC	6.5446	5.3	6.1
458	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W/O CC/MCC	5.1212	3.2	3.6
459	08	SURG	SPINAL FUSION EXCEPT CERVICAL W MCC	6.3848	6.3	7.9
460	08	SURG	SPINAL FUSION EXCEPT CERVICAL W/O MCC	4.0375	2.9	3.4
461	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W MCC	4.4825	5.6	6.7
462	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W/O MCC	3.1941	2.9	3.2
463	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W MCC	5.1319	9.8	13.0
464	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W CC	2.9440	5.5	7.0

465	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W/O CC/MCC	1.8374	2.7	3.5
466	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W MCC	5.1132	6.6	8.3
467	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W CC	3.4704	3.4	4.1
468	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W/O CC/MCC	2.7914	2.2	2.5
469	08	SURG	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W MCC OR TOTAL ANKLE REPLACEMENT	3.1742	4.9	6.2
470	08	SURG	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	1.9898	2.2	2.5
471	08	SURG	CERVICAL SPINAL FUSION W MCC	5.0107	6.3	8.6
472	08	SURG	CERVICAL SPINAL FUSION W CC	2.9468	2.4	3.2
473	08	SURG	CERVICAL SPINAL FUSION W/O CC/MCC	2.3729	1.5	1.8
474	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W MCC	3.7951	8.9	11.1
475	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W CC	2.1488	5.8	7.1
476	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W/O CC/MCC	1.1507	3.1	4.0
477	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	3.1384	8.2	10.2
478	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	2.2792	5.3	6.6
479	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	1.7980	3.4	4.2
480	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC	3.0304	6.4	7.5
481	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC	2.0623	4.4	4.8
482	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC	1.6645	3.5	3.7
483	08	SURG	MAJOR JOINT/LIMB REATTACHMENT PROCEDURE OF UPPER EXTREMITIES	2.3835	1.6	1.9
485	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W MCC	3.3041	8.0	9.6
486	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.2184	5.3	6.3

487	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC/MCC	1.6502	3.7	4.2
488	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION W CC/MCC	2.1125	3.8	5.0
489	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION W/O CC/MCC	1.2974	2.1	2.5
492	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W MCC	3.3905	6.1	7.7
493	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W CC	2.2461	4.0	4.8
494	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W/O CC/MCC	1.7539	2.7	3.2
495	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W MCC	3.4623	7.3	9.8
496	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W CC	1.9609	3.5	4.5
497	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W/O CC/MCC	1.4350	1.9	2.4
498	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W CC/MCC	2.2780	5.1	6.8
499	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W/O CC/MCC	1.1192	2.1	2.6
500	08	SURG	SOFT TISSUE PROCEDURES W MCC	3.0680	7.3	9.7
501	08	SURG	SOFT TISSUE PROCEDURES W CC	1.6874	4.2	5.2
502	08	SURG	SOFT TISSUE PROCEDURES W/O CC/MCC	1.2911	2.5	3.0
503	08	SURG	FOOT PROCEDURES W MCC	2.5622	6.8	8.5
504	08	SURG	FOOT PROCEDURES W CC	1.7295	4.8	5.8
505	08	SURG	FOOT PROCEDURES W/O CC/MCC	1.5798	2.8	3.4
506	08	SURG	MAJOR THUMB OR JOINT PROCEDURES	1.4103	3.8	4.8
507	08	SURG	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W CC/MCC	1.9425	4.5	5.9
508	08	SURG	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W/O CC/MCC	1.4474	2.1	2.6
509	08	SURG	ARTHROSCOPY	1.6703	4.4	5.6
510	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W MCC	2.7324	5.0	6.3
511	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W CC	1.8473	3.4	4.0
512	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W/O CC/MCC	1.5221	2.2	2.5

513	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W CC/MCC	1.6396	4.1	5.3
514	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W/O CC/MCC	0.9998	2.3	2.9
515	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W MCC	3.0820	6.4	8.3
516	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.8854	3.8	4.7
517	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC/MCC	1.3809	2.2	2.7
518	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W MCC OR DISC DEVICE/NEUROSTIM	3.1002	3.4	5.4
519	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W CC	1.8620	3.1	4.0
520	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC	1.3141	1.9	2.3
533	08	MED	FRACTURES OF FEMUR W MCC	1.5305	4.2	5.7
534	08	MED	FRACTURES OF FEMUR W/O MCC	0.7755	2.9	3.5
535	08	MED	FRACTURES OF HIP & PELVIS W MCC	1.2548	3.8	4.9
536	08	MED	FRACTURES OF HIP & PELVIS W/O MCC	0.7570	2.9	3.4
537	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W CC/MCC	0.9105	3.1	3.7
538	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W/O CC/MCC	0.7270	2.5	2.9
539	08	MED	OSTEOMYELITIS W MCC	2.0192	6.1	8.2
540	08	MED	OSTEOMYELITIS W CC	1.2969	4.5	5.7
541	08	MED	OSTEOMYELITIS W/O CC/MCC	0.8827	3.2	4.0
542	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W MCC	1.8253	5.2	6.9
543	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W CC	1.0725	3.7	4.6
544	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W/O CC/MCC	0.7984	2.8	3.3
545	08	MED	CONNECTIVE TISSUE DISORDERS W MCC	2.4791	5.6	8.0
546	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.2144	3.6	4.6
547	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC/MCC	0.8576	2.7	3.3
548	08	MED	SEPTIC ARTHRITIS W MCC	2.0672	6.1	7.8
549	08	MED	SEPTIC ARTHRITIS W CC	1.2442	4.1	5.1

550	08	MED	SEPTIC ARTHRITIS W/O CC/MCC	0.9238	3.0	3.6
551	08	MED	MEDICAL BACK PROBLEMS W MCC	1.5916	4.4	5.7
552	08	MED	MEDICAL BACK PROBLEMS W/O MCC	0.9010	3.0	3.6
553	08	MED	BONE DISEASES & ARTHROPATHIES W MCC	1.2376	3.9	5.0
554	08	MED	BONE DISEASES & ARTHROPATHIES W/O MCC	0.7569	2.8	3.4
555	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W MCC	1.2792	3.7	5.0
556	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC	0.7677	2.7	3.3
557	08	MED	TENDONITIS, MYOSITIS & BURSITIS W MCC	1.4324	4.6	5.7
558	08	MED	TENDONITIS, MYOSITIS & BURSITIS W/O MCC	0.8635	3.2	3.8
559	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	1.7987	4.8	6.6
560	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	1.0217	3.6	4.6
561	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	0.7561	2.7	3.5
562	08	MED	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W MCC	1.4081	4.1	5.2
563	08	MED	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W/O MCC	0.8381	3.0	3.4
564	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W MCC	1.5722	4.7	6.1
565	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W CC	0.9758	3.4	4.1
566	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W/O CC/MCC	0.7623	2.6	3.2
570	09	SURG	SKIN DEBRIDEMENT W MCC	3.0347	7.6	10.2
571	09	SURG	SKIN DEBRIDEMENT W CC	1.7029	5.2	6.5
572	09	SURG	SKIN DEBRIDEMENT W/O CC/MCC	1.1786	3.4	4.2
573	09	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W MCC	5.2515	10.7	15.3
574	09	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W CC	3.0459	7.5	10.4

575	09	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	1.7586	4.8	6.0
576	09	SURG	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W MCC	4.8807	8.4	12.8
577	09	SURG	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W CC	2.5092	4.7	6.9
578	09	SURG	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	1.5297	2.7	3.5
579	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W MCC	2.7978	6.5	8.8
580	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.5898	4.1	5.3
581	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC/MCC	1.2364	2.4	3.0
582	09	SURG	MASTECTOMY FOR MALIGNANCY W CC/MCC	1.5695	2.4	3.4
583	09	SURG	MASTECTOMY FOR MALIGNANCY W/O CC/MCC	1.3781	1.7	2.0
584	09	SURG	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W CC/MCC	1.8714	3.6	4.7
585	09	SURG	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W/O CC/MCC	1.5657	2.2	2.7
592	09	MED	SKIN ULCERS W MCC	1.7082	5.4	7.1
593	09	MED	SKIN ULCERS W CC	1.1294	4.2	5.3
594	09	MED	SKIN ULCERS W/O CC/MCC	0.8102	3.2	3.9
595	09	MED	MAJOR SKIN DISORDERS W MCC	1.9869	5.2	7.1
596	09	MED	MAJOR SKIN DISORDERS W/O MCC	1.0115	3.5	4.4
597	09	MED	MALIGNANT BREAST DISORDERS W MCC	1.7200	4.9	6.6
598	09	MED	MALIGNANT BREAST DISORDERS W CC	1.1623	3.5	4.7
599	09	MED	MALIGNANT BREAST DISORDERS W/O CC/MCC	0.7164	2.2	2.9
600	09	MED	NON-MALIGNANT BREAST DISORDERS W CC/MCC	0.9560	3.5	4.3
601	09	MED	NON-MALIGNANT BREAST DISORDERS W/O CC/MCC	0.6192	2.7	3.0
602	09	MED	CELLULITIS W MCC	1.4440	4.7	5.9
603	09	MED	CELLULITIS W/O MCC	0.8477	3.3	3.9
604	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W MCC	1.4168	3.9	5.0
605	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W/O MCC	0.8605	2.7	3.3

606	09	MED	MINOR SKIN DISORDERS W MCC	1.3808	4.2	5.8
607	09	MED	MINOR SKIN DISORDERS W/O MCC	0.8010	2.8	3.6
614	10	SURG	ADRENAL & PITUITARY PROCEDURES W CC/MCC	2.3636	3.5	4.8
615	10	SURG	ADRENAL & PITUITARY PROCEDURES W/O CC/MCC	1.4812	2.0	2.3
616	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W MCC	4.1352	10.1	12.7
617	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W CC	2.0736	5.9	7.0
618	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W/O CC/MCC	1.1593	3.5	4.3
619	10	SURG	O.R. PROCEDURES FOR OBESITY W MCC	2.9207	3.0	4.7
620	10	SURG	O.R. PROCEDURES FOR OBESITY W CC	1.8096	2.0	2.5
621	10	SURG	O.R. PROCEDURES FOR OBESITY W/O CC/MCC	1.5783	1.5	1.7
622	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W MCC	3.7980	8.7	12.0
623	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W CC	1.9232	5.5	6.6
624	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W/O CC/MCC	1.2960	3.3	4.0
625	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W MCC	2.7833	4.8	7.0
626	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W CC	1.6106	2.5	3.6
627	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W/O CC/MCC	1.0850	1.4	1.7
628	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W MCC	3.6750	7.3	10.0
629	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.3387	6.0	7.2
630	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC/MCC	1.5345	2.9	3.6
637	10	MED	DIABETES W MCC	1.3813	3.9	5.1
638	10	MED	DIABETES W CC	0.8722	2.9	3.6
639	10	MED	DIABETES W/O CC/MCC	0.6319	2.1	2.6

640	10	MED	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W MCC	1.1902	3.3	4.5
641	10	MED	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W/O MCC	0.7519	2.6	3.3
642	10	MED	INBORN AND OTHER DISORDERS OF METABOLISM	1.2635	3.2	4.3
643	10	MED	ENDOCRINE DISORDERS W MCC	1.6341	5.0	6.3
644	10	MED	ENDOCRINE DISORDERS W CC	1.0125	3.5	4.3
645	10	MED	ENDOCRINE DISORDERS W/O CC/MCC	0.7429	2.7	3.2
652	11	SURG	KIDNEY TRANSPLANT	3.3146	5.3	6.1
653	11	SURG	MAJOR BLADDER PROCEDURES W MCC	5.4890	10.5	13.5
654	11	SURG	MAJOR BLADDER PROCEDURES W CC	2.8733	6.2	7.3
655	11	SURG	MAJOR BLADDER PROCEDURES W/O CC/MCC	2.0772	3.7	4.4
656	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W MCC	3.3276	6.0	7.9
657	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W CC	1.9474	3.6	4.3
658	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W/O CC/MCC	1.5664	2.3	2.6
659	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W MCC	2.7271	6.1	8.2
660	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W CC	1.4476	3.2	4.2
661	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W/O CC/MCC	1.0728	2.0	2.3
662	11	SURG	MINOR BLADDER PROCEDURES W MCC	3.1787	7.3	10.3
663	11	SURG	MINOR BLADDER PROCEDURES W CC	1.6403	3.9	5.2
664	11	SURG	MINOR BLADDER PROCEDURES W/O CC/MCC	1.1857	2.0	2.4
665	11	SURG	PROSTATECTOMY W MCC	3.1788	8.2	10.5
666	11	SURG	PROSTATECTOMY W CC	1.7791	4.2	5.8
667	11	SURG	PROSTATECTOMY W/O CC/MCC	1.0804	2.2	2.8
668	11	SURG	TRANSURETHRAL PROCEDURES W MCC	2.8146	7.1	9.2
669	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.5825	4.0	5.2
670	11	SURG	TRANSURETHRAL PROCEDURES W/O CC/MCC	0.9635	2.1	2.6
671	11	SURG	URETHRAL PROCEDURES W CC/MCC	1.6835	3.9	5.3
672	11	SURG	URETHRAL PROCEDURES W/O CC/MCC	1.0569	1.9	2.3
673	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W MCC	3.5773	7.9	10.9

674	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W CC	2.3121	5.3	7.0
675	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W/O CC/MCC	1.6253	2.8	3.6
682	11	MED	RENAL FAILURE W MCC	1.5320	4.5	5.9
683	11	MED	RENAL FAILURE W CC	0.9190	3.2	4.0
684	11	MED	RENAL FAILURE W/O CC/MCC	0.6198	2.3	2.7
686	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W MCC	1.7176	5.1	6.8
687	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.0537	3.3	4.3
688	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC/MCC	0.7909	2.0	2.4
689	11	MED	KIDNEY & URINARY TRACT INFECTIONS W MCC	1.1116	3.9	4.8
690	11	MED	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	0.7941	3.0	3.6
691	11	MED	URINARY STONES W ESW LITHOTRIPSY W CC/MCC	1.6242	3.0	3.9
692	11	MED	URINARY STONES W ESW LITHOTRIPSY W/O CC/MCC	1.1306	2.0	2.4
693	11	MED	URINARY STONES W/O ESW LITHOTRIPSY W MCC	1.3236	3.8	5.1
694	11	MED	URINARY STONES W/O ESW LITHOTRIPSY W/O MCC	0.7021	2.1	2.6
695	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W MCC	1.1487	3.6	4.7
696	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W/O MCC	0.6886	2.4	3.0
697	11	MED	URETHRAL STRICTURE	0.9600	2.5	3.6
698	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W MCC	1.6151	4.9	6.2
699	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W CC	1.0279	3.4	4.2
700	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W/O CC/MCC	0.7597	2.5	3.1
707	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC/MCC	1.7914	2.3	3.2
708	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC/MCC	1.4065	1.3	1.4
709	12	SURG	PENIS PROCEDURES W CC/MCC	2.0318	3.6	5.8
710	12	SURG	PENIS PROCEDURES W/O CC/MCC	1.6695	1.7	2.2
711	12	SURG	TESTES PROCEDURES W CC/MCC	2.0835	5.2	7.2
712	12	SURG	TESTES PROCEDURES W/O CC/MCC	1.0768	2.4	2.9

713	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC/MCC	1.4634	2.9	4.2
714	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC/MCC	0.9105	1.7	2.1
715	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W CC/MCC	2.2099	5.4	7.6
716	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W/O CC/MCC	1.4630	1.5	1.8
717	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W CC/MCC	1.9543	4.2	5.8
718	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W/O CC/MCC	1.2326	2.5	3.0
722	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W MCC	1.6597	5.1	7.0
723	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W CC	1.1015	3.5	4.5
724	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.6892	1.9	2.5
725	12	MED	BENIGN PROSTATIC HYPERTROPHY W MCC	1.2143	4.0	5.1
726	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O MCC	0.7645	2.6	3.3
727	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W MCC	1.4380	4.7	6.0
728	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W/O MCC	0.7914	3.0	3.6
729	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W CC/MCC	1.0820	3.3	4.5
730	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W/O CC/MCC	0.5684	1.9	2.3
734	13	SURG	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W CC/MCC	2.3059	3.7	5.2
735	13	SURG	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W/O CC/MCC	1.3650	1.8	2.1
736	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W MCC	4.0306	8.9	11.6

737	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W CC	2.0314	4.6	5.4
738	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W/O CC/MCC	1.3923	2.8	3.1
739	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W MCC	3.5977	6.6	9.4
740	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.7429	3.0	4.0
741	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC/MCC	1.3278	1.7	2.0
742	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC/MCC	1.7140	3.0	3.9
743	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	1.1156	1.8	2.0
744	13	SURG	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W CC/MCC	1.6903	4.1	5.6
745	13	SURG	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W/O CC/MCC	1.0694	2.1	2.6
746	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES W CC/MCC	1.6777	3.5	5.1
747	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES W/O CC/MCC	0.9582	1.6	2.0
748	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	1.2940	1.6	2.0
749	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W CC/MCC	2.6020	5.7	7.8
750	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	1.2239	2.4	2.9
754	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W MCC	1.8414	5.2	7.1
755	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.0699	3.3	4.4
756	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.7801	2.2	2.6
757	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W MCC	1.4409	4.9	6.3
758	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W CC	1.0204	3.7	4.6
759	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.7107	2.6	3.2

760	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W CC/MCC	0.8717	2.6	3.3
761	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W/O CC/MCC	0.5494	1.8	2.1
768	14	SURG	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	1.1314	2.7	4.2
769	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	1.4579	3.2	4.3
770	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	1.0679	1.8	2.6
776	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.6590	2.5	3.1
779	14	MED	ABORTION W/O D&C	0.7543	1.7	2.7
783	14	SURG	CESAREAN SECTION W STERILIZATION W MCC	1.7455	4.6	6.3
784	14	SURG	CESAREAN SECTION W STERILIZATION W CC	1.1021	3.4	4.1
785	14	SURG	CESAREAN SECTION W STERILIZATION W/O CC/MCC	0.8455	2.7	3.0
786	14	SURG	CESAREAN SECTION W/O STERILIZATION W MCC	1.5548	4.4	5.9
787	14	SURG	CESAREAN SECTION W/O STERILIZATION W CC	1.0811	3.5	4.2
788	14	SURG	CESAREAN SECTION W/O STERILIZATION W/O CC/MCC	0.9007	3.0	3.2
789	15	MED	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.6637	1.8	1.8
790	15	MED	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	5.4863	17.9	17.9
791	15	MED	PREMATURITY W MAJOR PROBLEMS	3.7470	13.3	13.3
792	15	MED	PREMATURITY W/O MAJOR PROBLEMS	2.2608	8.6	8.6
793	15	MED	FULL TERM NEONATE W MAJOR PROBLEMS	3.8489	4.7	4.7
794	15	MED	NEONATE W OTHER SIGNIFICANT PROBLEMS	1.3623	3.4	3.4
795	15	MED	NORMAL NEWBORN	0.1844	3.1	3.1
796	14	SURG	VAGINAL DELIVERY W STERILIZATION/D&C W MCC	1.4682	3.4	5.0
797	14	SURG	VAGINAL DELIVERY W STERILIZATION/D&C W CC	0.8469	2.2	2.4

798	14	SURG	VAGINAL DELIVERY W STERILIZATION/D&C WO CC/MCC	0.8469	2.2	2.4
799	16	SURG	SPLENECTOMY W MCC	4.7016	8.3	11.0
800	16	SURG	SPLENECTOMY W CC	2.6268	4.7	6.1
801	16	SURG	SPLENECTOMY W/O CC/MCC	1.5563	2.5	2.8
802	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W MCC	3.3472	7.4	10.0
803	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W CC	1.7221	4.1	5.2
804	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W/O CC/MCC	1.2305	2.1	2.6
805	14	MED	VAGINAL DELIVERY W/O STERILIZATION/D&C W MCC	1.0232	3.0	4.1
806	14	MED	VAGINAL DELIVERY W/O STERILIZATION/D&C W CC	0.7074	2.4	2.7
807	14	MED	VAGINAL DELIVERY W/O STERILIZATION/D&C W/O CC/MCC	0.6140	2.1	2.2
808	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W MCC	2.1492	5.5	7.5
809	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W CC	1.2045	3.6	4.5
810	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W/O CC/MCC	0.9220	2.6	3.2
811	16	MED	RED BLOOD CELL DISORDERS W MCC	1.3560	3.7	4.9
812	16	MED	RED BLOOD CELL DISORDERS W/O MCC	0.8832	2.7	3.5
813	16	MED	COAGULATION DISORDERS	1.6115	3.7	4.9
814	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W MCC	1.6630	4.5	6.3
815	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.9777	3.1	3.9
816	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC/MCC	0.7216	2.2	2.7
817	14	SURG	OTHER ANTEPARTUM DIAGNOSES W O.R. PROCEDURE W MCC	2.5317	3.8	6.5
818	14	SURG	OTHER ANTEPARTUM DIAGNOSES W O.R. PROCEDURE W CC	1.3585	2.8	4.1
819	14	SURG	OTHER ANTEPARTUM DIAGNOSES W O.R. PROCEDURE W/O CC/MCC	0.8390	1.6	2.1
820	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W MCC	5.4437	10.9	15.2
821	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC	2.3943	4.3	6.1

822	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/O CC/MCC	1.2098	1.9	2.4
823	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER PROC W MCC	4.5246	10.4	13.8
824	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER PROC W CC	2.1944	5.3	7.1
825	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER PROC W/O CC/MCC	1.3590	2.5	3.5
826	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W MCC	4.9479	9.9	12.7
827	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC	2.2517	4.7	6.1
828	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC/MCC	1.6354	3.0	3.7
829	17	SURG	MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS W OTHER PROCEDURE W CC/MCC	3.1097	6.4	9.6
830	17	SURG	MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS W OTHER PROCEDURE W/O CC/MCC	1.4188	2.6	3.2
831	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O O.R. PROCEDURE W MCC	1.0281	3.2	4.5
832	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O O.R. PROCEDURE W CC	0.7188	2.5	3.6
833	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O O.R. PROCEDURE W/O CC/MCC	0.4803	1.9	2.5
834	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W MCC	5.5078	10.0	16.5
835	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W CC	2.1360	4.5	7.1
836	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W/O CC/MCC	1.2126	2.6	3.9
837	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX OR W HIGH DOSE CHEMO AGENT W MCC	5.3741	12.8	18.3
838	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX W CC OR HIGH DOSE CHEMO AGENT	2.3526	5.8	7.8
839	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX W/O CC/MCC	1.2559	4.5	4.9
840	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W MCC	3.2929	7.0	10.0
841	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.6348	4.2	5.7
842	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC/MCC	1.1211	2.9	3.8

843	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W MCC	1.8460	5.3	7.3
844	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.1788	3.7	4.9
845	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC/MCC	0.8662	2.6	3.4
846	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W MCC	2.8179	6.2	8.7
847	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W CC	1.3265	3.6	4.1
848	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W/O CC/MCC	0.9326	2.9	3.3
849	17	MED	RADIOTHERAPY	1.9702	5.0	7.0
853	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	5.0571	9.9	12.8
854	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W CC	2.2028	5.7	7.1
855	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W/O CC/MCC	1.5600	3.6	4.5
856	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W MCC	4.4883	8.9	12.0
857	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W CC	2.0567	5.4	6.7
858	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W/O CC/MCC	1.3801	3.7	4.5
862	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W MCC	1.8277	5.0	6.6
863	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W/O MCC	0.9848	3.5	4.3
864	18	MED	FEVER AND INFLAMMATORY CONDITIONS	0.8643	2.8	3.4
865	18	MED	VIRAL ILLNESS W MCC	1.3822	3.9	5.3
866	18	MED	VIRAL ILLNESS W/O MCC	0.8204	2.7	3.4
867	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W MCC	2.1329	5.6	7.6
868	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W CC	1.0769	3.6	4.6
869	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W/O CC/MCC	0.7679	2.7	3.3
870	18	MED	SEPTICEMIA OR SEVERE SEPSIS W MV >96 HOURS OR PERIPHERAL EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)	6.2953	12.4	14.4

871	18	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W MCC	1.8564	4.8	6.3
872	18	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W/O MCC	1.0529	3.7	4.4
876	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	3.3014	7.2	14.8
880	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	0.8111	2.6	3.6
881	19	MED	DEPRESSIVE NEUROSES	0.7585	3.8	5.0
882	19	MED	NEUROSES EXCEPT DEPRESSIVE	0.7750	3.2	4.4
883	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	1.3199	4.8	8.0
884	19	MED	ORGANIC DISTURBANCES & INTELLECTUAL DISABILITY	1.3479	4.3	6.7
885	19	MED	PSYCHOSES	1.1961	5.8	8.2
886	19	MED	BEHAVIORAL & DEVELOPMENTAL DISORDERS	0.9887	3.7	6.3
887	19	MED	OTHER MENTAL DISORDER DIAGNOSES	1.0645	3.0	4.7
894	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.5169	2.1	2.9
895	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY	1.4328	8.6	11.5
896	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W MCC	1.7468	4.9	6.9
897	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O MCC	0.8208	3.4	4.3
901	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W MCC	4.4649	9.2	13.7
902	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W CC	1.9204	4.9	6.6
903	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W/O CC/MCC	1.1639	2.9	3.7
904	21	SURG	SKIN GRAFTS FOR INJURIES W CC/MCC	3.2260	6.7	9.8
905	21	SURG	SKIN GRAFTS FOR INJURIES W/O CC/MCC	1.7692	3.5	4.8
906	21	SURG	HAND PROCEDURES FOR INJURIES	1.8432	2.8	4.7
907	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W MCC	4.2161	7.2	10.2
908	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	1.9928	4.0	5.2

909	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC/MCC	1.3254	2.5	3.1
913	21	MED	TRAUMATIC INJURY W MCC	1.4719	3.6	5.2
914	21	MED	TRAUMATIC INJURY W/O MCC	0.8378	2.5	3.2
915	21	MED	ALLERGIC REACTIONS W MCC	1.6769	3.7	4.9
916	21	MED	ALLERGIC REACTIONS W/O MCC	0.6353	1.8	2.2
917	21	MED	POISONING & TOXIC EFFECTS OF DRUGS W MCC	1.4737	3.5	4.8
918	21	MED	POISONING & TOXIC EFFECTS OF DRUGS W/O MCC	0.7787	2.3	3.1
919	21	MED	COMPLICATIONS OF TREATMENT W MCC	1.8243	4.3	6.0
920	21	MED	COMPLICATIONS OF TREATMENT W CC	1.0031	2.9	3.8
921	21	MED	COMPLICATIONS OF TREATMENT W/O CC/MCC	0.7066	2.2	2.7
922	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W MCC	1.5584	3.8	5.6
923	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O MCC	0.8698	2.7	3.9
927	22	SURG	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV >96 HRS W SKIN GRAFT	18.3845	22.2	29.0
928	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC/MCC	5.8756	10.7	15.0
929	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W/O CC/MCC	2.9722	5.8	7.9
933	22	MED	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV >96 HRS W/O SKIN GRAFT	2.8603	2.6	4.5
934	22	MED	FULL THICKNESS BURN W/O SKIN GRAFT OR INHAL INJ	1.8335	4.2	6.0
935	22	MED	NON-EXTENSIVE BURNS	1.8217	3.4	5.3
939	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W MCC	3.2787	6.5	9.4
940	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W CC	2.1745	3.7	5.0
941	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W/O CC/MCC	1.8514	2.3	3.0
945	23	MED	REHABILITATION W CC/MCC	1.3649	9.4	11.6
946	23	MED	REHABILITATION W/O CC/MCC	1.0427	7.1	7.9
947	23	MED	SIGNS & SYMPTOMS W MCC	1.2056	3.5	4.8
948	23	MED	SIGNS & SYMPTOMS W/O MCC	0.7802	2.6	3.3
949	23	MED	AFTERCARE W CC/MCC	1.1462	4.5	6.4
950	23	MED	AFTERCARE W/O CC/MCC	0.7449	3.4	4.8

951	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	0.7984	2.5	3.4
955	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	6.0969	7.4	10.8
956	24	SURG	LIMB REATTACHMENT, HIP & FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	3.7838	6.1	7.5
957	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W MCC	7.5985	9.7	13.6
958	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W CC	4.1798	7.0	8.7
959	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	2.4507	3.8	4.7
963	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W MCC	2.7950	5.3	8.0
964	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W CC	1.4749	4.0	4.9
965	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	0.9743	2.7	3.2
969	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE W MCC	5.5987	11.7	15.9
970	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE W/O MCC	2.7877	6.5	8.7
974	25	MED	HIV W MAJOR RELATED CONDITION W MCC	2.7230	6.4	9.0
975	25	MED	HIV W MAJOR RELATED CONDITION W CC	1.2899	4.1	5.3
976	25	MED	HIV W MAJOR RELATED CONDITION W/O CC/MCC	0.9386	3.1	3.9
977	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.1699	3.4	4.6
981		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	4.3705	8.4	11.4
982		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	2.4529	4.9	6.5
983		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.5691	2.5	3.3

987		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	3.3326	8.1	10.8
988		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W CC	1.6931	4.4	5.9
989		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.0407	2.1	2.8
998		**	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	.		
999		**	UNGROUPABLE	.		

Exhibit #2			
Base Rates and Cost-to-Charge Ratios			
Source: Medicare FY 2019 IPPS Impact File - Correction Notice (September 2018)			
Effective 1/1/2020			
Provider Number	**Name**	**Total CCR**	**Individual Hospital Base Rate**
060001	North Colorado Medical Center	0.268	$ 6,916.71
060003	Longmont United Hospital	0.323	$ 6,403.34
060004	Platte Valley Medical Center	0.42	$ 6,310.12
060006	Montrose Memorial Hospital	0.404	$ 6,128.68
060008	San Luis Valley Health	0.386	$ 5,640.01
060009	Lutheran Medical Center	0.235	$ 6,358.15
060010	Poudre Valley Hospital	0.302	$ 6,486.69
060011	Denver Health Medical Center	0.324	$ 8,168.44
060012	Centura Health-St Mary Corwin Medical Center	0.229	$ 6,805.17
060013	Mercy Regional Medical Center	0.287	$ 6,263.90
060014	Presbyterian St Lukes Medical Center	0.154	$ 6,891.45
060015	Centura Health-St Anthony Hospital	0.205	$ 6,352.69
060020	Parkview Medical Center Inc	0.164	$ 6,888.86
060022	University Colo Health Memorial Hospital Central	0.221	$ 6,412.84
060023	St Marys Medical Center	0.308	$ 6,577.63
060024	University Of Colorado Hospital Authority	0.169	$ 7,889.21
060027	Foothills Hospital	0.218	$ 6,300.19
060028	Saint Joseph Hospital	0.196	$ 6,988.66
060030	Mckee Medical Center	0.366	$ 6,349.59
060031	Centura Health-Penrose St Francis Health Services	0.212	$ 6,374.28
060032	Rose Medical Center	0.136	$ 6,722.61
060034	Swedish Medical Center	0.12	$ 6,526.34
060044	Colorado Plains Medical Center	0.264	$ 6,263.90

060049	Uchealth Yampa Valley Medical Center	0.539	$ 6,194.45
060054	Community Hospital	0.322	$ 6,255.63
060064	Centura Health-Porter Adventist Hospital	0.23	$ 6,258.23
060065	North Suburban Medical Center	0.115	$ 6,584.67
060071	Delta County Memorial Hospital	0.427	$ 5,092.53
060075	Valley View Hospital Association	0.414	$ 6,149.15
060076	Sterling Regional Medcenter	0.495	$ 6,263.90
060096	Vail Health Hospital	0.516	$ 6,201.69
060100	Medical Center Of Aurora, The	0.146	$ 6,452.67
060103	Centura Health-Avista Adventist Hospital	0.3	$ 6,310.12
060104	St Anthony North Health Campus	0.272	$ 7,190.28
060112	Sky Ridge Medical Center	0.115	$ 6,129.38
060113	Centura Health-Littleton Adventist Hospital	0.198	$ 6,176.75
060114	Parker Adventist Hospital	0.231	$ 6,233.61
060116	Good Samaritan Medical Center	0.21	$ 6,191.41
060117	Animas Surgical Hospital, Llc	0.356	$ 6,081.46
060118	St Anthony Summit Medical Center	0.338	$ 6,310.12
060119	Medical Center Of The Rockies	0.257	$ 6,148.60
060124	Orthocolorado Hospital At St Anthony Med Campus	0.184	$ 6,126.33
060125	Castle Rock Adventist Hospital	0.274	$ 6,194.40
060126	Banner Fort Collins Medical Center	0.535	$ 6,263.90
060127	Scl Health Community Hospital- Northglenn	0.223	$ 6,369.26

Exhibit #3	
Critical Access Hospitals	
Source: https://www.colorado.gov/pacific/cdphe/find-and-compare-facilities	
Effective 1/1/2020	
Hospital Name	**Location in Colorado**
Arkansas Valley Regional Medical Center	La Junta
Aspen Valley Hospital	Aspen
Centura Health - St Thomas More Hospital	Canon City
Colorado Canyons Hospital and Medical Center	Fruita
East Morgan County Hospital	Brush
Estes Park Medical Center	Estes Park
Grand River Hospital District	Rifle
Gunnison Valley Hospital	Gunnison
Haxtun Hospital District	Haxtun
Heart of the Rockies Regional Medical Center	Salida
Keefe Memorial Hospital	Cheyenne Wells
Kit Carson County Memorial Hospital	Burlington
Lincoln Community Hospital	Hugo
Melissa Memorial Hospital	Holyoke
Middle Park Medical Center	Kremmling/Granby
Mt San Rafael Hospital	Trinidad
Pagosa Springs Medical Center	Pagosa Springs
Pikes Peak Regional Hospital	Woodland Park
Pioneers Medical Center	Meeker
Prowers Medical Center	Lamar
Rangely District Hospital	Rangely
Rio Grande Hospital	Del Norte
San Luis Valley Hospital	La Jara
Sedgwick County Health Center	Julesburg
Southeast Colorado Hospital	Springfield
Southwest Memorial Hospital	Cortez
Spanish Peaks Regional Health Center	Walsenburg
St Vincent General Hospital District	Leadville
The Memorial Hospital	Craig
UC Health Pikes Peak Regional Hospital	Woodland Park
Weisbrod Memorial County Hospital	Eads
Wray Community District Hospital	Wray
Yuma District Hospital	Yuma

Exhibit #4				
Outpatient Surgery Facility Codes and Fees				
source: 2019 CN2 Addendum A.12212018				
Effective 1/1/2020				
APC	**Short Descriptor**	**Outpatient Hospital Rate (180% of Medicare $)**	**ASC Rate (85% of Hospital Rate)**	**Additional Instructions**
0701	Sr89 strontium	$ 2,704.24	$ 2,298.60	
0726	Dexrazoxane HCl injection	$ 413.87	$ 351.79	
0731	Sargramostim injection	$ 67.69	$ 57.54	
0736	Amphotericin b liposome inj	$ 86.52	$ 73.54	
0738	Rasburicase	$ 500.66	$ 425.56	
0751	Mechlorethamine hcl inj	$ 579.10	$ 492.24	
0752	Dactinomycin injection	$ 2,569.80	$ 2,184.33	
0759	Naltrexone, depot form	$ 5.86	$ 4.98	
0800	Leuprolide acetate	$ 2,148.60	$ 1,826.31	
0802	Etoposide oral	$ 136.01	$ 115.61	
0807	Aldesleukin injection	$ 7,448.66	$ 6,331.36	
0809	Bcg live intravesical vac	$ 253.11	$ 215.14	
0810	Goserelin acetate implant	$ 916.24	$ 778.80	
0812	Carmustine injection	$ 7,292.71	$ 6,198.80	
0820	Daunorubicin injection	$ 91.19	$ 77.51	
0823	Docetaxel injection	$ 2.72	$ 2.31	
0825	Nelarabine injection	$ 273.99	$ 232.89	
0836	Interferon alfa-2b inj	$ 61.46	$ 52.24	
0840	Inj melphalan hydrochl	$ 1,466.65	$ 1,246.65	
0843	Pegaspargase injection	$ 27,051.68	$ 22,993.93	
0844	Pentostatin injection	$ 3,773.31	$ 3,207.31	
0850	Streptozocin injection	$ 627.67	$ 533.52	
0851	Thiotepa injection	$ 1,334.84	$ 1,134.61	
0856	Porfimer sodium injection	$ 38,195.22	$ 32,465.94	
0858	Inj cladribine	$ 40.75	$ 34.64	
0864	Mitoxantrone hydrochl	$ 49.25	$ 41.86	
0873	Hyalgan supartz visco-3 dose	$ 153.55	$ 130.52	
0874	Synvisc or synvisc-one	$ 21.29	$ 18.10	
0875	Euflexxa inj per dose	$ 254.65	$ 216.45	
0877	Orthovisc inj per dose	$ 266.02	$ 226.12	
0887	Azathioprine parenteral	$ 412.84	$ 350.91	
0890	Lymphocyte immune globulin	$ 3,746.20	$ 3,184.27	
0901	Alpha 1 proteinase inhibitor	$ 8.03	$ 6.83	

0902	Injection,onabotulinumtoxinA	$ 11.05	$ 9.39	
0903	Cytomegalovirus imm IV /vial	$ 2,032.48	$ 1,727.61	
0910	Interferon beta-1b / .25 MG	$ 683.33	$ 580.83	
0925	Factor viii	$ 1.93	$ 1.64	
0927	Factor viii recombinant	$ 2.39	$ 2.03	
0928	Factor ix complex	$ 2.55	$ 2.17	
0929	Anti-inhibitor	$ 3.75	$ 3.19	
0931	Factor IX non-recombinant	$ 2.01	$ 1.71	
0932	Factor ix recombinant nos	$ 2.71	$ 2.30	
0943	Octagam injection	$ 66.10	$ 56.19	
0944	Gammagard liquid injection	$ 77.65	$ 66.00	
0946	Hepagam b im injection	$ 115.59	$ 98.25	
0947	Flebogamma injection	$ 63.12	$ 53.65	
0948	Gamunex-C/Gammaked	$ 71.09	$ 60.43	
0961	Albumin (human),5%, 50ml	$ 18.88	$ 16.05	
0963	Albumin (human), 5%, 250 ml	$ 94.41	$ 80.25	
0964	Albumin (human), 25%, 20 ml	$ 37.76	$ 32.10	
0965	Albumin (human), 25%, 50ml	$ 94.41	$ 80.25	
1015	Injection glatiramer acetate	$ 362.10	$ 307.79	
1064	I131 iodide cap, rx	$ 37.37	$ 31.76	
1083	Adalimumab injection	$ 2,323.96	$ 1,975.37	
1138	Hepagam b intravenous, inj	$ 115.59	$ 98.25	
1139	Protein c concentrate	$ 27.27	$ 23.18	
1142	Supprelin LA implant	$ 57,303.08	$ 48,707.62	
1150	I131 iodide sol, rx	$ 24.43	$ 20.77	
1166	Cytarabine liposome inj	$ 1,131.06	$ 961.40	
1168	Inj, temsirolimus	$ 132.76	$ 112.85	
1178	Busulfan injection	$ 18.67	$ 15.87	
1203	Verteporfin injection	$ 19.71	$ 16.75	
1207	Octreotide injection, depot	$ 357.32	$ 303.72	
1213	Antihemophilic viii/vwf comp	$ 1.79	$ 1.52	
1214	Inj IVIG privigen 500 mg	$ 71.34	$ 60.64	
1232	Mitomycin injection	$ 241.64	$ 205.39	
1235	Valrubicin injection	$ 2,391.60	$ 2,032.86	
1236	Levoleucovorin injection	$ 0.42	$ 0.36	
1237	Inj iron dextran	$ 25.30	$ 21.51	
1253	Triamcinolone A inj PRS-free	$ 6.94	$ 5.90	
1263	Antithrombin iii injection	$ 6.29	$ 5.35	
1268	Xyntha inj	$ 2.20	$ 1.87	
1274	Edetate calcium disodium inj	$ 10,069.96	$ 8,559.47	
1281	Bevacizumab injection	$ 3.57	$ 3.03	
1289	AbobotulinumtoxinA	$ 15.16	$ 12.89	
1295	Sm 153 lexidronam	$ 26,385.17	$ 22,427.39	

1296	Degarelix injection	$ 6.69	$ 5.69	
1297	Ferumoxytol, non-esrd	$ 1.76	$ 1.50	
1311	Canakinumab injection	$ 199.80	$ 169.83	
1312	Hizentra injection	$ 17.75	$ 15.09	
1327	Imiglucerase injection	$ 74.61	$ 63.42	
1340	Collagenase, clost hist inj	$ 81.09	$ 68.93	
1341	Amobarbital 125 MG inj	$ 101.92	$ 86.63	
1352	Wilate injection	$ 1.82	$ 1.55	
1353	Belimumab injection	$ 79.49	$ 67.57	
1408	Cyclophosphamide 100 MG inj	$ 74.90	$ 63.67	
1413	Lumizyme injection	$ 294.89	$ 250.66	
1415	Glassia injection	$ 8.38	$ 7.12	
1416	Factor xiii anti-hem factor	$ 14.81	$ 12.59	
1417	Gel-one	$ 967.25	$ 822.16	
1420	Aflibercept injection	$ 1,741.19	$ 1,480.01	
1421	Imported lipodox inj	$ 846.72	$ 719.71	
1426	Eribulin mesylate injection	$ 205.81	$ 174.94	
1431	Centruroides immune f(ab)	$ 8,267.04	$ 7,026.98	
1433	Calcitonin salmon injection	$ 4,733.15	$ 4,023.18	
1440	Inj desmopressin acetate	$ 22.69	$ 19.29	
1442	Non-HEU TC-99M add-on/dose	$ 18.00	$ 15.30	
1443	Icatibant injection	$ 646.21	$ 549.28	
1446	Visualization adjunct	$ 6.95	$ 5.91	
1458	Phentolaine mesylate inj	$ 707.12	$ 601.05	
1466	Inj, vincristine sul lip 1mg	$ 5,249.92	$ 4,462.43	
1467	Factor ix recombinan rixubis	$ 2.35	$ 2.00	
1468	Inj Aripiprazole Ext Rel 1mg	$ 9.43	$ 8.02	
1469	Inj filgrastim excl biosimil	$ 1.83	$ 1.56	
1471	Injection, Pertuzumab, 1 mg	$ 21.36	$ 18.16	
1472	Inj beta interferon im 1 mcg	$ 97.40	$ 82.79	
1474	Certolizumab pegol inj 1mg	$ 14.64	$ 12.44	
1475	Golimumab for iv use 1mg	$ 43.21	$ 36.73	
1476	Obinutuzumab inj	$ 112.74	$ 95.83	
1478	Inj human fibrinogen con nos	$ 2.10	$ 1.79	
1480	Elosulfase alfa, injection	$ 425.93	$ 362.04	
1482	Darbepoetin alfa, esrd use	$ 6.79	$ 5.77	
1485	Ferumoxytol, esrd use	$ 1.76	$ 1.50	
1486	Factor ix fc fusion recomb	$ 5.37	$ 4.56	
1488	Injection, ramucirumab	$ 103.82	$ 88.25	
1489	Injection, vedolizumab	$ 35.25	$ 29.96	
1490	Inj pembrolizumab	$ 88.83	$ 75.51	
1491	New Technology - Level 1A ($0-$10)	$ 9.00	$ 7.65	

1492	New Technology - Level 1B ($11-$20)	$ 27.90	$ 23.72	
1493	New Technology - Level 1C ($21-$30)	$ 45.90	$ 39.02	
1494	New Technology - Level 1D ($31-$40)	$ 63.90	$ 54.32	
1495	New Technology - Level 1E ($41-$50)	$ 81.90	$ 69.62	
1496	New Technology - Level 1A ($0-$10)	$ 9.00	$ 7.65	
1497	New Technology - Level 1B ($11-$20)	$ 27.90	$ 23.72	
1498	New Technology - Level 1C ($21-$30)	$ 45.90	$ 39.02	
1499	New Technology - Level 1D ($31-$40)	$ 63.90	$ 54.32	
1500	New Technology - Level 1E ($41-$50)	$ 81.90	$ 69.62	
1502	New Technology - Level 2 ($51 - $100)	$ 135.90	$ 115.52	
1503	New Technology - Level 3 ($101 - $200)	$ 270.90	$ 230.27	
1504	New Technology - Level 4 ($201 - $300)	$ 450.90	$ 383.27	
1505	New Technology - Level 5 ($301 - $400)	$ 630.90	$ 536.27	
1506	New Technology - Level 6 ($401 - $500)	$ 810.90	$ 689.27	
1507	New Technology - Level 7 ($501 - $600)	$ 990.90	$ 842.27	
1508	New Technology - Level 8 ($601 - $700)	$ 1,170.90	$ 995.27	
1509	New Technology - Level 9 ($701 - $800)	$ 1,350.90	$ 1,148.27	
1510	New Technology - Level 10 ($801 - $900)	$ 1,530.90	$ 1,301.27	
1511	New Technology - Level 11 ($901 - $1000)	$ 1,710.90	$ 1,454.27	
1512	New Technology - Level 12 ($1001 - $1100)	$ 1,890.90	$ 1,607.27	
1513	New Technology - Level 13 ($1101 - $1200)	$ 2,070.90	$ 1,760.27	
1514	New Technology - Level 14 ($1201- $1300)	$ 2,250.90	$ 1,913.27	

1515	New Technology - Level 15 ($1301 - $1400)	$ 2,430.90	$ 2,066.27	
1516	New Technology - Level 16 ($1401 - $1500)	$ 2,610.90	$ 2,219.27	
1517	New Technology - Level 17 ($1501-$1600)	$ 2,790.90	$ 2,372.27	
1518	New Technology - Level 18 ($1601-$1700)	$ 2,970.90	$ 2,525.27	
1519	New Technology - Level 19 ($1701-$1800)	$ 3,150.90	$ 2,678.27	
1520	New Technology - Level 20 ($1801-$1900)	$ 3,330.90	$ 2,831.27	
1521	New Technology - Level 21 ($1901-$2000)	$ 3,510.90	$ 2,984.27	
1522	New Technology - Level 22 ($2001-$2500)	$ 4,050.90	$ 3,443.27	
1523	New Technology - Level 23 ($2501-$3000)	$ 4,950.90	$ 4,208.27	
1524	New Technology - Level 24 ($3001-$3500)	$ 5,850.90	$ 4,973.27	
1525	New Technology - Level 25 ($3501-$4000)	$ 6,750.90	$ 5,738.27	
1526	New Technology - Level 26 ($4001-$4500)	$ 7,650.90	$ 6,503.27	
1527	New Technology - Level 27 ($4501-$5000)	$ 8,550.90	$ 7,268.27	
1528	New Technology - Level 28 ($5001-$5500)	$ 9,450.90	$ 8,033.27	
1529	New Technology - Level 29 ($5501-$6000)	$ 10,350.90	$ 8,798.27	
1530	New Technology - Level 30 ($6001-$6500)	$ 11,250.90	$ 9,563.27	
1531	New Technology - Level 31 ($6501-$7000)	$ 12,150.90	$ 10,328.27	
1532	New Technology - Level 32 ($7001-$7500)	$ 13,050.90	$ 11,093.27	
1533	New Technology - Level 33 ($7501-$8000)	$ 13,950.90	$ 11,858.27	
1534	New Technology - Level 34 ($8001-$8500)	$ 14,850.90	$ 12,623.27	
1535	New Technology - Level 35 ($8501-$9000)	$ 15,750.90	$ 13,388.27	
1536	New Technology - Level 36 ($9001-$9500)	$ 16,650.90	$ 14,153.27	

1537	New Technology - Level 37 ($9501-$10000)	$ 17,550.90	$ 14,918.27	
1539	New Technology - Level 2 ($51 - $100)	$ 135.90	$ 115.52	
1540	New Technology - Level 3 ($101 - $200)	$ 270.90	$ 230.27	
1541	New Technology - Level 4 ($201 - $300)	$ 450.90	$ 383.27	
1542	New Technology - Level 5 ($301 - $400)	$ 630.90	$ 536.27	
1543	New Technology - Level 6 ($401 - $500)	$ 810.90	$ 689.27	
1544	New Technology - Level 7 ($501 - $600)	$ 990.90	$ 842.27	
1545	New Technology - Level 8 ($601 - $700)	$ 1,170.90	$ 995.27	
1546	New Technology - Level 9 ($701 - $800)	$ 1,350.90	$ 1,148.27	
1547	New Technology - Level 10 ($801 - $900)	$ 1,530.90	$ 1,301.27	
1548	New Technology - Level 11 ($901 - $1000)	$ 1,710.90	$ 1,454.27	
1549	New Technology - Level 12 ($1001 - $1100)	$ 1,890.90	$ 1,607.27	
1550	New Technology - Level 13 ($1101 - $1200)	$ 2,070.90	$ 1,760.27	
1551	New Technology - Level 14 ($1201- $1300)	$ 2,250.90	$ 1,913.27	
1552	New Technology - Level 15 ($1301 - $1400)	$ 2,430.90	$ 2,066.27	
1553	New Technology - Level 16 ($1401 - $1500)	$ 2,610.90	$ 2,219.27	
1554	New Technology - Level 17 ($1501-$1600)	$ 2,790.90	$ 2,372.27	
1555	New Technology - Level 18 ($1601-$1700)	$ 2,970.90	$ 2,525.27	
1556	New Technology - Level 19 ($1701-$1800)	$ 3,150.90	$ 2,678.27	
1557	New Technology - Level 20 ($1801-$1900)	$ 3,330.90	$ 2,831.27	
1558	New Technology - Level 21 ($1901-$2000)	$ 3,510.90	$ 2,984.27	
1559	New Technology - Level 22 ($2001-$2500)	$ 4,050.90	$ 3,443.27	

1560	New Technology - Level 23 ($2501-$3000)	$ 4,950.90	$ 4,208.27	
1561	New Technology - Level 24 ($3001-$3500)	$ 5,850.90	$ 4,973.27	
1562	New Technology - Level 25 ($3501-$4000)	$ 6,750.90	$ 5,738.27	
1563	New Technology - Level 26 ($4001-$4500)	$ 7,650.90	$ 6,503.27	
1564	New Technology - Level 27 ($4501-$5000)	$ 8,550.90	$ 7,268.27	
1565	New Technology - Level 28 ($5001-$5500)	$ 9,450.90	$ 8,033.27	
1566	New Technology - Level 29 ($5501-$6000)	$ 10,350.90	$ 8,798.27	
1567	New Technology - Level 30 ($6001-$6500)	$ 11,250.90	$ 9,563.27	
1568	New Technology - Level 31 ($6501-$7000)	$ 12,150.90	$ 10,328.27	
1569	New Technology - Level 32 ($7001-$7500)	$ 13,050.90	$ 11,093.27	
1570	New Technology - Level 33 ($7501-$8000)	$ 13,950.90	$ 11,858.27	
1571	New Technology - Level 34 ($8001-$8500)	$ 14,850.90	$ 12,623.27	Also map CPT® 22849, 22850, 22852, and 22855 to this APC value.
1572	New Technology - Level 35 ($8501-$9000)	$ 15,750.90	$ 13,388.27	
1573	New Technology - Level 36 ($9001-$9500)	$ 16,650.90	$ 14,153.27	
1574	New Technology - Level 37 ($9501-$10000)	$ 17,550.90	$ 14,918.27	
1575	New Technology - Level 38 ($10,001-$15,000)	$ 22,500.90	$ 19,125.77	Also map CPT® 23472, 23474, 27130, 27132, 27134, 27137, 27138, 27447, and 27702 to this APC value.
1576	New Technology - Level 39 ($15,001-$20,000)	$ 31,500.90	$ 26,775.77	
1577	New Technology - Level 40 ($20,001-$25,000)	$ 40,500.90	$ 34,425.77	
1578	New Technology - Level 41 ($25,001-$30,000)	$ 49,500.90	$ 42,075.77	

1579	New Technology - Level 42 ($30,001-$40,000)	$ 63,000.90	$ 53,550.77	
1580	New Technology - Level 43 ($40,001-$50,000)	$ 81,000.90	$ 68,850.77	
1581	New Technology - Level 44 ($50,001-$60,000)	$ 99,000.90	$ 84,150.77	
1582	New Technology - Level 45 ($60,001-$70,000)	$ 117,000.90	$ 99,450.77	
1583	New Technology - Level 46 ($70,001-$80,000)	$ 135,000.90	$ 114,750.77	
1584	New Technology - Level 47 ($80,001-$90,000)	$ 153,000.90	$ 130,050.77	
1585	New Technology - Level 48 ($90,001-$100,000)	$ 171,000.90	$ 145,350.77	
1589	New Technology - Level 38 ($10,001-$15,000)	$ 22,500.90	$ 19,125.77	
1590	New Technology - Level 39 ($15,001-$20,000)	$ 31,500.90	$ 26,775.77	
1591	New Technology - Level 40 ($20,001-$25,000)	$ 40,500.90	$ 34,425.77	
1592	New Technology - Level 41 ($25,001-$30,000)	$ 49,500.90	$ 42,075.77	
1593	New Technology - Level 42 ($30,001-$40,000)	$ 63,000.90	$ 53,550.77	
1594	New Technology - Level 43 ($40,001-$50,000)	$ 81,000.90	$ 68,850.77	
1595	New Technology - Level 44 ($50,001-$60,000)	$ 99,000.90	$ 84,150.77	
1596	New Technology - Level 45 ($60,001-$70,000)	$ 117,000.90	$ 99,450.77	
1597	New Technology - Level 46 ($70,001-$80,000)	$ 135,000.90	$ 114,750.77	
1598	New Technology - Level 47 ($80,001-$90,000)	$ 153,000.90	$ 130,050.77	
1599	New Technology - Level 48 ($90,001-$100,000)	$ 171,000.90	$ 145,350.77	
1607	Eptifibatide injection	$ 29.31	$ 24.91	
1608	Etanercept injection	$ 1,161.97	$ 987.67	
1609	Rho(D) immune globulin h, sd	$ 48.63	$ 41.34	
1613	Trastuzumab injection	$ 187.42	$ 159.31	
1630	Hep b ig, im	$ 202.20	$ 171.87	
1643	Y90 ibritumomab, rx	$ 83,990.95	$ 71,392.31	
1656	Factor viii fc fusion recomb	$ 3.62	$ 3.08	
1658	Injection, belinostat, 10mg	$ 67.93	$ 57.74	

1660	Injection, oritavancin	$ 41.55	$ 35.32	
1662	Inj tedizolid phosphate	$ 2.57	$ 2.18	
1669	Erythro lactobionate /500 mg	$ 141.96	$ 120.67	
1670	Tetanus immune globulin inj	$ 460.26	$ 391.22	
1675	P32 Na phosphate	$ 1,314.05	$ 1,116.94	
1683	Basiliximab	$ 6,635.03	$ 5,639.78	
1684	Corticorelin ovine triflutal	$ 15.47	$ 13.15	
1685	Darbepoetin alfa, non-esrd	$ 6.79	$ 5.77	
1686	Epoetin alfa, non-esrd	$ 22.09	$ 18.78	
1687	Digoxin immune fab (ovine)	$ 6,638.93	$ 5,643.09	
1688	Ethanolamine oleate	$ 799.38	$ 679.47	
1689	Fomepizole	$ 13.33	$ 11.33	
1690	Hemin	$ 41.45	$ 35.23	
1694	Ziconotide injection	$ 13.66	$ 11.61	
1695	Nesiritide injection	$ 132.01	$ 112.21	
1696	Palifermin injection	$ 36.52	$ 31.04	
1700	Inj secretin synthetic human	$ 62.61	$ 53.22	
1701	Treprostinil injection	$ 119.04	$ 101.18	
1704	Humate-P, inj	$ 2.02	$ 1.72	
1705	Factor viia	$ 3.71	$ 3.15	
1709	Azacitidine injection	$ 2.65	$ 2.25	
1710	Clofarabine injection	$ 200.31	$ 170.26	
1711	Vantas implant	$ 6,498.58	$ 5,523.79	
1712	Paclitaxel protein bound	$ 20.88	$ 17.75	
1739	Pegademase bovine, 25 iu	$ 662.33	$ 562.98	
1743	Nandrolone decanoate 50 mg	$ 39.04	$ 33.18	
1745	Radium ra223 dichloride ther	$ 245.90	$ 209.02	
1746	Factor xiii recomb a-subunit	$ 26.84	$ 22.81	
1747	Monovisc inj per dose	$ 1,402.82	$ 1,192.40	
1748	Inj tbo filgrastim 1 microg	$ 1.04	$ 0.88	
1761	Rolapitant, oral, 1mg	$ 3.98	$ 3.38	
1809	Injection, alemtuzumab	$ 3,315.83	$ 2,818.46	
1822	Injection, zarxio	$ 1.15	$ 0.98	
1823	Injection, dalbavancin	$ 25.83	$ 21.96	
1824	Ceftaroline fosamil inj	$ 5.21	$ 4.43	
1825	Ceftazidime and avibactam	$ 151.65	$ 128.90	
1826	Hyqvia 100mg immuneglobulin	$ 25.43	$ 21.62	
1827	Factor viii recomb obizur	$ 5.13	$ 4.36	
1829	Penicillin g benzathine inj	$ 25.02	$ 21.27	
1832	Dimethyl sulfoxide 50% 50 ml	$ 964.78	$ 820.06	
1844	Factor viii pegylated recomb	$ 3.09	$ 2.63	
1846	Factor viii nuwiq recomb 1iu	$ 2.55	$ 2.17	

1847	Injection, inflectra	$ 110.45	$ 93.88	
1848	Artiss fibrin sealant	$ 315.21	$ 267.93	
1849	Foscarnet sodium injection	$ 148.08	$ 125.87	
1850	Gamma globulin 1 cc inj	$ 68.49	$ 58.22	
1851	Gamma globulin > 10 cc inj	$ 684.86	$ 582.13	
1852	Interferon beta-1a inj	$ 5,014.75	$ 4,262.54	
1853	Minocycline hydrochloride	$ 2.83	$ 2.41	
1854	Pentobarbital sodium inj	$ 84.74	$ 72.03	
1856	Factor viii recomb novoeight	$ 2.41	$ 2.05	
1857	Inj, factor x, (human), 1iu	$ 12.90	$ 10.97	
1859	Argatroban nonesrd use 1mg	$ 2.21	$ 1.88	
1861	Inj., bendeka 1 mg	$ 42.91	$ 36.47	
1862	Gelsyn-3 injection 0.1 mg	$ 3.92	$ 3.33	
1901	New Technology - Level 49 ($100,001-$115,000)	$ 193,500.90	$ 164,475.77	
1902	New Technology - Level 49 ($100,001-$115,000)	$ 193,500.90	$ 164,475.77	
1903	New Technology - Level 50 ($115,001-$130,000)	$ 220,500.90	$ 187,425.77	
1904	New Technology - Level 50 ($115,001-$130,000)	$ 220,500.90	$ 187,425.77	
1905	New Technology - Level 51 ($130,001-$145,000)	$ 247,500.90	$ 210,375.77	
1906	New Technology - Level 51 ($130,001-$145,000)	$ 247,500.90	$ 210,375.77	
1907	New Technology - Level 52 ($145,001-$160,000)	$ 274,500.90	$ 233,325.77	
1908	New Technology - Level 52 ($145,001-$160,000)	$ 274,500.90	$ 233,325.77	
2616	Brachytx, non-str,Yttrium-90	$ 29,926.58	$ 25,437.59	
2632	Iodine I-125 sodium iodide	$ 68.17	$ 57.94	
2634	Brachytx, non-str, HA, I-125	$ 249.46	$ 212.04	
2635	Brachytx, non-str, HA, P-103	$ 48.82	$ 41.50	
2636	Brachy linear, non-str,P-103	$ 88.79	$ 75.47	
2638	Brachytx, stranded, I-125	$ 65.52	$ 55.69	
2639	Brachytx, non-stranded,I-125	$ 63.02	$ 53.57	
2640	Brachytx, stranded, P-103	$ 134.41	$ 114.25	
2641	Brachytx, non-stranded,P-103	$ 108.23	$ 92.00	
2642	Brachytx, stranded, C-131	$ 143.89	$ 122.31	
2643	Brachytx, non-stranded,C-131	$ 141.05	$ 119.89	
2645	Brachytx, non-str, Gold-198	$ 155.32	$ 132.02	
2646	Brachytx, non-str, HDR Ir-192	$ 523.40	$ 444.89	
2647	Brachytx, NS, Non-HDRIr-192	$ 152.86	$ 129.93	
2648	Brachytx planar, p-103	$ 8.44	$ 7.17	

2698	Brachytx, stranded, NOS	$ 65.52	$ 55.69	
2699	Brachytx, non-stranded, NOS	$ 48.82	$ 41.50	
2731	Immune globulin, powder	$ 68.30	$ 58.06	
2770	Quinupristin/dalfopristin	$ 753.07	$ 640.11	
2993	Gen, neuro, trans sen/stim	$ -	$ -	
4001	Echo guidance radiotherapy	$ 93.42	$ 79.41	
4002	Stereoscopic x-ray guidance	$ 101.20	$ 86.02	
4003	Radiation treatment delivery, MeV <= 5; simple	$ 358.74	$ 304.93	
4004	Radiation treatment delivery, 6-10 MeV; simple	$ 262.73	$ 223.32	
4005	Radiation treatment delivery, 11-19 MeV; simple	$ 262.73	$ 223.32	
4006	Radiation treatment delivery, MeV>=20; simple	$ 262.08	$ 222.77	
4007	Radiation treatment delivery, MeV<=5; intermediate	$ 496.91	$ 422.37	
4008	Radiation treatment delivery, 6-10 MeV; intermediate	$ 362.63	$ 308.24	
4009	Radiation treatment delivery, 11-19 MeV; intermediate	$ 360.68	$ 306.58	
4010	Radiation treatment delivery, MeV >=20; intermediate	$ 360.68	$ 306.58	
4011	Radiation treatment delivery, MeV<=5; complex	$ 490.43	$ 416.87	
4012	Radiation treatment delivery, 6-10 MeV; complex	$ 480.69	$ 408.59	
4013	Radiation treatment delivery, 11-19 MeV; complex	$ 481.34	$ 409.14	
4014	Radiation treatment delivery, MeV >=20; complex	$ 481.34	$ 409.14	
4015	Radiation tx delivery imrt	$ 652.59	$ 554.70	
4016	Delivery comp imrt	$ 650.65	$ 553.05	
5012	Clinic Visits and Related Services	$ 208.53	$ 177.25	
5021	Level 1 Type A ED Visits	$ 125.51	$ 106.68	
5022	Level 2 Type A ED Visits	$ 230.33	$ 195.78	
5023	Level 3 Type A ED Visits	$ 401.38	$ 341.17	
5024	Level 4 Type A ED Visits	$ 648.67	$ 551.37	
5025	Level 5 Type A ED Visits	$ 945.54	$ 803.71	
5031	Level 1 Type B ED Visits	$ 140.11	$ 119.09	
5032	Level 2 Type B ED Visits	$ 167.11	$ 142.04	
5033	Level 3 Type B ED Visits	$ 294.59	$ 250.40	
5034	Level 4 Type B ED Visits	$ 389.52	$ 331.09	

5035	Level 5 Type B ED Visits	$ 578.29	$ 491.55	
5041	Critical Care	$ 1,332.04	$ 1,132.23	
5045	Trauma Response with Critical Care	$ 0.00	$ 0.00	See 18-5(B)(6)e)
5051	Level 1 Skin Procedures	$ 317.61	$ 269.97	
5052	Level 2 Skin Procedures	$ 565.34	$ 480.54	
5053	Level 3 Skin Procedures	$ 869.20	$ 738.82	
5054	Level 4 Skin Procedures	$ 2,788.13	$ 2,369.91	
5055	Level 5 Skin Procedures	$ 4,979.03	$ 4,232.18	
5061	Hyperbaric Oxygen	$ 205.92	$ 175.03	
5071	Level 1 Excision/ Biopsy/ Incision and Drainage	$ 1,042.81	$ 886.39	
5072	Level 2 Excision/ Biopsy/ Incision and Drainage	$ 2,475.90	$ 2,104.52	
5073	Level 3 Excision/ Biopsy/ Incision and Drainage	$ 4,280.92	$ 3,638.78	
5091	Level 1 Breast/Lymphatic Surgery and Related Procedures	$ 5,068.82	$ 4,308.50	
5092	Level 2 Breast/Lymphatic Surgery and Related Procedures	$ 8,847.38	$ 7,520.27	Also map CPT® 22632 to this APC value.
5093	Level 3 Breast/Lymphatic Surgery and Related Procedures	$ 13,407.89	$ 11,396.71	
5094	Level 4 Breast/Lymphatic Surgery and Related Procedures	$ 21,828.85	$ 18,554.52	
5101	Level 1 Strapping and Cast Application	$ 242.32	$ 205.97	
5102	Level 2 Strapping and Cast Application	$ 424.04	$ 360.43	
5111	Level 1 Musculoskeletal Procedures	$ 405.16	$ 344.39	
5112	Level 2 Musculoskeletal Procedures	$ 2,364.01	$ 2,009.41	
5113	Level 3 Musculoskeletal Procedures	$ 4,722.01	$ 4,013.71	
5114	Level 4 Musculoskeletal Procedures	$ 10,259.26	$ 8,720.37	Also map CPT® 22634, 22800, and 22830 to this APC value.
5115	Level 5 Musculoskeletal Procedures	$ 19,284.98	$ 16,392.23	Also map CPT® 22600, 22610, 22630, 22633, and 22857

5116	Level 6 Musculoskeletal Procedures	$ 27,724.43	$ 23,565.77	Also map CPT® 22558 to this APC value.
5151	Level 1 Airway Endoscopy	$ 295.15	$ 250.88	
5152	Level 2 Airway Endoscopy	$ 695.70	$ 591.35	
5153	Level 3 Airway Endoscopy	$ 2,464.72	$ 2,095.01	
5154	Level 4 Airway Endoscopy	$ 4,933.19	$ 4,193.21	
5155	Level 5 Airway Endoscopy	$ 9,265.63	$ 7,875.79	
5161	Level 1 ENT Procedures	$ 371.05	$ 315.39	
5162	Level 2 ENT Procedures	$ 876.83	$ 745.31	
5163	Level 3 ENT Procedures	$ 2,302.38	$ 1,957.02	
5164	Level 4 ENT Procedures	$ 4,016.29	$ 3,413.85	
5165	Level 5 ENT Procedures	$ 7,963.61	$ 6,769.07	
5166	Cochlear Implant Procedure	$ 57,541.99	$ 48,910.69	
5181	Level 1 Vascular Procedures	$ 1,116.02	$ 948.62	
5182	Level 2 Vascular Procedures	$ 1,968.53	$ 1,673.25	
5183	Level 3 Vascular Procedures	$ 4,754.74	$ 4,041.53	
5184	Level 4 Vascular Procedures	$ 7,877.74	$ 6,696.08	
5191	Level 1 Endovascular Procedures	$ 5,058.74	$ 4,299.93	
5192	Level 2 Endovascular Procedures	$ 8,421.35	$ 7,158.15	Also map CPT® 22846 to this APC value.
5193	Level 3 Endovascular Procedures	$ 17,404.27	$ 14,793.63	
5194	Level 4 Endovascular Procedures	$ 27,638.10	$ 23,492.39	
5200	Implantation Wireless PA Pressure Monitor	$ 52,813.31	$ 44,891.31	
5211	Level 1 Electrophysiologic Procedures	$ 1,654.79	$ 1,406.57	
5212	Level 2 Electrophysiologic Procedures	$ 9,175.30	$ 7,799.01	
5213	Level 3 Electrophysiologic Procedures	$ 34,584.73	$ 29,397.02	
5221	Level1 Pacemaker and Similar Procedures	$ 5,634.95	$ 4,789.71	
5222	Level 2 Pacemaker and Similar Procedures	$ 13,327.40	$ 11,328.29	
5223	Level 3 Pacemaker and Similar Procedures	$ 17,782.81	$ 15,115.39	
5224	Level 4 Pacemaker and Similar Procedures	$ 31,822.22	$ 27,048.89	
5231	Level 1 ICD and Similar Procedures	$ 39,593.63	$ 33,654.59	

5232	Level 2 ICD and Similar Procedures	$ 55,181.48	$ 46,904.26	
5241	Level 1 Blood Product Exchange and Related Services	$ 689.22	$ 585.84	
5242	Level 2 Blood Product Exchange and Related Services	$ 2,244.60	$ 1,907.91	
5243	Level 3 Blood Product Exchange and Related Services	$ 7,060.50	$ 6,001.43	
5244	Level 4 Blood Product Exchange and Related Services	$ 68,206.97	$ 57,975.92	
5301	Level 1 Upper GI Procedures	$ 1,370.79	$ 1,165.17	
5302	Level 2 Upper GI Procedures	$ 2,670.03	$ 2,269.53	
5303	Level 3 Upper GI Procedures	$ 5,084.44	$ 4,321.77	
5311	Level 1 Lower GI Procedures	$ 1,340.80	$ 1,139.68	
5312	Level 2 Lower GI Procedures	$ 1,763.62	$ 1,499.08	
5313	Level 3 Lower GI Procedures	$ 4,202.24	$ 3,571.90	
5331	Complex GI Procedures	$ 8,092.93	$ 6,878.99	
5341	Abdominal/Peritoneal/Biliary and Related Procedures	$ 5,305.18	$ 4,509.40	
5361	Level 1 Laparoscopy and Related Services	$ 8,272.53	$ 7,031.65	
5362	Level 2 Laparoscopy and Related Services	$ 13,934.93	$ 11,844.69	
5371	Level 1 Urology and Related Services	$ 416.56	$ 354.08	
5372	Level 2 Urology and Related Services	$ 1,012.05	$ 860.24	
5373	Level 3 Urology and Related Services	$ 3,131.55	$ 2,661.82	
5374	Level 4 Urology and Related Services	$ 5,268.35	$ 4,478.10	
5375	Level 5 Urology and Related Services	$ 7,236.97	$ 6,151.42	
5376	Level 6 Urology and Related Services	$ 13,770.99	$ 11,705.34	
5377	Level 7 Urology and Related Services	$ 29,375.19	$ 24,968.91	
5401	Dialysis	$ 1,101.11	$ 935.94	
5411	Level 1 Gynecologic Procedures	$ 298.67	$ 253.87	
5412	Level 2 Gynecologic Procedures	$ 491.40	$ 417.69	
5413	Level 3 Gynecologic Procedures	$ 1,004.47	$ 853.80	
5414	Level 4 Gynecologic Procedures	$ 4,250.29	$ 3,612.75	

5415	Level 5 Gynecologic Procedures	$ 7,426.49	$ 6,312.52	
5416	Level 6 Gynecologic Procedures	$ 11,419.94	$ 9,706.95	
5431	Level 1 Nerve Procedures	$ 2,936.66	$ 2,496.16	
5432	Level 2 Nerve Procedures	$ 8,218.91	$ 6,986.07	
5441	Level 1 Nerve Injections	$ 445.46	$ 378.64	
5442	Level 2 Nerve Injections	$ 1,077.86	$ 916.18	
5443	Level 3 Nerve Injections	$ 1,376.71	$ 1,170.20	
5461	Level 1 Neurostimulator and Related Procedures	$ 5,183.64	$ 4,406.09	
5462	Level 2 Neurostimulator and Related Procedures	$ 10,763.15	$ 9,148.68	
5463	Level 3 Neurostimulator and Related Procedures	$ 33,672.89	$ 28,621.96	
5464	Level 4 Neurostimulator and Related Procedures	$ 49,856.13	$ 42,377.71	
5471	Implantation of Drug Infusion Device	$ 28,921.30	$ 24,583.11	
5481	Laser Eye Procedures	$ 893.12	$ 759.15	
5491	Level 1 Intraocular Procedures	$ 3,450.89	$ 2,933.26	
5492	Level 2 Intraocular Procedures	$ 6,552.47	$ 5,569.60	
5493	Level 3 Intraocular Procedures	$ 17,705.34	$ 15,049.54	
5494	Level 4 Intraocular Procedures	$ 29,221.60	$ 24,838.36	
5501	Level 1 Extraocular, Repair, and Plastic Eye Procedures	$ 510.34	$ 433.79	
5502	Level 2 Extraocular, Repair, and Plastic Eye Procedures	$ 1,453.12	$ 1,235.15	
5503	Level 3 Extraocular, Repair, and Plastic Eye Procedures	$ 3,262.82	$ 2,773.40	
5504	Level 4 Extraocular, Repair, and Plastic Eye Procedures	$ 5,355.49	$ 4,552.17	
5521	Level 1 Imaging without Contrast	$ 112.14	$ 95.32	
5522	Level 2 Imaging without Contrast	$ 202.52	$ 172.14	
5523	Level 3 Imaging without Contrast	$ 415.01	$ 352.76	
5524	Level 4 Imaging without Contrast	$ 895.48	$ 761.16	
5571	Level 1 Imaging with Contrast	$ 363.13	$ 308.66	
5572	Level 2 Imaging with Contrast	$ 694.58	$ 590.39	
5573	Level 3 Imaging with Contrast	$ 1,245.15	$ 1,058.38	
5591	Level 1 Nuclear Medicine and Related Services	$ 636.28	$ 540.84	

5592	Level 2 Nuclear Medicine and Related Services	$ 819.94	$ 696.95	
5593	Level 3 Nuclear Medicine and Related Services	$ 2,212.88	$ 1,880.95	
5594	Level 4 Nuclear Medicine and Related Services	$ 2,475.97	$ 2,104.57	
5611	Level 1 Therapeutic Radiation Treatment Preparation	$ 222.79	$ 189.37	
5612	Level 2 Therapeutic Radiation Treatment Preparation	$ 579.28	$ 492.39	
5613	Level 3 Therapeutic Radiation Treatment Preparation	$ 2,145.46	$ 1,823.64	
5621	Level 1 Radiation Therapy	$ 210.58	$ 178.99	
5622	Level 2 Radiation Therapy	$ 404.03	$ 343.43	
5623	Level 3 Radiation Therapy	$ 935.73	$ 795.37	
5624	Level 4 Radiation Therapy	$ 1,268.50	$ 1,078.23	
5625	Level 5 Radiation Therapy	$ 1,942.15	$ 1,650.83	
5626	Level 6 Radiation Therapy	$ 3,043.03	$ 2,586.58	
5627	Level 7 Radiation Therapy	$ 13,759.63	$ 11,695.69	
5661	Therapeutic Nuclear Medicine	$ 415.60	$ 353.26	
5671	Level 1 Pathology	$ 91.76	$ 78.00	
5672	Level 2 Pathology	$ 260.51	$ 221.43	
5673	Level 3 Pathology	$ 493.60	$ 419.56	
5674	Level 4 Pathology	$ 1,004.62	$ 853.93	
5691	Level 1 Drug Administration	$ 68.18	$ 57.95	
5692	Level 2 Drug Administration	$ 107.55	$ 91.42	
5693	Level 3 Drug Administration	$ 336.92	$ 286.38	
5694	Level 4 Drug Administration	$ 519.08	$ 441.22	
5721	Level1 Diagnostic Tests and Related Services	$ 244.71	$ 208.00	
5722	Level 2 Diagnostic Tests and Related Services	$ 454.16	$ 386.04	
5723	Level 3 Diagnostic Tests and Related Services	$ 819.49	$ 696.57	
5724	Level 4 Diagnostic Tests and Related Services	$ 1,643.02	$ 1,396.57	
5731	Level 1 Minor Procedures	$ 30.91	$ 26.27	
5732	Level 2 Minor Procedures	$ 57.82	$ 49.15	
5733	Level 3 Minor Procedures	$ 100.62	$ 85.53	
5734	Level 4 Minor Procedures	$ 191.66	$ 162.91	
5735	Level 5 Minor Procedures	$ 626.69	$ 532.69	
5741	Level 1 Electronic Analysis of Devices	$ 66.89	$ 56.86	
5742	Level 2 Electronic Analysis of	$ 211.57	$ 179.83	

	Devices			
5743	Level 3 Electronic Analysis of Devices	$ 504.74	$ 429.03	
5771	Cardiac Rehabilitation	$ 212.67	$ 180.77	
5781	Resuscitation and Cardioversion	$ 947.68	$ 805.53	
5791	Pulmonary Treatment	$ 344.88	$ 293.15	
5801	Ventilation Initiation and Management	$ 917.95	$ 780.26	
5811	Manipulation Therapy	$ 44.60	$ 37.91	
5821	Level 1 Health and Behavior Services	$ 60.08	$ 51.07	
5822	Level 2 Health and Behavior Services	$ 137.50	$ 116.88	
5823	Level 3 Health and Behavior Services	$ 229.59	$ 195.15	
5853	Partial Hospitalization (3 or more services) for CMHCs	$ 217.04	$ 184.48	
5863	Partial Hospitalization (3 or more services) for Hospital-based PHPs	$ 397.55	$ 337.92	
5871	Dental Procedures	$ 1,618.52	$ 1,375.74	
5881	Ancillary Outpatient Services When Patient Dies	$ 12,097.15	$ 10,282.58	
7000	Amifostine	$ 1,752.14	$ 1,489.32	
7011	Oprelvekin injection	$ 768.45	$ 653.18	
7035	Teniposide	$ 4,635.28	$ 3,939.99	
7041	Tirofiban HCl	$ 14.87	$ 12.64	
7043	Infliximab not biosimil 10mg	$ 141.90	$ 120.62	
7046	Doxorubicin inj 10mg	$ 690.42	$ 586.86	
7048	Alteplase recombinant	$ 158.00	$ 134.30	
7308	Aminolevulinic acid hcl top	$ 728.26	$ 619.02	
8004	Ultrasound Composite	$ 539.32	$ 458.42	
8005	CT and CTA without Contrast Composite	$ 476.91	$ 405.37	
8006	CT and CTA with Contrast Composite	$ 865.39	$ 735.58	
8007	MRI and MRA without Contrast Composite	$ 979.60	$ 832.66	
8008	MRI and MRA with Contrast Composite	$ 1,540.08	$ 1,309.07	
8010	Mental Health Services Composite	$ 397.55	$ 337.92	
8011	Comprehensive Observation Services	$ 4,296.24	$ 3,651.80	

9002	Tenecteplase injection	$ 219.16	$ 186.29	
9003	Palivizumab	$ 2,169.09	$ 1,843.73	
9005	Reteplase injection	$ 908.96	$ 772.62	
9006	Tacrolimus injection	$ 370.12	$ 314.60	
9012	Arsenic trioxide injection	$ 138.66	$ 117.86	
9014	Inj., cerliponase alfa 1 mg	$ 171.72	$ 145.96	
9015	Inj., haegarda 10 units	$ 17.40	$ 14.79	
9016	Inj., triptorelin xr 3.75 mg	$ 5,088.00	$ 4,324.80	
9018	Inj, rimabotulinumtoxinB	$ 21.66	$ 18.41	
9019	Caspofungin acetate	$ 22.75	$ 19.34	
9024	Amphotericin b lipid complex	$ 31.90	$ 27.12	
9028	Inj inotuzumab ozogam 0.1 mg	$ 3,964.40	$ 3,369.74	
9029	Inj., guselkumab, 1 mg	$ 183.36	$ 155.86	
9030	Inj., copanlisib, 1 mg	$ 140.22	$ 119.19	
9031	Inj, etelcalcetide, 0.1 mg	$ 5.37	$ 4.56	
9032	Baclofen 10 MG injection	$ 316.84	$ 269.31	
9033	Cidofovir injection	$ 860.53	$ 731.45	
9034	Inj cuvitru, 100 mg	$ 24.11	$ 20.49	
9035	Axicabtagene ciloleucel car+	$ 711,684.00	$ 604,931.40	
9036	Injection, renflexis	$ 115.89	$ 98.51	
9038	Inj estrogen conjugate	$ 555.54	$ 472.21	
9042	Glucagon hydrochloride	$ 385.89	$ 328.01	
9043	Inj, afstyla, 1 i.u.	$ 2.45	$ 2.08	
9044	Ibutilide fumarate injection	$ 433.36	$ 368.36	
9052	Fluciciovine F-18	$ 701.19	$ 596.01	
9056	Gallium Ga-68	$ 120.13	$ 102.11	
9058	Buprenorphine implant 74.2mg	$ 2,268.42	$ 1,928.16	
9059	Vonvendi inj 1 iu vwf:rco	$ 3.63	$ 3.09	
9065	Argatroban esrd dialysis 1mg	$ 2.21	$ 1.88	
9067	Lutetium lu 177 dotatat ther	$ 453.15	$ 385.18	
9070	Inj luxturna 1 billion vec g	$ 5,333.92	$ 4,533.83	
9071	Capsaicin 8% patch	$ 5.69	$ 4.84	
9073	Buprenorph xr 100 mg or less	$ 3,014.64	$ 2,562.44	
9074	Makena, 10 mg	$ 50.27	$ 42.73	
9075	Inj, kovaltry, 1 i.u.	$ 2.28	$ 1.94	
9078	Testosterone undecanoate 1mg	$ 2.45	$ 2.08	
9079	Genvisc 850, inj, 1mg	$ 19.08	$ 16.22	
9083	Inj, phenylephrine ketorolac	$ 851.84	$ 724.06	
9084	Florbetapir f18	$ 5,441.69	$ 4,625.44	
9085	Inj sulf hexa lipid microsph	$ 38.24	$ 32.50	
9086	Hepa vacc ped/adol 3 dose	$ 51.65	$ 43.90	
9087	Inj, clevidipine butyrate	$ 5.02	$ 4.27	

9088	Peng benzathine/procaine inj	$ 19.98	$ 16.98	
9089	Oral fludarabine phosphate	$ 146.56	$ 124.58	
9090	Melphalan oral 2 mg	$ 21.60	$ 18.36	
9091	Daunorubicin citrate inj	$ 438.84	$ 373.01	
9092	Interferon alfa-2a inj	$ 304.79	$ 259.07	
9093	Plicamycin (mithramycin) inj	$ 11.02	$ 9.37	
9094	Radiesse injection	$ 853.02	$ 725.07	
9095	Inj, sculptra, 0.5mg	$ 5.90	$ 5.02	
9096	Inj retacrit esrd on dialysi	$ 2.10	$ 1.79	
9097	Inj retacrit non-esrd use	$ 21.05	$ 17.89	
9098	Chorionic gonadotropin/1000u	$ 43.11	$ 36.64	
9099	Inj fosnetupitant, palonoset	$ 973.08	$ 827.12	
9104	Antithymocyte globuln rabbit	$ 1,352.25	$ 1,149.41	
9108	Thyrotropin injection	$ 2,924.02	$ 2,485.42	
9119	Injection, pegfilgrastim 6mg	$ 8,437.89	$ 7,172.21	
9120	Injection, Fulvestrant	$ 176.28	$ 149.84	
9122	Triptorelin pamoate	$ 481.29	$ 409.10	
9124	Daptomycin injection	$ 0.58	$ 0.49	
9125	Risperidone, long acting	$ 16.94	$ 14.40	
9126	Natalizumab injection	$ 35.69	$ 30.34	
9130	Inj, Imm Glob Bivigam, 500mg	$ 126.93	$ 107.89	
9131	Inj, Ado-trastuzumab Emt 1mg	$ 55.40	$ 47.09	
9132	Kcentra, per i.u.	$ 3.48	$ 2.96	
9133	Rabies ig, im/sc	$ 602.98	$ 512.53	
9134	Rabies ig, heat treated	$ 584.90	$ 497.17	
9135	Varicella-zoster ig, im	$ 2,684.47	$ 2,281.80	
9139	Rabies vaccine, im	$ 524.58	$ 445.89	
9140	Rabies vaccine, id	$ 234.02	$ 198.92	
9171	Factor ix idelvion inj	$ 7.70	$ 6.55	
9172	Injection, dexamethasone 9%	$ 1.99	$ 1.69	
9173	Injection, fulphila	$ 663.83	$ 564.26	
9174	Inj, durolane 1 mg	$ 1,860.30	$ 1,581.26	
9175	Puraply 1 sq cm	$ 128.16	$ 108.94	
9176	Puraply am 1 sq cm	$ 124.13	$ 105.51	
9177	Antithrombin recombinant	$ 186.03	$ 158.13	
9179	Injection, Aristada Initio	$ 5.28	$ 4.49	
9180	Injection, patisiran	$ 6.01	$ 5.11	
9181	Injection, risperidone	$ 18.13	$ 15.41	
9182	Inj mogamulizumab-kpkc	$ 361.57	$ 307.33	
9183	Injection, plazomicin	$ 0.59	$ 0.50	
9184	Iodine i-131 iobenguane, dx	$ 576.22	$ 489.79	
9185	Iodine i-131 iobenguane, tx	$ 576.22	$ 489.79	

9186	Inj., rituximab, 10 mg	$ 165.57	$ 140.73	
9187	Injection, burosumab-twza 1m	$ 648.72	$ 551.41	
9188	Inj crotalidae im f(ab')2 eq	$ 2,261.88	$ 1,922.60	
9189	Inj., ibalizumab-uiyk, 10 mg	$ 108.28	$ 92.04	
9190	Inj., vestronidase alfa-vjbk	$ 395.43	$ 336.12	
9191	Inj., fibryga, 1 mg	$ 1.91	$ 1.62	
9192	Inj, bortezomib, nos, 0.1 mg	$ 68.51	$ 58.23	
9193	Nivestym	$ 1.39	$ 1.18	
9194	Tisagenlecleucel car-pos t	$ 881,575.43	$ 749,339.12	
9207	Inj., velcade 0.1 mg	$ 82.00	$ 69.70	
9208	Agalsidase beta injection	$ 316.12	$ 268.70	
9209	Laronidase injection	$ 55.41	$ 47.10	
9210	Palonosetron hcl	$ 30.85	$ 26.22	
9213	Pemetrexed injection	$ 122.79	$ 104.37	
9214	Bevacizumab injection	$ 142.65	$ 121.25	
9215	Cetuximab injection	$ 109.14	$ 92.77	
9217	Leuprolide acetate suspnsion	$ 411.15	$ 349.48	
9224	Galsulfase injection	$ 701.91	$ 596.62	
9225	Fluocinolone acetonide implt	$ 36,234.90	$ 30,799.67	
9228	Tigecycline injection	$ 3.71	$ 3.15	
9229	Ibandronate sodium injection	$ 101.23	$ 86.05	
9230	Abatacept injection	$ 95.27	$ 80.98	
9231	Decitabine injection	$ 25.32	$ 21.52	
9232	Idursulfase injection	$ 965.80	$ 820.93	
9233	Ranibizumab injection	$ 672.06	$ 571.25	
9234	Alglucosidase alfa injection	$ 254.05	$ 215.94	
9235	Panitumumab injection	$ 205.88	$ 175.00	
9236	Eculizumab injection	$ 414.86	$ 352.63	
9237	Inj, lanreotide acetate	$ 105.92	$ 90.03	
9239	Buprenorphine xr over 100 mg	$ 3,014.64	$ 2,562.44	
9240	Injection, ixabepilone	$ 127.78	$ 108.61	
9242	Injection, fosaprepitant	$ 3.94	$ 3.35	
9243	Inj., treanda 1 mg	$ 55.04	$ 46.78	
9245	Romiplostim injection	$ 128.52	$ 109.24	
9251	C1 esterase inhibitor inj	$ 97.66	$ 83.01	
9252	Plerixafor injection	$ 594.74	$ 505.53	
9253	Temozolomide injection	$ 19.00	$ 16.15	
9255	Paliperidone palmitate inj	$ 19.69	$ 16.74	
9256	Dexamethasone intra implant	$ 360.30	$ 306.26	
9257	Inj., emicizumab-kxwh 0.5 mg	$ 87.95	$ 74.76	
9258	Telavancin injection	$ 9.84	$ 8.36	
9259	Pralatrexate injection	$ 488.90	$ 415.57	
9260	Ofatumumab injection	$ 105.39	$ 89.58	

9261	Ustekinumab sub cu inj, 1 mg	$ 343.85	$ 292.27	
9263	Ecallantide injection	$ 860.33	$ 731.28	
9264	Tocilizumab injection	$ 8.52	$ 7.24	
9265	Romidepsin injection	$ 580.64	$ 493.54	
9269	C-1 esterase, berinert	$ 88.10	$ 74.89	
9270	Gammaplex IVIG	$ 93.71	$ 79.65	
9271	Velaglucerase alfa	$ 621.71	$ 528.45	
9272	Inj, denosumab	$ 33.44	$ 28.42	
9273	Sipuleucel-T auto CD54+	$ 78,154.97	$ 66,431.72	
9274	Crotalidae Poly Immune Fab	$ 5,850.94	$ 4,973.30	
9276	Cabazitaxel injection	$ 302.38	$ 257.02	
9278	Incobotulinumtoxin A	$ 9.15	$ 7.78	
9281	Injection, pegloticase	$ 4,202.26	$ 3,571.92	
9284	Ipilimumab injection	$ 271.57	$ 230.83	
9286	Belatacept injection	$ 6.85	$ 5.82	
9287	Brentuximab vedotin inj	$ 270.87	$ 230.24	
9289	Erwinaze injection	$ 746.69	$ 634.69	
9293	Injection, glucarpidase	$ 563.96	$ 479.37	
9294	Inj, taliglucerase alfa 10 u	$ 72.69	$ 61.79	
9295	Injection, Carfilzomib, 1 mg	$ 65.37	$ 55.56	
9296	Inj, ziv-aflibercept, 1mg	$ 14.98	$ 12.73	
9297	Inj, Omacetaxine Mep, 0.01mg	$ 5.36	$ 4.56	
9298	Inj, Ocriplasmin, 0.125 mg	$ 1,505.41	$ 1,279.60	
9300	Omalizumab injection	$ 66.72	$ 56.71	
9301	Aminolevulinic acid, 10% gel	$ 2.49	$ 2.12	
9302	Inj daunorubicin, cytarabine	$ 336.07	$ 285.66	
9441	Inj ferric carboxymaltos 1mg	$ 1.91	$ 1.62	
9445	Injection, ruconest	$ 49.77	$ 42.30	
9448	Oral netupitant, palonosetro	$ 543.49	$ 461.97	
9449	Injection, blinatumomab	$ 198.66	$ 168.86	
9450	Fluocinol acet intravit imp	$ 882.59	$ 750.20	
9451	Injection, peramivir	$ 2.92	$ 2.48	
9452	Inj ceftolozane tazobactam	$ 9.82	$ 8.35	
9453	Injection, nivolumab	$ 49.57	$ 42.13	
9454	Inj, pasireotide long acting	$ 521.32	$ 443.12	
9455	Injection, siltuximab	$ 171.63	$ 145.89	
9456	Injection, isavuconazonium	$ 1.53	$ 1.30	
9460	Injection, cangrelor	$ 27.82	$ 23.65	
9462	Injection, delafloxacin	$ 0.83	$ 0.71	
9463	Inj., aprepitant, 1 mg	$ 3.79	$ 3.22	
9464	Inj., rolapitant, 0.5 mg	$ 1.69	$ 1.44	
9466	Inj., benralizumab, 1 mg	$ 301.45	$ 256.23	
9467	Inj rituximab, hyaluronidase	$ 82.30	$ 69.96	

9468	Factor ix recomb gly rebinyn	$ 6.99	$ 5.94	
9469	Inj triamcinolone ace xr 1mg	$ 33.99	$ 28.89	
9470	Aripiprazole lauroxil 1mg	$ 4.39	$ 3.73	
9471	Hymovis injection 1 mg	$ 34.66	$ 29.46	
9472	Inj talimogene laherparepvec	$ 89.99	$ 76.49	
9473	Injection, mepolizumab, 1mg	$ 53.25	$ 45.26	
9474	Inj irinotecan liposome 1 mg	$ 81.96	$ 69.67	
9475	Injection, necitumumab, 1 mg	$ 10.03	$ 8.53	
9476	Injection, daratumumab 10 mg	$ 94.33	$ 80.18	
9477	Injection, elotuzumab, 1mg	$ 11.55	$ 9.82	
9478	Inj sebelipase alfa 1 mg	$ 974.03	$ 827.93	
9479	Instill, ciprofloxacin otic	$ 53.96	$ 45.87	
9480	Injection trabectedin 0.1mg	$ 541.21	$ 460.03	
9481	Injection, reslizumab	$ 16.73	$ 14.22	
9482	Sotalol hydrochloride IV	$ 17.97	$ 15.27	
9483	Inj, atezolizumab,10 mg	$ 138.44	$ 117.67	
9484	Inj, eteplirsen, 10 mg	$ 302.62	$ 257.23	
9485	Inj, olaratumab, 10 mg	$ 91.87	$ 78.09	
9486	Inj, granisetron, xr, 0.1 mg	$ 6.44	$ 5.47	
9487	Ustekinumab, iv inject,1 mg	$ 22.10	$ 18.79	
9488	Conivaptan hcl	$ 55.97	$ 47.57	
9489	Inj, nusinersen, 0.1mg	$ 1,983.37	$ 1,685.86	
9490	Inj, bezlotoxumab, 10 mg	$ 72.29	$ 61.45	
9491	Injection, avelumab, 10 mg	$ 147.28	$ 125.19	
9492	Inj., durvalumab, 10 mg	$ 133.15	$ 113.18	
9493	Injection, edaravone, 1 mg	$ 34.52	$ 29.34	
9494	Injection, ocrelizumab	$ 103.22	$ 87.74	
9495	Gemtuzumab ozogamicin inj	$ 347.68	$ 295.53	
9497	Loxapine for inhalation 1 mg	$ 271.44	$ 230.72	
9500	Platelets, irradiated	$ 309.44	$ 263.02	
9501	Platelet pheres leukoreduced	$ 875.34	$ 744.04	
9502	Platelet pheresis irradiated	$ 995.24	$ 845.95	
9503	Fr frz plasma donor retested	$ 113.06	$ 96.10	
9504	RBC deglycerolized	$ 596.05	$ 506.64	
9505	RBC irradiated	$ 398.45	$ 338.68	
9507	Platelets, pheresis	$ 606.74	$ 515.73	
9508	Plasma 1 donor frz w/in 8 hr	$ 128.75	$ 109.44	
9509	Frozen plasma, pooled, sd	$ 136.73	$ 116.22	
9510	Whole blood for transfusion	$ 200.12	$ 170.10	
9511	Cryoprecipitate each unit	$ 88.92	$ 75.58	
9512	RBC leukocytes reduced	$ 332.60	$ 282.71	
9513	Plasma, frz between 8-24hour	$ 137.99	$ 117.29	

9514	Plasma protein fract,5%,50ml	$ 48.51	$ 41.23	
9515	Platelets, each unit	$ 194.33	$ 165.18	
9516	Plaelet rich plasma unit	$ 225.41	$ 191.60	
9517	Red blood cells unit	$ 252.22	$ 214.39	
9518	Washed red blood cells unit	$ 640.67	$ 544.57	
9519	Plasmaprotein fract,5%,250ml	$ 138.56	$ 117.78	
9520	Blood split unit	$ 226.91	$ 192.87	
9521	Platelets leukoreduced irrad	$ 300.85	$ 255.72	
9522	RBC leukoreduced irradiated	$ 460.04	$ 391.03	
9523	Cryoprecipitatereducedplasma	$ 159.71	$ 135.75	
9524	Blood, l/r, cmv-neg	$ 316.69	$ 269.19	
9525	Platelets, hla-m, l/r, unit	$ 1,520.69	$ 1,292.59	
9526	Platelets leukocytes reduced	$ 245.90	$ 209.02	
9527	Blood, l/r, froz/degly/wash	$ 537.07	$ 456.51	
9528	Plt, aph/pher, l/r, cmv-neg	$ 801.11	$ 680.94	
9529	Blood, l/r, irradiated	$ 405.85	$ 344.97	
9530	Plate pheres leukoredu irrad	$ 1,124.87	$ 956.14	
9531	Plt, pher, l/r cmv-neg, irr	$ 886.16	$ 753.24	
9532	RBC, frz/deg/wsh, l/r, irrad	$ 404.12	$ 343.50	
9533	RBC, l/r, cmv-neg, irrad	$ 412.72	$ 350.81	
9534	Pathogen reduced plasma pool	$ 74.57	$ 63.38	
9535	Pathogen reduced plasma sing	$ 141.03	$ 119.88	
9536	Platelets pheresis path redu	$ 1,124.87	$ 956.14	

Exhibit #5		
Rural Health Clinics		
Source: https://www.colorado.gov/pacific/cdphe/find-and-compare-facilities		
Effective 1/1/2020		
Facility	**City**	**County**
AKRON CLINIC	Akron	Washington
ARKANSAS VALLEY FAMILY PRACTICE, LLC	La Junta	Otero
BANNER FAMILY MEDICINE BRUSH CLINIC	Brush	Morgan
BANNER HEALTH CLINIC FORT MORGAN	Ft. Morgan	Morgan
BASIN CLINIC	Naturita	Montrose
BUENA VISTA HEALTH CENTER	Buena Vista	Chaffee
BUTTON FAMILY PRACTICE	Canon City	Fremont
CENTENNIAL FAMILY HEALTH CENTER	Ordway	Crowley
CORTEZ PRIMARY CARE CLINIC	Cortez	Montezuma
CREEDE FAMILY PRACTICE OF RIO GRANDE HOSPITAL	Creede	Mineral
CUSTER COUNTY MEDICAL CENTER	Westcliffe	Custer
EADS MEDICAL CLINIC	Eads	Kiowa
EASTERN PLAINS MEDICAL CLINIC OF CALHAN	Calhan	El Paso
FAMILY PRACTICE OF HOLYOKE	Holyoke	Phillips
FLORENCE MEDICAL CENTER	Florence	Fremont
GRAND RIVER HEALTH CLINIC WEST	Parachute	Garfield
GRAND RIVER PRIMARY CARE	Rifle	Garfield
KIT CARSON CLINIC	Kit Carson	Cheyenne
LAKE CITY AREA MEDICAL CENTER	Lake City	Hinsdale
LAMAR MEDICAL CLINIC	Lamar	Prowers
MANCOS VALLEY HEALTH CENTER	Mancos	Montezuma
MEEKER FAMILY HEALTH CENTER	Meeker	Rio Blanco
MEMORIAL HOSPITAL	Craig	Moffat
MIDDLE PARK MEDICAL CENTER	Winter Park	Grand
MIDDLE PARK MEDICAL CENTER	Grandby	Grand
MIDDLE PARK MEDICAL CENTER - KREMMLING CLINIC	Kremmling	Grand
MONTE VISTA RHC OF RIO GRANDE HOSPITAL	Monte Vista	Rio Grande
MT SAN RAFAEL HOSPITAL HEALTH CLINIC	Trinidad	Las Animas
NORTH PARK MEDICAL CENTER - WALDEN	Walden	Jackson
PAGOSA MOUNTAIN CLINIC	Pagosa Springs	Archuleta
PARKE HEALTH CLINIC	Burlington	Kit Carson
PEDIATRIC ASSOCIATION OF CANON CITY	Canon City	Fremont
PRAIRIE VIEW RURAL HEALTH CLINIC	Cheyenne Wells	Cheyenne
RIO GRANDE HOSPITAL CLINIC	Del Norte	Rio Grande
ROCKY FORD FAMILY HEALTH CENTER	Rocky Ford	Otero

SABATINI PEDIATRICS PC	Canon City	Fremont
SAN LUIS VALLEY HEALTH ANTONITO CLINIC	Antonito	Conejos
SAN LUIS VALLEY LA JARA MEDICAL CLINIC	La Jara	Conejos
SOUTHEAST COLORADO PHYSICIANS CLINIC	Springfield	Baca
SOUTHWEST MEMORIAL PRIMARY CARE	Cortez	Montezuma
SOUTHWEST SCHOOL-BASED HEALTH CENTER	Cortez	Montezuma
SOUTHWEST WALK-IN CARE	Cortez	Montezuma
SPANISH PEAKS FAMILY CLINIC	Walsenburg	Huerfano
ST THOMAS MORE RURAL HEALTH CLINIC	Canon City	Fremont
STERLING REGIONAL MEDICAL CENTER	Sterling	Logan
STRATTON MEDICAL CLINIC	Stratton	Kit Carson
VALLEY MEDICAL CLINIC	Julesburg	Sedgwick
WALSH MEDICAL CLINIC	Walsh	Baca
WASHINGTON COUNTY CLINIC	Akron	Washington
YUMA CLINIC	Yuma	Yuma

Exhibit #6		
Dental Fee Schedule		
Effective 1/1/2020		
Proc	**Description**	**Rate**
D0120	PERIODIC ORAL EVALUATION - EST PATIENT	$ 67.25
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	$ 113.00
D0145	ORAL EVAL PT UND 3 YR AGE CNSL W/PRIM CAREGIVER	$ 105.25
D0150	COMP ORAL EVALUATION - NEW OR EST PATIENT	$ 119.00
D0160	DTL&EXT ORAL EVALUATION - PROBLEM FOCUSED REPORT	$ 238.00
D0170	RE-EVALUATION - LIMITED PROBLEM FOCUSED	$ 79.25
D0171	RE-EVALUATION POST-OPERATIVE OFFICE VISIT	$ 79.25
D0180	COMP PERIODONTAL EVALUATION - NEW OR EST PATIENT	$ 129.25
D0190	SCREENING OF A PATIENT	$ 67.25
D0191	ASSESSMENT OF A PATIENT	$ 47.50
D0210	INTRAORAL-COMPLETE SERIES	$ 182.00
D0220	INTRAORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE	$ 36.75
D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FILM	$ 32.75
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	$ 56.50
D0250	EXTRAORAL 2D PRJECTN RAD IMG BY RAD SRCE/ DTECTR	$ 69.50
D0251	EXTRAORAL 2D POSTERIOR DENTAL RAD IMAGE	$ 63.75
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	$ 35.25
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	$ 56.75
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	$ 69.00
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	$ 79.50
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	$ 120.50
D0310	SIALOGRAPHY	$ 517.50
D0320	TEMPOROMANDIBULAR JOINT ARTHROGRAM INCL INJ	$ 915.00
D0321	OTHER TEMPOROMANDIBULAR JOINT FILMS BY REPORT	BR
D0322	TOMOGRAPHIC SURVEY	$ 742.25
D0330	PANORAMIC RADIOGRAPHIC IMAGE	$ 160.50
D0340	2D CEPHLOMTRIC RAD IMG - ACQSTN MEASRE& ANALYSIS	$ 181.00
D0350	2D ORAL/FACIAL PHOTOGRAPHIC IMAGES	$ 86.50
D0351	3D PHOTOGRAPHIC IMAGE	$ 86.50
D0364	CONE BEAM 3	$ 288.25
D0365	CNE BEAM CAPTR INTERPJ W FLD VIEW 1 ARCH MNDBL	$ 367.50
D0366	CNE BEAM CAPTR INTERPJ W FLD VIEW 1 ARCH MAXL	$ 367.50
D0367	CNE BEAM CAPTR INTERPJ W FLD VIEW BTH JAWS	$ 414.50
D0368	CNE BEAM CAPTR INTERPJ FR TMJ 2 OR MORE	$ 426.00
D0369	MAXILLOFACIAL MRI CAPTURE AND INTERPRETATION	$ 241.50
D0370	MAXLFCL US IMAGE CAPTR AND INTRPJ	$ 138.25

D0371	SIALOENDOSCOPY CAPTURE AND INTERPRETATION	BR	
D0380	CNE BEAM CAPTR LMTD FLD <1 WHL JAW	$	297.00
D0381	CNE BEAM CAPTR W FLD VIEW 1 ARCH MNDBL	$	402.25
D0382	CNE BEAM CAPTR W FLD VIEW 1 ARCH MAXL	$	402.25
D0383	CNE BEAM CAPTR W FLD VIEW BTH JAWS	$	402.25
D0384	CNE BEAM CAPTR FR TMJ 2 OR MORE	$	431.50
D0385	MAXILLOFACIAL MRI IMAGE CAPTURE	$	2,649.00
D0386	MAXILLOFACIAL ULTRASOUND IMAGE CAPTURE	$	662.75
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE	BR	
D0393	TREATMENT SIMULATION USING 3D IMAGE VOLUME	BR	
D0394	DIGITAL SUBTR OF 2 > IMAGES OF THE SAME MODALITY	BR	
D0395	FUSION OF 2/> 3D IMAGE VOLUMES OF 1/> MODALITIES	BR	
D0411	HBA1C IN-OFFICE POINT OF SERVICE TESTING	BR	
D0412	BLOOD GLCSE LVL TST - IN-OFFICE USING GLCSE MTR	BR	
D0414	LAB MICRBAL SPEC CULTRE/SENS/REPORT PREP TRNSMSN	$	70.75
D0415	COLLECTION MICROORGANISMS CULTURE & SENSITIVITY	$	51.25
D0416	VIRAL CULTURE	$	76.25
D0417	CLCT & PREP SALIVA SAMPLE FOR LAB DX TESTING	$	68.75
D0418	ANALYSIS OF SALIVA SAMPLE	$	70.75
D0422	COLLECT/PREP GENETIC SAMPLE FOR LAB ANALYSIS	$	51.25
D0423	GENETIC TEST SUSCEPT TO DSEASE SPECIMEN ANLYS	BR	
D0425	CARIES SUSCEPTIBILITY TESTS	$	44.25
D0431	ADJUNCTIVE PREDX TST NOT INCL CYTOLOGY/BX PROC	$	70.75
D0460	PULP VITALITY TESTS	$	70.75
D0470	DIAGNOSTIC CASTS	$	156.25
D0472	ACCESSION OF TISSUE GROSS EXAMINATION PREP/REPRT	$	97.50
D0473	ACCESS TISSUE GR&MIC EXAMINATION PREP/REPRT	$	205.75
D0474	ACCESS TISS GR&MIC EX ASSESS SURG MARG PREP/RPT	$	230.50
D0475	DECALCIFICATION PROCEDURE	$	124.25
D0476	SPECIAL STAINS FOR MICROORGANISMS	$	120.75
D0477	SPECIAL STAINS NOT FOR MICROORGANISMS	$	165.00
D0478	IMMUNOHISTOCHEMICAL STAINS	$	150.75
D0479	TISSUE INSITU HYBRIDIZATION INCL INTERPRETATION	$	230.50
D0480	ACESS EXFOLIATIVE CYTOL SMEAR MIC EXAM PREP/REPT	$	142.00
D0481	ELECTRON MICROSCOPY	$	532.00
D0482	DIRECT IMMUNOFLUORESCENCE	$	177.25
D0483	INDIRECT IMMUNOFLUORESCENCE	$	177.25
D0484	CONSULTATION ON SLIDES PREPARED ELSEWHERE	$	265.75
D0485	CONSULT INCL PREP SLIDES BX MATL SPL REF SRC	$	367.25
D0486	ACCESSION TRANSEPITHELIAL CYTOLOG SAMPL MIC EXAM	$	170.50
D0502	OTHER ORAL PATHOLOGY PROCEDURES BY REPORT	BR	
D0600	DX PX QUANT/MNITR/RECRD CHNGS ENAML/DENTN/CEMNTM	BR	
D0601	CARIES RISK ASSESS DOCU FINDING OF LOW RISK	$	106.25

D0602	CARIES RISK AX AND DOCU WITH A FNDNG OF MOD RISK	$	106.25
D0603	CARIES RISK AX AND DOCU WITH FNDNG OF HIGH RISK	$	106.25
D0999	UNSPECIFIED DIAGNOSTIC PROCEDURE BY REPORT	BR	
D1110	PROPHYLAXIS - ADULT	$	117.25
D1120	PROPHYLAXIS - CHILD	$	80.75
D1206	TOPICAL APPLICATION OF FLUORIDE VARNISH	$	64.25
D1208	TOPICAL APPLICATION OF FLUORIDE EXCL VARNISH	$	43.00
D1310	NUTRITIONAL COUNSELING CONTROL OF DENTAL DISEASE	$	62.75
D1320	TOBACCO CNSL CONTROL&PREVENTION ORAL DISEASE	$	68.00
D1330	ORAL HYGIENE INSTRUCTIONS	$	86.00
D1351	SEALANT - PER TOOTH	$	69.75
D1352	PREV RSN REST MOD HIGH CARIES RISK PT-PERM TOOTH	$	89.50
D1353	SEALANT REPAIR PER TOOTH	$	89.50
D1354	INTERIM CARIES ARRESTING MEDICATION APPLICATION	$	69.75
D1510	SPACE MAINTAINER - FIXED - UNILATERAL	$	425.25
D1516	SPACE MAINTAINER - FIXED - BILATERIAL MAXILLARY	$	595.25
D1517	SPACE MAINTAINER - FIXED - BILATERIAL MANDIBULAR	$	595.25
D1520	SPACE MAINTAINER - REMOVABLE - UNILATERAL	$	467.50
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL MAXILRY	$	722.75
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL MNDBULR	$	722.75
D1550	RECMNT/REBND OF SPACE MAINTAINER	$	91.75
D1555	REMOVAL OF FIXED SPACE MAINTAINER	$	88.50
D1575	DISTAL SHOE SPACE MAINTANR - FIXED - UNILATERIAL	$	467.50
D1999	UNSPECIFIED PREVENTIVE PROCEDURE BY REPORT	BR	
D2140	AMALGAM - ONE SURFACE PRIMARY OR PERMANENT	$	201.25
D2150	AMALGAM - TWO SURFACES PRIMARY OR PERMANENT	$	260.50
D2160	AMALGAM - THREE SURFACES PRIMARY OR PERMANENT	$	314.75
D2161	AMALGAM-FOUR/MORE SURFACES PRIMARY/PERMANENT	$	383.50
D2330	RESIN-BASED COMPOSITE - ONE SURFACE ANTERIOR	$	204.25
D2331	RESIN-BASED COMPOSITE - TWO SURFACES ANTERIOR	$	260.75
D2332	RESIN-BASED COMPOSITE - THREE SURFACES ANTERIOR	$	319.00
D2335	RESIN-BASED COMPOSITE 4/> SURFACES INCISAL ANGLE	$	377.50
D2390	RESIN-BASED COMPOSITE CROWN ANTERIOR	$	418.25
D2391	RESIN-BASED COMPOSITE - ONE SURFACE POSTERIOR	$	239.25
D2392	RESIN-BASED COMPOSITE - TWO SURFACES POSTERIOR	$	313.00
D2393	RESIN-BASED COMPOSITE - THREE SURFACES POSTERIOR	$	389.00
D2394	RESIN COMPOS - FOUR OR MORE SURFACES POSTERIOR	$	476.25
D2410	GOLD FOIL - ONE SURFACE	$	352.00
D2420	GOLD FOIL - TWO SURFACES	$	586.75
D2430	GOLD FOIL - THREE SURFACES	$	1,016.75
D2510	INLAY - METALLIC - ONE SURFACE	$	930.50
D2520	INLAY - METALLIC - TWO SURFACES	$	1,055.75
D2530	INLAY - METALLIC - THREE OR MORE SURFACES	$	1,217.00

D2542	ONLAY - METALLIC - TWO SURFACES	$ 1,193.50
D2543	ONLAY - METALLIC - THREE SURFACES	$ 1,248.25
D2544	ONLAY - METALLIC - FOUR OR MORE SURFACES	$ 1,298.00
D2610	INLAY - PORCELAIN/CERAMIC - ONE SURFACE	$ 1,095.00
D2620	INLAY - PORCELAIN/CERAMIC - TWO SURFACES	$ 1,155.75
D2630	INLAY - PORCELAIN/CERAMIC - THREE/MORE SURFACES	$ 1,231.00
D2642	ONLAY - PORCELAIN/CERAMIC - TWO SURFACES	$ 1,196.50
D2643	ONLAY - PORCELAIN/CERAMIC - THREE SURFACES	$ 1,290.50
D2644	ONLAY - PORCELAIN/CERAMIC - 4 OR MORE SURFACES	$ 1,368.75
D2650	INLAY - RESIN-BASED COMPOSITE - ONE SURFACE	$ 719.50
D2651	INLAY - RESIN-BASED COMPOSITE - TWO SURFACES	$ 857.00
D2652	INLAY RESIN BASED COMPOSITE 3 OR MORE SURFACES	$ 901.00
D2662	ONLAY - RESIN-BASED COMPOSITE - TWO SURFACES	$ 782.00
D2663	ONLAY - RESIN-BASED COMPOSITE - THREE SURFACES	$ 919.75
D2664	ONLAY RESIN BASED COMPOSIT FOUR OR MORE SURFACES	$ 985.25
D2710	CROWN - RESIN-BASED COMPOSITE (INDIRECT)	$ 585.25
D2712	CROWN 3/4 RESIN-BASED COMPOSITE (INDIRECT)	$ 585.25
D2720	CROWN - RESIN WITH HIGH NOBLE METAL	$ 1,442.00
D2721	CROWN - RESIN WITH PREDOMINANTLY BASE METAL	$ 1,351.50
D2722	CROWN - RESIN WITH NOBLE METAL	$ 1,381.00
D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	$ 1,480.00
D2750	CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	$ 1,460.50
D2751	CROWN - PORCELAIN FUSED PREDOMINANTLY BASE METAL	$ 1,360.00
D2752	CROWN - PORCELAIN FUSED TO NOBLE METAL	$ 1,392.75
D2780	CROWN - 3/4 CAST HIGH NOBLE METAL	$ 1,401.00
D2781	CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	$ 1,318.50
D2782	CROWN - 3/4 CAST NOBLE METAL	$ 1,361.50
D2783	CROWN - 3/4 PORCELAIN/CERAMIC	$ 1,440.50
D2790	CROWN - FULL CAST HIGH NOBLE METAL	$ 1,409.25
D2791	CROWN - FULL CAST PREDOMINANTLY BASE METAL	$ 1,335.25
D2792	CROWN - FULL CAST NOBLE METAL	$ 1,360.00
D2794	CROWN - TITANIUM	$ 1,442.00
D2799	PROVISIONAL CROWN	$ 585.25
D2910	RECMNT/REBND INLAY ONLAY/PART CVRGE RESTORATION	$ 131.75
D2915	RECMNT/REBND CAST OR PREFABRICATED POST AND CORE	$ 131.75
D2920	RE-CEMENT OR RE-BOND CROWN	$ 133.50
D2921	REATTACHMENT OF TOOTH FRAG INCISAL EDGE/CUSP	$ 192.25
D2929	PREFABR STAINLESS PORC CROWN - PRIMARY TOOTH	$ 528.75
D2930	PREFABR STAINLESS STEEL CROWN - PRIMARY TOOTH	$ 363.75
D2931	PREFABR STAINLESS STEEL CROWN - PERMANENT TOOTH	$ 411.50
D2932	PREFABRICATED RESIN CROWN	$ 439.00
D2933	PREFABR STAINLESS STEEL CROWN W/RESIN WINDOW	$ 503.25
D2934	PREFAB ESTHETIC COAT STNLESS STEEL CROWN PRIM	$ 503.25

D2940	PROTECTIVE RESTORATION	$ 138.75
D2941	INTERIM THERAPEUTIC RESTORATION PRIM DENTITION	$ 138.75
D2949	RESTOR FOUNDATION N INDIR RESTOR	$ 138.75
D2950	CORE BUILDUP INCLUDING ANY PINS WHEN REQUIRED	$ 347.50
D2951	PIN RETENTION - PER TOOTH ADDITION RESTORATION	$ 78.75
D2952	POST AND CORE ADDITION TO CROWN INDIRECTLY FAB	$ 548.75
D2953	EACH ADDITIONAL INDIRECTLY FAB POST SAME TOOTH	$ 274.25
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	$ 439.00
D2955	POST REMOVAL	$ 338.50
D2957	EACH ADDITIONAL PREFABRICATED POST - SAME TOOTH	$ 219.50
D2960	LABIAL VENEER (RESIN LAMINATE) - CHAIRSIDE	$ 1,060.75
D2961	LABIAL VENEER (RESIN LAMINATE) - LABORATORY	$ 1,203.75
D2962	LABIAL VENEER (PORCELAIN LAMINATE) - LABORATORY	$ 1,307.75
D2971	ADD PROC NEW CRWN UND XSTING PART DENTUR FRMEWRK	$ 210.25
D2975	COPING	$ 640.00
D2980	CROWN REPAIR BY REPORT	$ 256.00
D2981	INLAY REPAIR BY REPORT	$ 256.00
D2982	ONLAY REPAIR BY REPORT	$ 256.00
D2983	VENEER REPAIR BY REPORT	$ 256.00
D2990	RESIN INFILT OF INCIPIENT LESIONS	$ 91.75
D2999	UNSPECIFIED RESTORATIVE PROCEDURE BY REPORT	BR
D3110	PULP CAP - DIRECT (EXCLUDING FINAL RESTORATION)	$ 125.00
D3120	PULP CAP - INDIRECT	$ 100.50
D3220	TX PULP-REMV PULP CORONAL DENTINOCEMENTL JUNC	$ 257.00
D3221	PULPAL DEBRIDEMENT PRIMARY AND PERMANENT TEETH	$ 282.00
D3222	PART PULPOTOMY FOR APEXOGENEIS PERM TOOTH	$ 260.75
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	$ 252.00
D3240	PULPAL THERAPY - POSTERIOR PRIMARY TOOTH	$ 310.25
D3310	ENDODONTIC THERAPY ANTERIOR TOOTH	$ 988.00
D3320	ENDODONTIC THERAPY PREMOLAR TOOTH	$ 1,210.75
D3330	ENODODONTIC THERAPY MOLAR	$ 1,501.25
D3331	TREATMENT RC OBSTRUCTION; NON-SURGICAL ACCESS	$ 387.50
D3332	INCOMPLETE ENDO TX; INOP UNRESTORABLE/FX TOOTH	$ 736.00
D3333	INTERNAL ROOT REPAIR OF PERFORATION DEFECTS	$ 339.00
D3346	RETREATMENT PREVIOUS RC THERAPY - ANTERIOR	$ 1,317.50
D3347	RETREATMENT PREVIOUS RC THERAPY - PREMOLAR	$ 1,550.00
D3348	RETREATMENT PREVIOUS ROOT CANAL THERAPY - MOLAR	$ 1,918.00
D3351	APEXIFICATION/RECALCIFICAT INIT VST	$ 604.00
D3352	APEXIFICAT/RECALCIFICAT INT MED REPL	$ 270.75
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	$ 833.00
D3355	PULPAL REGENERATION - INITIAL VISIT	$ 604.00
D3356	PULPAL REGEN - INTERIM MED RPLCMNT	$ 270.75
D3357	PULPAL REGENERATION - COMPLETION OF TREATMENT	BR

D3410	APICOECTOMY - ANTERIOR	$ 1,197.50
D3421	APICOECTOMY - PREMOLAR (FIRST ROOT)	$ 1,333.25
D3425	APICOECTOMY - MOLAR (FIRST ROOT)	$ 1,510.25
D3426	APICOECTOMY (EACH ADDITIONAL ROOT)	$ 510.50
D3427	PERIRADICULAR SURGERY WITHOUT APICOECTOMY	$ 1,083.25
D3428	BG IN CONJ PERIRADICULAR SURG/TOOTH SINGLE SITE	$ 1,579.00
D3429	BG IN CONJ PERIRADICUL SURG EACH CONTIG TH SSS	$ 1,506.00
D3430	RETROGRADE FILLING - PER ROOT	$ 375.00
D3431	BIO MAT SFT OSS REGE CONJ PERIR SUR	$ 1,854.00
D3432	GTR RESORB BRRER PER SITE IN CONJ PERIRAD SURG	$ 1,593.25
D3450	ROOT AMPUTATION - PER ROOT	$ 781.00
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	$ 2,916.00
D3470	INTENTIONAL REIMPLANTATION W/NECESSARY SPLINTING	$ 1,489.25
D3910	SURGICAL PROCEDURE ISOLATION TOOTH W/RUBBER DAM	$ 208.25
D3920	HEMISECTION NOT INCLUDING ROOT CANAL THERAPY	$ 593.50
D3950	CANAL PREPARATION&FITTING PREFORMED DOWEL/POST	$ 270.75
D3999	UNSPECIFIED ENDODONTIC PROCEDURE BY REPORT	BR
D4210	GINGIVECT/PLSTY 4/>CNTIG/TOOTH BOUND SPACES-QUAD	$ 1,249.50
D4211	GINGIVECT/PLSTY 1-3 CNTIG/TOOTH BOUND SPACE-QUAD	$ 555.00
D4212	GINGIVECT/PLSTY 1-3CNTIG PER TOOTH	$ 444.25
D4230	ANAT CROWN EXP 4/> CONTIGUOUS TEETH PER QUAD	$ 1,749.00
D4231	ANATOMICAL CROWN EXPOSURE 1-3 TEETH PER QUADRANT	$ 833.00
D4240	GINGL FLP PROC 4/> CONTIG/TOOTH BOUND SPACE-QUAD	$ 1,582.50
D4241	GINGL FLP PROC 1-3 CONTIG/TOOTH BOUND SPACE-QUAD	$ 916.25
D4245	APICALLY POSITIONED FLAP	$ 1,166.00
D4249	CLINICAL CROWN LENGTHENING - HARD TISSUE	$ 1,734.75
D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	$ 2,637.25
D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	$ 1,416.00
D4263	BONE REPLACEMENT GRAFT - FIRST SITE IN QUADRANT	$ 943.75
D4264	BONE REPLACEMENT GRAFT - EA ADD SITE QUADRANT	$ 805.00
D4265	BIOLOGIC MATERIALS AID SOFT&OSSEOUS TISSUE REGEN	BR
D4266	GUID TISSUE REGEN - RESORBABLE BARRIER PER SITE	$ 971.50
D4267	GUID TISSUE REGEN - NONRESORB BARRIER PER SITE	$ 1,249.50
D4268	SURGICAL REVISION PROCEDURE PER TOOTH	BR
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	$ 1,873.75
D4273	AUTOGNS CONECTIVE TISSUE GRFT 1ST TOOTH/IMPLANT	$ 2,290.25
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE	$ 1,299.25
D4275	NONAUTGNS CONECTV TISSUE GRFT 1ST TOOTH/IMPLANT	$ 1,721.25
D4276	COMB CNCTIVE TISSUE&DBL PEDICLE GRAFT PER TOOTH	$ 2,567.75
D4277	FREE SOFT TISSUE GRAFT, 1ST TOOTH/ IMPLANT	$ 1,943.25
D4278	FREE SOFT TISSUE GRAFT, E/ADNL TOOTH, IMPLNT	$ 638.50
D4283	AUTO CNNCTV TISSUE GRFT PROC E/A TOOTH, IMPLANT	$ 1,951.50
D4285	NON-AUTO CNNCTV TSSUE GRFT PROC E/A TOOTH/IMPLNT	$ 1,468.50

D4320	PROVISIONAL SPLINTING - INTRACORONAL	$	612.50
D4321	PROVISIONAL SPLINTING - EXTRACORONAL	$	556.75
D4341	PRDONTAL SCALING&ROOT PLANING 4/MORE TEETH-QUAD	$	352.50
D4342	PRDONTAL SCALING&ROOT PLANING 1-3 TEETH-QUAD	$	204.25
D4346	SCALNG GNGIVAL INFLAMM FULL MOUTH AFTR ORAL EVAL	$	204.25
D4355	FULL MOUTH DEBRID ENABLE COMP EVALUATION&DX	$	241.25
D4381	LOC DEL ANTIMICROBL AGTS CREVICULR TISS TOOTH BR	BR	
D4910	PERIODONTAL MAINTENANCE	$	217.25
D4920	UNSCHEDULED DRESSING CHANGE	$	157.75
D4921	GINGIVAL IRRIGATION PER QUADRANT	BR	
D4999	UNSPECIFIED PERIODONTAL PROCEDURE BY REPORT	BR	
D5110	COMPLETE DENTURE - MAXILLARY	$	2,383.50
D5120	COMPLETE DENTURE - MANDIBULAR	$	2,383.50
D5130	IMMEDIATE DENTURE - MAXILLARY	$	2,598.50
D5140	IMMEDIATE DENTURE - MANDIBULAR	$	2,598.50
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	$	2,011.50
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	$	2,337.75
D5213	MAX PART DENTUR-CAST METL FRMEWRK W/RSN BASE	$	2,633.50
D5214	MAND PART DENTUR- CAST METL FRMEWRK W/RSN BASE	$	2,633.50
D5221	IMMED MAXILLARY PARTIAL DENTURE RESIN BASE	$	2,194.25
D5222	IMMED MANDIBULAR PARTIAL DENTURE RESIN BASE	$	2,548.75
D5223	IMMED MAXIL PART DENTURE CAST METL FRAME W/RESIN	$	2,870.50
D5224	IMMED MAND PART DENTURE CAST METL FRAME W/RESIN	$	2,870.50
D5225	MAXILLARY PARTIAL DENTRUE FLEXIBLE BASE	$	2,011.50
D5226	MANDIBULAR PARTIAL DENTURE FLEXIBLE BASE	$	2,337.75
D5282	RMVBL UNIL PRTL DNTR CST MTL INCL CLSP TTH MXLRY	$	1,535.25
D5283	RMVBL UNIL PRTL DNTR CST MTL INCL CLSP TTH MNDBL	$	1,535.25
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	$	130.50
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	$	130.50
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	$	130.50
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	$	130.50
D5511	REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR	$	261.00
D5512	REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY	$	261.00
D5520	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	$	217.25
D5611	REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR	$	282.50
D5612	REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY	$	282.50
D5621	REPAIR CAST FRAMEWORK, MANDIBULAR	$	304.50
D5622	REPAIR CAST FRAMEWORK, MAXILLARY	$	304.50
D5630	REPAIR OR REPLACE BROKEN CLASP PER TOOTH	$	369.50
D5640	REPLACE BROKEN TEETH - PER TOOTH	$	239.25
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	$	326.25
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE PER TOOTH	$	391.50
D5670	REPLACE ALL TEETH&ACRYLIC CAST METAL FRMEWRK MAX	$	956.75

D5671	REPLACE ALL TEETH&ACRYLIC CAST METL FRMEWRK MAND	$ 956.75
D5710	REBASE COMPLETE MAXILLARY DENTURE	$ 967.75
D5711	REBASE COMPLETE MANDIBULAR DENTURE	$ 924.00
D5720	REBASE MAXILLARY PARTIAL DENTURE	$ 913.75
D5721	REBASE MANDIBULAR PARTIAL DENTURE	$ 913.75
D5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)	$ 546.00
D5731	RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)	$ 546.00
D5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)	$ 500.25
D5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)	$ 500.25
D5750	RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)	$ 728.50
D5751	RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)	$ 728.50
D5760	RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)	$ 717.75
D5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)	$ 717.75
D5810	INTERIM COMPLETE DENTURE (MAXILLARY)	$ 1,152.50
D5811	INTERIM COMPLETE DENTURE (MANDIBULAR)	$ 1,239.50
D5820	INTERIM PARTIAL DENTURE (MAXILLARY)	$ 891.50
D5821	INTERIM PARTIAL DENTURE (MANDIBULAR)	$ 946.00
D5850	TISSUE CONDITIONING MAXILLARY	$ 228.50
D5851	TISSUE CONDITIONING MANDIBULAR	$ 228.50
D5862	PRECISION ATTACHMENT BY REPORT	BR
D5863	OVERDENTURE COMPLETE MAXILLARY	$ 2,522.25
D5864	OVERDENTURE PARTIAL MAXILLARY	$ 3,327.00
D5865	OVERDENTURE COMPLETE MIBULAR	$ 2,522.25
D5866	OVERDENTURE PARTIAL MIBULAR	$ 3,457.50
D5867	REPLACEMENT REPL PART SEMI-PRCISN/PRCISN ATTCH	BR
D5875	MODIFICATION REMV PROSTH AFTER IMPLANT SURGERY	BR
D5876	ADD MTL SUBSTRUCTR TO ACRYLIC FULL DNTR PER ARCH	BR
D5899	UNS REMOVABLE PROSTHODONTIC PROCEDURE REPORT	BR
D5911	FACIAL MOULAGE (SECTIONAL)	$ 604.50
D5912	FACIAL MOULAGE (COMPLETE)	$ 604.50
D5913	NASAL PROSTHESIS	$ 12,730.25
D5914	AURICULAR PROSTHESIS	$ 12,730.25
D5915	ORBITAL PROSTHESIS	$ 17,227.25
D5916	OCULAR PROSTHESIS	$ 4,595.00
D5919	FACIAL PROSTHESIS	BR
D5922	NASAL SEPTAL PROSTHESIS	BR
D5923	OCULAR PROSTHESIS INTERIM	BR
D5924	CRANIAL PROSTHESIS	BR
D5925	FACIAL AUGMENTATION IMPLANT PROSTHESIS	BR
D5926	NASAL PROSTHESIS REPLACEMENT	BR
D5927	AURICULAR PROSTHESIS REPLACEMENT	BR
D5928	ORBITAL PROSTHESIS REPLACEMENT	BR
D5929	FACIAL PROSTHESIS REPLACEMENT	BR

D5931	OBTURATOR PROSTHESIS SURGICAL	$ 6,854.25
D5932	OBTURATOR PROSTHESIS DEFINITIVE	$ 12,819.50
D5933	OBTURATOR PROSTHESIS MODIFICATION	BR
D5934	MANDIBULAR RESECTION PROSTHESIS W/GUIDE FLANGE	$ 11,684.00
D5935	MANDIBULAR RESECTION PROSTHESIS W/O GUIDE FLANGE	$ 10,166.50
D5936	OBTURATOR PROSTHESIS INTERIM	$ 11,419.00
D5937	TRISMUS APPLIANCE (NOT FOR TMD TREATMENT)	$ 1,435.25
D5951	FEEDING AID	$ 1,865.75
D5952	SPEECH AID PROSTHESIS PEDIATRIC	$ 6,058.50
D5953	SPEECH AID PROSTHESIS ADULT	$ 11,505.75
D5954	PALATAL AUGMENTATION PROSTHESIS	$ 10,662.25
D5955	PALATAL LIFT PROSTHESIS DEFINITIVE	$ 9,861.75
D5958	PALATAL LIFT PROSTHESIS INTERIM	BR
D5959	PALATAL LIFT PROSTHESIS MODIFICATION	BR
D5960	SPEECH AID PROSTHESIS MODIFICATION	BR
D5982	SURGICAL STENT	$ 967.75
D5983	RADIATION CARRIER	$ 2,174.75
D5984	RADIATION SHIELD	$ 2,174.75
D5985	RADIATION CONE LOCATOR	$ 2,174.75
D5986	FLUORIDE GEL CARRIER	$ 217.25
D5987	COMMISSURE SPLINT	$ 3,262.00
D5988	SURGICAL SPLINT	$ 652.50
D5991	VESICULOBULLOUS DISEASE MEDICAMENT CARRIER	$ 250.00
D5992	ADJUST MAXILLOFACIAL PROSTH APPLIANCE BY REPORT	BR
D5993	MAINT / CLEAN MAXILLOFACIAL PROSTH BY REPORT	BR
D5994	PERIDONL MEDIC CARRIER PERIPH SEAL LAB PRCESSD	BR
D5999	UNSPECIFIED MAXILLOFACIAL PROSTHESIS BY REPORT	BR
D6010	SURG PLACEMENT IMPLANT BODY: ENDOSTEAL IMPLANT	$ 3,981.75
D6011	SECOND STAGE IMPLANT SURGERY	BR
D6012	SURG PLCMT INTERIM IMPL TRNSITIONL PROS: ENDOS	$ 3,762.25
D6013	SURGICAL PLACEMENT OF MINI IMPLANT	$ 3,981.75
D6040	SURGICAL PLACEMENT: EPOSTEAL IMPLANT	$ 13,700.25
D6050	SURGICAL PLACEMENT: TRANSOSTEAL IMPLANT	$ 10,220.75
D6051	INTERIM ABUTMENT	BR
D6052	SEMI-PRECISION ATTACHMENT ABUTMENT	$ 1,687.50
D6055	CONNECTING BAR IMPLANT OR ABUTMENT SUPPORTED	$ 1,196.00
D6056	PREFABRICATED ABUTMENT INCLUDES PLACEMENT	$ 826.50
D6057	CUSTOM FABRICATED ABUTMENT INCLUDES PLACEMENT	$ 1,022.00
D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	$ 2,292.00
D6059	ABUT SUPP PORCELAIN TO METL CROWN HI NOBLE METL	$ 2,261.50
D6060	ABUT SUPP PORCELAIN TO MTL CROWN PREDOM BASE MTL	$ 2,137.75
D6061	ABUT SUPP PORCELAIN TO METAL CROWN NOBLE METAL	$ 2,181.25
D6062	ABUTMENT SUPP CAST METAL CROWN HIGH NOBLE METAL	$ 2,172.50

D6063	ABUTMENT SUPP CAST METAL CROWN PREDOM BASE METAL	$ 1,891.75
D6064	ABUTMENT SUPP CAST METAL CROWN NOBLE METAL	$ 1,979.00
D6065	IMPL SUPP PORCELAIN/CERAMIC CROWN	$ 2,255.00
D6066	IMPL SUPP PORCLN FUSED METL CRWN TITNM/HIGH NOBL	$ 2,196.25
D6067	IMPL SUPP METAL CROWN TITIANM/HIGH NOBLE METL	$ 2,131.25
D6068	ABUT SUPP RETAINER PORCELAIN/CERAMIC FPD	$ 2,272.50
D6069	ABUT RETAINR PORCELN TO METL FPD HI NOBL METL	$ 2,261.50
D6070	ABUT RETN PORCELN TO METL FPD PREDOM BASE METL	$ 2,137.75
D6071	ABUT SUPP RETN PORCELN FUSD METAL FPD NOBLE METL	$ 2,181.25
D6072	ABUT SUPP RETN CAST METL FPD HIGH NOBLE METL	$ 2,207.00
D6073	ABUT RTNR CAST METL FPD PREDOM BASE METL	$ 2,016.00
D6074	ABUTMENT RTNR CAST METAL FPD NOBLE METAL	$ 2,142.00
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	$ 2,255.00
D6076	IMPL SUPP RTNR PORCLN FUSED METL FPD TITNM/HIGH	$ 2,196.25
D6077	IMPL SUPP RTNR CST METL FPD TITNM/HIGH NOBLE	$ 2,131.25
D6080	IMPL MAINT PROC REMV CLEAN PROSTH & ABUT REINSRT	$ 187.25
D6081	SCALNG/DBRDMNT IMPLNT WO FLAP ENTRY/CLOS	$ 95.75
D6085	PROVISIONAL IMPLANT CROWN	$ 656.75
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS BY REPORT	BR
D6091	REPL ATTACHMNT IMPL/ABUT SUPP PROS PER ATTACHMNT	$ 902.50
D6092	RECEMENT / REBOND IMPLANT/ABUTMENT SUPP CROWN	$ 176.25
D6093	RECMNT/REBOND IMPL/ABUTMNT SUPP FIX PART DENTURE	$ 276.25
D6094	ABUTMENT SUPPORTED CROWN TITANIUM	$ 1,793.75
D6095	REPAIR IMPLANT ABUTMENT BY REPORT	BR
D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	BR
D6100	IMPLANT REMOVAL BY REPORT	BR
D6101	DBRDMNT OF PERI-IMPLANT DEFECT	$ 645.75
D6102	DBRDMNT OF PERI-IMPLANT DEFECT	$ 887.25
D6103	BONE GRFT RPR PERIIMPLNT DFCT W/O FLAP ENTR/CLSE	$ 739.50
D6104	BONE GRAFT AT TIME OF IMPLANT PLACEMENT	$ 739.50
D6110	IMPL/ABUTMENT SUPPORTED RD - MAXILLARY	$ 2,972.75
D6111	IMPL/ABUTMENT SUPPORTED RD - MANDIBULAR	$ 2,972.75
D6112	IMPL/ABUTMENT SUPPORTED RPD - MAXILLARY	$ 2,972.75
D6113	IMPLANT / ABUTMENT SUPPORTED RPD - MANDIBULAR	$ 2,972.75
D6114	IMPLANT / ABUTMENT SUPPORTED FD - MAXILLARY	$ 5,206.00
D6115	IMPLANT/ABUTMENT SUPPORTED FD - MANDIBULAR	$ 5,206.00
D6116	IMPL/ABUTMENT SUPPORTED FD - MAXILLARY - PARTIAL	$ 3,992.50
D6117	IMPL/ABUT SUPPORTED FD - MANDIBULAR - PARTIAL	$ 3,992.50
D6118	IMP/ABUT SPRTD INTRM FIXED DENTR EDENTLS MANDBLR	$ 2,707.25
D6119	IMP/ABUT SPRTD INTRM FIXED DENTR EDENTLS MAXLARY	$ 2,707.25
D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX BY REPORT	$ 402.25
D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD	$ 1,848.25
D6199	UNSPECIFIED IMPLANT PROCEDURE BY REPORT	BR

D6205	PONTIC - INDIRECT RESIN BASED COMPOSITE	$	931.25
D6210	PONTIC - CAST HIGH NOBLE METAL	$	1,423.75
D6211	PONTIC - CAST PREDOMINANTLY BASE METAL	$	1,334.25
D6212	PONTIC - CAST NOBLE METAL	$	1,388.25
D6214	PONTIC - TITANIUM	$	1,432.75
D6240	PONTIC - PORCELAIN FUSED TO HIGH NOBLE METAL	$	1,406.00
D6241	PONTIC - PORCELN FUSED PREDOMINANTLY BASE METAL	$	1,298.50
D6242	PONTIC - PORCELAIN FUSED TO NOBLE METAL	$	1,370.00
D6245	PONTIC - PORCELAIN/CERAMIC	$	1,450.75
D6250	PONTIC - RESIN WITH HIGH NOBLE METAL	$	1,388.25
D6251	PONTIC - RESIN WITH PREDOMINANTLY BASE METAL	$	1,280.50
D6252	PONTIC - RESIN WITH NOBLE METAL	$	1,321.75
D6253	PROVISIONAL PONTIC	$	598.25
D6545	RETAINER - CAST METAL RESIN BONDED FIX PROSTH	$	530.25
D6548	RETAINER - PORCELN/CERAMIC RSN BONDED FIX PROSTH	$	582.75
D6549	RESIN RETAINER FOR RESIN BONDED FIXED PROSTHESIS	$	382.00
D6600	RETAINER INLAY - PORCELAIN/CERAMIC TWO SURFACES	$	1,052.25
D6601	RETAINER INLAY - PORC/CERAMIC 3 OR MORE SURFACES	$	1,103.25
D6602	RETAINER INLAY CAST HIGH NOBLE METAL 2 SURFACES	$	1,124.25
D6603	RETAINR INLAY - CAST HI NOBLE METAL 3/MORE SURFS	$	1,237.00
D6604	RETAINER INLAY - CAST PREDOM BASE METAL 2 SURFS	$	1,102.00
D6605	RTAINR INLAY - CAST PREDOM BASE MTL 3/MORE SURFS	$	1,167.50
D6606	RETAINER INLAY - CAST NOBLE METAL TWO SURFACES	$	1,084.25
D6607	RETNR INLAY CAST NOBLE METAL 3 OR MORE SURFACES	$	1,202.75
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC TWO SURFACES	$	1,143.50
D6609	RETAINER ONLAY PORCELAIN/CERAMIC 3/MORE SURFACES	$	1,193.50
D6610	RETAINER ONLAY - HIGH NOBLE METAL TWO SURFACES	$	1,212.75
D6611	RETAINER ONLAY HIGH NOBLE METAL 3/MORE SURFACES	$	1,326.50
D6612	RETAINER ONLAY CAST PREDOM BASE METAL 2 SURFACES	$	1,206.25
D6613	RETNR ONLAY CAST PREDOM BASE METAL 3/MORE SURFS	$	1,260.75
D6614	RETAINER ONLAY - CAST NOBLE METAL TWO SURFACES	$	1,180.75
D6615	RETNR ONLAY CAST NOBLE METAL 3 OR MORE SURFACES	$	1,227.00
D6624	RETAINER INLAY - TITANIUM	$	1,124.25
D6634	RETAINER ONLAY - TITANIUM	$	1,180.75
D6710	RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE	$	1,204.50
D6720	RETAINER CROWN - RESIN WITH HIGH NOBLE METAL	$	1,405.25
D6721	RETAINER CROWN - RESIN WITH PREDOM BASE METAL	$	1,333.00
D6722	RETAINER CROWN - RESIN WITH NOBLE METAL	$	1,357.25
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	$	1,477.50
D6750	RETNR CROWN PORCELAIN FUSED TO HIGH NOBLE METAL	$	1,439.25
D6751	RETNR CROWN PORCELAIN FUSED PREDOM BASE METAL	$	1,342.50
D6752	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	$	1,374.75
D6780	RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL	$	1,357.25

D6781	RETAINER CROWN 3/4 CAST PREDOMINANTLY BASE METAL	$ 1,357.25
D6782	RETAINER CROWN - 3/4 CAST NOBLE METAL	$ 1,260.75
D6783	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	$ 1,397.25
D6790	RETAINER CROWN - FULL CAST HIGH NOBLE METAL	$ 1,389.25
D6791	RETAINER CROWN FULL CAST PREDOM BASE METAL	$ 1,316.75
D6792	RETAINER CROWN - FULL CAST NOBLE METAL	$ 1,365.00
D6793	PROVISIONAL RETAINER CROWN	$ 570.25
D6794	RETAINER CROWN - TITANIUM	$ 1,365.00
D6920	CONNECTOR BAR	$ 388.50
D6930	RECEMENT / REBOND FIXED PARTIAL DENTURE	$ 226.25
D6940	STRESS BREAKER	$ 513.75
D6950	PRECISION ATTACHMENT	$ 992.50
D6980	FIXED PARTIAL DENTURE REPAIR BY REPORT	BR
D6985	PEDIATRIC PARTIAL DENTURE FIXED	$ 863.25
D6999	UNSPECIFIED FIXED PROSTHODONTIC PROCEDURE REPORT	BR
D7111	EXTRACTION CORONAL REMNANTS - PRIMARY TOOTH	$ 181.50
D7140	EXTRACTION ERUPTED TOOTH OR EXPOSED ROOT	$ 241.25
D7210	SURG REMOVAL ERUPTED TOOTH REMV BONE ELEV FLAP	$ 360.50
D7220	REMOVAL OF IMPACTED TOOTH - SOFT TISSUE	$ 451.75
D7230	REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY	$ 601.00
D7240	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY	$ 705.50
D7241	REMV IMP TOOTH - CMPL BONY W/UNUSUAL SURG COMPS	$ 886.25
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS	$ 380.75
D7251	CORONECTOMY INTENTIONAL PARTIAL TOOTH REMOVAL	$ 746.50
D7260	OROANTRAL FISTULA CLOSURE	$ 3,281.25
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	$ 1,367.00
D7270	TOOTH REIMPL &OR STBL ACC EVULSED/DISPLCD TOOTH	$ 1,025.25
D7272	TOOTH TRANSPLANTATION	$ 1,367.00
D7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH	$ 956.75
D7282	MOBILIZ ERUPTED/MALPOSITIONED TOOTH AID ERUPTION	$ 478.50
D7283	PLCMT DEVICE FACILITATE ERUPTION IMPACTED TOOTH	$ 410.00
D7285	BIOPSY OF ORAL TISSUE HARD	$ 1,914.00
D7286	BIOPSY OF ORAL TISSUE SOFT	$ 820.50
D7287	EXFOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	$ 328.00
D7288	BRUSH BIOPSY - TRANSEPITHELIAL SAMPLE COLLECTION	$ 328.00
D7290	SURGICAL REPOSITIONING OF TEETH	$ 820.50
D7291	TRANSSEPTAL FIBEROT/SUPRA CRESTAL FIBEROT BR	BR
D7292	SURG PLCMT: TEMP ANCHORAGE SCREW RET PLATE FLAP	$ 1,312.50
D7293	SURG PLCMT: TEMP ANCHORAGE DEVICE RQR SURG FLAP	$ 820.50
D7294	SURG PLCMT: TEMP ANCHORAGE DEVICE W/O SURG FLAP	$ 683.50
D7295	HARVEST BONE FOR USE AUTOGENOUS GRAFTING PROC	BR
D7296	CORTICOTOMY 1 - 3 TEETH OR TOOTH SPACES PER QUAD	BR
D7297	CORTCTMY 4 OR MORE TEETH OR TOOTH SPCES PER QUAD	BR

D7310	ALVEOLOPLASTY W/EXTRACTION 4/> TEETH/SPACE QUAD	$ 582.50
D7311	ALVEOLOPLSTY CONJNC XTRACT 1-3 TEETH/SPACES QUAD	$ 509.75
D7320	ALVEOLOPLASTY NOT W/EXTRACTIONS 4/> TEETH/SPACE	$ 947.00
D7321	ALVEOLOPLSTY NOT CNJNC XTRCT 1-3 TEETH/SPCE QUAD	$ 801.00
D7340	VESTIBULOPLASTY RIDGE EXT SEC EPITHELIALIZATION	$ 4,005.25
D7350	VESTIBULOPLASTY RIDGE EXT W/SOFT TISS GRAFTS	$ 11,652.25
D7410	EXCISION OF BENIGN LESION UP TO 1.25 CM	$ 1,747.75
D7411	EXCISION OF BENIGN LESION GREATER THAN 1.25 CM	$ 2,767.50
D7412	EXCISION OF BENIGN LESION COMPLICATED	$ 3,058.75
D7413	EXCISION OF MALIGNANT LESION UP TO 1.25 CM	$ 2,039.00
D7414	EXCISION OF MALIGNANT LESION > 1.25 CM	$ 3,058.75
D7415	EXCISION OF MALIGNANT LESION COMPLICATED	$ 3,422.50
D7440	EXC MALIG TUMOR-LESION DIAMETER UP TO 1.25 CM	$ 2,767.50
D7441	EXC MALIG TUMOR-LESION DIAM GREATER THAN 1.25 CM	$ 4,078.25
D7450	REMOVAL BEN ODONTOGENIC CYST/TUMR- UP T0 1.25 CM	$ 1,747.75
D7451	REMOVAL BENIGN ODONTOGENIC CYST/TUMOR- > 1.25 CM	$ 2,388.50
D7460	REMOVAL BEN NONODONTOGENIC CYST/TUMR- UP 1.25 CM	$ 1,747.75
D7461	REMOVAL BEN NONODONTOGENIC CYST/TUMOR > 1.25 CM	$ 2,388.50
D7465	DESTRUCTION LESION PHYSICAL/CHEM METHOD BY REPRT	$ 947.00
D7471	REMOVAL OF LATERAL EXOSTOSIS	$ 2,164.50
D7472	REMOVAL OF TORUS PALATINUS	$ 2,572.25
D7473	REMOVAL OF TORUS MANDIBULARIS	$ 2,426.50
D7485	SURGICAL REDUCTION OF OSSEOUS TUBEROSITY	$ 2,164.50
D7490	RADICAL RESECTION OF MAXILLA OR MANDIBLE	$ 17,478.25
D7510	INCISION & DRAINAGE ABSCESS-INTRAORAL SOFT TISS	$ 626.50
D7511	I & D ABSCESS INTRAORAL SOFT TISSUE COMPLICATED	$ 947.00
D7520	INCISION & DRAINAGE ABSCESS-EXTRAORAL SOFT TISS	$ 2,983.00
D7521	I & D ABSCESS EXTRAORAL SOFT TISSUE COMPLICATED	$ 3,277.00
D7530	REMOVAL FB FROM MUCOSA SKIN/SUBCUT ALVEOL TISSUE	$ 1,074.75
D7540	REMV REACT-PRODUC FOREIGN BODIES-MUSCULOSKEL SYS	$ 1,191.25
D7550	PART OSTEC/SEQUESTRECTOMY REMOVAL NON-VITAL BONE	$ 742.75
D7560	MAXILLARY SINUSOTOMY REMOVAL TOOTH FRAGMENT/FB	$ 5,899.00
D7610	MAXILLA-OPEN REDUCTION	$ 9,540.00
D7620	MAXILLA-CLOSED REDUCTION	$ 7,154.25
D7630	MANDIBLE-OPEN REDUCTION	$ 12,403.75
D7640	MANDIBLE-CLOSED REDUCTION	$ 7,871.25
D7650	MALAR AND/OR ZYGOMATIC ARCH - OPEN REDUCTION	$ 5,963.00
D7660	MALAR AND/OR ZYGOMATIC ARCH - CLOSED REDUCTION	$ 3,516.25
D7670	ALVEOLUS-CLOSED REDUCTION W/STABILIZATION TEETH	$ 2,744.00
D7671	ALVEOLUS-OPEN REDUCTION W/STABILIZATION TEETH	$ 5,170.50
D7680	FCE BNS - COMP RDUC W/FIX&MX SURG APPRCHES CPT	$ 17,888.75
D7710	MAXILLA - OPEN REDUCTION	$ 11,212.00
D7720	MAXILLA - CLOSED REDUCTION	$ 7,871.25

D7730	MANDIBLE - OPEN REDUCTION	$ 16,219.75
D7740	MANDIBLE - CLOSED REDUCTION	$ 8,025.50
D7750	MALAR AND/OR ZYGOMATIC ARCH - OPEN REDUCTION	$ 10,207.25
D7760	MALAR AND/OR ZYGOMATIC ARCH - CLOSED REDUCTION	$ 4,095.50
D7770	ALVEOLUS - OPEN REDUCTION STABILIZATION OF TEETH	$ 5,549.25
D7771	ALVEOLUS CLOSED REDUCTION STABILIZATION OF TEETH	$ 4,282.00
D7780	FACIAL BONES-COMP RDUC FIX & MX SURG APPROACHES	$ 23,852.00
D7810	OPEN REDUCTION OF DISLOCATION	$ 10,492.75
D7820	CLOSED REDUCTION OF DISLOCATION	$ 1,718.75
D7830	MANIPULATION UNDER ANESTHESIA	$ 984.25
D7840	CONDYLECTOMY	$ 14,303.00
D7850	SURGICAL DISCECTOMY WITH/WITHOUT IMPLANT	$ 12,351.25
D7852	DISC REPAIR	$ 14,143.00
D7854	SYNOVECTOMY	$ 14,594.25
D7856	MYOTOMY	$ 10,355.75
D7858	JOINT RECONSTRUCTION	$ 29,518.00
D7860	ARTHROTOMY	$ 12,581.50
D7865	ARTHROPLASTY	$ 20,275.00
D7870	ARTHROCENTESIS	$ 670.00
D7871	NON-ARTHROSCOPIC LYSIS AND LAVAGE	$ 1,339.75
D7872	ARTHROSCOPY - DIAGNOSIS WITH OR WITHOUT BIOPSY	$ 7,151.50
D7873	ARTHROSCOPY SURGICAL: LAVAGE&LYSIS ADHESIONS	$ 8,611.00
D7874	ARTHROSCOPY SURGICAL: DISC REPSTN&STABILIZATION	$ 12,351.25
D7875	ARTHROSCOPY - SURGICAL: SYNOVECTOMY	$ 13,531.00
D7876	ARTHROSCOPY - SURGICAL: DISCECTOMY	$ 14,588.75
D7877	ARTHROSCOPY - SURGICAL: DEBRIDEMENT	$ 12,875.75
D7880	OCCLUSAL ORTHOTIC DEVICE BY REPORT	$ 1,608.00
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	$ 174.50
D7899	UNSPECIFIED TMD THERAPY BY REPORT	BR
D7910	SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM	$ 955.50
D7911	COMPLICATED SUTURE - UP TO 5 CM	$ 2,385.75
D7912	COMPLICATED SUTURE - GREATER THAN 5 CM	$ 4,293.75
D7920	SKIN GRAFT	$ 7,035.00
D7921	COLL APPL AUTOLOGOUS BLD CNCNTRT PRODUCT	$ 649.50
D7940	OSTEOPLASTY - FOR ORTHOGNATHIC DEFORMITIES	BR
D7941	OSTEOTOMY - MANDIBULAR RAMI	$ 17,915.25
D7943	OSTEOT-MANDIB RAMI W/BONE GRFT;INCL OBTAIN GRAFT	$ 16,458.50
D7944	OSTEOTOMY - SEGMENTED OR SUBAPICAL	$ 14,667.50
D7945	OSTEOTOMY - BODY OF MANDIBLE	$ 19,517.00
D7946	LEFORT I (MAXILLA - TOTAL)	$ 24,178.25
D7947	LEFORT I (MAXILLA - SEGMENTED)	$ 20,333.25
D7948	LEFORT II/LEFORT III - W/O BONE GRAFT	$ 26,392.00
D7949	LEFORT II OR LEFORT III - WITH BONE GRAFT	$ 34,374.00

D7950	OSSEOUS OSTEOPERIOSTEAL/CARTILAGE GRAFT MAND/MAX	BR
D7951	SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTES	BR
D7952	SINUS AUGMENTATION VIA A VERTICAL APPROACH	BR
D7953	BONE REPLCMT GRAFT RIDGE PRESERVATION PER SITE	$ 990.75
D7955	REPAIR MAXLOFACIAL SOFT &/ HARD TISSUE DEFECT	BR
D7960	FRENULECTOMY SEP PROC NOT INCIDENTL ANOTHER PROC	$ 801.00
D7963	FRENULOPLASTY	$ 1,311.00
D7970	EXCISION OF HYPERPLASTIC TISSUE - PER ARCH	$ 1,165.25
D7971	EXCISION OF PERICORONAL GINGIVA	$ 437.25
D7972	SURGICAL REDUCTION OF FIBROUS TUBEROSITY	$ 1,631.50
D7979	NON-SURGICAL SIALOLITHOTOMY	BR
D7980	SURGICAL SIALOLITHOTOMY	$ 1,835.25
D7981	EXCISION OF SALIVARY GLAND BY REPORT	BR
D7982	SIALODOCHOPLASTY	$ 4,340.25
D7983	CLOSURE OF SALIVARY FISTULA	$ 4,165.75
D7990	EMERGENCY TRACHEOTOMY	$ 3,583.00
D7991	CORONOIDECTOMY	$ 8,739.00
D7995	SYNTHETIC GRAFT-MANDIBLE/FACIAL BONES BY REPORT	BR
D7996	IMPLANT-MANDIBLE AUGMENTATION PURPOSES BY REPORT	BR
D7997	APPLIANCE REMOVAL INCLUDES REMOVAL OF ARCHBAR	$ 670.00
D7998	INTRAORAL PLCMT FIX DEVICE NOT CONJUNCTION W/FX	$ 2,913.00
D7999	UNSPECIFIED ORAL SURGERY PROCEDURE BY REPORT	BR
D8010	LIMITED ORTHODONTIC TREATMENT PRIMARY DENTITION	BR
D8020	LTD ORTHODONTIC TREATMENT TRANSITIONAL DENTITION	BR
D8030	LTD ORTHODONTIC TREATMENT ADOLESCENT DENTITION	BR
D8040	LIMITED ORTHODONTIC TREATMENT ADULT DENTITION	BR
D8050	INTERCEPTIVE ORTHODONTIC TX PRIMARY DENTITION	BR
D8060	INTRCPTV ORTHODONTIC TX TRANSITIONAL DENTITION	BR
D8070	COMP ORTHODONTIC TX TRANSITIONAL DENTITION	BR
D8080	COMPREHENSIVE ORTHODONTIC TX ADOLES DENTITION	BR
D8090	COMPREHENSIVE ORTHODONTIC TX ADULT DENTITION	BR
D8210	REMOVABLE APPLIANCE THERAPY	BR
D8220	FIXED APPLIANCE THERAPY	BR
D8660	PREORTHODONTIC TREATMENT VISIT	BR
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT	BR
D8680	ORTHODONTIC RETENTION	BR
D8681	REMOVABLE ORTHODONTIC RETAINER ADJUSTMENT	BR
D8690	ORTHODONTIC TREATMENT	BR
D8691	REPAIR OF ORTHODONTIC APPLIANCE	BR
D8692	REPLACEMENT OF LOST OR BROKEN RETAINER	BR
D8693	RE-CEMENT OR RE-BOND FIXED RETAINER	BR
D8694	REPAIR OF FIXED RETAINERS INCLUDES REATTACHMENT	BR
D8695	REMOVAL OF FIXED ORTHO APPLIANCES TX NOT COMPLT	BR

D8999	UNSPECIFIED ORTHODONTIC PROCEDURE BY REPORT	BR
D9110	PALLIATIVE EMERGENCY TX DENTAL PAIN MINOR PROC	$ 181.00
D9120	FIXED PARTIAL DENTURE SECTIONING	$ 204.75
D9130	TMJ JOINT DYSFUNCTION - NON-INVASIVE PHYSL THERP	BR
D9210	LOCAL ANES-NOT CONJUNCTION W/OP/SURGICAL PROC	$ 96.75
D9211	REGIONAL BLOCK ANESTHESIA	$ 107.00
D9212	TRIGEMINAL DIVISION BLOCK ANESTHESIA	$ 167.00
D9215	LOCAL ANESTHESIA CONJUCTION OPERATIVE/SURG PROC	$ 80.25
D9219	EVALUATION FOR DEEP SEDATION / GA	$ 190.25
D9222	DEEP SEDATION / GENERAL ANESTHESIA FIRST 15 MIN	$ 567.25
D9223	DEEP SEDATION/ GEN ANESTH EACH 15 MIN INCREMENT	$ 434.00
D9230	INHALATION OF NITROUS OXIDE/ANXIOLYSIS ANALGESIA	$ 160.00
D9239	IV MOD (CONSCIOUS) SEDTION/ANALGSIA FIRST 15 MIN	$ 467.00
D9243	IV MOD (CONSCIOUS) SEDATION EACH 15 MIN INCRMENT	$ 366.75
D9248	NON-INTRAVENOUS CONSCIOUS SEDATION	$ 233.75
D9310	CONSULT DX SERV DENT/PHY NOT REQUESTING DENT/PHY	$ 251.50
D9311	CONSULT WITH A MEDICAL HEALTHCARE PROFESSIONAL	$ 251.50
D9410	HOUSE/EXTENDED CARE FACILITY CALL	$ 287.25
D9420	HOSPITAL OR AMBULATORY SURGICAL CENTER CALL	$ 465.00
D9430	OFFICE VISIT OBSERVATION NO OTHER SRVC PERFORMED	BR
D9440	OFFICE VISIT - AFTER REGULARLY SCHEDULED HOURS	$ 157.00
D9450	CASE PRESENTATION DTL&EXT TREATMENT PLANNING	$ 78.50
D9610	THERAPEUTIC PARENTERAL DRUG SINGL ADMINISTRATION	BR
D9612	TX PARENTERAL DRUGS 2/> ADMINISTRATIONS DIFF MED	BR
D9613	INFLTRN SUSTND RELSE THRPTIC DRG SNGLE MTPL SITE	$ 81.75
D9630	OTHER DRUGS AND/OR MEDICAMENTS BY REPORT	BR
D9910	APPLICATION OF DESENSITIZING MEDICAMENT	$ 99.00
D9911	APPLIC DESENZT RSN CERV &OR ROOT SURF-TOOTH	$ 138.00
D9920	BEHAVIOR MANAGEMENT BY REPORT	BR
D9930	TX COMPLICATIONS - UNUSUAL CIRCUMSTANCES REPORT	BR
D9932	CLEAN/INSPECT REMOVBL COMPLETE MAXILLARY DENTURE	$ 242.50
D9933	CLEAN INSPECT REMVBL COMPLETE MANDIBULAR DENTURE	$ 242.50
D9934	CLEAN/ INSPECT REMVBL PARTIAL MAXILLARY DENTURE	$ 242.50
D9935	CLEAN INSPECT REMVBL PARTIAL MANDIBULAR DENTURE	$ 242.50
D9941	FABRICATION OF ATHLETIC MOUTHGUARD	$ 282.25
D9942	REPAIR AND/OR RELINE OF OCCLUSAL GUARD	$ 338.75
D9943	OCCLUSAL GUARD ADJUSTMENT	$ 169.25
D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL ARCH	$ 818.50
D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL ARCH	$ 818.50
D9946	OCCLUSAL GUARD HARD APPLIANCE PARTIAL ARCH	$ 818.50
D9950	OCCLUSION ANALYSIS - MOUNTED CASE	$ 536.00
D9951	OCCLUSAL ADJUSTMENT - LIMITED	$ 239.75
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	$ 1,128.75

D9961	DUPLICATE/COPY PATIENT'S RECORDS	BR	
D9970	ENAMEL MICROABRASION	$	126.75
D9971	ODONTOPLASTY 1-2 TEETH; INCL REMOVAL ENAMEL PROJ	$	163.75
D9972	EXTERNAL BLEACHING - PER ARCH	$	564.50
D9973	EXTERNAL BLEACHING - PER TOOTH	$	93.25
D9974	INTERNAL BLEACHING - PER TOOTH	$	493.75
D9975	EXTERNAL BLEACHING - PER ARCH	$	564.50
D9985	SALES TAX	BR	
D9986	MISSED APPOINTMENT	BR	
D9987	CANCELLED APPOINTMENT	BR	
D9990	CERT TRNSLATION OR SIGN LANGUAGE SRVCS PER VISIT	BR	
D9991	DENTAL CASE MGMT ADDRESS APPNTMNT COMPL BARRIERS	$	99.00
D9992	DENTAL CASE MANAGEMENT - CARE COORDINATION	$	99.00
D9993	DENTAL CASE MGMT - MOTIVATIONAL INTERVIEWING	$	99.00
D9994	DENTAL CASE MGMT - PATIENT EDU IMPRV ORAL HEALTH	$	135.25
D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME ENCOUNTER	$	451.25
D9996	TELDENTRY ASYNCHRNS INFO FWD DENTIST SBSQNT REVW	$	338.75
D9999	UNSPECIFIED ADJUNCTIVE PROC BY REPORT (01/2019)	BR	

Exhibit #7
Evaluation and Management (E&M) Documentation Guidelines
for Colorado Workers' Compensation Claims

Effective for Dates of Service on and after 1/1/2020

This E&M Guidelines for Colorado Workers' Compensation Claims is intended for the providers who manage injured workers' medical and non-medical care. Providers may also use the "1997 Documentation Guidelines for Evaluation and Management Services" as developed by Medicare. The Level of Service is determined by:

Key Components:

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

or

Time (as per CPT® and Rule 18)

Documentation requirements for any billed office visit:

- Chief complaint and medical necessity.
- Patient specific and pertain directly to the current visit.
- Information copied directly from prior records without change is not considered current or counted.
- CPT® criteria for a consultation is required to bill a consultation code.

Table I – History (Hx) Component: All three elements in the table must be met and documented.

History Elements	Requirements for a Problem Focused (PF) Level	Requirements for an Extended Problem Focused (EPF) Level	Requirements for a Detailed (D) Level	Requirements for a Comprehensive (C) Level
A. History of Present Illness/Injury (HPI)	1-3 elements	1-3 elements	4+ elements (requires a detailed patient specific description of the patient's progress with the current TX plan, which **should include objective functional gains/losses, ADLs, RTW, etc.)**	4+ elements (requires a detailed patient specific description of the patient's progress with the current TX plan, which **should include objective functional gains/losses, ADLs, RTW, etc.)**
B. Review of Systems (ROS)	Present	Present	Present	Present
C. Past Medical, Family, Social, Occupational History (PMFSOH)	None	None	Pertinent 1 of 4 types of histories	Pertinent 3 or more types of histories

A. HPI Elements represents the injured worker relaying his/her condition to the physician and should include the following:

1. Location (where?)
2. Quality (sharp, dull?)
3. Severity (pain level 1-10 or pain diagram)
4. Duration (how long?)
5. Timing (how often, regularity of occurrence, only at night, etc.?)
6. Context (what ADLs or functions aggravates/relieves, accident described?)
7. Modifying factors (doing what, what makes it worse or better?)
8. Associated signs (nausea, numbness or tingling when?)

For the provider to achieve an *"extended" HPI* in an initial patient/injured worker visit it is necessary for the provider to discuss the causality of the patient's work related injury(s) to the patient's job duties.

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

B. Review of Systems (ROS) should be qualitative versus quantitative, documenting what is pertinent to that patient for the date of service.

1. Constitutional symptoms (e.g., fever, weight loss)
2. Eyes
3. Ears, Nose, Mouth, Throat
4. Cardiovascular
5. Respiratory
6. Gastrointestinal
7. Genitourinary
8. Musculoskeletal
9. Integumentary (skin and/or breast)
10. Neurological
11. Psychiatric
12. Endocrine
13. Hematologic/Lymphatic
14. Allergic/Immunologic

C. PMFSOH consists of a review of four areas (NOTE: Employers should **not** have access to any patient or family genetic/hereditary diagnoses or testing information, etc.)

1. Past history – the patient's past experiences with illnesses, operations, injuries and treatments.
2. Family history – a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk and any family situations that can interfere with or support the injured worker's treatment plan and returning to work.
3. Occupational/Social History/Military – an age appropriate review of past and current work activities, occupational history, current work status, any work situations that support or interfere with return to work. For established visits specific updates of progress must be discussed.
4. Non-Occupational/Social History – Hobbies, current recreational physical activities and the patient's support relationships, etc. For established visits specific updates of progress must be discussed.

TABLE II: Examination Component: Each bullet is counted only when it is pertinent and related to the workers' compensation injury and the medical decision making process.

Physician's Examination Component	
Level of Examination Performed and Documented	**# of Bullets Required for each level**
Problem Focused (PF)	1-5 elements identified by a bullet as indicated in the guideline
Expanded Problem Focused (EPF)	6 elements identified by a bullet as indicated in this guideline
Detailed (D)	7-12 elements identified by a bullet as indicated in this guideline
Comprehensive (C)	≥13 elements identified by a bullet as indicated in this guideline

Examination Components:

Constitutional Measurement:

- Vital signs (may be measured and recorded by ancillary staff) – any of three (3) vital signs is counted as one bullet:
  1. sitting or standing blood pressure
  2. supine blood pressure
  3. pulse rate and regularity
  4. respiration
  5. temperature
  6. height
  7. weight or BMI
- One bullet for commenting on the general appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)

Musculoskeletal:

- Inspection and/or palpation of digits and nails (e.g., clubbing, cyanosis, inflammatory conditions, petechia, ischemia, infections, nodes) equals one bullet
- Gait and station assessment equals one bullet

Each of the six body areas with three (3) assessments is counted as one bullet.

1. head and or neck
2. spine or ribs and pelvis or all three
3. right upper extremity (shoulder, elbow, wrist, entire hand)
4. left upper extremity (shoulder, elbow, wrist, entire hand)
5. right lower extremity (hip, knee, ankle, entire foot)

6. left lower extremity (hip, knee, ankle, entire foot)

Assessment of a given body area includes:

- Inspection, percussion and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions
- Assessment of range of motion with notation of any pain (e.g., straight leg raise), crepitation or contracture
- Assessment of stability with notation of any dislocation (luxation), subluxation or laxity
- Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (fasciculation, tardive dyskinesia)

Neck: One bullet for both examinations.

- Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) and
- Examination of thyroid (e.g., enlargement, tenderness, mass)

Neurological: One bullet for each neurological examination/assessment(s) per extremity.

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

Cardiovascular:

1. One bullet for any extremity examination/assessment of peripheral vascular system by:
   - Observation (e.g., swelling, varicosities)
   - Palpation (e.g., pulses, temperature, edema, tenderness)
2. One bullet for palpation of heart (e.g., location, size, thrills)
3. One bullet for auscultation of heart with notation of abnormal sounds and murmurs
4. One bullet for examination of each one of the following:
   - carotid arteries (e.g., pulse amplitude, bruits)
   - abdominal aorta (e.g., size, bruits)
   - femoral arteries (e.g., pulse amplitude, bruits)

Skin: One bullet for pertinent body part(s) inspection and/or palpation of skin and subcutaneous tissue (e.g., scars, rashes, lesions, café au lait spots, ecchymosis, ulcers.)

Respiratory: One bullet for each examination/assessment.

- Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)
- Percussion of chest (e.g., dullness, flatness, hyperresonance)
- Palpation of chest (e.g., tactile fremitus)
- Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)

Gastrointestinal: One bullet for each examination /assessment.

- Examination of abdomen with notation of presence of masses or tenderness and liver and spleen
- Examination of presence or absence of hernia
- Examination (when indicated) of anus, perineum and rectum, including sphincter tone, present of hemorrhoids, rectal masses and/or obtain stool sample of occult blood test when indicated

Psychiatric:

1. One bullet for assessment of mood and affect (e.g., depression, anxiety, agitation) if not counted under the Neurological system
2. One bullet for a mental status examination which includes:
   - attention span and concentration; and
   - language (e.g., naming objects, repeating phrases, spontaneous speech) orientation to time, place and person; and
   - recent and remote memory; and
   - fund of knowledge (e.g., awareness of current events, past history, vocabulary.)

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

- Inspection of conjunctivae and lids; and
- Examination of pupils and irises (e.g., reaction of light and accommodation, size and symmetry); and
- Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)

Ears, Nose, Mouth and Throat: One bullet for all of the following examinations/assessments:

- External inspection of ears and nose (e.g., overall appearance, scars, lesions, asses)
- Otoscopic examination of external auditory canals and tympanic membranes
- Assessment of hearing with tuning fork and clinical speech reception thresholds (e.g., whispered voice, finger rub, tuning fork)

One bullet for all of the following examinations/assessments:

- Inspection of nasal mucosa, septum and turbinates
- Inspection of lips, teeth and gums
- Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx (e.g., asymmetry, lesions, hydration of mucosal surfaces)

Genitourinary Male: One bullet for each of the following examinations of the male genitalia:

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

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

- Examination of external genitalia (e.g., general appearance, hair distribution, lesions) and vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele rectocele)
- Examination of urethra (e.g., masses, tenderness, scarring)
- Examination of bladder (e.g., fullness, masses, tenderness)
- Cervix (e.g., general appearance, lesions, discharge)
- Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent or support)
- Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity)

Chest: One bullet for both examinations/assessments of both breasts:

- Inspection of breasts (e.g., symmetry, nipple discharge); and
- Palpation of breasts and axillae (e.g., masses or lumps, tenderness.)

Lymphatic palpation of lymph nodes: Two or more areas is counted as one bullet:

- Neck
- Axillae
- Groin
- Other

Verify all of the completed examination components listed in the report are documented, including the relevance/relatedness to the injury and or "reasonable and necessity" for that specified patient's condition. Any examination bullet that is not clearly related to the injury or a patient's specific condition will not be counted/considered in the total number of bullets for the level of service.

TABLE III: Medical Decision Making Component (MDM): TABLES 1,2 & 3

Overall MDM is determined by the highest 2 out of 3 categories below:

Type of Decision Making	A. # of Points for the # of Diagnosis and Management Options	B. # of Points for Amount and Complexity of Data	C. Level of Risk
Straightforward	0-1	0-1	Minimal
Low	2	2	Low
Moderate	3	3	Moderate
High	4+	4+	High

TABLE 1 - Number of Diagnosis and Management Options:

Category of Problem(s)	**Occurrence of Problem(s)**		**Value**
Self-limited or minor problem	(max = 2)	X	1
Established problem, stable or improved		X	1
Established problem, minor worsening		X	2
Established patient with worsening of condition and no additional workup planned	(max = 1)	X	**3**
Established patient with less than anticipated improvement, Worsening of condition and additional workup planned		X	4
New problem with no additional workup planned	(max = 1)	X	**3**
New problem with additional workup planned		X	4

TABLE 2 - Amount and/or Complexity of Data Reviewed:

Amount and/or Complexity of Data Reviewed	Points
Lab(s) ordered and/or reports reviewed	1
X-ray (s) ordered and/or reports reviewed	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than the patient	1
Medicine section (CPT® 90701-99199) ordered and /or physical therapy reports reviewed and commented on progress (state whether the patient is progressing and how they are functionally progressing or not and document any planned changes to the plan of care).	2
Review and summary of old records and/or discussion with other health provider	2
Independent visualization of images, tracing or specimen	2

TABLE 3 - Table of Risk (the highest one in any one category determines the overall risk for this portion):

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered or Addressed	Management Option(s) Section
Minimal	One self-limiting or minor problem, e.g., cold, insect bite, tinea corporis, minor non-sutured laceration.	Lab tests requiring venipuncture; Chest X-rays; EKG, EEG; Urinalysis; Ultrasound; KOH prep	Rest; Gargles; Elastic bandages; Superficial dressings
Low	Two or more self-limited or minor problems; One stable chronic illness, e.g., well controlled HTN, NIDDM, cataract, BPH; Acute, uncomplicated illness or injury, e.g., allergic rhinitis, simple sprain, cystitis, acute laceration repair	Physiologic tests not under stress, e.g., PFTs; Non-cardiovascular imaging studies with contrast, e.g., barium enema; Superficial needle biopsy; Lab tests requiring arterial puncture; Skin biopsies	Over-the-counter drugs; Minor surgery with no identified risk factors; PT/OT; IV fluids w/o additives; Simple or layered closure; Vaccine injection
Moderate	One or more chronic illness with mild exacerbation, progression or side effects of treatment; Two or more stable chronic illnesses; Undiagnosed new problem with uncertain prognosis, e.g., new extremity neurologic complaints; Acute illness with systemic symptoms, e.g., pyelonephritis colitis; Acute complicated injury, e.g., head injury, with brief loss of consciousness.	Physiologic tests under stress, e.g., cardiac stress test; Discography; Diagnostic injections; Deep needle or incisional biopsies; Cardiovascular imaging studies, with contrast, and no identified risk factors, e.g., arteriogram, cardiac catheterization; Obtain fluid from body cavity, e.g., thoracentesis, lumbar puncture.	Minor surgery, with identified risk factors; Elective major surgery (open, percutaneous, or endoscopic), with no identified risk factors; Prescription drug management; Therapeutic nuclear medicine; IV fluids with additives; Closed treatment of fracture or dislocation, without manipulation; Disability counseling and/or work restrictions, Inability to return the injured worker to work and requiring detailed functional improvement plan.

High	One or more chronic illness, with severe exacerbation, progression or side effects of treatment; Acute or chronic illness or injury, which poses a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolism, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness, with potential threat to self or others; An abrupt change in neurological status, e.g., seizure, TIA, weakness, sensory loss.	Cardiovascular imaging studies with contrast, with identified risk factors; Cardiac EP studies; Diagnostic endoscopies, with identified risk factors.	Elective major surgery (open, percutaneous, endoscopic), with identified risk factors; Emergency major surgery; Parenteral controlled substances; Drug therapy requiring intensive monitoring for toxicity, Decision not to resuscitate, or to de- escalate care because of poor prognosis; Potential for significant permanent work restrictions or total disability which would significantly restrict employment opportunities; Management of addiction behavior or other significant psychiatric condition; Treatment plan for patients with symptoms causing severe functional deficits without supporting physiological findings or verified related medical diagnosis.

New Patient/Office Consultations Level of Service Based on Key Components: CPT® consultation criteria must be met before a consultation can be billed for any level of service.

Level of Service (requires all three key components at the same level or higher)	**History**	**Examination**	**Medical Decision Making (MDM)**
99201 / 99241	Problem Focused (PF)	PF	Straight Forward (SF)
99202 / 99242	Extended PF	EPF	SF
99203 / 99243	Detailed (D)	D	Low
99204 / 99244	Comprehensive (C)	C	Moderate
99205 / 99245	Comprehensive (C)	C	High

Established Patient Office Visit Level of Service Based on Key Components

Level of Service (requires at least two of the three key components at the same level or higher and one of the two must be MDM)	**History**	**Examination**	**Medical Decision Making (MDM)**
99211	N/A	N/A	N/A
99212	Problem Focused (PF)	PF	SF
99213	Extended PF	EPF	Low
99214	Detailed (D)	D	Moderate
99215	Comprehensive (C)	C	High

Time Component:

- If greater than 50% of a physician's time at an E&M visit is spent either face-to-face with the patient counseling and/or coordination of care, with or without an interpreter, and there is detailed patient specific documentation of the counseling and/or coordination of care, then time can determine the level of service.
- If time is used to establish the level of visit and total amount of time falls in between two levels, then the provider's time shall be more than half way to reaching the higher level.

A. Counseling: Primary care physicians should have *shared decision making conferences* with their patients to *establish viable functional goals* prior to making referrals for diagnostic testing and/or to specialists. Shared decision making occurs when the physician shares with the patient all the treatment alternatives reflected in the Colorado Medical Treatment Guidelines as well as any possible side effects or limitations, and the patient shares with the primary physician his/her desired outcome from the treatment. Patients should be encouraged to express their goals, outcome expectations and desires from treatment as well as any personal habits or traits that may be impacted by procedures or their possible side effects.

1. The physician's time spent face-to-face with the patient and/or their family counseling him/her or them in one or more of the following:

- Injury/disease education that includes discussion of diagnostic tests results and a disease specific treatment plan.
- Return to work, temporary and/or permanent restrictions
- Review of other physician's notes (i.e., IME consultation)
- Self-management of symptoms while at home and/or work
- Correct posture/mechanics to perform work functions
- Exercises for muscle strengthening and stretching
- Appropriate tool and equipment use to prevent re-injury and/or worsening of the existing injury/condition
- Patient/injured worker expectations and specific goals
- Family and other interpersonal relationships and how they relate to psychological/social issues
- Discussion of pharmaceutical management (includes drug dosage, specific drug side effects and potential of addiction /problems)
- Assessment of vocational plans (i.e., restrictions as they relate to current and future employment job requirements)
- Discussion of the workers' compensation process (i.e. IMEs, MMI, role of case manager)

B. Coordination of Care: Coordination of care requires the physician to either call another health care provider (outside of their own clinic) regarding the patient's diagnosis and/or treatment or the physician telephones or visits the employer in-person to safely return the patient to work.

New Patient/Office Consultations Based on Time

Level of Service	Avg. time (minutes) as listed for the specific CPT® code
99201 / 99241	10
99202 / 99242	20
99203 / 99243	30
99204 / 99244	45
99205 / 99245	60

Established Patient Office Visit Based on Time

Level of Service	Avg. time (minutes) as listed for the specific CPT® code
99211	5
99212	10
99213	15
99214	25
99215	40

Exhibit #8

2019 Clinical Diagnostic Laboratory Fee Schedule

source: Medicare file - CLAB2019Q3

Effective 1/1/2020

HCPCS	MOD	SHORTDESC	INDICATOR	RATE
36415		Routine venipuncture	N	$ 3.00
36416		Capillary blood draw	B	$ 3.00
78267		Breath tst attain/anal c-14	N	$ 11.06
78268		Breath test analysis c-14	N	$ 94.41
80047		Metabolic panel ionized ca	N	$ 13.73
80047	QW	Metabolic panel ionized ca	N	$ 13.73
80048		Metabolic panel total ca	N	$ 9.40
80048	QW	Metabolic panel total ca	N	$ 9.40
80051		Electrolyte panel	N	$ 7.79
80051	QW	Electrolyte panel	N	$ 7.79
80053		Comprehen metabolic panel	N	$ 11.74
80053	QW	Comprehen metabolic panel	N	$ 11.74
80055		Obstetric panel	N	$ 53.12
80061		Lipid panel	N	$ 14.88
80061	QW	Lipid panel	N	$ 14.88
80069		Renal function panel	N	$ 9.65
80069	QW	Renal function panel	N	$ 9.65
80074		Acute hepatitis panel	N	$ 52.93
80076		Hepatic function panel	N	$ 9.08
80081		Obstetric panel	N	$ 83.18
80150		Assay of amikacin	N	$ 16.75
80155		Drug assay caffeine	N	$ 38.57
80156		Assay carbamazepine total	N	$ 16.18
80157		Assay carbamazepine free	N	$ 14.73
80158		Drug assay cyclosporine	N	$ 20.06
80159		Drug assay clozapine	N	$ 20.55
80162		Assay of digoxin total	N	$ 14.75
80163		Assay of digoxin free	N	$ 14.75
80164		Assay dipropylacetic acd tot	N	$ 15.05
80165		Dipropylacetic acid free	N	$ 15.05
80168		Assay of ethosuximide	N	$ 18.15

80169		Drug assay everolimus	N	$ 15.26
80170		Assay of gentamicin	N	$ 18.20
80171		Drug screen quant gabapentin	N	$ 21.67
80173		Assay of haloperidol	N	$ 16.18
80175		Drug screen quan lamotrigine	N	$ 14.73
80176		Assay of lidocaine	N	$ 16.32
80177		Drug scrn quan levetiracetam	N	$ 14.73
80178		Assay of lithium	N	$ 7.35
80178	QW	Assay of lithium	N	$ 7.35
80180		Drug scrn quan mycophenolate	N	$ 20.06
80183		Drug scrn quant oxcarbazepin	N	$ 14.73
80184		Assay of phenobarbital	N	$ 15.30
80185		Assay of phenytoin total	N	$ 14.73
80186		Assay of phenytoin free	N	$ 15.29
80188		Assay of primidone	N	$ 18.44
80190		Assay of procainamide	N	$ 60.00
80192		Assay of procainamide	N	$ 18.61
80194		Assay of quinidine	N	$ 16.22
80195		Assay of sirolimus	N	$ 15.26
80197		Assay of tacrolimus	N	$ 15.26
80198		Assay of theophylline	N	$ 15.71
80199		Drug screen quant tiagabine	N	$ 27.11
80200		Assay of tobramycin	N	$ 17.92
80201		Assay of topiramate	N	$ 13.24
80202		Assay of vancomycin	N	$ 15.05
80203		Drug screen quant zonisamide	N	$ 14.73
80299		Quantitative assay drug	N	$ 18.64
80305		Drug test prsmv dir opt obs	N	$ 12.60
80305	QW	Drug test prsmv dir opt obs	N	$ 12.60
80306		Drug test prsmv instrmnt	N	$ 17.14
80307		Drug test prsmv chem anlyzr	N	$ 64.65
80400		Acth stimulation panel	N	$ 36.24
80402		Acth stimulation panel	N	$ 96.62
80406		Acth stimulation panel	N	$ 86.95
80408		Aldosterone suppression eval	N	$ 139.44
80410		Calcitonin stimul panel	N	$ 89.31
80412		Crh stimulation panel	N	$ 801.62
80414		Testosterone response	N	$ 57.37
80415		Estradiol response panel	N	$ 62.09
80416		Renin stimulation panel	N	$ 209.32
80417		Renin stimulation panel	N	$ 48.88

80418		Pituitary evaluation panel	N	$ 643.84
80420		Dexamethasone panel	N	$ 161.88
80422		Glucagon tolerance panel	N	$ 51.19
80424		Glucagon tolerance panel	N	$ 56.11
80426		Gonadotropin hormone panel	N	$ 164.90
80428		Growth hormone panel	N	$ 74.12
80430		Growth hormone panel	N	$ 129.33
80432		Insulin suppression panel	N	$ 165.61
80434		Insulin tolerance panel	N	$ 285.03
80435		Insulin tolerance panel	N	$ 114.45
80436		Metyrapone panel	N	$ 101.29
80438		Trh stimulation panel	N	$ 56.01
80439		Trh stimulation panel	N	$ 74.68
81000		Urinalysis nonauto w/scope	N	$ 4.02
81001		Urinalysis auto w/scope	N	$ 3.52
81002		Urinalysis nonauto w/o scope	N	$ 3.48
81003		Urinalysis auto w/o scope	N	$ 2.49
81003	QW	Urinalysis auto w/o scope	N	$ 2.49
81005		Urinalysis	N	$ 2.41
81007		Urine screen for bacteria	N	$ 29.98
81007	QW	Urine screen for bacteria	N	$ 29.98
81015		Microscopic exam of urine	N	$ 3.39
81020		Urinalysis glass test	N	$ 4.70
81025		Urine pregnancy test	N	$ 8.61
81050		Urinalysis volume measure	N	$ 3.64
81105		Hpa-1 genotyping	N	$ 135.80
81106		Hpa-2 genotyping	N	$ 135.80
81107		Hpa-3 genotyping	N	$ 135.80
81108		Hpa-4 genotyping	N	$ 135.80
81109		Hpa-5 genotyping	N	$ 135.80
81110		Hpa-6 genotyping	N	$ 135.80
81111		Hpa-9 genotyping	N	$ 135.80
81112		Hpa-15 genotyping	N	$ 135.80
81120		Idh1 common variants	N	$ 193.25
81121		Idh2 common variants	N	$ 295.79
81161		Dmd dup/delet analysis	N	$ 279.00
81162		Brca1&2 gen full seq dup/del	N	$ 2,027.64
81163		Brca1&2 gene full seq alys	N	$ 468.00
81164		Brca1&2 gen ful dup/del alys	N	$ 584.23
81165		Brca1 gene full seq alys	N	$ 282.88
81166		Brca1 gene full dup/del alys	N	$ 301.35

81167		Brca2 gene full dup/del alys	N	$	282.88
81170		Abl1 gene	N	$	300.00
81171		Aff2 gene detc abnor alleles	N	$	137.00
81172		Aff2 gene charac alleles	N	$	274.83
81173		Ar gene full gene sequence	N	$	301.35
81174		Ar gene known famil variant	N	$	185.20
81175		Asxl1 full gene sequence	N	$	676.50
81176		Asxl1 gene target seq alys	N	$	268.77
81177		Atn1 gene detc abnor alleles	N	$	137.00
81178		Atxn1 gene detc abnor allele	N	$	137.00
81179		Atxn2 gene detc abnor allele	N	$	137.00
81180		Atxn3 gene detc abnor allele	N	$	137.00
81181		Atxn7 gene detc abnor allele	N	$	137.00
81182		Atxn8os gen detc abnor allel	N	$	137.00
81183		Atxn10 gene detc abnor allel	N	$	137.00
81184		Cacna1a gen detc abnor allel	N	$	137.00
81185		Cacna1a gene full gene seq	N	$	846.27
81186		Cacna1a gen known famil vrnt	N	$	185.20
81187		Cnbp gene detc abnor allele	N	$	137.00
81188		Cstb gene detc abnor allele	N	$	137.00
81189		Cstb gene full gene sequence	N	$	274.83
81190		Cstb gene known famil vrnt	N	$	185.20
81200		Aspa gene	N	$	47.25
81201		Apc gene full sequence	N	$	780.00
81202		Apc gene known fam variants	N	$	280.00
81203		Apc gene dup/delet variants	N	$	200.00
81204		Ar gene charac alleles	N	$	137.00
81205		Bckdhb gene	N	$	94.99
81206		Bcr/abl1 gene major bp	N	$	182.18
81207		Bcr/abl1 gene minor bp	N	$	160.93
81208		Bcr/abl1 gene other bp	N	$	214.62
81209		Blm gene	N	$	39.31
81210		Braf gene	N	$	175.40
81212		Brca1&2 185&5385&6174 vrnt	N	$	440.00
81215		Brca1 gene known famil vrnt	N	$	375.25
81216		Brca2 gene full seq alys	N	$	185.12
81217		Brca2 gene known famil vrnt	N	$	375.25
81218		Cebpa gene full sequence	N	$	268.77
81219		Calr gene com variants	N	$	135.14
81220		Cftr gene com variants	N	$	556.60
81221		Cftr gene known fam variants	N	$	97.22

81222		Cftr gene dup/delet variants	N	$ 435.07
81223		Cftr gene full sequence	N	$ 499.00
81224		Cftr gene intron poly t	N	$ 168.75
81225		Cyp2c19 gene com variants	N	$ 291.36
81226		Cyp2d6 gene com variants	N	$ 450.91
81227		Cyp2c9 gene com variants	N	$ 174.81
81228		Cytogen micrarray copy nmbr	N	$ 900.00
81229		Cytogen m array copy no&snp	N	$ 1,160.00
81230		Cyp3a4 gene common variants	N	$ 174.81
81231		Cyp3a5 gene common variants	N	$ 174.81
81232		Dpyd gene common variants	N	$ 174.81
81233		Btk gene common variants	N	$ 175.40
81234		Dmpk gene detc abnor allele	N	$ 137.00
81235		Egfr gene com variants	N	$ 324.58
81236		Ezh2 gene full gene sequence	N	$ 282.88
81237		Ezh2 gene common variants	N	$ 175.40
81238		F9 full gene sequence	N	$ 600.00
81239		Dmpk gene charac alleles	N	$ 274.83
81240		F2 gene	N	$ 65.69
81241		F5 gene	N	$ 73.37
81242		Fancc gene	N	$ 36.62
81243		Fmr1 gene detection	N	$ 57.04
81244		Fmr1 gene charac alleles	N	$ 44.89
81245		Flt3 gene	N	$ 165.51
81246		Flt3 gene analysis	N	$ 83.00
81247		G6pd gene alys cmn variant	N	$ 174.81
81248		G6pd known familial variant	N	$ 375.25
81249		G6pd full gene sequence	N	$ 600.00
81250		G6pc gene	N	$ 58.49
81251		Gba gene	N	$ 47.25
81252		Gjb2 gene full sequence	N	$ 101.12
81253		Gjb2 gene known fam variants	N	$ 61.52
81254		Gjb6 gene com variants	N	$ 35.00
81255		Hexa gene	N	$ 51.45
81256		Hfe gene	N	$ 72.62
81257		Hba1/hba2 gene	N	$ 102.26
81258		Hba1/hba2 gene fam vrnt	N	$ 375.25
81259		Hba1/hba2 full gene sequence	N	$ 600.00
81260		Ikbkap gene	N	$ 39.31
81261		Igh gene rearrange amp meth	N	$ 219.99
81262		Igh gene rearrang dir probe	N	$ 68.55

81263		Igh vari regional mutation	N	$	327.24
81264		Igk rearrangeabn clonal pop	N	$	172.73
81265		Str markers specimen anal	N	$	238.94
81266		Str markers spec anal addl	N	$	304.81
81267		Chimerism anal no cell selec	N	$	230.51
81268		Chimerism anal w/cell select	N	$	289.76
81269		Hba1/hba2 gene dup/del vrnts	N	$	202.40
81270		Jak2 gene	N	$	101.85
81271		Htt gene detc abnor alleles	N	$	137.00
81272		Kit gene targeted seq analys	N	$	329.51
81273		Kit gene analys d816 variant	N	$	124.87
81274		Htt gene charac alleles	N	$	274.83
81275		Kras gene variants exon 2	N	$	193.25
81276		Kras gene addl variants	N	$	193.25
81283		Ifnl3 gene	N	$	73.37
81284		Fxn gene detc abnor alleles	N	$	137.00
81285		Fxn gene charac alleles	N	$	274.83
81286		Fxn gene full gene sequence	N	$	274.83
81287		Mgmt gene prmtr mthyltn alys	N	$	124.64
81288		Mlh1 gene	N	$	192.32
81289		Fxn gene known famil variant	N	$	185.20
81290		Mcoln1 gene	N	$	39.31
81291		Mthfr gene	N	$	65.34
81292		Mlh1 gene full seq	N	$	675.40
81293		Mlh1 gene known variants	N	$	331.00
81294		Mlh1 gene dup/delete variant	N	$	202.40
81295		Msh2 gene full seq	N	$	381.70
81296		Msh2 gene known variants	N	$	337.73
81297		Msh2 gene dup/delete variant	N	$	213.30
81298		Msh6 gene full seq	N	$	641.85
81299		Msh6 gene known variants	N	$	308.00
81300		Msh6 gene dup/delete variant	N	$	238.00
81301		Microsatellite instability	N	$	348.56
81302		Mecp2 gene full seq	N	$	527.87
81303		Mecp2 gene known variant	N	$	120.00
81304		Mecp2 gene dup/delet variant	N	$	150.00
81305		Myd88 gene p.leu265pro vrnt	N	$	175.40
81306		Nudt15 gene common variants	N	$	291.36
81310		Npm1 gene	N	$	246.52
81311		Nras gene variants exon 2&3	N	$	295.79
81312		Pabpn1 gene detc abnor allel	N	$	137.00

81313		Pca3/klk3 antigen	N	$	255.05
81314		Pdgfra gene	N	$	329.51
81315		Pml/raralpha com breakpoints	N	$	230.35
81316		Pml/raralpha 1 breakpoint	N	$	230.35
81317		Pms2 gene full seq analysis	N	$	676.50
81318		Pms2 known familial variants	N	$	331.00
81319		Pms2 gene dup/delet variants	N	$	203.50
81320		Plcg2 gene common variants	N	$	291.36
81321		Pten gene full sequence	N	$	600.00
81322		Pten gene known fam variant	N	$	47.56
81323		Pten gene dup/delet variant	N	$	300.00
81324		Pmp22 gene dup/delet	N	$	758.36
81325		Pmp22 gene full sequence	N	$	769.58
81326		Pmp22 gene known fam variant	N	$	47.56
81327		Sept9 gen prmtr mthyltn alys	N	$	192.00
81328		Slco1b1 gene com variants	N	$	174.81
81329		Smn1 gene dos/deletion alys	N	$	137.00
81330		Smpd1 gene common variants	N	$	47.00
81331		Snrpn/ube3a gene	N	$	51.07
81332		Serpina1 gene	N	$	48.50
81333		Tgfbi gene common variants	N	$	137.00
81334		Runx1 gene targeted seq alys	N	$	329.51
81335		Tpmt gene com variants	N	$	174.81
81336		Smn1 gene full gene sequence	N	$	301.35
81337		Smn1 gen nown famil seq vrnt	N	$	185.20
81340		Trb@ gene rearrange amplify	N	$	232.13
81341		Trb@ gene rearrange dirprobe	N	$	55.10
81342		Trg gene rearrangement anal	N	$	223.88
81343		Ppp2r2b gen detc abnor allel	N	$	137.00
81344		Tbp gene detc abnor alleles	N	$	137.00
81345		Tert gene targeted seq alys	N	$	185.20
81346		Tyms gene com variants	N	$	174.81
81350		Ugt1a1 gene	N	$	234.00
81355		Vkorc1 gene	N	$	88.20
81361		Hbb gene com variants	N	$	174.81
81362		Hbb gene known fam variant	N	$	375.25
81363		Hbb gene dup/del variants	N	$	202.40
81364		Hbb full gene sequence	N	$	324.58
81370		Hla i & ii typing lr	N	$	446.80
81371		Hla i & ii type verify lr	N	$	404.52
81372		Hla i typing complete lr	N	$	403.59

81373		Hla i typing 1 locus lr	N	$ 127.43
81374		Hla i typing 1 antigen lr	N	$ 80.83
81375		Hla ii typing ag equiv lr	N	$ 245.27
81376		Hla ii typing 1 locus lr	N	$ 135.80
81377		Hla ii type 1 ag equiv lr	N	$ 102.01
81378		Hla i & ii typing hr	N	$ 383.96
81379		Hla i typing complete hr	N	$ 372.65
81380		Hla i typing 1 locus hr	N	$ 196.94
81381		Hla i typing 1 allele hr	N	$ 169.90
81382		Hla ii typing 1 loc hr	N	$ 137.42
81383		Hla ii typing 1 allele hr	N	$ 121.26
81400		Mopath procedure level 1	N	$ 63.96
81401		Mopath procedure level 2	N	$ 137.00
81402		Mopath procedure level 3	N	$ 150.33
81403		Mopath procedure level 4	N	$ 185.20
81404		Mopath procedure level 5	N	$ 274.83
81405		Mopath procedure level 6	N	$ 301.35
81406		Mopath procedure level 7	N	$ 282.88
81407		Mopath procedure level 8	N	$ 846.27
81408		Mopath procedure level 9	N	$ 2,000.00
81410		Aortic dysfunction/dilation	N	$ 504.00
81411		Aortic dysfunction/dilation	N	$ 1,350.19
81412		Ashkenazi jewish assoc dis	N	$ 2,448.56
81413		Car ion chnnlpath inc 10 gns	N	$ 649.89
81414		Car ion chnnlpath inc 2 gns	N	$ 649.89
81415		Exome sequence analysis	N	$ 4,780.00
81416		Exome sequence analysis	N	$ 12,000.00
81417		Exome re-evaluation	N	$ 320.00
81420		Fetal chrmoml aneuploidy	N	$ 759.05
81422		Fetal chrmoml microdeltj	N	$ 759.05
81425		Genome sequence analysis	N	$ 5,031.20
81426		Genome sequence analysis	N	$ 2,709.95
81427		Genome re-evaluation	N	$ 2,337.65
81430		Hearing loss sequence analys	N	$ 1,625.00
81431		Hearing loss dup/del analys	N	$ 679.57
81432		Hrdtry brst ca-rlatd dsordrs	N	$ 754.50
81433		Hrdtry brst ca-rlatd dsordrs	N	$ 487.70
81434		Hereditary retinal disorders	N	$ 597.91
81435		Hereditary colon ca dsordrs	N	$ 649.89
81436		Hereditary colon ca dsordrs	N	$ 649.89
81437		Heredtry nurondcrn tum dsrdr	N	$ 487.70

81438		Heredtry nurondcrn tum dsrdr	N	$ 487.70
81439		Hrdtry cardmypy gene panel	N	$ 649.89
81440		Mitochondrial gene	N	$ 3,324.00
81442		Noonan spectrum disorders	N	$ 2,143.60
81443		Genetic tstg severe inh cond	N	$ 2,448.56
81445		Targeted genomic seq analys	N	$ 597.91
81448		Hrdtry perph neurphy panel	N	$ 649.89
81450		Targeted genomic seq analys	N	$ 759.53
81455		Targeted genomic seq analys	N	$ 2,919.60
81460		Whole mitochondrial genome	N	$ 1,287.00
81465		Whole mitochondrial genome	N	$ 936.00
81470		X-linked intellectual dblt	N	$ 914.00
81471		X-linked intellectual dblt	N	$ 914.00
81490		Autoimmune rheumatoid arthr	N	$ 840.65
81493		Cor artery disease mrna	N	$ 1,050.00
81500		Onco (ovar) two proteins	N	$ 260.50
81503		Onco (ovar) five proteins	N	$ 897.00
81504		Oncology tissue of origin	N	$ 520.00
81506		Endo assay seven anal	N	$ 74.67
81507		Fetal aneuploidy trisom risk	N	$ 795.00
81508		Ftl cgen abnor two proteins	N	$ 54.30
81509		Ftl cgen abnor 3 proteins	N	$ 1,487.37
81510		Ftl cgen abnor three anal	N	$ 55.54
81511		Ftl cgen abnor four anal	N	$ 153.50
81512		Ftl cgen abnor five anal	N	$ 69.52
81518		Onc brst mrna 11 genes	N	$ 3,873.00
81519		Oncology breast mrna	N	$ 3,873.00
81520		Onc breast mrna 58 genes	N	$ 2,789.12
81521		Onc breast mrna 70 genes	N	$ 3,873.00
81525		Oncology colon mrna	N	$ 3,116.00
81528		Oncology colorectal scr	N	$ 508.87
81535		Oncology gynecologic	N	$ 579.46
81536		Oncology gynecologic	N	$ 177.56
81538		Oncology lung	N	$ 2,871.00
81539		Oncology prostate prob score	N	$ 760.00
81540		Oncology tum unknown origin	N	$ 3,750.00
81541		Onc prostate mrna 46 genes	N	$ 3,873.00
81545		Oncology thyroid	N	$ 3,600.00
81551		Onc prostate 3 genes	N	$ 2,030.00
81595		Cardiology hrt trnspl mrna	N	$ 3,240.00
81596		Nfct ds chrnc hcv 6 assays	N	$ 72.19

82009		Test for acetone/ketones	N	$ 5.02
82010		Acetone assay	N	$ 9.08
82010	QW	Acetone assay	N	$ 9.08
82013		Acetylcholinesterase assay	N	$ 12.41
82016		Acylcarnitines qual	N	$ 16.49
82017		Acylcarnitines quant	N	$ 18.74
82024		Assay of acth	N	$ 42.91
82030		Assay of adp & amp	N	$ 28.67
82040		Assay of serum albumin	N	$ 5.50
82040	QW	Assay of serum albumin	N	$ 5.50
82042		Other source albumin quan ea	N	$ 7.78
82042	QW	Other source albumin quan ea	N	$ 7.78
82043		Ur albumin quantitative	N	$ 6.42
82043	QW	Ur albumin quantitative	N	$ 6.42
82044		Ur albumin semiquantitative	N	$ 6.23
82044	QW	Ur albumin semiquantitative	N	$ 6.23
82045		Albumin ischemia modified	N	$ 37.71
82075		Assay of breath ethanol	N	$ 30.00
82085		Assay of aldolase	N	$ 10.79
82088		Assay of aldosterone	N	$ 45.28
82103		Alpha-1-antitrypsin total	N	$ 14.93
82104		Alpha-1-antitrypsin pheno	N	$ 16.07
82105		Alpha-fetoprotein serum	N	$ 18.64
82106		Alpha-fetoprotein amniotic	N	$ 18.64
82107		Alpha-fetoprotein l3	N	$ 71.57
82108		Assay of aluminum	N	$ 28.31
82120		Amines vaginal fluid qual	N	$ 5.99
82120	QW	Amines vaginal fluid qual	N	$ 5.99
82127		Amino acid single qual	N	$ 15.41
82128		Amino acids mult qual	N	$ 15.41
82131		Amino acids single quant	N	$ 22.98
82135		Assay aminolevulinic acid	N	$ 18.28
82136		Amino acids quant 2-5	N	$ 19.61
82139		Amino acids quan 6 or more	N	$ 18.74
82140		Assay of ammonia	N	$ 16.19
82143		Amniotic fluid scan	N	$ 9.35
82150		Assay of amylase	N	$ 7.20
82150	QW	Assay of amylase	N	$ 7.20
82154		Androstanediol glucuronide	N	$ 32.04
82157		Assay of androstenedione	N	$ 32.53
82160		Assay of androsterone	N	$ 27.78

82163		Assay of angiotensin ii	N	$ 22.80
82164		Angiotensin i enzyme test	N	$ 16.22
82172		Assay of apolipoprotein	N	$ 21.09
82175		Assay of arsenic	N	$ 21.08
82180		Assay of ascorbic acid	N	$ 10.98
82190		Atomic absorption	N	$ 16.56
82232		Assay of beta-2 protein	N	$ 17.97
82239		Bile acids total	N	$ 19.03
82240		Bile acids cholylglycine	N	$ 29.53
82247		Bilirubin total	N	$ 5.57
82247	QW	Bilirubin total	N	$ 5.57
82248		Bilirubin direct	N	$ 5.57
82252		Fecal bilirubin test	N	$ 5.06
82261		Assay of biotinidase	N	$ 18.74
82270		Occult blood feces	N	$ 4.38
82271		Occult blood other sources	N	$ 5.32
82271	QW	Occult blood other sources	N	$ 5.32
82272		Occult bld feces 1-3 tests	N	$ 4.23
82274		Assay test for blood fecal	N	$ 17.67
82274	QW	Assay test for blood fecal	N	$ 17.67
82286		Assay of bradykinin	N	$ 5.73
82300		Assay of cadmium	N	$ 25.72
82306		Vitamin d 25 hydroxy	N	$ 32.89
82308		Assay of calcitonin	N	$ 29.77
82310		Assay of calcium	N	$ 5.73
82310	QW	Assay of calcium	N	$ 5.73
82330		Assay of calcium	N	$ 15.20
82330	QW	Assay of calcium	N	$ 15.20
82331		Calcium infusion test	N	$ 13.34
82340		Assay of calcium in urine	N	$ 6.70
82355		Calculus analysis qual	N	$ 12.86
82360		Calculus assay quant	N	$ 14.30
82365		Calculus spectroscopy	N	$ 14.33
82370		X-ray assay calculus	N	$ 13.92
82373		Assay c-d transfer measure	N	$ 20.06
82374		Assay blood carbon dioxide	N	$ 5.43
82374	QW	Assay blood carbon dioxide	N	$ 5.43
82375		Assay carboxyhb quant	N	$ 13.69
82376		Assay carboxyhb qual	N	$ 14.07
82378		Carcinoembryonic antigen	N	$ 21.07
82379		Assay of carnitine	N	$ 18.74

82380		Assay of carotene	N	$ 10.25
82382		Assay urine catecholamines	N	$ 27.30
82383		Assay blood catecholamines	N	$ 29.08
82384		Assay three catecholamines	N	$ 28.06
82387		Assay of cathepsin-d	N	$ 20.06
82390		Assay of ceruloplasmin	N	$ 11.93
82397		Chemiluminescent assay	N	$ 15.69
82415		Assay of chloramphenicol	N	$ 14.08
82435		Assay of blood chloride	N	$ 5.11
82435	QW	Assay of blood chloride	N	$ 5.11
82436		Assay of urine chloride	N	$ 5.75
82438		Assay other fluid chlorides	N	$ 5.43
82441		Test for chlorohydrocarbons	N	$ 6.67
82465		Assay bld/serum cholesterol	N	$ 4.84
82465	QW	Assay bld/serum cholesterol	N	$ 4.84
82480		Assay serum cholinesterase	N	$ 8.75
82482		Assay rbc cholinesterase	N	$ 9.81
82485		Assay chondroitin sulfate	N	$ 22.95
82495		Assay of chromium	N	$ 22.53
82507		Assay of citrate	N	$ 30.89
82523		Collagen crosslinks	N	$ 20.76
82523	QW	Collagen crosslinks	N	$ 20.76
82525		Assay of copper	N	$ 13.79
82528		Assay of corticosterone	N	$ 25.02
82530		Cortisol free	N	$ 18.57
82533		Total cortisol	N	$ 18.11
82540		Assay of creatine	N	$ 5.15
82542		Col chromotography qual/quan	N	$ 24.09
82550		Assay of ck (cpk)	N	$ 7.23
82550	QW	Assay of ck (cpk)	N	$ 7.23
82552		Assay of cpk in blood	N	$ 14.88
82553		Creatine mb fraction	N	$ 12.83
82554		Creatine isoforms	N	$ 13.19
82565		Assay of creatinine	N	$ 5.69
82565	QW	Assay of creatinine	N	$ 5.69
82570		Assay of urine creatinine	N	$ 5.75
82570	QW	Assay of urine creatinine	N	$ 5.75
82575		Creatinine clearance test	N	$ 10.51
82585		Assay of cryofibrinogen	N	$ 14.14
82595		Assay of cryoglobulin	N	$ 7.18
82600		Assay of cyanide	N	$ 21.55

82607		Vitamin b-12	N	$ 16.75
82608		B-12 binding capacity	N	$ 15.91
82610		Cystatin c	N	$ 18.52
82615		Test for urine cystines	N	$ 9.55
82626		Dehydroepiandrosterone	N	$ 28.08
82627		Dehydroepiandrosterone	N	$ 24.71
82633		Desoxycorticosterone	N	$ 34.43
82634		Deoxycortisol	N	$ 32.53
82638		Assay of dibucaine number	N	$ 13.61
82642		Dihydrotestosterone	N	$ 32.53
82652		Vit d 1 25-dihydroxy	N	$ 42.78
82656		Pancreatic elastase fecal	N	$ 12.81
82657		Enzyme cell activity	N	$ 22.17
82658		Enzyme cell activity ra	N	$ 44.03
82664		Electrophoretic test	N	$ 61.50
82668		Assay of erythropoietin	N	$ 20.88
82670		Assay of estradiol	N	$ 31.04
82671		Assay of estrogens	N	$ 35.89
82672		Assay of estrogen	N	$ 24.11
82677		Assay of estriol	N	$ 26.87
82679		Assay of estrone	N	$ 27.73
82679	QW	Assay of estrone	N	$ 27.73
82693		Assay of ethylene glycol	N	$ 16.56
82696		Assay of etiocholanolone	N	$ 26.24
82705		Fats/lipids feces qual	N	$ 5.66
82710		Fats/lipids feces quant	N	$ 18.67
82715		Assay of fecal fat	N	$ 22.97
82725		Assay of blood fatty acids	N	$ 18.77
82726		Long chain fatty acids	N	$ 20.06
82728		Assay of ferritin	N	$ 15.15
82731		Assay of fetal fibronectin	N	$ 71.57
82735		Assay of fluoride	N	$ 20.60
82746		Assay of folic acid serum	N	$ 16.34
82747		Assay of folic acid rbc	N	$ 19.25
82757		Assay of semen fructose	N	$ 19.26
82759		Assay of rbc galactokinase	N	$ 23.87
82760		Assay of galactose	N	$ 12.44
82775		Assay galactose transferase	N	$ 23.41
82776		Galactose transferase test	N	$ 11.74
82777		Galectin-3	N	$ 44.25
82784		Assay iga/igd/igg/igm each	N	$ 10.34

82785		Assay of ige	N	$ 18.29
82787		Igg 1 2 3 or 4 each	N	$ 8.91
82800		Blood ph	N	$ 11.00
82803		Blood gases any combination	N	$ 26.07
82805		Blood gases w/o2 saturation	N	$ 78.77
82810		Blood gases o2 sat only	N	$ 9.77
82820		Hemoglobin-oxygen affinity	N	$ 13.34
82930		Gastric analy w/ph ea spec	N	$ 6.71
82938		Gastrin test	N	$ 19.66
82941		Assay of gastrin	N	$ 19.59
82943		Assay of glucagon	N	$ 15.88
82945		Glucose other fluid	N	$ 4.37
82946		Glucagon tolerance test	N	$ 17.77
82947		Assay glucose blood quant	N	$ 4.37
82947	QW	Assay glucose blood quant	N	$ 4.37
82948		Reagent strip/blood glucose	N	$ 5.04
82950		Glucose test	N	$ 5.27
82950	QW	Glucose test	N	$ 5.27
82951		Glucose tolerance test (gtt)	N	$ 14.30
82951	QW	Glucose tolerance test (gtt)	N	$ 14.30
82952		Gtt-added samples	N	$ 4.36
82952	QW	Gtt-added samples	N	$ 4.36
82955		Assay of g6pd enzyme	N	$ 10.77
82960		Test for g6pd enzyme	N	$ 6.72
82962		Glucose blood test	N	$ 3.28
82963		Assay of glucosidase	N	$ 23.87
82965		Assay of gdh enzyme	N	$ 13.15
82977		Assay of ggt	N	$ 8.00
82977	QW	Assay of ggt	N	$ 8.00
82978		Assay of glutathione	N	$ 15.84
82979		Assay rbc glutathione	N	$ 10.49
82985		Assay of glycated protein	N	$ 16.76
82985	QW	Assay of glycated protein	N	$ 16.76
83001		Assay of gonadotropin (fsh)	N	$ 20.65
83001	QW	Assay of gonadotropin (fsh)	N	$ 20.65
83002		Assay of gonadotropin (lh)	N	$ 20.57
83002	QW	Assay of gonadotropin (lh)	N	$ 20.57
83003		Assay growth hormone (hgh)	N	$ 18.52
83006		Growth stimulation gene 2	N	$ 75.60
83009		H pylori (c-13) blood	N	$ 74.84
83010		Assay of haptoglobin quant	N	$ 13.97

83012		Assay of haptoglobins	N	$ 26.89
83013		H pylori (c-13) breath	N	$ 74.84
83014		H pylori drug admin	N	$ 8.73
83015		Heavy metal qual any anal	N	$ 20.94
83018		Heavy metal quant each nes	N	$ 24.41
83020		Hemoglobin electrophoresis	N	$ 14.30
83021		Hemoglobin chromotography	N	$ 20.06
83026		Hemoglobin copper sulfate	N	$ 4.01
83030		Fetal hemoglobin chemical	N	$ 10.74
83033		Fetal hemoglobin assay qual	N	$ 8.00
83036		Glycosylated hemoglobin test	N	$ 10.79
83036	QW	Glycosylated hemoglobin test	N	$ 10.79
83037		Glycosylated hb home device	N	$ 10.79
83037	QW	Glycosylated hb home device	N	$ 10.79
83045		Blood methemoglobin test	N	$ 6.49
83050		Blood methemoglobin assay	N	$ 8.20
83051		Assay of plasma hemoglobin	N	$ 8.12
83060		Blood sulfhemoglobin assay	N	$ 9.19
83065		Assay of hemoglobin heat	N	$ 9.00
83068		Hemoglobin stability screen	N	$ 9.47
83069		Assay of urine hemoglobin	N	$ 4.39
83070		Assay of hemosiderin qual	N	$ 5.27
83080		Assay of b hexosaminidase	N	$ 18.74
83088		Assay of histamine	N	$ 32.81
83090		Assay of homocystine	N	$ 18.74
83150		Assay of homovanillic acid	N	$ 22.41
83491		Assay of corticosteroids 17	N	$ 19.47
83497		Assay of 5-hiaa	N	$ 14.33
83498		Assay of progesterone 17-d	N	$ 30.19
83500		Assay free hydroxyproline	N	$ 25.17
83505		Assay total hydroxyproline	N	$ 27.01
83516		Immunoassay nonantibody	N	$ 12.81
83516	QW	Immunoassay nonantibody	N	$ 12.81
83518		Immunoassay dipstick	N	$ 9.64
83518	QW	Immunoassay dipstick	N	$ 9.64
83519		Ria nonantibody	N	$ 18.40
83520		Immunoassay quant nos nonab	N	$ 17.27
83520	QW	Immunoassay quant nos nonab	N	$ 17.27
83525		Assay of insulin	N	$ 12.70
83527		Assay of insulin	N	$ 14.39
83528		Assay of intrinsic factor	N	$ 19.82

83540		Assay of iron	N	$ 7.19
83550		Iron binding test	N	$ 9.71
83570		Assay of idh enzyme	N	$ 9.83
83582		Assay of ketogenic steroids	N	$ 15.75
83586		Assay 17- ketosteroids	N	$ 14.22
83593		Fractionation ketosteroids	N	$ 29.22
83605		Assay of lactic acid	N	$ 11.87
83605	QW	Assay of lactic acid	N	$ 11.87
83615		Lactate (ld) (ldh) enzyme	N	$ 6.71
83625		Assay of ldh enzymes	N	$ 14.22
83630		Lactoferrin fecal (qual)	N	$ 21.81
83631		Lactoferrin fecal (quant)	N	$ 21.81
83632		Placental lactogen	N	$ 22.47
83633		Test urine for lactose	N	$ 11.25
83655		Assay of lead	N	$ 13.45
83655	QW	Assay of lead	N	$ 13.45
83661		L/s ratio fetal lung	N	$ 24.43
83662		Foam stability fetal lung	N	$ 21.01
83663		Fluoro polarize fetal lung	N	$ 21.01
83664		Lamellar bdy fetal lung	N	$ 21.01
83670		Assay of lap enzyme	N	$ 10.18
83690		Assay of lipase	N	$ 7.65
83695		Assay of lipoprotein(a)	N	$ 14.39
83698		Assay lipoprotein pla2	N	$ 46.31
83700		Lipopro bld electrophoretic	N	$ 12.51
83701		Lipoprotein bld hr fraction	N	$ 33.86
83704		Lipoprotein bld quan part	N	$ 35.06
83718		Assay of lipoprotein	N	$ 9.10
83718	QW	Assay of lipoprotein	N	$ 9.10
83719		Assay of blood lipoprotein	N	$ 12.93
83721		Assay of blood lipoprotein	N	$ 10.60
83721	QW	Assay of blood lipoprotein	N	$ 10.60
83722		Lipoprtn dir meas sd ldl chl	N	$ 35.06
83727		Assay of lrh hormone	N	$ 19.10
83735		Assay of magnesium	N	$ 7.44
83775		Assay malate dehydrogenase	N	$ 8.19
83785		Assay of manganese	N	$ 27.33
83789		Mass spectrometry qual/quan	N	$ 24.11
83825		Assay of mercury	N	$ 18.06
83835		Assay of metanephrines	N	$ 18.82
83857		Assay of methemalbumin	N	$ 11.93

83861		Microfluid analy tears	N	$ 22.48
83861	QW	Microfluid analy tears	N	$ 22.48
83864		Mucopolysaccharides	N	$ 28.50
83872		Assay synovial fluid mucin	N	$ 6.51
83873		Assay of csf protein	N	$ 19.12
83874		Assay of myoglobin	N	$ 14.35
83876		Assay myeloperoxidase	N	$ 50.86
83880		Assay of natriuretic peptide	N	$ 39.26
83880	QW	Assay of natriuretic peptide	N	$ 39.26
83883		Assay nephelometry not spec	N	$ 15.11
83885		Assay of nickel	N	$ 27.23
83915		Assay of nucleotidase	N	$ 12.39
83916		Oligoclonal bands	N	$ 27.39
83918		Organic acids total quant	N	$ 23.60
83919		Organic acids qual each	N	$ 18.28
83921		Organic acid single quant	N	$ 21.21
83930		Assay of blood osmolality	N	$ 7.35
83935		Assay of urine osmolality	N	$ 7.57
83937		Assay of osteocalcin	N	$ 33.16
83945		Assay of oxalate	N	$ 14.45
83950		Oncoprotein her-2/neu	N	$ 71.57
83951		Oncoprotein dcp	N	$ 71.57
83970		Assay of parathormone	N	$ 45.86
83986		Assay ph body fluid nos	N	$ 3.98
83986	QW	Assay ph body fluid nos	N	$ 3.98
83987		Exhaled breath condensate	N	$ 3.98
83993		Assay for calprotectin fecal	N	$ 21.81
84030		Assay of blood pku	N	$ 6.11
84035		Assay of phenylketones	N	$ 4.07
84060		Assay acid phosphatase	N	$ 8.21
84066		Assay prostate phosphatase	N	$ 10.73
84075		Assay alkaline phosphatase	N	$ 5.75
84075	QW	Assay alkaline phosphatase	N	$ 5.75
84078		Assay alkaline phosphatase	N	$ 8.26
84080		Assay alkaline phosphatases	N	$ 16.43
84081		Assay phosphatidylglycerol	N	$ 18.35
84085		Assay of rbc pg6d enzyme	N	$ 10.49
84087		Assay phosphohexose enzymes	N	$ 11.47
84100		Assay of phosphorus	N	$ 5.27
84105		Assay of urine phosphorus	N	$ 5.78
84106		Test for porphobilinogen	N	$ 5.82

84110		Assay of porphobilinogen	N	$ 9.38
84112		Eval amniotic fluid protein	N	$ 98.11
84119		Test urine for porphyrins	N	$ 13.36
84120		Assay of urine porphyrins	N	$ 16.35
84126		Assay of feces porphyrins	N	$ 39.11
84132		Assay of serum potassium	N	$ 5.11
84132	QW	Assay of serum potassium	N	$ 5.11
84133		Assay of urine potassium	N	$ 4.79
84134		Assay of prealbumin	N	$ 16.21
84135		Assay of pregnanediol	N	$ 21.27
84138		Assay of pregnanetriol	N	$ 21.05
84140		Assay of pregnenolone	N	$ 22.97
84143		Assay of 17-hydroxypregneno	N	$ 25.34
84144		Assay of progesterone	N	$ 23.18
84145		Procalcitonin (pct)	N	$ 29.77
84146		Assay of prolactin	N	$ 21.53
84150		Assay of prostaglandin	N	$ 41.77
84152		Assay of psa complexed	N	$ 20.44
84153		Assay of psa total	N	$ 20.44
84154		Assay of psa free	N	$ 20.44
84155		Assay of protein serum	N	$ 4.07
84155	QW	Assay of protein serum	N	$ 4.07
84156		Assay of protein urine	N	$ 4.07
84157		Assay of protein other	N	$ 4.07
84157	QW	Assay of protein other	N	$ 4.07
84160		Assay of protein any source	N	$ 5.75
84163		Pappa serum	N	$ 16.73
84165		Protein e-phoresis serum	N	$ 11.93
84166		Protein e-phoresis/urine/csf	N	$ 19.81
84181		Western blot test	N	$ 18.92
84182		Protein western blot test	N	$ 29.21
84202		Assay rbc protoporphyrin	N	$ 15.94
84203		Test rbc protoporphyrin	N	$ 9.74
84206		Assay of proinsulin	N	$ 26.69
84207		Assay of vitamin b-6	N	$ 31.22
84210		Assay of pyruvate	N	$ 14.48
84220		Assay of pyruvate kinase	N	$ 10.49
84228		Assay of quinine	N	$ 12.93
84233		Assay of estrogen	N	$ 87.88
84234		Assay of progesterone	N	$ 72.09
84235		Assay of endocrine hormone	N	$ 71.23

84238		Assay nonendocrine receptor	N	$ 40.63
84244		Assay of renin	N	$ 24.44
84252		Assay of vitamin b-2	N	$ 22.49
84255		Assay of selenium	N	$ 28.37
84260		Assay of serotonin	N	$ 34.43
84270		Assay of sex hormone globul	N	$ 24.15
84275		Assay of sialic acid	N	$ 14.93
84285		Assay of silica	N	$ 26.15
84295		Assay of serum sodium	N	$ 5.35
84295	QW	Assay of serum sodium	N	$ 5.35
84300		Assay of urine sodium	N	$ 5.40
84302		Assay of sweat sodium	N	$ 5.40
84305		Assay of somatomedin	N	$ 23.63
84307		Assay of somatostatin	N	$ 20.31
84311		Spectrophotometry	N	$ 8.10
84315		Body fluid specific gravity	N	$ 3.28
84375		Chromatogram assay sugars	N	$ 39.00
84376		Sugars single qual	N	$ 6.11
84377		Sugars multiple qual	N	$ 6.11
84378		Sugars single quant	N	$ 12.81
84379		Sugars multiple quant	N	$ 12.81
84392		Assay of urine sulfate	N	$ 5.49
84402		Assay of free testosterone	N	$ 28.30
84403		Assay of total testosterone	N	$ 28.68
84410		Testosterone bioavailable	N	$ 56.98
84425		Assay of vitamin b-1	N	$ 23.59
84430		Assay of thiocyanate	N	$ 12.93
84431		Thromboxane urine	N	$ 35.11
84432		Assay of thyroglobulin	N	$ 17.84
84436		Assay of total thyroxine	N	$ 7.63
84437		Assay of neonatal thyroxine	N	$ 7.18
84439		Assay of free thyroxine	N	$ 10.02
84442		Assay of thyroid activity	N	$ 16.43
84443		Assay thyroid stim hormone	N	$ 18.67
84443	QW	Assay thyroid stim hormone	N	$ 18.67
84445		Assay of tsi globulin	N	$ 56.51
84446		Assay of vitamin e	N	$ 15.75
84449		Assay of transcortin	N	$ 20.00
84450		Transferase (ast) (sgot)	N	$ 5.75
84450	QW	Transferase (ast) (sgot)	N	$ 5.75
84460		Alanine amino (alt) (sgpt)	N	$ 5.89

84460	QW	Alanine amino (alt) (sgpt)	N	$ 5.89
84466		Assay of transferrin	N	$ 14.18
84478		Assay of triglycerides	N	$ 6.38
84478	QW	Assay of triglycerides	N	$ 6.38
84479		Assay of thyroid (t3 or t4)	N	$ 7.18
84480		Assay triiodothyronine (t3)	N	$ 15.75
84481		Free assay (ft-3)	N	$ 18.82
84482		T3 reverse	N	$ 17.51
84484		Assay of troponin quant	N	$ 12.47
84485		Assay duodenal fluid trypsin	N	$ 8.00
84488		Test feces for trypsin	N	$ 8.11
84490		Assay of feces for trypsin	N	$ 9.93
84510		Assay of tyrosine	N	$ 11.56
84512		Assay of troponin qual	N	$ 10.09
84520		Assay of urea nitrogen	N	$ 4.39
84520	QW	Assay of urea nitrogen	N	$ 4.39
84525		Urea nitrogen semi-quant	N	$ 5.13
84540		Assay of urine/urea-n	N	$ 5.56
84545		Urea-n clearance test	N	$ 7.35
84550		Assay of blood/uric acid	N	$ 5.02
84550	QW	Assay of blood/uric acid	N	$ 5.02
84560		Assay of urine/uric acid	N	$ 5.27
84577		Assay of feces/urobilinogen	N	$ 18.67
84578		Test urine urobilinogen	N	$ 4.47
84580		Assay of urine urobilinogen	N	$ 9.55
84583		Assay of urine urobilinogen	N	$ 6.05
84585		Assay of urine vma	N	$ 17.22
84586		Assay of vip	N	$ 39.26
84588		Assay of vasopressin	N	$ 37.71
84590		Assay of vitamin a	N	$ 12.90
84591		Assay of nos vitamin	N	$ 17.06
84597		Assay of vitamin k	N	$ 15.24
84600		Assay of volatiles	N	$ 17.87
84620		Xylose tolerance test	N	$ 13.16
84630		Assay of zinc	N	$ 12.65
84681		Assay of c-peptide	N	$ 23.13
84702		Chorionic gonadotropin test	N	$ 16.73
84703		Chorionic gonadotropin assay	N	$ 8.36
84703	QW	Chorionic gonadotropin assay	N	$ 8.36
84704		Hcg free betachain test	N	$ 16.73
84830		Ovulation tests	N	$ 12.70

85002		Bleeding time test	N	$ 5.01
85004		Automated diff wbc count	N	$ 7.18
85007		Bl smear w/diff wbc count	N	$ 3.82
85008		Bl smear w/o diff wbc count	N	$ 3.82
85009		Manual diff wbc count b-coat	N	$ 5.07
85013		Spun microhematocrit	N	$ 7.00
85014		Hematocrit	N	$ 2.63
85014	QW	Hematocrit	N	$ 2.63
85018		Hemoglobin	N	$ 2.63
85018	QW	Hemoglobin	N	$ 2.63
85025		Complete cbc w/auto diff wbc	N	$ 8.63
85025	QW	Complete cbc w/auto diff wbc	N	$ 8.63
85027		Complete cbc automated	N	$ 7.18
85032		Manual cell count each	N	$ 4.79
85041		Automated rbc count	N	$ 3.35
85044		Manual reticulocyte count	N	$ 4.79
85045		Automated reticulocyte count	N	$ 4.44
85046		Reticyte/hgb concentrate	N	$ 6.19
85048		Automated leukocyte count	N	$ 2.82
85049		Automated platelet count	N	$ 4.97
85055		Reticulated platelet assay	N	$ 35.74
85130		Chromogenic substrate assay	N	$ 13.21
85170		Blood clot retraction	N	$ 16.30
85175		Blood clot lysis time	N	$ 20.37
85210		Clot factor ii prothrom spec	N	$ 14.43
85220		Blooc clot factor v test	N	$ 19.61
85230		Clot factor vii proconvertin	N	$ 19.89
85240		Clot factor viii ahg 1 stage	N	$ 19.89
85244		Clot factor viii reltd antgn	N	$ 22.69
85245		Clot factor viii vw ristoctn	N	$ 25.49
85246		Clot factor viii vw antigen	N	$ 25.49
85247		Clot factor viii multimetric	N	$ 25.49
85250		Clot factor ix ptc/chrstmas	N	$ 21.16
85260		Clot factor x stuart-power	N	$ 19.89
85270		Clot factor xi pta	N	$ 19.89
85280		Clot factor xii hageman	N	$ 21.50
85290		Clot factor xiii fibrin stab	N	$ 18.15
85291		Clot factor xiii fibrin scrn	N	$ 9.88
85292		Clot factor fletcher fact	N	$ 21.04
85293		Clot factor wght kininogen	N	$ 21.04
85300		Antithrombin iii activity	N	$ 13.17

85301		Antithrombin iii antigen	N	$ 12.01
85302		Clot inhibit prot c antigen	N	$ 13.35
85303		Clot inhibit prot c activity	N	$ 15.37
85305		Clot inhibit prot s total	N	$ 12.90
85306		Clot inhibit prot s free	N	$ 17.03
85307		Assay activated protein c	N	$ 17.03
85335		Factor inhibitor test	N	$ 14.30
85337		Thrombomodulin	N	$ 17.27
85345		Coagulation time lee & white	N	$ 4.79
85347		Coagulation time activated	N	$ 4.73
85348		Coagulation time otr method	N	$ 4.49
85360		Euglobulin lysis	N	$ 9.34
85362		Fibrin degradation products	N	$ 7.65
85366		Fibrinogen test	N	$ 80.46
85370		Fibrinogen test	N	$ 12.62
85378		Fibrin degrade semiquant	N	$ 9.72
85379		Fibrin degradation quant	N	$ 11.31
85380		Fibrin degradj d-dimer	N	$ 11.31
85384		Fibrinogen activity	N	$ 9.72
85385		Fibrinogen antigen	N	$ 14.46
85390		Fibrinolysins screen i&r	N	$ 15.48
85397		Clotting funct activity	N	$ 30.86
85400		Fibrinolytic plasmin	N	$ 8.56
85410		Fibrinolytic antiplasmin	N	$ 8.56
85415		Fibrinolytic plasminogen	N	$ 19.10
85420		Fibrinolytic plasminogen	N	$ 7.26
85421		Fibrinolytic plasminogen	N	$ 11.32
85441		Heinz bodies direct	N	$ 4.67
85445		Heinz bodies induced	N	$ 7.57
85460		Hemoglobin fetal	N	$ 8.59
85461		Hemoglobin fetal	N	$ 9.36
85475		Hemolysin acid	N	$ 9.86
85520		Heparin assay	N	$ 14.55
85525		Heparin neutralization	N	$ 13.15
85530		Heparin-protamine tolerance	N	$ 14.55
85536		Iron stain peripheral blood	N	$ 7.18
85540		Wbc alkaline phosphatase	N	$ 9.56
85547		Rbc mechanical fragility	N	$ 9.56
85549		Muramidase	N	$ 20.83
85555		Rbc osmotic fragility	N	$ 7.47
85557		Rbc osmotic fragility	N	$ 14.84

85576		Blood platelet aggregation	N	$ 24.91
85576	QW	Blood platelet aggregation	N	$ 24.91
85597		Phospholipid pltlt neutraliz	N	$ 19.97
85598		Hexagnal phosph pltlt neutrl	N	$ 19.97
85610		Prothrombin time	N	$ 4.37
85610	QW	Prothrombin time	N	$ 4.37
85611		Prothrombin test	N	$ 4.38
85612		Viper venom prothrombin time	N	$ 17.49
85613		Russell viper venom diluted	N	$ 10.64
85635		Reptilase test	N	$ 10.94
85651		Rbc sed rate nonautomated	N	$ 4.27
85652		Rbc sed rate automated	N	$ 3.00
85660		Rbc sickle cell test	N	$ 6.12
85670		Thrombin time plasma	N	$ 6.41
85675		Thrombin time titer	N	$ 7.61
85705		Thromboplastin inhibition	N	$ 10.70
85730		Thromboplastin time partial	N	$ 6.67
85732		Thromboplastin time partial	N	$ 7.18
85810		Blood viscosity examination	N	$ 12.97
86000		Agglutinins febrile antigen	N	$ 7.76
86001		Allergen specific igg	N	$ 7.82
86003		Allg spec ige crude xtrc ea	N	$ 5.80
86005		Allg spec ige multiallg scr	N	$ 8.85
86008		Allg spec ige recomb ea	N	$ 19.93
86021		Wbc antibody identification	N	$ 16.73
86022		Platelet antibodies	N	$ 20.41
86023		Immunoglobulin assay	N	$ 13.84
86038		Antinuclear antibodies	N	$ 13.43
86039		Antinuclear antibodies (ana)	N	$ 12.40
86060		Antistreptolysin o titer	N	$ 8.11
86063		Antistreptolysin o screen	N	$ 6.41
86140		C-reactive protein	N	$ 5.75
86141		C-reactive protein hs	N	$ 14.39
86146		Beta-2 glycoprotein antibody	N	$ 28.28
86147		Cardiolipin antibody ea ig	N	$ 28.28
86148		Anti-phospholipid antibody	N	$ 17.85
86152		Cell enumeration & id	N	$ 273.00
86155		Chemotaxis assay	N	$ 17.76
86156		Cold agglutinin screen	N	$ 8.07
86157		Cold agglutinin titer	N	$ 8.96
86160		Complement antigen	N	$ 13.33

86161		Complement/function activity	N	$ 13.33
86162		Complement total (ch50)	N	$ 22.58
86171		Complement fixation each	N	$ 11.12
86200		Ccp antibody	N	$ 14.39
86215		Deoxyribonuclease antibody	N	$ 14.72
86225		Dna antibody native	N	$ 15.27
86226		Dna antibody single strand	N	$ 13.45
86235		Nuclear antigen antibody	N	$ 19.93
86255		Fluorescent antibody screen	N	$ 13.39
86256		Fluorescent antibody titer	N	$ 13.39
86277		Growth hormone antibody	N	$ 17.49
86280		Hemagglutination inhibition	N	$ 9.10
86294		Immunoassay tumor qual	N	$ 25.57
86294	QW	Immunoassay tumor qual	N	$ 25.57
86300		Immunoassay tumor ca 15-3	N	$ 23.13
86301		Immunoassay tumor ca 19-9	N	$ 23.13
86304		Immunoassay tumor ca 125	N	$ 23.13
86305		Human epididymis protein 4	N	$ 23.13
86308		Heterophile antibody screen	N	$ 5.75
86308	QW	Heterophile antibody screen	N	$ 5.75
86309		Heterophile antibody titer	N	$ 7.18
86310		Heterophile antibody absrbj	N	$ 8.19
86316		Immunoassay tumor other	N	$ 23.13
86317		Immunoassay infectious agent	N	$ 16.65
86318		Immunoassay infectious agent	N	$ 18.09
86318	QW	Immunoassay infectious agent	N	$ 18.09
86320		Serum immunoelectrophoresis	N	$ 29.92
86325		Other immunoelectrophoresis	N	$ 24.85
86327		Immunoelectrophoresis assay	N	$ 29.92
86329		Immunodiffusion nes	N	$ 15.61
86331		Immunodiffusion ouchterlony	N	$ 13.31
86332		Immune complex assay	N	$ 27.08
86334		Immunofix e-phoresis serum	N	$ 24.83
86335		Immunfix e-phorsis/urine/csf	N	$ 32.61
86336		Inhibin a	N	$ 17.32
86337		Insulin antibodies	N	$ 23.79
86340		Intrinsic factor antibody	N	$ 16.75
86341		Islet cell antibody	N	$ 23.57
86343		Leukocyte histamine release	N	$ 13.84
86344		Leukocyte phagocytosis	N	$ 10.39
86352		Cell function assay w/stim	N	$ 150.96

86353		Lymphocyte transformation	N	$ 54.47
86355		B cells total count	N	$ 41.92
86356		Mononuclear cell antigen	N	$ 29.75
86357		Nk cells total count	N	$ 41.92
86359		T cells total count	N	$ 41.92
86360		T cell absolute count/ratio	N	$ 52.20
86361		T cell absolute count	N	$ 29.75
86367		Stem cells total count	N	$ 77.78
86376		Microsomal antibody each	N	$ 16.17
86382		Neutralization test viral	N	$ 18.79
86384		Nitroblue tetrazolium dye	N	$ 13.61
86386		Nuclear matrix protein 22	N	$ 21.78
86386	QW	Nuclear matrix protein 22	N	$ 21.78
86403		Particle agglut antbdy scrn	N	$ 11.54
86406		Particle agglut antbdy titr	N	$ 11.82
86430		Rheumatoid factor test qual	N	$ 6.30
86431		Rheumatoid factor quant	N	$ 6.30
86480		Tb test cell immun measure	N	$ 68.87
86481		Tb ag response t-cell susp	N	$ 100.00
86590		Streptokinase antibody	N	$ 12.66
86592		Syphilis test non-trep qual	N	$ 4.75
86593		Syphilis test non-trep quant	N	$ 4.89
86602		Antinomyces antibody	N	$ 11.31
86603		Adenovirus antibody	N	$ 14.30
86606		Aspergillus antibody	N	$ 16.73
86609		Bacterium antibody	N	$ 14.31
86611		Bartonella antibody	N	$ 11.31
86612		Blastomyces antibody	N	$ 14.34
86615		Bordetella antibody	N	$ 14.65
86617		Lyme disease antibody	N	$ 17.21
86618		Lyme disease antibody	N	$ 18.92
86618	QW	Lyme disease antibody	N	$ 18.92
86619		Borrelia antibody	N	$ 14.86
86622		Brucella antibody	N	$ 9.92
86625		Campylobacter antibody	N	$ 14.58
86628		Candida antibody	N	$ 13.34
86631		Chlamydia antibody	N	$ 13.14
86632		Chlamydia igm antibody	N	$ 14.09
86635		Coccidioides antibody	N	$ 12.75
86638		Q fever antibody	N	$ 13.47
86641		Cryptococcus antibody	N	$ 16.01

86644		Cmv antibody	N	$ 15.99
86645		Cmv antibody igm	N	$ 18.72
86648		Diphtheria antibody	N	$ 16.90
86651		Encephalitis californ antbdy	N	$ 14.65
86652		Encephaltis east eqne anbdy	N	$ 14.65
86653		Encephaltis st louis antbody	N	$ 14.65
86654		Encephaltis west eqne antbdy	N	$ 14.65
86658		Enterovirus antibody	N	$ 14.47
86663		Epstein-barr antibody	N	$ 14.58
86664		Epstein-barr nuclear antigen	N	$ 16.99
86665		Epstein-barr capsid vca	N	$ 20.16
86666		Ehrlichia antibody	N	$ 11.31
86668		Francisella tularensis	N	$ 14.16
86671		Fungus nes antibody	N	$ 13.62
86674		Giardia lamblia antibody	N	$ 16.35
86677		Helicobacter pylori antibody	N	$ 16.85
86682		Helminth antibody	N	$ 14.45
86684		Hemophilus influenza antibdy	N	$ 17.60
86687		Htlv-i antibody	N	$ 9.32
86688		Htlv-ii antibody	N	$ 15.56
86689		Htlv/hiv confirmj antibody	N	$ 21.51
86692		Hepatitis delta agent antbdy	N	$ 19.07
86694		Herpes simplex nes antbdy	N	$ 15.99
86695		Herpes simplex type 1 test	N	$ 14.65
86696		Herpes simplex type 2 test	N	$ 21.51
86698		Histoplasma antibody	N	$ 13.88
86701		Hiv-1antibody	N	$ 9.87
86701	QW	Hiv-1antibody	N	$ 9.87
86702		Hiv-2 antibody	N	$ 15.02
86703		Hiv-1/hiv-2 1 result antbdy	N	$ 15.23
86704		Hep b core antibody total	N	$ 13.39
86705		Hep b core antibody igm	N	$ 13.08
86706		Hep b surface antibody	N	$ 11.93
86707		Hepatitis be antibody	N	$ 12.85
86708		Hepatitis a antibody	N	$ 13.76
86709		Hepatitis a igm antibody	N	$ 12.51
86710		Influenza virus antibody	N	$ 15.06
86711		John cunningham antibody	N	$ 16.89
86713		Legionella antibody	N	$ 17.00
86717		Leishmania antibody	N	$ 13.61
86720		Leptospira antibody	N	$ 16.20

86723		Listeria monocytogenes	N	$	14.65
86727		Lymph choriomeningitis ab	N	$	14.30
86732		Mucormycosis antibody	N	$	15.00
86735		Mumps antibody	N	$	14.50
86738		Mycoplasma antibody	N	$	14.71
86741		Neisseria meningitidis	N	$	14.65
86744		Nocardia antibody	N	$	15.99
86747		Parvovirus antibody	N	$	16.70
86750		Malaria antibody	N	$	14.65
86753		Protozoa antibody nos	N	$	13.76
86756		Respiratory virus antibody	N	$	15.89
86757		Rickettsia antibody	N	$	21.51
86759		Rotavirus antibody	N	$	18.23
86762		Rubella antibody	N	$	15.99
86765		Rubeola antibody	N	$	14.31
86768		Salmonella antibody	N	$	14.65
86771		Shigella antibody	N	$	24.48
86774		Tetanus antibody	N	$	16.44
86777		Toxoplasma antibody	N	$	15.99
86778		Toxoplasma antibody igm	N	$	16.01
86780		Treponema pallidum	N	$	14.71
86780	QW	Treponema pallidum	N	$	14.71
86784		Trichinella antibody	N	$	13.96
86787		Varicella-zoster antibody	N	$	14.31
86788		West nile virus ab igm	N	$	18.72
86789		West nile virus antibody	N	$	15.99
86790		Virus antibody nos	N	$	14.31
86793		Yersinia antibody	N	$	14.65
86794		Zika virus igm antibody	N	$	18.72
86800		Thyroglobulin antibody	N	$	17.67
86803		Hepatitis c ab test	N	$	15.85
86803	QW	Hepatitis c ab test	N	$	15.85
86804		Hep c ab test confirm	N	$	17.21
86805		Lymphocytotoxicity assay	N	$	189.51
86806		Lymphocytotoxicity assay	N	$	52.88
86807		Cytotoxic antibody screening	N	$	78.65
86808		Cytotoxic antibody screening	N	$	32.98
86812		Hla typing a b or c	N	$	28.67
86813		Hla typing a b or c	N	$	64.44
86816		Hla typing dr/dq	N	$	30.95
86817		Hla typing dr/dq	N	$	106.14

86821		Lymphocyte culture mixed	N	$ 40.62
86825		Hla x-math non-cytotoxic	N	$ 109.49
86826		Hla x-match noncytotoxc addl	N	$ 36.53
86828		Hla class i&ii antibody qual	N	$ 64.19
86829		Hla class i/ii antibody qual	N	$ 64.19
86830		Hla class i phenotype qual	N	$ 95.52
86831		Hla class ii phenotype qual	N	$ 81.88
86832		Hla class i high defin qual	N	$ 323.75
86833		Hla class ii high defin qual	N	$ 325.80
86834		Hla class i semiquant panel	N	$ 397.29
86835		Hla class ii semiquant panel	N	$ 358.85
86850		Rbc antibody screen	N	$ 9.77
86880		Coombs test direct	N	$ 5.99
86885		Coombs test indirect qual	N	$ 6.36
86886		Coombs test indirect titer	N	$ 5.75
86900		Blood typing serologic abo	N	$ 3.32
86901		Blood typing serologic rh(d)	N	$ 3.32
86902		Blood type antigen donor ea	N	$ 6.35
86904		Blood typing patient serum	N	$ 16.34
86905		Blood typing rbc antigens	N	$ 4.25
86906		Bld typing serologic rh phnt	N	$ 8.61
86940		Hemolysins/agglutinins auto	N	$ 9.11
86941		Hemolysins/agglutinins	N	$ 13.45
87003		Small animal inoculation	N	$ 18.71
87015		Specimen infect agnt concntj	N	$ 7.42
87040		Blood culture for bacteria	N	$ 11.47
87045		Feces culture aerobic bact	N	$ 10.49
87046		Stool cultr aerobic bact ea	N	$ 10.49
87070		Culture othr specimn aerobic	N	$ 9.57
87071		Culture aerobic quant other	N	$ 10.49
87073		Culture bacteria anaerobic	N	$ 10.49
87075		Cultr bacteria except blood	N	$ 10.52
87076		Culture anaerobe ident each	N	$ 8.97
87077		Culture aerobic identify	N	$ 8.97
87077	QW	Culture aerobic identify	N	$ 8.97
87081		Culture screen only	N	$ 7.36
87084		Culture of specimen by kit	N	$ 27.07
87086		Urine culture/colony count	N	$ 8.97
87088		Urine bacteria culture	N	$ 8.99
87101		Skin fungi culture	N	$ 8.56
87102		Fungus isolation culture	N	$ 9.34

87103		Blood fungus culture	N	$ 20.46
87106		Fungi identification yeast	N	$ 11.47
87107		Fungi identification mold	N	$ 11.47
87109		Mycoplasma	N	$ 17.10
87110		Chlamydia culture	N	$ 21.77
87116		Mycobacteria culture	N	$ 12.00
87118		Mycobacteric identification	N	$ 14.61
87140		Culture type immunofluoresc	N	$ 6.19
87143		Culture typing glc/hplc	N	$ 13.92
87147		Culture type immunologic	N	$ 5.75
87149		Dna/rna direct probe	N	$ 22.28
87150		Dna/rna amplified probe	N	$ 38.99
87152		Culture type pulse field gel	N	$ 7.74
87153		Dna/rna sequencing	N	$ 128.17
87158		Culture typing added method	N	$ 7.74
87164		Dark field examination	N	$ 11.93
87166		Dark field examination	N	$ 12.56
87168		Macroscopic exam arthropod	N	$ 4.75
87169		Macroscopic exam parasite	N	$ 4.75
87172		Pinworm exam	N	$ 4.75
87176		Tissue homogenization cultr	N	$ 6.54
87177		Ova and parasites smears	N	$ 9.89
87181		Microbe susceptible diffuse	N	$ 5.27
87184		Microbe susceptible disk	N	$ 7.66
87185		Microbe susceptible enzyme	N	$ 5.27
87186		Microbe susceptible mic	N	$ 9.61
87187		Microbe susceptible mlc	N	$ 40.17
87188		Microbe suscept macrobroth	N	$ 7.38
87190		Microbe suscept mycobacteri	N	$ 7.31
87197		Bactericidal level serum	N	$ 16.69
87205		Smear gram stain	N	$ 4.75
87206		Smear fluorescent/acid stai	N	$ 5.99
87207		Smear special stain	N	$ 6.66
87209		Smear complex stain	N	$ 19.97
87210		Smear wet mount saline/ink	N	$ 5.82
87210	QW	Smear wet mount saline/ink	N	$ 5.82
87220		Tissue exam for fungi	N	$ 4.75
87230		Assay toxin or antitoxin	N	$ 21.93
87250		Virus inoculate eggs/animal	N	$ 21.73
87252		Virus inoculation tissue	N	$ 28.97
87253		Virus inoculate tissue addl	N	$ 22.45

87254		Virus inoculation shell via	N	$	21.73
87255		Genet virus isolate hsv	N	$	37.62
87260		Adenovirus ag if	N	$	14.43
87265		Pertussis ag if	N	$	13.32
87267		Enterovirus antibody dfa	N	$	13.42
87269		Giardia ag if	N	$	13.61
87270		Chlamydia trachomatis ag if	N	$	13.32
87271		Cytomegalovirus dfa	N	$	13.42
87272		Cryptosporidium ag if	N	$	13.32
87273		Herpes simplex 2 ag if	N	$	13.32
87274		Herpes simplex 1 ag if	N	$	13.32
87275		Influenza b ag if	N	$	13.32
87276		Influenza a ag if	N	$	16.07
87278		Legion pneumophilia ag if	N	$	15.60
87279		Parainfluenza ag if	N	$	16.43
87280		Respiratory syncytial ag if	N	$	13.42
87281		Pneumocystis carinii ag if	N	$	13.32
87283		Rubeola ag if	N	$	60.80
87285		Treponema pallidum ag if	N	$	13.32
87290		Varicella zoster ag if	N	$	13.42
87299		Antibody detection nos if	N	$	16.10
87300		Ag detection polyval if	N	$	13.32
87301		Adenovirus ag ia	N	$	13.32
87305		Aspergillus ag ia	N	$	13.32
87320		Chylmd trach ag ia	N	$	15.00
87324		Clostridium ag ia	N	$	13.32
87327		Cryptococcus neoform ag ia	N	$	13.42
87328		Cryptosporidium ag ia	N	$	13.82
87329		Giardia ag ia	N	$	13.32
87332		Cytomegalovirus ag ia	N	$	13.32
87335		E coli 0157 ag ia	N	$	13.32
87336		Entamoeb hist dispr ag ia	N	$	16.00
87337		Entamoeb hist group ag ia	N	$	13.32
87338		Hpylori stool ia	N	$	15.98
87338	QW	Hpylori stool ia	N	$	15.98
87339		H pylori ag ia	N	$	16.00
87340		Hepatitis b surface ag ia	N	$	11.48
87341		Hepatitis b surface ag ia	N	$	11.48
87350		Hepatitis be ag ia	N	$	12.81
87380		Hepatitis delta ag ia	N	$	18.36
87385		Histoplasma capsul ag ia	N	$	13.32

87389		Hiv-1 ag w/hiv-1 & hiv-2 ab	N	$	26.75
87389	QW	Hiv-1 ag w/hiv-1 & hiv-2 ab	N	$	26.75
87390		Hiv-1 ag ia	N	$	24.06
87391		Hiv-2 ag ia	N	$	21.90
87400		Influenza a/b ag ia	N	$	14.13
87420		Resp syncytial ag ia	N	$	13.91
87425		Rotavirus ag ia	N	$	13.32
87427		Shiga-like toxin ag ia	N	$	13.32
87430		Strep a ag ia	N	$	16.81
87449		Ag detect nos ia mult	N	$	13.32
87449	QW	Ag detect nos ia mult	N	$	13.32
87450		Ag detect nos ia single	N	$	10.66
87451		Ag detect polyval ia mult	N	$	10.66
87471		Bartonella dna amp probe	N	$	38.99
87472		Bartonella dna quant	N	$	47.60
87475		Lyme dis dna dir probe	N	$	22.28
87476		Lyme dis dna amp probe	N	$	38.99
87480		Candida dna dir probe	N	$	22.28
87481		Candida dna amp probe	N	$	38.99
87482		Candida dna quant	N	$	55.74
87483		Cns dna amp probe type 12-25	N	$	463.09
87485		Chylmd pneum dna dir probe	N	$	22.28
87486		Chylmd pneum dna amp probe	N	$	38.99
87487		Chylmd pneum dna quant	N	$	47.60
87490		Chylmd trach dna dir probe	N	$	22.75
87491		Chylmd trach dna amp probe	N	$	38.99
87492		Chylmd trach dna quant	N	$	53.47
87493		C diff amplified probe	N	$	38.99
87495		Cytomeg dna dir probe	N	$	30.03
87496		Cytomeg dna amp probe	N	$	38.99
87497		Cytomeg dna quant	N	$	47.60
87498		Enterovirus probe&revrs trns	N	$	38.99
87500		Vanomycin dna amp probe	N	$	38.99
87501		Influenza dna amp prob 1+	N	$	57.02
87502		Influenza dna amp probe	N	$	95.80
87502	QW	Influenza dna amp probe	N	$	95.80
87503		Influenza dna amp prob addl	N	$	29.22
87505		Nfct agent detection gi	N	$	142.54
87506		Iadna-dna/rna probe tq 6-11	N	$	262.99
87507		Iadna-dna/rna probe tq 12-25	N	$	463.09
87510		Gardner vag dna dir probe	N	$	22.28

87511		Gardner vag dna amp probe	N	$	38.99
87512		Gardner vag dna quant	N	$	46.40
87516		Hepatitis b dna amp probe	N	$	38.99
87517		Hepatitis b dna quant	N	$	47.60
87520		Hepatitis c rna dir probe	N	$	31.22
87521		Hepatitis c probe&rvrs trnsc	N	$	38.99
87522		Hepatitis c revrs trnscrpj	N	$	47.60
87525		Hepatitis g dna dir probe	N	$	29.80
87526		Hepatitis g dna amp probe	N	$	39.26
87527		Hepatitis g dna quant	N	$	46.40
87528		Hsv dna dir probe	N	$	22.28
87529		Hsv dna amp probe	N	$	38.99
87530		Hsv dna quant	N	$	47.60
87531		Hhv-6 dna dir probe	N	$	58.00
87532		Hhv-6 dna amp probe	N	$	38.99
87533		Hhv-6 dna quant	N	$	46.40
87534		Hiv-1 dna dir probe	N	$	22.28
87535		Hiv-1 probe&reverse trnscrpj	N	$	38.99
87536		Hiv-1 quant&revrse trnscrpj	N	$	94.55
87537		Hiv-2 dna dir probe	N	$	22.28
87538		Hiv-2 probe&revrse trnscripj	N	$	38.99
87539		Hiv-2 quant&revrse trnscripj	N	$	58.62
87540		Legion pneumo dna dir prob	N	$	22.28
87541		Legion pneumo dna amp prob	N	$	38.99
87542		Legion pneumo dna quant	N	$	46.40
87550		Mycobacteria dna dir probe	N	$	22.28
87551		Mycobacteria dna amp probe	N	$	48.24
87552		Mycobacteria dna quant	N	$	47.60
87555		M.tuberculo dna dir probe	N	$	26.88
87556		M.tuberculo dna amp probe	N	$	41.68
87557		M.tuberculo dna quant	N	$	47.60
87560		M.avium-intra dna dir prob	N	$	27.29
87561		M.avium-intra dna amp prob	N	$	38.99
87562		M.avium-intra dna quant	N	$	47.60
87580		M.pneumon dna dir probe	N	$	22.28
87581		M.pneumon dna amp probe	N	$	38.99
87582		M.pneumon dna quant	N	$	302.62
87590		N.gonorrhoeae dna dir prob	N	$	26.88
87591		N.gonorrhoeae dna amp prob	N	$	38.99
87592		N.gonorrhoeae dna quant	N	$	47.60
87623		Hpv low-risk types	N	$	38.99

87624		Hpv high-risk types	N	$ 38.99
87625		Hpv types 16 & 18 only	N	$ 40.55
87631		Resp virus 3-5 targets	N	$ 142.63
87631	QW	Resp virus 3-5 targets	N	$ 142.63
87632		Resp virus 6-11 targets	N	$ 237.14
87633		Resp virus 12-25 targets	N	$ 463.09
87633	QW	Resp virus 12-25 targets	N	$ 463.09
87634		Rsv dna/rna amp probe	N	$ 77.99
87634	QW	Rsv dna/rna amp probe	N	$ 77.99
87640		Staph a dna amp probe	N	$ 38.99
87641		Mr-staph dna amp probe	N	$ 38.99
87650		Strep a dna dir probe	N	$ 22.28
87650	QW	Strep a dna dir probe	N	$ 22.28
87651		Strep a dna amp probe	N	$ 38.99
87651	QW	Strep a dna amp probe	N	$ 38.99
87652		Strep a dna quant	N	$ 46.40
87653		Strep b dna amp probe	N	$ 38.99
87660		Trichomonas vagin dir probe	N	$ 22.28
87661		Trichomonas vaginalis amplif	N	$ 38.99
87662		Zika virus dna/rna amp probe	N	$ 57.02
87797		Detect agent nos dna dir	N	$ 30.03
87798		Detect agent nos dna amp	N	$ 38.99
87799		Detect agent nos dna quant	N	$ 47.60
87800		Detect agnt mult dna direc	N	$ 44.57
87801		Detect agnt mult dna ampli	N	$ 77.99
87801	QW	Detect agnt mult dna ampli	N	$ 77.99
87802		Strep b assay w/optic	N	$ 13.32
87803		Clostridium toxin a w/optic	N	$ 16.00
87804		Influenza assay w/optic	N	$ 16.55
87804	QW	Influenza assay w/optic	N	$ 16.55
87806		Hiv antigen w/hiv antibodies	N	$ 32.77
87806	QW	Hiv antigen w/hiv antibodies	N	$ 32.77
87807		Rsv assay w/optic	N	$ 13.32
87807	QW	Rsv assay w/optic	N	$ 13.32
87808		Trichomonas assay w/optic	N	$ 15.29
87808	QW	Trichomonas assay w/optic	N	$ 15.29
87809		Adenovirus assay w/optic	N	$ 21.76
87809	QW	Adenovirus assay w/optic	N	$ 21.76
87810		Chylmd trach assay w/optic	N	$ 35.29
87850		N. gonorrhoeae assay w/optic	N	$ 24.56
87880		Strep a assay w/optic	N	$ 16.53

87880	QW	Strep a assay w/optic	N	$ 16.53
87899		Agent nos assay w/optic	N	$ 16.07
87899	QW	Agent nos assay w/optic	N	$ 16.07
87900		Phenotype infect agent drug	N	$ 144.83
87901		Genotype dna hiv reverse t	N	$ 286.05
87902		Genotype dna/rna hep c	N	$ 286.05
87903		Phenotype dna hiv w/culture	N	$ 542.95
87904		Phenotype dna hiv w/clt add	N	$ 28.97
87905		Sialidase enzyme assay	N	$ 13.58
87905	QW	Sialidase enzyme assay	N	$ 13.58
87906		Genotype dna/rna hiv	N	$ 143.03
87910		Genotype cytomegalovirus	N	$ 286.05
87912		Genotype dna hepatitis b	N	$ 286.05
88130		Sex chromatin identification	N	$ 19.97
88140		Sex chromatin identification	N	$ 8.88
88142		Cytopath c/v thin layer	N	$ 22.51
88143		Cytopath c/v thin layer redo	N	$ 23.04
88147		Cytopath c/v automated	N	$ 50.56
88148		Cytopath c/v auto rescreen	N	$ 16.88
88150		Cytopath c/v manual	N	$ 14.99
88152		Cytopath c/v auto redo	N	$ 27.64
88153		Cytopath c/v redo	N	$ 24.03
88155		Cytopath c/v index add-on	N	$ 14.65
88164		Cytopath tbs c/v manual	N	$ 14.99
88165		Cytopath tbs c/v redo	N	$ 42.22
88166		Cytopath tbs c/v auto redo	N	$ 14.99
88167		Cytopath tbs c/v select	N	$ 14.99
88174		Cytopath c/v auto in fluid	N	$ 25.37
88175		Cytopath c/v auto fluid redo	N	$ 29.44
88230		Tissue culture lymphocyte	N	$ 129.44
88233		Tissue culture skin/biopsy	N	$ 156.36
88235		Tissue culture placenta	N	$ 163.63
88237		Tissue culture bone marrow	N	$ 143.75
88239		Tissue culture tumor	N	$ 163.91
88240		Cell cryopreserve/storage	N	$ 13.07
88241		Frozen cell preparation	N	$ 12.09
88245		Chromosome analysis 20-25	N	$ 192.42
88248		Chromosome analysis 50-100	N	$ 192.42
88249		Chromosome analysis 100	N	$ 192.42
88261		Chromosome analysis 5	N	$ 264.34
88262		Chromosome analysis 15-20	N	$ 138.49

88263		Chromosome analysis 45	N	$ 166.99
88264		Chromosome analysis 20-25	N	$ 144.61
88267		Chromosome analys placenta	N	$ 199.75
88269		Chromosome analys amniotic	N	$ 184.81
88271		Cytogenetics dna probe	N	$ 23.80
88272		Cytogenetics 3-5	N	$ 40.70
88273		Cytogenetics 10-30	N	$ 35.70
88274		Cytogenetics 25-99	N	$ 42.38
88275		Cytogenetics 100-300	N	$ 51.19
88280		Chromosome karyotype study	N	$ 33.47
88283		Chromosome banding study	N	$ 76.22
88285		Chromosome count additional	N	$ 26.91
88289		Chromosome study additional	N	$ 38.26
88371		Protein western blot tissue	N	$ 24.70
88372		Protein analysis w/probe	N	$ 26.22
88720		Bilirubin total transcut	N	$ 5.57
88738		Hgb quant transcutaneous	N	$ 5.57
88740		Transcutaneous carboxyhb	N	$ 9.37
88741		Transcutaneous methb	N	$ 9.37
89050		Body fluid cell count	N	$ 5.25
89051		Body fluid cell count	N	$ 6.12
89055		Leukocyte assessment fecal	N	$ 4.75
89060		Exam synovial fluid crystals	N	$ 7.95
89125		Specimen fat stain	N	$ 5.88
89160		Exam feces for meat fibers	N	$ 4.85
89190		Nasal smear for eosinophils	N	$ 5.79
89300		Semen analysis w/huhner	N	$ 9.92
89300	QW	Semen analysis w/huhner	N	$ 9.92
89310		Semen analysis w/count	N	$ 9.57
89320		Semen anal vol/count/mot	N	$ 13.39
89321		Semen anal sperm detection	N	$ 13.39
89321	QW	Semen anal sperm detection	N	$ 13.39
89322		Semen anal strict criteria	N	$ 17.22
89325		Sperm antibody test	N	$ 11.86
89329		Sperm evaluation test	N	$ 21.76
89330		Evaluation cervical mucus	N	$ 10.99
89331		Retrograde ejaculation anal	N	$ 21.76
0001U		Rbn dna hea 35 ag 11 bld grp	N	$ 720.00
0002M		Liver dis 10 assays w/ash	N	$ 503.40
0002U		Onc clrct 3 ur metab alg plp	N	$ 25.00
0003M		Liver dis 10 assays w/nash	N	$ 503.40

0003U		Onc ovar 5 prtn ser alg scor	N	$ 950.00
0004M		Scoliosis dna alys	N	$ 79.00
0005U		Onco prst8 3 gene ur alg	N	$ 760.00
0006M		Onc hep gene risk classifier	N	$ 150.00
0006U		Detc ia meds 120+ analytes	N	$ 246.92
0007M		Onc gastro 51 gene nomogram	N	$ 375.00
0007U		Rx test prsmv ur w/def conf	N	$ 114.43
0008U		Hpylori detcj abx rstnc dna	N	$ 597.91
0009M		Fetal aneuploidy trisom risk	N	$ 132.86
0009U		Onc brst ca erbb2 amp/nonamp	N	$ 107.00
0010U		Nfct ds strn typ whl gen seq	N	$ 427.26
0011M		Onc prst8 ca mrna 12 gen alg	N	$ 760.00
0011U		Rx mntr lc-ms/ms oral fluid	N	$ 114.43
0012M		Onc mrna 5 gen rsk urthl ca	N	$ 760.00
0012U		Germln do gene reargmt detcj	N	$ 2,515.60
0013M		Onc mrna 5 gen recr urthl ca	N	$ 760.00
0013U		Onc sld org neo gene reargmt	N	$ 2,515.60
0014U		Hem hmtlmf neo gene reargmt	N	$ 2,515.60
0016U		Onc hmtlmf neo rna bcr/abl1	N	$ 182.18
0017U		Onc hmtlmf neo jak2 mut dna	N	$ 101.85
0018U		Onc thyr 10 microrna seq alg	L	$ -
0019U		Onc rna tiss predict alg	L	$ -
0021U		Onc prst8 detcj 8 autoantb	L	$ -
0022U		Trgt gen seq dna&rna 23 gene	L	$ -
0023U		Onc aml dna detcj/nondetcj	L	$ -
0024U		Glyca nuc mr spectrsc quan	N	$ 35.06
0025U		Tenofovir liq chrom ur quan	N	$ 95.30
0026U		Onc thyr dna&mrna 112 genes	N	$ 3,600.00
0027U		Jak2 gene trgt seq alys	N	$ 150.52
0029U		Rx metab advrs trgt seq alys	L	$ -
0030U		Rx metab warf trgt seq alys	L	$ -
0031U		Cyp1a2 gene	N	$ 174.81
0032U		Comt gene	N	$ 174.81
0033U		Htr2a htr2c genes	N	$ 349.62
0034U		Tpmt nudt15 genes	N	$ 466.17
0035U		Neuro csf prion prtn qual	L	$ -
0036U		Xome tum & nml spec seq alys	N	$ 4,780.00
0037U		Trgt gen seq dna 324 genes	N	$ 3,500.00
0038U		Vitamin d srm microsamp quan	N	$ 32.89
0039U		Dna antb 2strand hi avidity	N	$ 15.27
0040U		Bcr/abl1 gene major bp quan	N	$ 455.45

0041U		B brgdrferi antb 5 prtn igm	L	$ -
0042U		B brgdrferi antb 12 prtn igg	L	$ -
0043U		Tbrf b grp antb 4 prtn igm	L	$ -
0044U		Tbrf b grp antb 4 prtn igg	L	$ -
0045U		Onc brst dux carc is 12 gene	N	$ 3,873.00
0046U		Flt3 gene itd variants quan	N	$ 165.51
0047U		Onc prst8 mrna 17 gene alg	N	$ 3,873.00
0048U		Onc sld org neo dna 468 gene	L	$ -
0049U		Npm1 gene analysis quan	N	$ 246.52
0050U		Trgt gen seq dna 194 genes	L	$ -
0051U		Rx mntr lc-ms/ms ur 31 pnl	N	$ 205.63
0052U		Lpoprtn bld w/5 maj classes	N	$ 33.86
0053U		Onc prst8 ca fish alys 4 gen	L	$ -
0054U		Rx mntr 14+ drugs & sbsts	N	$ 165.52
0055U		Card hrt trnspl 96 dna seq	L	$ -
0056U		Hem aml dna gene reargmt	L	$ -
0058U		Onc merkel cll carc srm quan	N	$ 358.85
0059U		Onc merkel cll carc srm +/-	N	$ 358.85
0060U		Twn zyg gen seq alys chrms2	N	$ 759.05
0061U		Tc meas 5 bmrk sfdi m-s alys	N	$ 27.85
0080U		Onc Lng 5 Clin Rsk Factr Alg	N	$ 3,520.00
G0027		Semen analysis	N	$ 7.23
G0103		Psa screening	N	$ 20.44
G0123		Screen cerv/vag thin layer	N	$ 22.51
G0143		Scr c/v cyto,thinlayer,rescr	N	$ 27.05
G0144		Scr c/v cyto,thinlayer,rescr	N	$ 43.97
G0145		Scr c/v cyto,thinlayer,rescr	N	$ 29.44
G0147		Scr c/v cyto, automated sys	N	$ 14.99
G0148		Scr c/v cyto, autosys, rescr	N	$ 31.94
G0306		Cbc/diffwbc w/o platelet	N	$ 8.63
G0307		Cbc without platelet	N	$ 7.18
G0328		Fecal blood scrn immunoassay	N	$ 18.05
G0328	QW	Fecal blood scrn immunoassay	N	$ 18.05
G0432		Eia hiv-1/hiv-2 screen	N	$ 19.57
G0433		Elisa hiv-1/hiv-2 screen	N	$ 18.29
G0433	QW	Elisa hiv-1/hiv-2 screen	N	$ 18.29
G0435		Oral hiv-1/hiv-2 screen	N	$ 13.32
G0471		Ven blood coll snf/hha	N	$ 5.00
G0472		Hep c screen high risk/other	N	$ 46.35
G0472	QW	Hep c screen high risk/other	N	$ 46.35
G0475		Hiv combination assay	N	$ 26.75

G0475	QW	Hiv combination assay	N	$ 26.75
G0476		Hpv combo assay ca screen	N	$ 38.99
G0480		Drug test def 1-7 classes	N	$ 114.43
G0481		Drug test def 8-14 classes	N	$ 156.59
G0482		Drug test def 15-21 classes	N	$ 198.74
G0483		Drug test def 22+ classes	N	$ 246.92
G0499		Hepb screen high risk indiv	N	$ 31.41
G0659		Drug test def simple all cl	N	$ 64.65
G9143		Warfarin respon genetic test	N	$ 134.13
P2028		Cephalin floculation test	N	$ 5.50
P2029		Congo red blood test	N	$ 5.50
P2031		Hair analysis	N	$ 5.50
P2033		Blood thymol turbidity	N	$ 5.50
P2038		Blood mucoprotein	N	$ 5.50
P3000		Screen pap by tech w md supv	N	$ 14.99
P9612		Catheterize for urine spec	N	$ 3.00
P9615		Urine specimen collect mult	N	$ 3.00
Q0111		Wet mounts/ w preparations	N	$ 14.99
Q0112		Potassium hydroxide preps	N	$ 5.83
Q0113		Pinworm examinations	N	$ 4.75
Q0114		Fern test	N	$ 9.74
Q0115		Post-coital mucous exam	N	$ 25.00

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Office of the Attorney General

Tracking number: 2019-00331

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Workers' Compensation

on 09/24/2019

7 CCR 1101-3

WORKERS' COMPENSATION RULES OF PROCEDURE WITH TREATMENT GUIDELINES

The above-referenced rules were submitted to this office on 09/24/2019 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

October 08, 2019 14:52:55

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Public Employees' Retirement Board

Agency

Public Employees' Retirement Association

CCR number

8 CCR 1502-1

Rule title

8 CCR 1502-1 COLORADO PERA RULES 1 - eff 01/01/2020

Effective date

01/01/2020

COLORADO PERA RULES

Effective January 1, 2020

2.15 Employer Assignments

A. State Division

(1) Within the State Division, one group shall be designated Institutions of Higher Education, and the other shall be designated Agencies and Instrumentalities.

(A) The Institutions of Higher Education group of the State Division shall consist of the following employers and their employees and any other institutions of higher education established subsequent to the adoption of the Rules:
Adams State University
Aims Community College
Arapahoe Community College
Auraria Higher Education Center
Community College of Aurora
Colorado Mesa University
Colorado Mountain College
Colorado Northwestern Community College
Colorado School of Mines
Colorado State University
Colorado State University at Pueblo
Commission on Higher Education
Community College of Denver
Fort Lewis College
Front Range Community College
Lamar Community College
Metropolitan State University of Denver
Morgan Community College
Northeastern Junior College
Otero Junior College
Pikes Peak Community College
Pueblo Community College
Red Rocks Community College
State Board for Community Colleges and Occupational Education
Trinidad State Junior College
University of Colorado
University of Northern Colorado
Western State Colorado University

(B) The Agencies and Instrumentalities group of the State Division shall consist of the following employers and their employees and any other state agency or instrumentality established subsequent to the adoption of the Rules:
CollegeInvest
College Assist
Colorado Association of School Boards
Colorado Association of School Executives
Colorado High School Activities Association
Colorado House of Representatives
Colorado Senate
Colorado Water Resources & Power Development Authority
Colorado Community College System
CoverColorado Department of Agriculture
Department of Corrections

Department of Education
Department of Health Care Policy and Financing
Department of Human Services
Department of Labor and Employment
Department of Law
Department of Local Affairs
Department of Military and Veterans Affairs
Department of Natural Resources
Department of Personnel and Administration
Department of Public Health and Environment
Department of Public Safety
Department of Regulatory Agencies
Department of Revenue
Department of State
Department of the Treasury
Department of Transportation
Fire and Police Pension Association
Joint Budget Committee
Judicial Department
Legislative Council
Office of the District Attorneys
Office of Economic Development and International Trade
Office of the Governor
Office of Information Technology
Office of Legislative Legal Services
Office of the Lieutenant Governor
Office of the State Auditor
Pinnacol Assurance
Public Employees' Retirement Association
School for the Deaf and the Blind
Special District Association of Colorado
State Historical Society

B. The School Division shall consist of the following affiliated employers and their employees and any other school district established and affiliated subsequent to the adoption of the Rules:

Adams County
Adams 12 Five Star Schools
Adams County School District 14
Bennett School District 29J
Brighton School District 27J
Mapleton School District 1
Strasburg School District 31J
Westminster Public Schools

Alamosa County
Alamosa County School District Re-11J
Sangre de Cristo School District Re-22J

Arapahoe County
Adams-Arapahoe School District 28J
Byers School District 32J
Cherry Creek School District 5

Deer Trail School District 26J
Englewood School District 1
Littleton School District 6
Sheridan School District 2

Archuleta County
Archuleta County School District 50 Jt

Baca County
Campo School District RE-6
Pritchett School District RE-3
Springfield School District RE-4
Vilas School District RE-5
Walsh School District RE-1

Bent County
Las Animas School District RE-1
McClave School District RE-2

Boulder County
Boulder Valley School District RE2
St. Vrain Valley School District RE1J

Chaffee County
Buena Vista School District R-31
Salida School District R-32(J)

Cheyenne County
Cheyenne County School District Re-5
Kit Carson School District R-1

Clear Creek County
Clear Creek School District RE-1

Conejos County
North Conejos School District RE1J
Sanford School District 6J
South Conejos School District RE 10

Costilla County
Centennial School District R-1
Sierra Grande School District R-30

Crowley County
Crowley County School District RE-1

Custer County
Custer County Consolidated School District C-1

Delta County
Delta County School District 50(J)

Dolores County
Dolores County School District Re No. 2

Douglas County
Douglas County School District Re 1

Eagle County
Eagle County School District Re 50

Elbert County
Agate School District 300
Big Sandy School District 100J
Elbert School District 200
Elizabeth School District C-1
Kiowa School District C-2

El Paso County
Academy School District #20
Calhan School District RJ1
Cheyenne Mountain School District 12
Colorado Springs School District 11
Edison School District 54 Jt
Ellicott School District 22
Falcon School District 49
Fountain School District 8
Hanover School District 28
Harrison School District 2
Lewis-Palmer School District 38
Manitou Springs School District 14
Miami/Yoder School District 60 Jt
Peyton School District 23 Jt
Widefield School District 3

Fremont County
Canon City School District Re-1
Cotopaxi School District Re-3
Florence School District Re-2

Garfield County
Garfield School District 16
Garfield School District Re-2
Roaring Fork School District Re-1

Gilpin County
Gilpin County School District Re-1

Grand County
East Grand School District 2
West Grand School District 1

Gunnison County
Gunnison Watershed School District Re1J

Hinsdale County
Hinsdale County School District Re-1

Huerfano County
Huerfano School District Re-1
La Veta School District Re-2

Jackson County
North Park School District R-1

Jefferson County

Jefferson County School District R-1

Kiowa County

Kiowa County School District RE-1

Plainview School District Re-2

Kit Carson County

Arriba-Flagler Consolidated School District No. 20

Bethune School District R-5

Burlington School District Re-6J

Hi-Plains School District R-23

Stratton School District R-4

Lake County

Lake County School District R-1

La Plata County

Bayfield School District 10Jt-R

Durango School District 9-R

Ignacio School District 11 Jt

Larimer County

Estes Park School District R-3

Poudre School District R-1

Thompson School District R-2J

Las Animas County

Aguilar Reorganized School District 6

Branson Reorganized School District 82

Hoehne Reorganized School District 3

Kim Reorganized School District 88

Primero Reorganized School District 2

Trinidad School District 1

Lincoln County

Genoa/Hugo School District C-113

Karval School District Re 23

Limon School District Re 4J

Logan County

Buffalo School District Re-4

Frenchman School District Re-3

Plateau School District Re-5

Valley School District Re-1

Mesa County

De Beque School District 49 Jt

Mesa County Valley School District 51

Plateau Valley School District 50

Mineral County

Creede Consolidated School District 1

Moffat County

Hayden School District Re 1

Moffat County School District Re No.1

Montezuma County
Dolores School District RE 4A
Mancos School District Re-6
Montezuma-Cortez School District Re 1

Montrose County
Montrose County School District Re-1J
West End School District Re-2

Morgan County
Brush School District Re-2 (J)
Fort Morgan School District Re-3
Weldon Valley School District Re-20 (J)
Wiggins School District Re-50 (J)

Otero County
Cheraw School District 31
East Otero School District R1
Fowler School District R4J
Manzanola School District 3J
Rocky Ford School District R2
Swink School District 33

Ouray County
Ouray School District R-1
Ridgway School District R-2

Park County
Park County School District Re-2
Platte Canyon School District 1

Phillips County
Haxtun School District Re-2J
Holyoke School District Re-1J

Pitkin County
Aspen School District 1

Prowers County
Granada School District Re-1
Holly School District Re-3
Lamar School District Re-2
Wiley School District Re-13 Jt

Pueblo County
Pueblo City School District 60
Pueblo County Rural School District 70

Rio Blanco County
Meeker School District RE1
Rangely School District RE4

Rio Grande County
Del Norte School District C-7
Monte Vista School District C-8
Sargent School District Re-33J

Routt County
South Routt School District Re 3
Steamboat Springs School District Re 2

Saguache County
Center Consolidated School District 26 Jt
Moffat School District 2
Mountain Valley School District Re 1

San Juan County

Silverton School District 1

San Miguel County
Norwood School District R-2J
Telluride School District R-1

Sedgwick County
Julesburg School District Re 1
Revere School District

Summit County
Summit School District Re 1

Teller County
Cripple Creek-Victor School District Re-1
Woodland Park School District RE-2

Washington County
Akron School District R-1
Arickaree School District R-2
Lone Star School District 101
Otis School District R-3
Woodlin School District R-104

Weld County
Ault-Highland School District Re-9
Briggsdale School District Re-10
Eaton School District Re-2
Weld County School District Re-1
Greeley School District 6
Johnstown-Milliken School District Re-5J
Keenesburg School District Re-3
Pawnee School District Re-12
Platte Valley School District Re-7
Prairie School District Re-11
Weld County School District Re-8
Windsor School District Re-4

Yuma County
Idalia School District RJ-3
Liberty School District J-4
Wray School District RD-2

Yuma School District 1

Boards of Cooperative Educational Services (BOCES)

Adams County Board of Cooperative Educational Services
Centennial Board of Cooperative Educational Services
Colorado Digital Board of Cooperative Educational Services
Colorado River Board of Cooperative Educational Services
East Central Board of Cooperative Educational Services
Expeditionary Learning School Board of Cooperative Educational Services
Grand Valley Board of Cooperative Educational Services
Mount Evans Board of Cooperative Educational Services
Mountain Board of Cooperative Educational Services
Northeast Board of Cooperative Educational Services
Northwest Colorado Board of Cooperative Educational Services
Pikes Peak Board of Cooperative Educational Services
Rio Blanco Board of Cooperative Educational Services
San Juan Board of Cooperative Educational Services
San Luis Valley Board of Cooperative Educational Services
Santa Fe Trail Board of Cooperative Educational Services
South Central Board of Cooperative Educational Services
Southeastern Board of Cooperative Educational Services
Uncompaghre Board of Cooperative Educational Services
Ute Pass Board of Cooperative Educational Services

Vocational Schools

Technical College of the Rockies

Other

Colorado Consortium for Earth and Space Science Education

C. Local Government Division

The Local Government Division shall consist of the following affiliated employers and their employees and any other entity of local government or public agency other than state that elect to affiliate with the Association:

Adams and Jefferson County Hazardous Response Authority
Alamosa Housing Authority
Arapahoe Park and Recreation District
Aurora Housing Authority
Baca Grande Water & Sanitation District
Beulah Water Works District
Black Hawk-Central City Sanitation District
Blanca-Fort Garland Metropolitan District
Boulder County
Boulder County Public Trustee’s Office
Boxelder Sanitation District
Brush Housing Authority
Carbon Valley Park & Recreation District
Castle Pines Metropolitan District
Castle Pines North Metropolitan District
Center Housing Authority
Central Colorado Water Conservancy District

City of Alamosa
City of Boulder
City of Castle Pines
City of Colorado Springs
City of Fort Morgan
City of Las Animas
City of Lone Tree
City of Manitou Springs
City of Pueblo
City of Wray
City of Yuma
Clearview Library District
Collbran Conservancy District
Colorado District Attorneys' Council
Colorado First Conservation District
Colorado Health Facilities Authority
Colorado Housing and Finance Authority
Colorado Library Consortium
Colorado River Fire Protection District
Colorado School District Self-Insurance Pool
Colorado Springs Utilities
Columbine Knolls-Grove Metropolitan Recreation District
Costilla Housing Authority
County Technical Services
Cucharas Sanitation and Water District
Douglas County Housing Partnership
Douglas County Libraries
Durango Fire Protection District
East Cheyenne Groundwater Management District
East Larimer County Water District
Eastern Rio Blanco Metropolitan Recreation & Park District
Eaton Housing Authority
Elbert County Library District
Elizabeth Park and Recreation District
El Paso – Teller County Emergency Telephone Service Authority
Estes Park Housing Authority
Estes Park Local Marketing District
Estes Valley Fire Protection District
Estes Valley Public Library District
Forest Lakes Metropolitan District
Fremont Conservation District
Fremont Sanitation District
Garfield County Housing Authority
Grand Junction Regional Airport Authority
Grand Valley Fire Protection District
Green Mountain Water and Sanitation District
GVR Metropolitan District
Housing Authority of Arriba
Housing Authority of the City of Boulder
Housing Authority of the City of Colorado Springs
Housing Authority of the County of Adams

Housing Authority of the Town of Limon
Lamar Housing Authority
Lamar Utilities Board
Left Hand Water District
Longmont Housing Authority
Longs Peak Water District
Louisville Fire Protection District
Meeker Cemetery District
Meeker Regional Library District
Meeker Sanitation District
Montrose Fire Protection District
Montrose Recreation District
Monument Sanitation District
Morgan Conservation District
Morgan County Quality Water District
Mountain View Fire Protection District
Mountain Water and Sanitation District
Niwot Sanitation District
North Carter Lake Water District
North Chaffee County Regional Library
North Front Range Water Quality Planning Association
Northeast Colorado Health Department
Northeastern Colorado Association of Local Governments
Park Center Water District
Pine Drive Water District
Pikes Peak Regional Building Department
Plum Creek Water Reclamation Authority
Pueblo City-County Health Department
Pueblo Library District
Pueblo Transit Authority
Pueblo Urban Renewal Authority
Rampart Regional Library District
Rangely Regional Library District
Red Feather Mountain Library District
Red, White & Blue Fire Protection District
Republican River Water Conservation District
Rifle Fire Protection District
Rio Blanco Fire Protection District
Rio Blanco Water Conservancy District
Routt County Conservation District
Sable-Altura Fire Protection District
San Luis Valley Development Resources Group
San Luis Valley Water Conservancy District
San Miguel County Public Library District
San Miguel Regional and Telluride Housing Authority
Scientific and Cultural Facilities District
Sheridan Sanitation District #1
Soldier Canyon Water Treatment Authority
Statewide Internet Portal Authority
Steamboat II Water and Sanitation District
Strasburg Metropolitan Parks & Recreation District

St. Vrain Sanitation District
Tabernash Meadows Water and Sanitation District
Town of Alma
Town of Bayfield
Town of Crawford
Town of Dinosaur
Town of Eckley
Town of Estes Park
Town of Firestone
Town of Lake City
Town of Lochbuie
Town of Mountain Village
Town of Platteville
Town of Rico Town of Rye
Town of Seibert
Town of Silver Plume
Town of Timnath
Tri-County Health Department
Tri-Lakes Wasterwater Treatment Facility
Unison Housing Partners
Upper Colorado Environmental Plant Center
Upper Thompson Sanitation District
Washington-Yuma Counties Combined Communications Center
Weld County Department of Public Health and Environment
West Greeley Conservation District
Western Rio Blanco Metropolitan Recreation and Park District
White River Conservation District
Wray Housing Authority
Yuma Housing Authority

D. Judicial Division

The Judicial Division shall consist of judges elected or appointed to positions in the following courts and any court established subsequent to the adoption of the Rules:

1st–22nd District Court
Adams County Court
Alamosa County Court
Arapahoe County Court
Archuleta County Court
Baca County Court
Bent County Court
Boulder County Court
Broomfield County Court
Chaffee County Court
Cheyenne County Court
Clear Creek County Court
Conejos County Court
Costilla County Court
Court of Appeals
Crowley County Court
Custer County Court
Delta County Court
Denver County Court

Denver Juvenile Court
Denver Probate Court
Dolores County Court
Douglas County Court
Eagle County Court
Elbert County Court
El Paso County Court
Fremont County Court
Garfield County Court
Gilpin County Court
Grand County Court
Gunnison County Court
Hinsdale County Court
Huerfano County Court
Jackson County Court
Jefferson County Court
Kiowa County Court
Kit Carson County Court
Lake County Court
La Plata County Court
Larimer County Court
Las Animas County Court
Lincoln County Court
Logan County Court
Mesa County Court
Mineral County Court
Moffat County Court
Montezuma County Court
Montrose County Court
Morgan County Court
Otero County Court
Ouray County Court
Park County Court
Phillips County Court
Pitkin County Court
Prowers County Court
Pueblo County Court
Rio Blanco County Court
Rio Grande County Court
Routt County Court
Saguache County Court
San Juan County Court
San Miguel County Court
Sedgwick County Court
Summit County Court
Supreme Court
Teller County Court
Washington County Court
Weld County Court
Yuma County Court

E. Denver Public Schools Division Denver Public School District No. 1

RULE 3: MEMBERSHIP

3.25 Member Records

The Association shall require such information as may be necessary to determine membership status or benefit eligibility including, but not limited to:

A. Employer Responsibility

An employer shall provide any information necessary to determine membership status or benefit eligibility including, but not limited to:

(1) Written or electronic notice of changes in employment status resulting from hire, transfer, promotion, leave of absence, resignation, termination, reinstatement or death.

(2) Upon request from the Association, certification of previous employment status for periods during which service credit is in question.

(3) Upon request from the Association, pay patterns, work patterns or other information required to determine service credit or benefits payable.

B. Member Responsibility

A member shall provide any information necessary to determine benefit eligibility and to maintain contact with the member including, but not limited to:

(1) Written notice of changes in name, address or named beneficiary.

(2) Proof of age for the member or cobeneficiary when such age cannot be determined by existing Association records.

RULE 4: CONTRIBUTIONS

4.15 Payment of Unpaid Contributions

A. Retiree

A person who retired before the Association first notified the employer of a claim for unpaid contributions shall be treated as an inactive member for determining the amount due the Association, and for all other purposes of 24-51-402(3) through (5), C.R.S.

B. Non-Member

The cost to purchase service for an individual who was not a member or inactive member when the Association first notified the employer of a claim for unpaid contributions shall be the amount of member contributions which would have been paid, had the individual been properly covered as a member, plus interest accrued from the last date the individual was paid but not properly covered to completion of payment.

C. Member or Inactive Member

For an individual who was a member or inactive member at the time the Association first notified the employer of a claim:

(1) Cost

The cost to purchase service credit under 24-51-402(3)(b)(1)(A), C.R.S., shall be based on the salary amount and percentage used pursuant to 24-51-505, C.R.S. Such cost shall not be applicable if the individual has less than one year of service credit.

(2) Salary Increase Only

If payment of unpaid contributions results in an increase in salary, but no increase in service credit, the amount due shall be the unpaid employer and member contributions plus interest, as provided by 24-51-402(3)(b) (1)(B), C.R.S.

(3) Notification to PERA

The Association must receive in writing, within one year after the date the employer pays the unpaid employer contributions, an election from an individual declaring the intent to pay unpaid employee contributions, or the individual's right to make such contributions shall be forfeited.

(4) Payment by Member or Inactive Member

(a) Deadline for Start of Payment

If an individual elects pursuant to 24-51-402(4), C.R.S., to pay all or any portion of the unpaid employee contributions, the lump-sum payment or the first installment payment must be made no later than the first full month following one year after the date the employer pays the unpaid employer contributions.

(b) Lump-Sum Payment

Eligibility to make payment under 24-51-402, C.R.S., shall be forfeited if payment is not made within 30 days following the date on which the lump-sum payment is due.

(c) Installment Payments

Installment payments shall be subject to the provisions of Rule 5.30 B. If the purchase agreement is cancelled pursuant to Rule 5.30 B(2) or (4), eligibility to make payments under 24-51-402, C.R.S., shall be forfeited.

D. Defined Contribution Plan

If an employer fails to provide an eligible employee membership in the Defined Contribution Plan or the required level of contributions to a member's account in the Defined Contribution Plan, the employer shall pay all unpaid employer contributions pursuant to 24-51-401 C.R.S. *et seq.*, plus interest at the actuarial investment assumption rate.

(1) Payment of Employer Contribution plus Interest to Account

The amount of contributions plus interest shall be allocated to the eligible employee or member's Defined

Contribution Plan account in the same proportion as would have been paid had the contributions been made timely. (For purpose of clarity, pursuant to 24-51-1505(1), C.R.S., any contribution exceeding the amount in table A in 24-51-401(1.7)(a), C.R.S., plus attributable interest, shall be paid to the employer's division trust fund.)

(2) Election by Eligible Employee or Member to Pay

The eligible employee or member shall have the option to pay the full amount of member contributions to the eligible employee or member's Defined Contribution Plan account. Any such individual who elects to pay all or any portion of unpaid member contributions shall notify the Association of such election within one year after the date the employer pays the unpaid employer contributions, and may make payment by any method provided in Rule 4.15C(4).

(3) Payment by Employer of Interest

Upon receipt by the Association of amounts paid pursuant to Rule 4.15D(2), the employer shall pay interest on the unpaid member contributions at the actuarial investment assumption rate during the time such member contributions should have been made until the date the contributions are received by the Association. The interest paid by the employer pursuant to this Rule 4.15D(3) shall be allocated to the eligible employee or member's Defined Contribution Plan account.

RULE 11: EMPLOYMENT AFTER RETIREMENT

11.10 Employment After Service Retirement

A retiree receiving a service retirement or reduced service retirement benefit may be employed, under certain conditions, without reduction in benefits.

A. Employment with an Affiliated Employer

(1) For a service retiree employed in a position subject to limits on employment after service retirement, employment of more than four hours per day shall be considered one day.

(2) Employment after service retirement shall include all of the time during which a retiree renders any paid service.

B. Employment with a Non-Affiliated Employer

A retiree receiving a service retirement or reduced service retirement benefit may be employed with a non-affiliated employer without a reduction in or suspension of benefits.

C. Employment of Benefit Recipients Other Than Retirees

Cobeneficiaries and survivors are not subject to employment limitations.

D. Employment Pursuant to Section 24-51-1101(1.8) and (1.9), C.R.S.

(1) For the purposes of Section 24-51-1101(1.8), C.R.S., an "employer" is defined to be an entire school district and the charter schools of the district. Charter schools are not separate employers for purposes of Section 24-51-1101(1.8), C.R.S.

(2) A service retiree who is working for an employer pursuant to Section 24-51-1101(1.8) or (1.9), C.R.S., may also work for one or more employers during the calendar year. Once the service retiree reaches one hundred ten days or seven hundred twenty hours in a calendar year, whichever is applicable, the retiree may only work any remaining days or hours, without a reduction in benefits, for the employer that designated that service retiree pursuant to Section 24-51-1101(1.8) or (1.9), C.R.S. Any employment with another employer will subject the retiree to a reduction in benefits pursuant to Section 24-51-1102, C.R.S.

(3) For purposes of Section 24-51-1101(1.8) and (1.9), the employer must provide the Association with a list of any and all service retirees employed by the employer no later than March 31st of the applicable calendar year. The list must be updated with each service retiree who is hired that year.

(4) For purposes of Section 24-51-1101(1.8) and (1.9), C.R.S., an employer is not required to designate all ten service retirees by March 31st of the applicable calendar year. However, once ten service retirees have been designated during a calendar year pursuant to Section 24-51-1101(1.8), C.R.S., no additional service retirees may be designated even if one or more of the designated service retirees ceases work for that employer.

E. Employment as an Instructor at a State College or University

(1) An instructor at a state college or university may, but is not required to, determine hours worked for purposes of the limit in Section 24-51-1101(1) or (1.8), C.R.S., as applicable, by deeming each one credit hour taught per semester to equal three hours worked per week in that semester. An instructor who determines hours worked using this method may not exceed seven hundred twenty or nine hundred sixteen hours worked in the calendar year, or the daily equivalent if combining the hourly employment limit with other daily employment.

(2) For the purposes of this Rule, ''state college or university'' has the same definition as 24-51-1101(1.8)(e)(I), C.R.S.

RULE 14: VOLUNTARY INVESTMENT PROGRAM (401(k) PLAN)

Rule 14 describes certain requirements of the Voluntary Investment Program, a 401(k) plan established pursuant to Section 401(k) of the Internal Revenue Code of 1986, as amended. In addition to this Rule 14 and Part 14 of Article 51 of Title 24, C.R.S., the Voluntary Investment Program, or "401(k) Plan", is also governed by PERA's 401(k) and Defined Contribution Plan and Trust Document adopted by the Board (the "Plan document").

14.10 Enrollment in the 401(k) Plan

A. Any employee of an affiliated employer may enroll in the 401(k) Plan in accordance with the terms of the Plan document.

B. A person whose assets are transferred from the state defined contribution match plan to the 401(k) Plan pursuant to 24-51-1402(5)(a), C.R.S., shall be automatically enrolled in the 401(k) Plan.

14.15 Changes in 401(k) Plan Participation

Requests for changes in the percent of contributions assigned to each fund or the total amount in each fund must be submitted in the time and manner designated by the Plan Administrator.

14.20 Suspension of Participation

A participant may stop contributions to the 401(k) Plan in accordance with the terms of the Plan document.

14.30 Contribution Report

A. The employer shall deliver all 401(k) Plan contributions, along with the required report, to the service provider designated by the Plan Administrator within five days of the date contributions were deducted from the employee's salary. If either the report or contributions are delinquent, interest shall be assessed and paid to participants as determined by the Plan Administrator in a manner consistent with the Employee Plans Compliance Resolution System, Rev. Proc. 2016-51, as updated and superseded by future IRS guidance.

B. The Plan Administrator shall prescribe the form in which 401(k) Plan contributions shall be reported. Interest on delinquent reports or contributions shall be assessed and paid to the Plan Administrator computed on a daily rate on the contribution amount from the due date to the day that both the required report and contributions are received. The Plan Administrator, in its sole discretion, may waive the interest so computed.

14.40 Distributions

Distribution of a participant's 401(k) account may commence as specified in the Plan document.

14.50 Loans

All eligible 401(k) participants may borrow monies from the participant's 401(k) account subject to loan provisions established by the Board and specified in the Plan document.

14.65 Compliance with Internal Revenue Service Code

A participant may only contribute to the plan up to the maximum contribution limits established by the Internal Revenue Service each year. If a participant contributes to another plan subject to the same maximum limit in the same year as the participant contributes to PERA's 401(k) plan, the participant is responsible for compliance with the Internal Revenue Service Code regarding maximum allowable contributions.

14.70 Beneficiary Designations

Designation of a beneficiary shall be made in the manner prescribed by the Plan document.

RULE 16: DEFINED CONTRIBUTION PLAN

16.10 Terms

A. Defined Contribution Plan means the Association's defined contribution plan established pursuant to 24-51-1501, C.R.S., as a component of the 401(k) Plan. The Defined Contribution Plan is a separate trust fund within the 401(k) Plan and is also governed by PERA's 401(k) and Defined Contribution Plan and Trust Document (the "Plan document"). The Defined Contribution Plan is a profit-sharing plan intended to satisfy the requirements of Section 401(a) of the Internal Revenue Code.

B. Defined Contribution Account refers to an account containing sums transferred to the account via trustee to trustee transfer together with the contributions to the Defined Contribution Plan on behalf of the member of the Defined Contribution Plan and the earnings thereon less any distributions, any losses, and the member's allocable portion of the costs and expenses of administering the Plan.

C. Commence Employment means the date the employee began actual performance of services in the position eligible for the Defined Contribution Plan and earned salary for such services, regardless of when the payment occurs.

D. Community College refers to any Community College in the state system of community and technical colleges governed by the State Board for Community Colleges and Occupational Education which shall include Arapahoe Community College, Colorado Northwestern Community College, the Community College of Aurora, the Community College of Denver, Front Range Community College, Lamar Community College, Morgan Community College, Northeastern Junior College, Otero Junior College, Pikes Peak Community College, Pueblo Community College, Red Rocks Community College, Trinidad State Junior College and the Colorado Community College and occupational education system.

E. Member of the Defined Contribution Plan means an employee who elected to participate in the Defined Contribution Plan pursuant to 24-51-1503(1) or 24-51-1506(4), C.R.S., or who became a member pursuant to 24-51-1501(2) or 24-51-1503(3), C.R.S, and is presently performing services for that PERA- affiliated employer for salary resulting in contributions to the Defined Contribution Plan. Member of the Defined Contribution Plan also means, to the extent required, a member who is inactive but who has a Defined Contribution Account.

F. Except as expressly provided herein, for purposes of Part 15 of the PERA Statutes and this Rule 16, all time periods shall be determined in accordance with 2-4-108, C.R.S.

G. Year of Membership in the Defined Contribution Plan means 12 months, not necessarily consecutive, during which contributions are made on the member's behalf pursuant to 24-51-1505(1), C.R.S., to the Defined Contribution Plan. A Defined Contribution Plan member's total years of membership in the Defined Contribution Plan shall be calculated by dividing the total number of months during which contributions were made on the member's behalf to the Defined Contribution Plan by 12. Credit shall not be provided for member contributions transferred pursuant to Rule 16.30 D after an employee elects to participate pursuant to 24-51-1506(4), C.R.S. Years of membership before a 12-month break in service shall not be includable for purposes of determining a Defined Contribution Plan member's years of membership after such 12-month break in service. Each time an election is made to participate in the Defined Contribution Plan after a 12-month break in service, the employee shall have a new Defined Contribution Account with a new vesting schedule.

H. For purposes of 24-51-1506(4), C.R.S., year of membership in the plan means 12 months of contributions, not necessarily consecutive, with an employer as defined in 24-51-1501(4), C.R.S. A member's total years of membership in the Defined Benefit Plan shall be calculated by dividing the total number of months of contributions by 12. Years of membership before a 12-month break in membership shall not be includable for purposes of determining a member's years of membership after such 12-month break in membership. Each time an election is made pursuant to 24-51-1502(1) or 1503(1), C.R.S., after a 12-month break in membership, the employee shall have a new calculation for years of membership for the purposes of 24-51-1506(4), C.R.S. Years of membership with an employer other than an employer defined in

24-51-1501(4), C.R.S., shall not count towards the calculation of years of membership pursuant to 24-51-1506(4), C.R.S.

I. For purposes of Rule 16.10 H., reference to 12-month break in membership means 12 consecutive months for which no contributions are made on the member's behalf to the Defined Benefit Plan with an employer defined in 24-51-1501(4), C.R.S.

J. 12-Month Break in Service means, except as otherwise required by federal law, 12 consecutive months for which no contributions are made on the member's behalf to the Defined Contribution Plan.

K. Transfer Account means an account within the PERA 401(k) account containing the vested portion of the Defined Contribution Account together with any earnings thereon, less any distributions, losses and the member's allocable portion of the costs and expenses of administering the Plan that is established if there is a 12-Month Break in Service from the Defined Contribution Plan or an election is made to become a member of the Association pursuant to 24-51-1506(1), C.R.S., and Rule 16.30 A. The Transfer Account will be an account within the PERA 401(k) account but will be subject to the same distribution and investment election rules as the Defined Contribution Account.

16.50 Beneficiary(ies)

Beneficiary designations shall be governed by the terms of the Plan document.

16.70 Return to Employment

A. A member of the Defined Contribution Plan who elects to receive a distribution of the entire vested balance of his or her Defined Contribution Account pursuant to this Rule and then subsequently returns to membership in the Association before there has been a 12-month break in service shall begin a new vesting schedule for future contributions.

B. A Member of the Defined Contribution Plan who has elected a lifetime annuity distribution option on or after an age that distributions are exempt from penalty under Internal Revenue Code Section 72(t) shall be deemed to be a Retiree of the Association subject to the provisions of Rule 11 and 24-51-1101, et seq., C.R.S.

C. A Participant in the state defined contribution plan established pursuant to Part 2 of Article 52 of Title 24, as said part existed prior to its repeal in 2009, who has elected a lifetime annuity distribution option on or after an age that distributions are exempt from penalty under Internal Revenue Code Section 72(t) shall be subject to the provisions of Rule 11 and 24-51-1101, et seq., C.R.S.

16.90 Distributions Upon Termination of Employment

Distribution of a member's Defined Contribution Account may commence as specified in the Plan document.

RULE 17: DEFERRED COMPENSATION PLAN (457(b) PLAN)

Rule 17 describes certain requirements of the Deferred Compensation Plan, which is a 457(b) plan established pursuant to Section 457(b) of the Internal Revenue Code of 1986, as amended. In addition to this Rule 17 and Part 16 of Article 51 of Title 24, C.R.S., the Deferred Compensation Plan, or "457 Plan", is also governed by the Deferred Compensation Plan document adopted by the Board (the "Plan document").

17.10 Enrollment in the 457(b) Plan

Any employee of an employer who has affiliated with the Deferred Compensation Plan pursuant to section 24-51-1602, C.R.S. may enroll in accordance with the Plan document.

17.20 Changes in 457(b) Plan Participation

Requests for changes in the amount or investment of contributions must be submitted in the time and manner determined by the Plan Administrator.

17.30 Suspension of Participation

A participant may stop contributions to the 457(b) Plan in accordance with the terms of the Plan document.

17.40 Contribution Report

The employer shall deliver all 457(b) Plan contributions, along with the required report, in the form and manner designated by the Plan Administrator, within five days of the date contributions were deducted from the employee's salary. If either the report or contributions are delinquent, interest shall be owed to participant accounts, and additional interest shall be assessed and paid to the Association as specified in Rule 4.10.

17.50 Distribution of Benefits

Distribution of a participant's 457 Plan account may commence as specified in the Plan document.

17.60 Loans

All eligible participants may borrow monies from the participant's 457(b) account subject to loan provisions established by the Board and specified in the Plan document.

17.70 Compliance with Internal Revenue Service Code

A participant may only contribute to the 457(b) Plan up to the maximum contribution limits established by the Internal Revenue Service each year. If a person contributes to another 457(b) plan in the same year as they contribute to the PERA 457(b) Plan, the person is responsible for compliance with the Internal Revenue Service Code regarding maximum allowable contributions.

PHILIP J. WEISER
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NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

STATE OF COLORADO
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Office of the Attorney General

Tracking number: 2019-00360

Opinion of the Attorney General rendered in connection with the rules adopted by the

Public Employees' Retirement Association

on 09/13/2019

8 CCR 1502-1

COLORADO PERA RULES

The above-referenced rules were submitted to this office on 09/17/2019 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

September 26, 2019 11:27:50

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Revenue

Agency

Liquor Enforcement Division

CCR number

1 CCR 203-2

Rule title

1 CCR 203-2 COLORADO LIQUOR RULES 1 - eff 10/01/2019

Effective date

10/01/2019

Regulation 47-506, 1 C.C.R. 203-2:

Basis and Purpose. The statutory authority for this regulation includes but is not limited to subsections 44-3-202(1)(b) and 44-3-501(3)-(4), C.R.S. The purpose of this regulation is to establish fees for certain applications, notices, reports, and services.

Below are the fees set by the State Licensing Authority pursuant to sections 44-3-501(3) and 44-3-501(4), C.R.S.

Alternating Proprietor Licensed Premises	$150.00
Application for New License	$1,550.00
Application for Transfer License	$1,550.00
Application for Transfer & Conversion for an Additional Liquor-Licensed Drugstore	$1,300.00
Branch Warehouse or Warehouse Storage Permit	$100.00
Change of Corporate or Trade Name	$50.00
Change of Location	$150.00
Concurrent Review	$100.00
Corporate/LLC Change (Per Person)	$100.00
Duplicate Liquor License	$50.00
Limited Liability Change	$100.00
Manager Permit Registration (Liquor-Licensed Drugstore)	$100.00
Master File Background	$250.00
Master File Location Fee (Per Location)	$25.00
Modification of License Premises (City or County)	$150.00
(except that a Temporary Modification of licensed premises to accommodate an outside service area Located on a sidewalk shall only incur an annual fee of $75.00, as outlined in Regulation 47-302(A)(4)).	
New Product Registration (Per Unit)	$0.00
Optional Premises Added to H&R License (Per Unit)	$100.00
Retail Warehouse Storage Permit	$100.00
Sole Source Registration	$100.00
Winery Direct Shipment Permit	$100.00
Subpoena Testimony (Per Hour)	$50.00

Colorado Department of Revenue
Liquor Enforcement Division
Adoption of Revised Rule on an Emergency Basis
Colorado Liquor Rules, 1 C.C.R. 203-2

Emergency Rule

Regulation 47-506 – Fees

Statement of Emergency Justification and Adoption

Pursuant to sections 24-4-103, 44-3-202, and 44-3-501, C.R.S., I, Heidi Humphreys, Deputy Executive Director/Chief Operating Officer of the Department of Revenue and State Licensing Authority, hereby adopt the aforementioned revised Colorado Liquor Rule, which is attached hereto.

Section 24-4-103(6), C.R.S., authorizes the State Licensing Authority to issue an emergency rule if the State Licensing Authority finds that the immediate adoption of the rule is imperatively necessary to comply with a state or federal law or federal regulation or for the preservation of public health, safety, or welfare and compliance with the requirements of section 24-4-103, C.R.S., would be contrary to the public interest.

I find: (1) the adoption of this revised rule effective October 1, 2019, is necessary to comply with the statutory mandates of the Colorado Liquor Code sections 44-3-101 to 44-3-1002, C.R.S.; (2) the adoption of this revised rule is necessary to preserve the public health, safety, and welfare; and (3) compliance with the notice and public hearing requirements of section 24-4-103, C.R.S., would be contrary to the public interest.

Statutory Authority

The statutory authority for this revised rule includes but is not limited to subsections 44-3-202(1)(b) and 44-3-501(2)-(3), C.R.S.

Purpose

The purpose of the revision to this rule on an emergency basis is to update the fee levels in accordance with statutory requirements and the needs of the Liquor Enforcement Division. Pursuant to subsection 44-3-501(3)(d), C.R.S., the fees established pursuant to section 44-3-501, C.R.S., shall be reviewed at least annually and adjusted to reflect the direct and indirect costs of the Liquor Enforcement Division and the State Licensing Authority. In accordance with the legislative declaration of section 44-3-102, C.R.S., the Colorado Liquor Code is deemed an exercise of the police powers of the State of Colorado for the protection of the economic and social welfare and the health, peace, and morals of the people of the State of Colorado. Regulation of the manufacture, distribution, and sale of alcohol beverages is regulated by the Colorado Liquor Code as a matter of statewide concern. It is imperatively necessary to adjust fees upward to ensure continued proper regulation and control over the

administration and enforcement of articles 3, 4, and 5 of title 44 to meet these legislative charges and responsibilities in order to preserve the public health, safety, and welfare of the State of Colorado.

The State Licensing Authority filed a permanent rulemaking notice in conjunction with this Statement of Emergency Justification and Adoption. A public hearing on the proposed permanent rule will take place on November 4, 2019, at 9:00 A.M., at the Marijuana Enforcement Division, 1707 Cole Blvd, Suite 300, Golden, CO 80401; in the "Red Rocks" conference room. That process will include the opportunity for substantial stakeholder and public participation.

Adoption

The State Licensing Authority is adopting this revised rule on an emergency basis to comply with subsection 44-3-501(3)(d) C.R.S., requiring adjustment of fees when necessary to reflect the direct and indirect costs of the Liquor Enforcement Division and the State Licensing Authority, and to assure the public is provided with notice of the fees that the State Licensing Authority currently collects. Adoption of these emergency rules will clarify the fee schedule for applicants and licensees.

This emergency rule is effective October 1, 2019. The prior version of Regulation 47-506, 1 C.C.R. 203-2 is hereby repealed and replaced by the attached emergency rule which will remain in effect until its expiration upon 120 days from the adoption date unless sooner terminated or replaced by a permanent rule.

Heidi Humphreys
Deputy Executive Director/Chief Operating Officer
Colorado Department of Revenue
State Licensing Authority

09.24.19
Date

Regulation 47-506, 1 C.C.R. 203-2:

Basis and Purpose. The statutory authority for this regulation includes BUT IS NOT LIMITED TO ~~is located at~~ subsections 44-3-202(1)(b) and 44-3-501(3)-(4), C.R.S. The purpose of this regulation is to establish fees for certain applications, notices, reports, and services.

Below are the fees set by the State Licensing Authority pursuant to sections 44-3-501(3) and 44-3-501(4), C.R.S.

Alternating Proprietor Licensed Premises	$150.00
Application for New License	~~$1,100.00~~ 1,550.00
Application for Transfer License	~~$1,100.00~~ 1,550.00
Application for Transfer & Conversion for an Additional Liquor-Licensed Drugstore	$1,300.00
Branch Warehouse or Warehouse Storage Permit	$100.00
Change of Corporate or Trade Name	$50.00
Change of Location	$150.00
Concurrent Review	$100.00
Corporate/LLC Change (Per Person)	$100.00
Duplicate Liquor License	$50.00
Limited Liability Change	$100.00
Manager Permit Registration (Liquor-Licensed Drugstore)	$100.00
Master File Background	$250.00
Master File Location Fee (Per Location)	$25.00
Modification of License Premises (City or County)	$150.00
(except that a Temporary Modification of licensed premises to accommodate an outside service area Located on a sidewalk shall only incur an annual fee of $75.00, as outlined in Regulation 47-302(A)(4)).	
New Product Registration (Per Unit)	$0.00
Optional Premises Added to H&R License (Per Unit)	$100.00
Retail Warehouse Storage Permit	$100.00
Sole Source Registration	$100.00
Winery Direct Shipment Permit	$100.00
Subpoena Testimony (Per Hour)	$50.00

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

STATE OF COLORADO
DEPARTMENT OF LAW

RALPH L. CARR
COLORADO JUDICIAL CENTER
1300 Broadway, 10th Floor
Denver, Colorado 80203
Phone (720) 508-6000

Office of the Attorney General

Tracking number: 2019-00601

Opinion of the Attorney General rendered in connection with the rules adopted by the

Liquor Enforcement Division

on 09/26/2019

1 CCR 203-2

COLORADO LIQUOR RULES

The above-referenced rules were submitted to this office on 09/30/2019 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

October 10, 2019 13:13:53

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Nonrulemaking Public Notices and other Miscellaneous Rulemaking Notices

Filed on 10/24/2019

Department

Department of Health Care Policy and Financing

Agency

Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)

COLORADO
Department of Health Care Policy & Financing

PUBLIC NOTICE

October 25, 2019

Clinical Diagnostic Laboratory Rate Decrease to Align with Medicare Upper Payment Limit

The Department of Health Care Policy and Financing (Department) intends to submit a State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS) to decrease clinical diagnostic laboratory rates on a per test basis to align with Medicare rates in accordance with the Social Security Act Section 1903(i)(7) Upper Payment Limit, effective November 1, 2019. The rate decrease is necessary to align the rates with the Medicare Upper Payment Limit. This rate decrease impacts clinical diagnostic laboratory test providers by decreasing the rates to be at or below Medicare rates.

The annual aggregate decrease in clinical diagnostic laboratory expenditures (including state funds and federal funds) is $25,628,957 in FFY 2019-20 and $27,958,862 in FFY 2020-21.

General Information

A link to this notice will be posted on the Department's website starting on October 25, 2019. Written comments may be addressed to:

Director, Health Programs Office
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

County Contact Information

Copies of the proposed changes are available for public review at the following county locations:

County Name	Official Name	Physical Address	Mailing Address
Adams	Adams County Human Services Department	11860 Pecos Street Westminster, CO 80234	Same as physical

Alamosa	Alamosa County Department of Human Services	8900 C Independence Way, Alamosa, CO 81101	PO Box 1310, Alamosa, CO 81101
Arapahoe	Arapahoe County Human Services	14980 E. Alameda Dr., Aurora, CO 80012	14980 E. Alameda Dr., Aurora, CO 80012
Arapahoe	Satellite Office	1690 W. Littleton Blvd., Littleton, CO 80120	
Archuleta	Archuleta County Human Services	551 Hot Springs Blvd., Pagosa Springs, CO 81147	PO Box 240, Pagosa Springs, CO 81147
Baca	Baca County Department of Social Services	772 Colorado St. Ste #1, Springfield, CO 81073	Same as physical
Bent	Bent County Social Services	138 6th Street, Las Animas, CO 81054	Same as physical
Boulder	Boulder County Department of Housing & Human Services	3400 Broadway, Boulder, CO 80304	PO Box 471, Boulder, CO 80306
Broomfield	Broomfield Health and Human Services	100 Spader Way, Broomfield, CO 80020	Same as physical
Chaffee	Chaffee County Department of Human Services	448 E. 1st St, Ste 166, Salida, CO 81201	PO Box 1007, Salida, CO 81201
Cheyenne	Cheyenne County Department of Human Services	560 W. 6 N, Cheyenne Wells, CO 80810	PO Box 146, Cheyenne Wells, CO 80810
Conejos	Conejos County Department of Social Services	12989 Cty. Rd. G.6, Conejos, CO 81129	PO Box 68, Conejos, CO 81129
Costilla	Costilla County Department of Social Services	233 Main St, San Luis, CO 81152	Same as physical
Crowley	Crowley County Department of Human Services	631 Main Street Ste 100, Ordway, CO 81063	Same as physical
Custer	Custer County Department of Human Services	205 S. 6th St., Westcliffe, CO 81252	PO Box 929 Westcliffe, CO 81252
Delta	Delta County Department of Human Services	560 Dodge St, Delta, CO 81416	Same as physical
Denver	Denver Department of Human Services	1200 Federal Blvd, Denver, CO 80204	Same as physical
Dolores	Dolores County Department of Social Services	409 Main Street, Dove Creek, CO 81324	PO Box 485 Dove Creek, CO 81324
Douglas	Douglas County Department of Human Services	4400 Castleton Court, Castle Rock, CO 80109	Same as physical

Eagle	Eagle County Department of Human Services	551 Broadway, Eagle, CO 81631	PO Box 660, Eagle, CO 81631
El Paso	El Paso County Department of Human Services	1675 W. Garden of the Gods Road, Colorado Springs, CO 80907	Same as physical
Elbert	Elbert County Health and Human Services	75 Ute. Ave, Kiowa, CO 80117	PO Box 924, Kiowa, CO 80117
Fremont	Fremont County Department of Human Services	172 Justice Center Road, Canon City, CO 81212	Same as physical
Garfield	Garfield County Department of Human Services	195 W. 14th St., Rifle, CO 81650	Same as physical
Gilpin	Gilpin County Department of Human Services	2960 Dory Hill Rd. Ste 100, Black Hawk, CO 80422	Same as physical
Grand	Grand County Department of Social Services	620 Hemlock St., Hot Sulphur Springs, CO 80451	PO Box 204, Hot Sulphur Springs, CO 80451
Huerfano	Huerfano County Department of Social Services	121 W. 6th St., Walsenburg, CO 81089	Same as physical
Jackson	Grand County Department of Social Services	620 Hemlock St., Hot Sulphur Springs, CO 80451	PO Box 204, Hot Sulphur Springs, CO 80451
Jefferson	Jefferson County Human Services	900 Jefferson County Parkway, Golden, CO 80401	Same as physical
Kiowa	Kiowa County Department of Social Services	1307 Maine St., Eads, CO 81036	PO Box 187, Eads, CO 81036-0187
Kit Carson	Kit Carson County Department of Human Services	252 S. 14th St., Burlington, CO 80807	PO Box 70, Burlington, CO 80807
La Plata	La Plata County Department of Human Services	10 Burnett Court 1st Floor, Durango, CO 81301	Same as physical
Lake	Lake County Department of Human Services	112 W. 5th St. Leadville, CO 80461	PO Box 884 Leadville, CO 80461
Larimer	Larimer County	1501 Blue Spruce Drive	Same as physical
Las Animas	Las Animas County Department of Human Services	204 S. Chestnut St., Trinidad, CO 81082	Same as physical
Lincoln	Lincoln County Department of Human Services	103 3rd Ave, Hugo, CO 80821	PO Box 37, Hugo, CO 80821
Logan	Logan County Department of Human Services	508 S. 10th Ave, STE B, Sterling, CO 80751	Same as physical

Mesa	Mesa County Department of Human Services	510 29 1/2 Rd, Grand Junction, CO 81504	PO Box 20000, Grand Junction, CO 81502
Mineral	Rio Grande/Mineral County Department of Social Services	1015 6th St, Del Norte, CO 81132	Same as physical
Moffat	Moffat County Department of Social Services	595 Breeze St., Craig, CO 81625	Same as physical
Montezuma	Montezuma County Department of Social Services	109 W. Main St. Room 2013, Cortez, CO 81321	Same as physical
Montrose	Montrose County Health & Human Services	1845 S. Townsend Ave., Montrose, CO 81401	PO Box 216, Montrose, CO 81402-216
Morgan	Morgan County Department of Human Services	800 E. Beaver Ave., Fort Morgan, CO 80701	PO Box 220, Fort Morgan, CO 80701
Otero	Otero County Department of Human Services	215 Raton Ave, La Junta, CO 81050	PO Box 494, La Junta, CO 81050
Ouray	Ouray DSS	177 Sherman St., Unit 104, Ridgway, CO 81432	PO Box 530 Ridgway, CO 81432
Phillips	Phillips County Department of Social Services	127 E Denver St., Holyoke, CO, 80734	Same as physical
Pitkin	Pitkin County Department of Health and Human Services	0405 Castle Creek Rd., Suite 104, Aspen, CO 81611	Same as physical
Pueblo	Pueblo County Department of Social Services	201 W. 8th St, Pueblo, CO 81003	320 W. 10th St, Pueblo, CO 81003
Rio Blanco	Rio Blanco County Department of Health and Human Services	345 Market St., Meeker, CO 81641	Same as physical
Routt	Routt County Department of Human Services	135 6th St., Steamboat Springs, CO 80477	PO Box 772790, Steamboat Springs, CO 80477
Saguache	Saguache County Department of Social Services	605 Christy Ave, Saguache, CO 81149	PO Box 215, Saguache, CO 81149
San Miguel	San Miguel DSS	333 W. Colorado Ave, Telluride, CO 81435 (San Miguel);	PO Box 96 Telluride, CO 81435
Sedgwick	Sedgwick County Human Services	118 W. 3rd St., Julesburg, CO 80737	PO Box 27, Julesburg, CO 80737
Washington	Washington County DHS	126 W. 5th St., Akron, CO 80720	PO Box 395, Akron, CO 80720

Yuma	Yuma County Department of Human Services	340 S. Birch, Wray, CO 80758	Same as physical

Calendar of Hearings

Hearing Date/Time	Agency	Location
11/18/2019 01:30 PM	Division of Motor Vehicles	1881 Pierce Street, Lakewood, CO 80214 Room 110
11/21/2019 09:15 AM	Division of Gaming - Rules promulgated by Gaming Commission	17301 W Colfax Ave, Suite 135, Golden CO 80401
11/19/2019 04:30 PM	Oil and Gas Conservation Commission	University of Northern Colorado, University Center Ball Room, 2101 10th Avenue Greeley, CO 80631
11/26/2019 09:00 AM	Water and Wastewater Facility Operators Certification Board (1003 Series)	CDPHE - 4300 Cherry Creek Drive South Denver, CO 80246 - Sabin Conference Room
11/15/2019 01:00 PM	Secretary of State	Blue Spruce Conference Room on the 2nd floor of the Secretary of States Office at 1700 Broadway, Denver, Colorado 80290
11/22/2019 10:00 AM	Executive Director of Health Care Policy and Financing	303 East 17th Avenue, 11th Floor, Denver, CO 80203