DEPARTMENT OF LABOR AND EMPLOYMENT

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

Rule 18 MEDICAL FEE SCHEDULE

18-1 STATEMENT OF PURPOSE

Pursuant to § 8-42-101(3)(a)(I) C.R.S. and Section 8-47-107, C.R.S., the Director promulgates this medical fee schedule to review and establish maximum allowable fees for health care services falling within the purview of the Act. The Director adopts and hereby incorporates by reference as modified herein the 2005 edition of the R*elative Values for Physicians* (*RVP*), developed by Relative Value Studies, Inc., published by Ingenix® St. Anthony Publishing and version 22.0 of *DRGs: Diagnosis Related Groups, Definitions Manual*, (*DRGs Definition Manual*) developed and published by 3M Health Information Systems using DRGs effective after October 1, 2004. The incorporation is limited to the specific editions named and does not include later revisions or additions. For information about inspecting or obtaining copies of the incorporated materials, contact the Medical Fee Schedule Administrator, 633 17th Street, Suite 400, Denver, Colorado 80202-3660. These materials may be examined at any state publications depository library. All guidelines and instructions are adopted as set forth in the *Relative Values for Physicians* or *DRGs: Diagnosis Related Groups, Definitions Manual*, unless otherwise specified in this rule.

This rule applies to all services rendered on or after January 1, 2006. All other bills shall be reimbursed in accordance with the fee schedule in effect at the time service was rendered.

18-2 STANDARD TERMINOLOGY FOR THIS RULE

(A) *RVP* – the 2005 edition of *Relative Values for Physicians*, incorporated by reference in Rule 18-1.

(B) DRGs Definitions Manual – version 22.0 of *DRGs: Diagnosis Related Groups, Definitions Manual*, incorporated by reference in Rule 18-1.

(C) For other terms, see Rule 16-2, Utilization Standards.

18-3 HOW TO OBTAIN COPIES

All users are responsible for the timely purchase and use of Rule 18 and its supporting documentation as referenced herein. The Division shall make available for public review and inspection copies of all materials incorporated by reference in Rule 18. Copies of the *RVP* may be purchased from St. Anthony Press, the DRGs Definitions Manual may be purchased from 3M

Health Information Systems and the *Workers' Compensation Rules of Procedures*, 7 CCR 1101-3, may be purchased from Weil Publishing, Augusta, ME. Unofficial copies of all rules, including Rule 18, are available on the Colorado Department of Labor and Employment web site at www.coworkforce.com/DWC/ .

18-4 CONVERSION FACTORS

The following conversion factors shall be used to determine the maximum allowed fee. The maximum fee is determined by multiplying the following section conversion factors by the established relative value unit(s) (RVU) found in the corresponding *RVP* sections:

RVP SECTION	CONVERSION FACTOR
Medicine	$ 7.41/RVU
Evaluation & Management (E&M)	$ 7.93 /RVU
Physical Medicine	$ 5.20/RVU
(Codes 97000-97804 and 97810-97814)	
Anesthesia	$43.60/RVU
Surgery X Codes	$36.95/RVU
(see Rule 18-5(D)(1)(e))	
Surgery	$88.61 /RVU
Radiology	$16.93/RVU
Pathology	$12.65/RVU

18-5 INSTRUCTIONS AND/OR MODIFICATIONS TO THE *RVP*

(A) Maximum allowance for all providers under Rule 16-5 is 100 percent of the fees as defined in this Rule 18.

(B) Interim relative value procedures (marked by an "I" in the left-hand margin of the *RVP*) are accepted as a basis of payment for services; however deleted Current Procedural Terminology codes (CPT codes marked by an "M" in the *RVP*) are not, unless otherwise advised by this rule. The American Medical Association's *Current Procedural Terminology* (*CPT*) 2005 may be referenced for further clarification of descriptions and billing, but if conflicts arise between the *RVP* and the *CPT* 2005, the *RVP* shall prevail.

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

(D) Surgery/Anesthesia

(1) Anesthesia Section:(Codes range from 00100 – 01999, and 99100-99140)

(a) All anesthesia base values shall be established by the use of the codes 00100 - 01999 as set forth in the *RVP*.

(b) CPT codes 99100-99140, anesthesia add-on codes, are reimbursed using the anesthesia conversion factor (CF) and unit values found in the RVP, Anesthesia Guidelines IX, “Qualifying Circumstances.”

(c) Justifying documentation shall be submitted with the billing for all stand-by anesthesia.

(d) When justified by a report, a second anesthesiologist can be reimbursed as recommended by the anesthesia guidelines in the *RVP*.

(e) Surgery X Codes

(1) The following codes limit the list found in the table under the "Anesthesia Value Guidelines" of the *RVP* Section X, “Anesthesia Services Where Time Units Are Not Allowed”.

01995	01996	31500	36400	36420	36425
36600	36620	36625	36660	62273	62280
62281	62282	62310	62311	62318	62319
64400	64402	64405	64408	64410	64412
64413	64415	64416	64417	64418	64420
64421	64425	64430	64435	64445	64446
64447	64448	64450	64470	64472	64475
64476	64479	64480	64483	64484	64505
64508	64510	64520	64530	64600	64605
64610	64620	64622	64623	64626	64627
64630	64640	64680			

(2) The maximum reimbursement for these codes shall be based upon the anesthesia value listed in the table in Section X multiplied by $36.95 conversion factor. No additional unit values are added for time when calculating the maximum values for reimbursement.

(3) When performing more than one surgery X code procedure in a single surgical setting, multiple surgery guidelines shall apply (100% of the listed value for the primary procedure and 50% of the listed value for additional procedures). Use modifier -51 to indicate multiple X code procedures performed on the same day during a single operative setting. The 50% reduction does apply to codes that are identified in the RVP as “Add-on” codes.

(4) Codes from Table X not found above may be found in another section of the *RVP* (e.g., surgery). Any codes found in the table

under the “Anesthesia Value Guidelines” of the *RVP*, Section X, “Anesthesia Services Where Time Units Are Not Allowed” but not contained in this list (Rule 18-5(D)(1)(e)(1)) are reimbursed in accordance with the assigned units from their respective sections times their respective conversion factor.

(2) Surgical Section: (Codes range from 10000-69999)

(a) The use of assistant surgeons shall be limited according to the American College Of Surgeons' *2002 Study: Physicians as Assistants at Surgery* (April 2002), available from the American College of Surgeons, Chicago, IL, or from their web page at http://www.facs.org/ahp/pubs/2002physasstsurg.pdf, (accessed June 3, 2005). The incorporation is limited to the edition named and does not include later revisions or additions. Copies of the material incorporated by reference may be inspected at any State publications depository library. For information about inspecting or obtaining copies of the incorporated material, contact the Medical Fee Schedule Administrator, 633 17th Street, Suite 400, Denver, Colorado, 80202-3660. Where the publication restricts use of such assistants to "almost never" or a procedure is not referenced in the publication, prior authorization for payment shall be obtained from the payer.

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

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

(d) The payer may use available billing information such as provider credential(s) and clinical record(s) to determine if an appropriate modifier should be used on the bill. To modify a billed code refer to Rule 16-11(B)(3).

(e) Non-physician providers, used as surgical assistants, shall use the modifier –81 and shall be reimbursed at 10 percent of the listed value.

(f) Starred (*) surgical procedures have been deleted from the CPT coding nomenclature.

(g) Global period

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

- Evaluation and management services unrelated to the primary surgical procedure,

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

(2) Separate identifiable services shall use the –25 modifier in conjunction with the billed service.

(h) Intradiscal Electrothermal Annuloplasty (IDEA) -

This is a new procedure and prior authorization is required. A wire is guided into the identified painful disc using fluoroscopy. The wire is then heated within the disc. The goal of the procedure is to burn the nerves and to tighten the injured tissue within the disc. A physician well trained in the procedure must perform this procedure. Please refer to Rule 17, Exhibit 1, Section F.8 for the required surgical indications for this procedure.

Billing code and maximum fees are as follows:

Billing Code:	S2370	$2,257.30

Fees are inclusive of all levels and all professional services except, fluoroscopy guidance; see code 76005.

(E) Radiology Section: (Codes range from 70000 - 79999)

(1) General

(a) The cost of dyes and contrast shall be reimbursed at 80 percent of billed charges.

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

(2) Modifiers

(a) The five-digit CPT code without a modifier indicates the provider performed both the professional and technical components of the radiological procedure.

(b) If the provider supplies only the professional component, as defined in the Radiology Guidelines section of the *RVP* then the five-digit CPT code must carry a modifier –26.

(c) Modifier –27 is not recognized for the technical component of a radiological procedure. If the provider supplies only the technical component, as defined in the Radiology Guidelines section of the *RVP* the five-digit CPT code must carry a modifier TC.

(d) The payer may use available billing information such as provider credential(s) and clinical record(s) to determine if an appropriate modifier should be used on the bill. To modify a billed code, refer to Rule 16-11(B)(3).

(3) Thermography

(a) The physician supervising and interpreting the thermographic evaluation shall be board certified by the examining board of one of the following national organizations and follow their recognized protocols:

American Academy of Thermology;

American Chiropractic College of Infrared Imaging.

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

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

Sympathetically Maintained Pain (SMP);

Autonomic neuropathy;

Chronic Neuropathic Pain (involving small caliber sensory fiber neuropathy).

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

(d) Thermography Billing Codes:

79993 Upper body w/ Autonomic Stress Testing $840.00

79995 Lower body w/Autonomic Stress Testing $840.00

79997 Whole Body w/Autonomic Stress Testing $1,260.00

When whole body thermography is performed, only "whole body" billing codes can be used; do not use separate upper and lower body billing codes and fees.

(e) Prior authorization for payment is required for thermography services only if the requested study does not meet the indicators for thermography as outlined in this radiology section. The billing shall include a report supplying the thermographic evaluation and reflecting compliance with Rule 18-5(E)(3).

(F) Pathology Section: (Codes range from 80000 - 89999)

(1) Modifiers

(a) The five-digit CPT code without a modifier indicates the provider performed both the professional and technical components of the pathological procedure.

(b) If the provider supplies only the professional component, as defined in the Pathology and Laboratory Guidelines section of the *RVP*, then the five-digit CPT code must carry a modifier –26.

(c) Modifier –27 is not recognized for the technical component of a pathology procedure. If the provider supplies only the technical component, as defined in the Pathology and Laboratory Guidelines section of the *RVP*, the five-digit CPT code must carry a modifier -TC.

(d) The payer may use available billing information such as provider credential(s) and clinical record(s) to determine if an appropriate modifier should be used on the bill. To modify a billed code refer to Rule 16-11(B)(3).

(G) Medicine Section: (Codes range from 90000 - 96999 and 98925 - 99199)

(1) Medicine codes 99500-99602 in the *RVP* are not adopted. For appropriate codes see Rule 18-6(N).

(2) Codes 99100-99140 are reimbursed in accordance with the anesthesia section of Rule 18.

(3) Biofeedback (Codes: 90901, 90911)

Prior authorization for payment shall be required from the payer after 12 visits. A licensed physician or psychologist shall prescribe all services and include the number of sessions**.** Session notes shall be periodically reviewed by the prescribing physician to determine the continued need for the service. All services shall be provided or supervised by an appropriate recognized provider as listed under Rule 16-5. Supervision shall be as defined in an applicable Rule 17 medical treatment guideline. Persons providing biofeedback shall be certified

by the Biofeedback Certification Institution of America, or be a licensed physician or psychologist, as listed under Rule 16-5(A)(1)(a) and (b) with evidence of equivalent biofeedback training.

(4) Osteopathic (DO) and Medical (MD) Manipulation: (Codes range from 98925 - 98929)

Evaluation and management (E&M) services can be billed separately when the provider's records document significant and identifiable services that are above and beyond the usual services required to perform manipulation. A modifier –25 on the E&M service is required when manipulation is also billed at the same visit for the same patient.

Prior authorization from the payer shall be obtained before billing for more than four body regions in one visit. Manipulative therapy is limited to no more than 34 visits. The provider's medical records shall reflect medical necessity and prior authorization for payment if treatment needs to exceed 34 visits.

For purposes of DO and MD manipulation, body regions referred to are: head region; cervical region; thoracic region; lumbar region; sacral region; pelvic region; lower extremities; upper extremities; rib cage region; abdomen and viscera region.

(5) Chiropractic (DC) Manipulation: (Codes range from 98940 - 98943)

E&M services can be billed separately when the provider's records document significant and identifiable services that are above and beyond the services required to perform manipulation. A modifier –25 on the E&M service is required when manipulation is also billed at the same visit for the same patient.

Prior authorization from the payer shall be obtained before billing for more than four body regions in one visit. Manipulative therapy is limited to no more than 34 visits. The provider's medical records shall reflect medical necessity and prior authorization for payment if treatment needs to exceed 34 visits.

For purposes of DC manipulation, the five spinal regions referred to are: cervical regions (includes atlanto-occipital joint); thoracic region (includes costovertebral and costotransverse joints); lumbar region; sacral region; and pelvic (sacro-iliac joint) region. The five extraspinal regions referred to are: head region (including temporomandibular joint, excluding atlanto-occipital); lower extremities; upper extremities; rib cage (excluding costotransvers and costovertebral joints) and abdomen.

(6) Psychiatric/Psychological Services: (Codes range from 90801-90899 and 96100-96117)

(a) A licensed clinical psychologist is reimbursed a maximum of 90 percent of the medical fee listed in the *RVP*. Other non-physician providers

performing psychological/psychiatric services shall be paid at 75 percent of the fee allowed for physicians.

(b) Most initial evaluations for delayed recovery can be completed in two (2) hours. Prior authorization for payment is required any time the following limitations are exceeded:

Evaluation Code:	90801-90802	limit: 4 hours
Testing Code:	96100-96117	limit: 6 hours

Psychotherapy Codes: 90804-90829 maximum allowance of 50 minutes per visit.

Psychotherapy for work-related conditions requiring more than 20 visits or continuing for more than three (3) months after the initiation of therapy, whichever comes first, requires prior authorization from the payer.

(7) Hyperbaric Oxygen Therapy Services (Code 99183)

The maximum unit value shall be 24 units, instead of 14 units as listed in the *RVP* for code 99183.

(H) Physical Medicine and Rehabilitation: (Codes range from 97001 – 97804**)**

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

(1) Prior authorization is required for codes 97802-97804. See Rule 18-6(O)(10).

(2) Recommendations

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

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

Prior authorization shall be obtained from the payer for any physical medicine treatment exceeding the recommendations of the medical treatment guidelines as set forth in Rule 17.

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

(4) Interdisciplinary Rehabilitation Programs – (Requires prior authorization)

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

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

(5) Procedures 97110 – 97535, 97542

Unless the provider's medical records reflect medical necessity and the provider obtains prior authorization for payment from the payer to exceed the one-hour limitation, the maximum amount of time allowed is one hour of procedures per day, per discipline.

(6) Modalities

Codes 97010 – 97028, unattended

Codes 97032 – 97039, attended

Billing Restrictions: There is a total limit of two (2) modalities (whether attended or unattended) per visit per discipline.

NOTE: Instruction and application of a TENS unit for the patient's independent use shall be billed using attended therapy 97032.

(7) Evaluation Services for Therapists: Physical Therapy (PT), Occupational Therapy (OT) (97001 – 97004) and Athletic Trainers (cf. §12-36-106 C.R.S.) (97005-97006)

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

(b) Payers are only required to pay for evaluation services directly performed by a physical therapist (97001-97002), occupational therapist

(97003-97004) or athletic trainer, as defined in §12-36-106 C.R.S., (97005-97006). All evaluation notes or reports must be written and signed by the PT or OT. Physicians shall bill the appropriate E&M code from the E&M section (99201-99499) of the *RVP*.

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

(d) Reimbursement to physical therapists, occupational therapists, speech language pathologists and audiologists for coordination of care with professionals shall be based upon codes 99371-99373. Coordination of care reimbursement is limited to telephone calls made to professionals outside of the therapist's/pathologist's/audiologist's employment facility(ies) and/or to the injured worker or their family and the prescribing physician.

(e) All interdisciplinary team conferences shall be billed under the case management services section in the *RVP* using codes 99361 or 99362.

(8) Special Tests

The following codes should be used for the respective tests:

97537	Job Site Evaluation
97750	Computer- Enhanced Evaluation
	Functional Capacity Evaluation
	Work Tolerance Screening
97755	Assistive technology assessment
96105 - 96115	Speech

(a) Billing Restrictions:

(1) 97537 requires prior authorization if exceeding 2 hours. 97750 requires prior authorization for payment for more than 4 hours.

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

(3) The value for the analysis and the written report is included in the billing rate codes.

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

(5) Reports from computerized equipment include a supporting analysis developed by the physical medicine professional performing the evaluation.

(b) Provider Restrictions: all special tests must be fully supervised by a physician, a physical therapist, an occupational therapist, a speech language pathologist/therapist or audiologist. Final reports must be written and signed by the physician, the physical therapist, the occupational therapist, the speech language pathologist/therapist or the audiologist.

(9) Speech Therapy/Evaluation and Treatment

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

(10) Supplies

See Rule 18-6(H).

(11) Unattended Treatment

When a patient uses a facility or its equipment but is performing unattended procedures, in either an individual or group setting, bill:

97152 fixed fee per day 1.5 RVU

(12) Non-Medical Facility

Fees, such as gyms, pools, etc., and training or supervision by non-medical providers require prior authorization from the payer and a written negotiated fee.

(13) Unlisted Service Physical Medicine

All unlisted services or procedures require a report.

(14) Work Conditioning, Work Hardening, Work Simulation

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

Restriction: Maximum daily time is two (2) hours per day without additional prior authorization.

(b) Work Hardening is an interdisciplinary program that uses a team of disciplines to meet the goal of employability and return to work. This type of program entails a progressive increase in the number of hours a

day that an individual completes work tasks until they can tolerate a full workday. In order to do this, the program must address the medical, psychological, behavioral, physical, functional and vocational components of employability and return to work. Refer to Rule 17, Medical Treatment Guidelines.

Restriction: Maximum daily time is six (6) hours per day without additional prior authorization.

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

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

(1) Prior authorization is required.

(2) Provider Restrictions: All procedures must be performed by or under the onsite supervision of a physician, physical therapist, occupational therapist, speech language pathologist or audiologist.

(3) Billing Codes: 97545 and 97546.

(I) Evaluation and Management Section (Codes range from 99201 – 99499)

(1) E&M Service Medical Record Documentation to Determine Correct Billing/Reimbursement Code

Medical record documentation shall encompass the *RVP* "E&M Guideline" criteria to justify the billed Evaluation and Management service. If 50 percent of the time spent with an injured worker during an E&M visit is disability counseling, then time can determine the level of E&M service.

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

(2) New or Established Patients

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

(3) Number of Office Visits

All providers, as defined in Rule 16-5.A-C, are limited to one office visit per patient per day per workers’ compensation claim unless prior authorization is obtained from the payer. The E&M Guideline criteria as specified in the *RVP* E&M Section shall be used in all office visits to determine the appropriate level.

(4) Case Management

(a) Case management codes 99361 - 99373 found in the evaluation and management section of the *RVP* may be billed if the services are performed on a separate day from an E&M office visit and when the medical records/documentation specifies all the following:

(1) the amount of time and date;

(2) the person or person(s) talked to; and

(3) the discussion and/or decision made during the call to coordinate care for the injured worker.

(b) An interdisciplinary team conference, consisting of medical professionals caring for the injured worker, shall select a team member to perform the following duties:

(1) Prepare the billing statement in accordance with Rule 16, Utilization Standards,

- One conference charge per facility per patient per day.
- Reimbursement for each interdisciplinary team conference shall be determined in 15-minute increments. Fifteen-minute conferences shall be reimbursed using code 99361 reducing the maximum allowance to 50 percent of the total value of the code.

(2) Prepare and submit a written report for each conference including at least the following information:

- Patient's identifying information;

- Diagnosis;
- Medical professionals attending the conference;
- A brief statement of conference recommendations and actions (no additional allowance shall be made for this statement); and
- Length of time of meeting.

18-6 DIVISION ESTABLISHED CODES AND VALUES

(A) Conferences Held at the Request of a Party

Telephonic or face-to-face conferences shall be related to the injured worker's treatment. All parties shall receive actual notification from the requesting party in advance and within 24 hours of scheduling.

99901 Maximum of $225.00 per hour;

billed at $56.25 per 15-minute increments.

(B) Cancellation Fees For Payer Made Appointments

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

One-half of the usual fee for the scheduled services, or

$150.00, whichever is less.

Cancellation Fee Billing Code: 99910

(2) Missed Appointments:

When claimants fail to keep scheduled appointments, the provider should contact the payer within two (2) business days. Upon reporting the missed appointment, the provider may request whether the payer wishes to reschedule the appointment for the claimant. If the claimant fails to keep the payer’s rescheduled appointment, the provider may bill for a cancellation fee according to this Rule 18-6(B).

(C) Copying Fees

The payer, payer's representative, injured worker and injured worker's representative shall pay a reasonable fee for the reproduction of the injured worker's medical record. Reasonable cost shall not exceed $14.00 for the first 10 or fewer pages, $0.50 per page for pages 11-40, and $0.33 per page thereafter. Actual postage or shipping costs and

applicable sales tax, if any, also may be charged. The per-page fee for records copied from microfilm shall be $1.50 per page.

Copying Fee Billing Code: 99911

(D) Deposition and Testimony Fees

(1) When requesting deposition or testimony from physicians or any other type of provider, guidance should be obtained from the *Interprofessional Code*, as prepared by the Colorado Bar Association, the Denver Bar Association, the Colorado Medical Society and the Denver Medical Society. If the parties cannot agree upon fees for the deposition or testimony services, or cancellation time frames and/or fees, the following Deposition and Testimony rules and fees shall be used:

(2) Deposition:

Payment for a physician's testimony at a deposition shall not exceed 35 RVU per hour times the medicine conversion factor ($7.41) billed in 0.5-hour increments. Calculation of the physician's time shall be "portal to portal."

The physician may request a full hour deposit in advance in order to schedule the deposition.

By prior agreement with the deposing party, the physician may charge for preparation time or for reviewing and signing the deposition.

The physician shall refund to the deposing party, any portion of an advance payment in excess of time actually spent preparing and/or testifying when the physician is notified of the cancellation of the deposition at least three (3) business days prior to the scheduled deposition.

However, if the provider is not notified at least three (3) business days in advance of a cancellation, or the deposition is shorter than the time scheduled, the provider shall be paid the number of hours he or she has reasonably spent in preparation and has scheduled for the deposition.

Deposition Billing Code: 99075 at 35 units per hr.

Billed in half-hour increments

(3) Testimony**:**

Calculation of the physician's time shall be "portal to portal."

For testifying at a hearing, the physician may request a four (4) hour deposit in advance in order to schedule the testimony.

By prior agreement, the physician may charge for preparation time for testimony.

The physician shall refund any portion of an advance payment in excess of time actually spent preparing and/or testifying when the physician is notified of the cancellation of the hearing at least five (5) business days prior to the date of the hearing.

However, if the provider is not notified of a cancellation at least five (5) business days prior to the date of the hearing, or the hearing is shorter than the time scheduled, the provider shall be paid the number of hours he or she has reasonably spent in preparation and has scheduled for the hearing.

Testimony Billing Code: 99085

Maximum Rate of $400.00 per hour

(E) Mileage Expenses

The payer shall reimburse an injured worker for reasonable and necessary mileage expenses for travel to and from medical appointments and reasonable mileage to obtain prescribed medications. The reimbursement rate shall be 30 cents per mile. The injured worker shall submit a statement to the payer showing the date(s) of travel and number of miles traveled, with receipts for any other reasonable and necessary travel expenses incurred.

Mileage Expense Billing Code: 99912

(F) Permanent Impairment Rating

(1) The payer is only required to pay for one combined whole-person permanent impairment rating per claim, except as otherwise provided in these Workers' Compensation Rules of Procedures. The authorized treating provider is required to submit in writing all permanent restrictions and future maintenance care related to the injury or occupational disease.

(2) Provider Restrictions

The permanent impairment rating shall be determined by the authorized treating physician, if Level II accredited, or by a Level II accredited physician selected by the authorized treating provider.

(3) Maximum Medical Improvement (MMI) Determined Without any Permanent Impairment

When physicians determine the injured worker is at MMI and has no permanent impairment, the physicians should be reimbursed an appropriate level of E&M service and the fee for completing the Physician's Report of Workers' Compensation Injury (Closing Report), WC164 (See Rule 18-6(G)(2)). Reimbursement for the appropriate level of E&M service is only applicable if the physician examines the injured worker and meets the criteria as defined in the *RVP*.

(4) MMI Determined with a Calculated Permanent Impairment Rating

(a) Calculated Impairment: The total fee includes the office visit, a complete physical examination, complete history, review of all medical records, determining MMI, completing all required measurements, referencing all tables used to determine the rating, using all report forms from the AMA's *Guide to the Evaluation of Permanent Impairment*, Third Edition (Revised), (AMA *Guides*), and completing the Division form, titled "Physician's Report of Workers Compensation Injury (Closing Report)" (Form WC164).

(b) Billing Codes and Reimbursement for MMI with a Calculated Permanent Impairment Rating:

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

99455 Reimbursed for 1.5 hours with a maximum not to exceed $309.27.

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

99456 Reimbursed for 2.5 hours with a maximum not to exceed $594.75.

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

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

(G) Report Preparation

(1) Routine Reports

Completion of routine reports or records are incorporated in all fees for service and include:

Diagnostic Testing

Procedure Reports

Progress notes

Office notes

Operative reports

Supply invoices, if requested by the payer

Requests for second copies of routine reports are reimbursable under the copying fee section of Rule 18.

(2) Completion of WC164 Form

(a) Initial Report

The completed "Physician's Report of Workers' Compensation Injury" (WC164) initial report is submitted to the payer after the first visit with the injured worker. This form shall include completion of items 1-7 and 10. Note that certain information in Item 2 (such as Insurer Claim #) may be omitted if not known by the provider.

(b) Closing Report

The "Physician's Report of Workers' Compensation Injury" (WC164) closing report is required from the authorized treating physician when an injured worker is at maximum medical improvement and/or has a permanent impairment. A physician may bill for the completion of the WC164 if neither code 99455 nor 99456 (see Rule 18-6(F)(4)) are billed. The form requires the completion of items 1-5, 6 b-c, 7, 8 and 10. If the injured worker has sustained a permanent impairment, then Item 9 must be completed and the following additional information shall be attached to the bill at the time MMI is determined:

(1) All necessary permanent impairment rating reports when the authorized treating physician is Level II Accredited, or

(2) The name of the Level II Accredited physician designated to perform the permanent impairment rating when a rating is necessary and the authorized treating physician is not determining the permanent impairment rating.

(c) Payer Requested WC164 Form

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

(d) Provider Initiated WC164 Form

If the provider wants to use the WC164 Form as a progress report or for any purpose other than those designated here in Rule 18-6(G)(2)(a), (b)

or (c)), and seeks reimbursement for completion of the form, the provider shall get prior approval from the payer.

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

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

99960	$42.00	Initial Report
99961	$42.00	Progress Report (Payer Requested or Provider Initiated)
99962	$42.00	Closing Report
99963	$42.00	Initial report including closing report on the same date of service

(3) Special Reports

The term special reports includes reports falling outside the requirements set forth in Rule 16, Utilization Standards, Rule 17, Medical Treatment Guidelines and Rule 18 and includes any form, questionnaire or letter with variable content. Reimbursement for preparation of special reports or records shall require prior agreement with the requesting party. In special circumstances (e.g., when reviewing and/or editing is necessary) and when prior agreement is made with the requesting party, institutions, clinics or physicians' offices may charge additional sums.

Special Report Preparation Billing Code:

99080 not to exceed $225.00-per hour.

Billed in half hour increments.

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.

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

(1) Payment for supplies shall reflect the provider's actual cost plus a 20 percent markup. Cost includes shipping and handling charges.

(2) Reimbursement for durable medical equipment (DME), orthotic and prosthetic devices may be based upon an appropriate CMS (Medicare) Healthcare

Common Procedure Coding System (HCPCS) Level II Code as a reasonable means for determining a fee unless CMS (Medicare) fees do not meet the provider's actual cost in which case the reimbursement would be cost plus 20 percent.

(3) "Supply et al." means any single supply, durable medical equipment (DME), orthotic, prosthesis or single drug dose, that costs the provider an amount greater than $300.00, and all implants regardless of their cost. Reimbursement shall have a maximum allowance of the provider's actual cost plus 20 percent.

(4) 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 provisions outlined in the physical medicine and rehabilitation section of the *RVP*.

Supplies Billing Code: 99070

(I) Inpatient Hospital Facility Fees

(1) Provider Restrictions

All non-emergency, inpatient admissions require prior authorization for payment.

(2) Bills for Services

(a) Inpatient hospital facility fees shall be billed on the UB-92 and require summary level billing by revenue code. The provider must submit itemized bills along with the UB-92.

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

The hospital shall indicate the DRG code number in the remarks section (form locator 78) of the UB-92 billing form and maintain documentation on file showing how the DRG was determined. The hospital shall determine the DRG using the *DRGs Definition Manual*. The attending physician shall not be required to certify this documentation unless a dispute arises between the hospital and the payer regarding DRG assignment. The payer may deny payment for services until the appropriate DRG code is supplied.

(c) Exhibit 1 to Rule 18 establishes the maximum length of stay (LOS) using the "arithmetic mean LOS". However, no additional allowance for exceeding this LOS, other than through the cost outlier criteria under Rule 18-6(I)(3)(d) is allowed.

(d) Any inpatient admission requiring the use of both an acute care hospital and its Medicare certified rehabilitation facility is considered as one admission and DRG. This does not apply to long term care and licensed rehabilitation facilities.

(3) Inpatient Facility Reimbursement:

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

(1) Children's hospital

(2) Veterans' Administration hospital

(3) State psychiatric hospital

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

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

(2) Medicare certified long-term care hospital

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

(4) CDPHE licensed psychiatric facilities that are privately owned.

(c) All other inpatient facilities are reimbursed as follows:

Retrieve the relative weights for the assigned DRG from the DRG table in Exhibit 1 to Rule 18 and locate the hospital's base rate in Exhibit 2 to Rule 18.

The "Maximum Fee Allowance" is determined by calculating:

(1) (DRG Relative Wt x Specific hospital base rate x 200%) + (cost plus 20% for all "supply et al.")

(2) "Supply et al." means any single supply, durable medical equipment (DME), orthotic, prosthesis or single drug dose, that costs the provider an amount greater than $300.00, and all implants regardless of their cost.

Reimbursement shall be at cost to the provider plus 20%. The billing provider is responsible for identifying and itemizing all "Supply et al." items. If there is any question regarding the cost

of an item, the billing provider shall provide documentation of their cost for the billed "supply et al." item(s).

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

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

total billed charges (excluding any "supply et al." billed charges) times the hospital's cost-to-charge ratio.

(2) Each hospital's cost-to-charge ratio is given in Exhibit 2 of Rule 18.

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

(4) If the "Difference" is greater than $25,800.00, additional reimbursement is warranted. The additional reimbursement is determined by the following equation:

"Difference" x .80 = additional fee allowance

(e) 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 DRG maximum value. The per diem value is calculated based upon the transferring hospital's DRG relative weight multiplied by the hospital's specific base rate (Exhibit 2 to Rule 18) divided by the DRG geometric mean length of stay. This per diem amount is multiplied times 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 DRG maximum value.

(J) Scheduled Outpatient Surgery Facility Fees

(1) Provider Restrictions

(a) All non-emergent outpatient surgeries require prior authorization from the payer.

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

(1) a hospital; or

(2) an Ambulatory Surgery Center (ASC.

(2) Bills for Services

(a) Outpatient facility fees shall be billed on the UB-92 and require summary level billing by revenue code. The provider must submit itemized bills along with the UB-92.

(b) All professional charges are subject to the RVP and Dental fee schedules as incorporated by Rule 18.

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

(3) Outpatient Surgery Facility Reimbursement:

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

(1) Children's hospital

(2) Veterans' Administration hospital

(3) State psychiatric hospital

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

(c) All other outpatient surgery facilities are reimbursed based on the following:

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

(1) The primary surgical code value plus 50% of any lesser-valued surgical code values. Surgical code values are in Exhibit 4.

Multiple procedures and bilateral procedures are to be indicated by the use of modifiers –51 and –50, respectively. The 50% reduction applies to all lower valued procedures.

Facility fee reimbursement is limited to a maximum of four surgical codes per surgical episode.

The following surgical codes not found in Exhibit 4 are to be billed using the appropriate radiological codes with a TC modifier:

23350	73040
25246	73115

62284	72240-72270
62290	72295 for each level
62291	72285 for each level

(2) The provider's cost plus 20% of any "Supply et al." item(s). "Supply et al." means any single supply, durable medical equipment (DME), orthotic, prosthesis or single drug dose, that costs the provider an amount greater than $300.00, and all implants regardless of their cost.

The billing provider is responsible for identifying and itemizing all "supply et al." items. If there is any question regarding the cost of an item, the billing provider shall provide documentation of their cost for the billed "supply et al." item(s).

(3) Diagnostic testing and preoperative labs are reimbursed by applying the appropriate conversion factor to the unit values for the specific CPT code as listed in the RVP and Rule 18. and

(4) Observation room maximum allowance shall not exceed a rate of $50.00 an hour and is limited to a maximum of 6 hours without prior authorization. Documentation should support the medical necessity for observation.

(d) The listed surgery code value in Exhibit 4 of this rule 18 includes reimbursement for:

(1) nursing,

(2) technician and related services,

(3) use by the recipient of the facility including the operating room and recovery room,

(4) drugs, biologics, surgical dressings, supplies, splints, cases and appliances,

(5) equipment directly related to the provision of surgical procedures,

(6) fluoroscopy and x-rays during the surgical episode,

(7) administration, record keeping, housekeeping items and services,

(8) intraocular lenses, and

(9) materials for anesthesia.

(e) Additional reimbursement is payable for code values not included in the surgery code value in Exhibit 4 of Rule 18:

(1) physicians,

(2) laboratory services,

(3) pre-operative diagnostic labs and x-rays, EKGs, etc.,

(4) ambulance services,

(5) blood, blood plasma, platelets,

(6) observation room,

(7) any “supply et al.,”

(8) all implants.

(f) Prior authorization is required for any non-emergent outpatient surgery not listed in Exhibit 4 that warrants a separate facility fee in order to provide a safe environment for the procedure to be performed. Separate facility fees are only warranted when the procedure(s) performed produces a risk to the injured worker if the procedure is not performed in a facility where credentialed emergency equipment and personnel are maintained, including but not limited to, any procedure requiring the administration of regional or general anesthesia. Minor procedures, including but not limited to, laceration repairs and trigger point injections, do not routinely warrant a separate facility fee as a scheduled outpatient surgery.

If an outpatient surgery procedure not found in Exhibit 4 is warranted and the payer authorizes the surgery, the maximum fee is to be commensurate with other similar procedures that are found in Exhibit 4 (i.e., CMS, APC payment rate times 200%).

(K) Outpatient Diagnostic Testing and Clinic Facility Fees

(1) Bills for Services

(a) All providers shall indicate whether they are billing for the total component of a diagnostic test on a UB-92.

(b) If the technical component only is being billed, the modifier “-TC” shall be appended to the respective CPT billing code(s).

(c) If the professional component only is being billed, the provider shall bill on a CMS 1500 with the "-26" modifier appended to the CPT code(s).

(2) Reimbursement

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

(1) Children's hospitals,

(2) Veterans' Administration hospitals

(3) State psychiatric hospitals

(b) Primary rural health facilities are reimbursed at 80% of billed charges for clinic visits and diagnostic testing. Primary rural health facilities are listed in Exhibit 5.

(c) All other facilities:

(1) No allowance for clinic visit fees.

(2) Clinic fees for diagnostic testing are considered part of the CPT code value's technical component. Outpatient diagnostic testing is reimbursed using the RVP CPT code unit value times the applicable conversion factor.

(L) Outpatient Urgent Care Facility Fees

(1) Provider Restrictions:

(a) Prior agreement or authorization is necessary for all facilities wishing to be allowed a separate Urgent Care fee.

(b) Urgent care facility fees are only payable if the facility qualifies as an Urgent Care facility. The facility shall meet all of the following criteria to be eligible for a separate Urgent Care facility fee:

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

(2) Access without appointment during all operating hours.

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

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

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

(6) Ambulance access

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

(8) Extended hours including evening and some weekend hours

(9) Basic X-ray availability on-site during all operating hours

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

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

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

(c) No separate facility fees are allowed for follow-up care. Subsequent care for an initial diagnosis does not qualify for a separate facility fee, unless the subsequent diagnosis is a new acute care situation and is entirely different from the initial diagnosis.

(2) Bills for Services

(a) Urgent care facility fees may be billed on a CMS 1500

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

(3) Urgent Care Reimbursement

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

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

(b) "Supply et al." means any single supply, durable medical equipment (DME), orthotic, prosthesis or single drug dose, that costs the provider an amount greater than $300.00, and all implants regardless of their cost or billed amount.

Reimbursement shall be at cost to the provider plus 20%. The billing provider is responsible for identifying and itemizing all "supply et al." items. If there is any question regarding the cost of an item, the billing

provider shall provide documentation of their cost for the billed "supply et al." item(s). Routine supplies, drugs and treatment rooms are included in the Urgent Care maximum fees.

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

(d) The Observation Room allowance shall not exceed a rate of $50.00 per hour and is limited to a maximum of 3 hours without prior authorization.

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

(1) Provider Restrictions

All outpatient ERDs must be licensed by the CDPHE.

(2) Bills For Services

(a) ERD facility fees shall be billed on the UB-92 and require summary level billing by revenue code. The provider must submit itemized bills along with the UB-92.

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

(3) ERD Reimbursement

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

(1) Children's hospitals

(2) Veterans' Administration hospitals

(3) State Psychiatric hospitals

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

(c) The ERD "Level of Care" is identified based upon one of five levels of care. The level of care is determined by the total number of points accumulated by assigning points to interventions completed by the ERD staff during an ERD visit. All levels of care include the following baseline level of care interventions:

(1) Registration,

(2) Triage,

(3) Initial nursing assessment,

(4) Periodic vital signs (as appropriate),

(5) 1 limited intervention which utilizes minimal resources (e.g. administration of an oral medication, obtaining blood for CBC, visual acuity, rapid strep),

(6) Discharge instructions,

(7) Exam room set up and clean up.

(8) These activities are equivalent to "Zero" (0) points.

(d) Additional ER staff interventions exceeding the baseline "Level of Care" have the following assigned points:

Additional Interventions	Points
Extended Triage	2
Extended Initial Nursing Assessment	3
Extended Nursing Discharge and arrangements	3
Nursing Reassessment (excluding vital signs) – each	3
Starting IV (with or without lab tests)	3
Other lab tests, obtaining specimen (each)	1
EKG – each	1
Patient transport (non-RN)	2
Accompany & remaining with patient to radiology, CT, etc. (RN)	7
All types of continuous Monitoring –each type (e.g., pulse ox – cardiac monitor)	1
Insertion of tubes – each (NG, Foley)	4
Administration of medications – oral	2
Administration of medications – IV, IM, suppository, SC	2
Initiation of oxygen therapy	1

Wound care dressing	
Simple	1
Intermediate	2
Complex	3
Assisting physician with complex exam or procedure	5
Chaperone exam or minimal assist	2
Other interventions – only if requiring more than 10 minutes	
staff time	3
Restraint application	4
Patient family Education – simple	1
Patient Education – complex	3
Consultation with other physicians/departments	1
Blood product administration –each unit	2

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

(1) ERD reimbursement amount for "Level of Care" points:

Code	Total Additional Intervention Points	Reimbursement
99281	0-10	$ 120.00
99282	11-20	$ 160.00
99283	21-30	$ 250.00
99284	31-40	$ 500.00
99285	41+	$ 1,500.00

(2) All diagnostic testing, laboratory services and therapeutic services (including, but not limited to, radiology, pathology, any respiratory therapy, PT or OT) shall be reimbursed by the

appropriate conversion factor times the unit value for the specific CPT code as listed in the RVP and Rule 18.

(3) The observation room allowance shall not exceed a rate of $50.00 per hour and is limited to a maximum of 3 hours without prior authorization. The documentation should support the medical necessity for observation.

(4) Routine supplies and treatment rooms are included in the ERD Level of Care maximum fees. However, any "supply et al." may be reimbursed separately at the provider's cost plus 20%.

"Supply et al." means any single supply, durable medical equipment (DME), orthotic, prosthesis or single drug dose, that costs the provider an amount greater than $300.00, and all implants regardless of their cost.

The billing provider is responsible for identifying and itemizing all "supply et al." items. If there is any question regarding the cost of an item, the billing provider shall provide documentation of their cost for the billed "supply et al." items(s).

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

(g) Trauma Center Fees are not paid for alerts. Activation fees are as follows:

Level I	$3,000.00
Level II	$2,500.00
Level III	$1,000.00
Level IV	$00.00

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

(2) Activation Fees mean a Trauma Team has been activated, not just alerted.

(N) Home Therapy

Prior authorization is required for all home therapy. The payer and the home health entity should agree in writing on the type of care, skill level of provider, frequency of care and duration of care at each visit, and any financial arrangements to prevent disputes.

(1) Home Infusion Therapy

The per diem rates for home infusion therapy shall include the initial patient evaluation, education, coordination of care, products, equipment, administration sets, supplies, supply management, and delivery services. Nursing fees should be billed as indicated in Rule 18-6(N)(2).

(a) Parenteral Nutrition:

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

(b) Antibiotic Therapy:

$105.00/day + AWP

(Average Wholsale Price)

(c) Chemotherapy:

$ 85.00/day + AWP

(d) Enteral nutrition:

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

(e) Pain Management: $ 95.00/day + AWP

(f) Fluid Replacement: $ 70.00/day + AWP

(g) Multiple Therapies:

Highest cost therapy + AWP

only cost for remaining therapy

Medication/Drug Restrictions - the payment for drugs may be based upon the average wholesale price (AWP) of the drug as determined through the use of industry publications such as the monthly *Price Alert*, First Databank, Inc.

(2) Nursing Services

99970 Skilled Nursing (LPN & RN)

$95.79 per hour

There is a limit of 2 hours without prior authorization.

99972 Certified Nurse Assistant (CNA):

$31.67 per hour for the first hour;

$9.46 for each additional half hour. Service must be at least 15 minutes

to bill an additional half hour charge.

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

(3) Physical Medicine

Physical medicine procedures are payable at the same rate as provided in the physical medicine and rehabilitation services section of ~~this~~ Rule 18.

(4) Travel Allowances

Travel is typically included in the fees listed. Any extensive travel may need to be billed separately. Travel allowances should be agreed upon with the payer and should not exceed $28.00 per visit, portal to portal. The $28.00 allowance includes mileage.

Bill code: 99971

(O) Pharmacy Fees

(1) Average Wholesale Price (AWP) + $4.00

(2) All bills shall reflect the National Drug Code (NDC)

(3) All prescriptions shall be filled with bio-equivalent generic drugs unless the physician indicates "Dispense As Written" (DAW) on the prescription.

(4) The above formula applies to both brand name and generic drugs.

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

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

(7) AWP for brand name and generic pharmaceuticals may be determined through the use of such monthly publication~~s~~ as *Price Alert*, First Databank, Inc.

(8) Compounding Pharmacies

Reimbursement for compounding pharmacies shall be based on the cost of the materials plus 20 percent, $50.00 per hour for the pharmacist's documented time, and actual cost of any mailing & handling.

Bill Code:

99913 Materials, mailing, handling

99914 Pharmacist

(9) Injured Worker Reimbursement

The payer is responsible for timely payment of pharmaceutical costs (see Rule 16-11(A)(3)). In the event the injured worker has directly paid pharmaceutical costs, the payer shall reimburse the injured worker for actual costs incurred for authorized pharmacy services. If the actual costs exceed the maximum fee allowed by this rule, the payer may seek a refund from the dispensing provider for the difference between the amount charged to the injured worker and the maximum fee. Each request for a refund shall indicate the prescription number and the date of service involved.

(10) Dietary Supplements, Vitamins and Herbal Medicines

Reimbursement for outpatient dietary supplements, vitamins and herbal medicines dispensed in conjunction with acupuncture and complementary alternative medicine are authorized only by prior agreement of the payer, except for specific vitamins supported by Rule 17.

(11) Prescription Writing

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

(12) Provider Reimbursement

Provider offices that prescribe and dispense medications from their office have a maximum allowance of AWP plus $4.00.

All medications administered in the course of the provider's care shall be reimbursed at actual cost incurred.

(13) Required Billing Forms

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

(1) CMS 1500 (formerly HCFA 1500) – the dispensing provider shall bill by using the procedure code 99070 and shall include the

metric quantity and National Drug Code (NDC) number of the drug being dispensed; or

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

(3) With the agreement of the payer, the National Council for Prescription Drug Programs (NCPDP) or ANSI ASC 837 (American National Standards Institute Accredited Standards Committee) electronic billing transaction containing the same information as in (1) or (2) in this sub-section.

(b) Items prescribed for the work-related injury that do not have an NDC code shall be billed as a supply, using procedure code 99070 for the billed supply.

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

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

(P) Complementary Alternative Medicine (CAM) (Requires prior authorization)

Complementary Alternative Medicine (CAM) is a term used to describe a broad range of treatment modalities, some of which are generally accepted in the medical community and others that remain outside the accepted practice of conventional western medicine. Providers of CAM may be both licensed and non-licensed health practitioners with training in one or more forms of therapy. Refer to Rule 17, Medical Treatment Guidelines for the specific types of CAM modalities.

(Q) Acupuncture

Acupuncture is an accepted procedure for the relief of pain and tissue inflammation. While commonly used for treatment of pain, it may also be used as an adjunct to physical rehabilitation and/or surgery to hasten return of functional recovery. Acupuncture may be performed with or without the use of electrical current on the needles at the acupuncture site.

(1) Provider Restrictions

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

(2) Billing Restrictions

(a). For treatments of more than fourteen (14) sessions or for services beyond the following billing codes, the provider must obtain prior authorization from the payer.

(b) Unless the provider's medical records reflect medical necessity and the provider obtains prior authorization for payment from the payer to exceed the one-hour limitation, the maximum amount of time allowed is one hour of procedures per day, per discipline for procedure codes 97110-97535 and 97810-97814.

(3) Billing Codes:

(a) Code 97810 represents one or more needles, without electrical stimulation, for the initial 15 minutes of personal one-on-one contact with patient, full body;

(b) Code 97811 represents each additional 15 minutes of personal one-on-one contact with the patient with re-insertion of needle(s) without electrical stimulation. No application of multiple procedure guidelines for reduction of value is used with this code.

(c) Code 97813 represents acupuncture, one or more needles, with electrical stimulation, initial 15 minutes of personal one-on-one contact

(d) Code 97814 represents each additional 15 minutes of personal one-on-one contact with the patient with electrical stimulation. No application of multiple procedure guidelines for reduction of value is used with this code.

(e) Non-Physician evaluation services

(1) New or established patient services are reimbursable only if the medical record specifies the appropriate history, physical examination, treatment plan or evaluation of the treatment plan. Payers are only required to pay for evaluation services directly performed by an LAc. All evaluation notes or reports must be written and signed by the LAc.

(2) LAc new patient visit: 97041;

Maximum value $83.20.

(3) LAc established patient visit: 97044;

Maximum value $56.16.

(f) Herbs require prior authorization and fee agreements as in this Rule 18-6(P)6));

(g) See the appropriate physical medicine and rehabilitation section of the *RVP* for other billing codes and limitations (Rule 18-5.H).

(h) The cost of disposable acupuncture needles is reimbursed at the provider's cost plus 20%.

18-7 DENTAL FEE SCHEDULE

The dental schedule is adopted using the American Dental Association's *Current Dental Terminology*, Fourth Edition (CDT-4). However, surgical treatment for dental trauma and subsequent, related procedures shall be billed using codes from the *RVP*. Reimbursement shall be in accordance with the surgery/anesthesia section of the *RVP*, its corresponding conversion factors, the Division's Rule 16, Utilization Standards, and Rule 17, Medical Treatment Guidelines. See Exhibit 6 for the listing and maximum allowance for dental codes.

Exhibit 1

DRGs with Relative Weights, Geometric and Arithmetic Means

DRG V22	MDC	TYPE		DRG TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS
1	01	SURG		CRANIOTOMY AGE >17 W CC	3.3344	7.5	10.0
2	01	SURG		CRANIOTOMY AGE >17 W/O CC	1.9467	3.6	4.6
3	01	SURG	*	CRANIOTOMY AGE 0-17	1.9767	12.7	12.7
4	01	SURG		NO LONGER VALID	0.0000	0.0	0.0
5	01	SURG		NO LONGER VALID	0.0000	0.0	0.0
6	01	SURG		CARPAL TUNNEL RELEASE	0.7850	2.2	3.4
7	01	SURG		PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	2.6570	6.6	9.6
8	01	SURG		PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	1.5588	1.9	2.7
9	01	MED		SPINAL DISORDERS & INJURIES	1.2435	4.3	5.9
10	01	MED		NERVOUS SYSTEM NEOPLASMS W CC	1.2241	4.7	6.2
11	01	MED		NERVOUS SYSTEM NEOPLASMS W/O CC	0.8771	2.9	3.9
12	01	MED		DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.9136	4.3	5.6
13	01	MED		MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.8171	4.0	4.9
14	01	MED		INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION	1.2719	4.6	5.9
15	01	MED		NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	0.9482	3.7	4.7
16	01	MED		NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.2454	4.7	6.2
17	01	MED		NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.6996	2.5	3.2

18	01	MED		CRANIAL & PERIPHERAL NERVE DISORDERS W CC	0.9919	4.1	5.4
19	01	MED		CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.7048	2.8	3.5
20	01	MED		NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	2.8318	8.0	10.4
21	01	MED		VIRAL MENINGITIS	1.5238	5.0	6.7
22	01	MED		HYPERTENSIVE ENCEPHALOPATHY	1.1206	4.0	5.1
23	01	MED		NONTRAUMATIC STUPOR & COMA	0.8365	3.2	4.2
24	01	MED		SEIZURE & HEADACHE AGE >17 W CC	1.0130	3.6	4.9
25	01	MED		SEIZURE & HEADACHE AGE >17 W/O CC	0.6143	2.5	3.2
26	01	MED		SEIZURE & HEADACHE AGE 0-17	0.5680	2.4	3.2
27	01	MED		TRAUMATIC STUPOR & COMA, COMA >1 HR	1.3496	3.2	5.1
28	01	MED		TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	1.3254	4.4	6.0
29	01	MED		TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	0.7061	2.6	3.4
30	01	MED	*	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	0.3343	2.0	2.0
31	01	MED		CONCUSSION AGE >17 W CC	0.9385	3.0	4.0
32	01	MED		CONCUSSION AGE >17 W/O CC	0.5978	2.0	2.5
33	01	MED	*	CONCUSSION AGE 0-17	0.2100	1.6	1.6
34	01	MED		OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.9827	3.6	4.8
35	01	MED		OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.6436	2.5	3.1
36	02	SURG		RETINAL PROCEDURES	0.6746	1.3	1.6
37	02	SURG		ORBITAL PROCEDURES	1.1542	2.7	3.9
38	02	SURG		PRIMARY IRIS PROCEDURES	0.5268	1.7	2.3
39	02	SURG		LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	0.6282	1.6	2.2

40	02	SURG		EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	0.9621	2.9	4.1
41	02	SURG	*	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	0.3403	1.6	1.6
42	02	SURG		INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	0.7373	2.0	2.8
43	02	MED		HYPHEMA	0.6451	2.7	3.5
44	02	MED		ACUTE MAJOR EYE INFECTIONS	0.6594	4.0	4.9
45	02	MED		NEUROLOGICAL EYE DISORDERS	0.7268	2.6	3.2
46	02	MED		OTHER DISORDERS OF THE EYE AGE >17 W CC	0.7758	3.3	4.3
47	02	MED		OTHER DISORDERS OF THE EYE AGE >17 W/O CC	0.5502	2.5	3.2
48	02	MED	*	OTHER DISORDERS OF THE EYE AGE 0-17	0.2998	2.9	2.9
49	03	SURG		MAJOR HEAD & NECK PROCEDURES	1.7480	3.3	4.6
50	03	SURG		SIALOADENECTOMY	0.8708	1.5	1.9
51	03	SURG		SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	0.7958	1.8	2.9
52	03	SURG		CLEFT LIP & PALATE REPAIR	0.7882	1.6	2.2
53	03	SURG		SINUS & MASTOID PROCEDURES AGE >17	1.2103	2.2	3.6
54	03	SURG	*	SINUS & MASTOID PROCEDURES AGE 0-17	0.4860	3.2	3.2
55	03	SURG		MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	0.9111	1.9	2.9
56	03	SURG		RHINOPLASTY	0.9082	1.9	2.8
57	03	SURG		T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	1.0275	2.5	3.9
58	03	SURG	*	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.2759	1.5	1.5

59	03	SURG		TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.6420	1.8	2.5
60	03	SURG	*	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.2101	1.5	1.5
61	03	SURG		MYRINGOTOMY W TUBE INSERTION AGE >17	1.5317	3.3	5.8
62	03	SURG	*	MYRINGOTOMY W TUBE INSERTION AGE 0-17	0.2975	1.3	1.3
63	03	SURG		OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.3887	3.0	4.4
64	03	MED		EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.3117	4.2	6.6
65	03	MED		DYSEQUILIBRIUM	0.5959	2.3	2.8
66	03	MED		EPISTAXIS	0.5861	2.4	3.1
67	03	MED		EPIGLOTTITIS	0.8402	2.8	3.6
68	03	MED		OTITIS MEDIA & URI AGE >17 W CC	0.6655	3.0	3.7
69	03	MED		OTITIS MEDIA & URI AGE >17 W/O CC	0.4960	2.4	2.9
70	03	MED		OTITIS MEDIA & URI AGE 0-17	0.4652	2.4	2.9
71	03	MED		LARYNGOTRACHEITIS	0.5215	3.0	3.6
72	03	MED		NASAL TRAUMA & DEFORMITY	0.7378	2.7	3.6
73	03	MED		OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.8347	3.3	4.5
74	03	MED	*	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	0.3382	2.1	2.1
75	04	SURG		MAJOR CHEST PROCEDURES	3.0337	7.6	9.9
76	04	SURG		OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.8240	8.3	11.0
77	04	SURG		OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.2231	3.5	4.7
78	04	MED		PULMONARY EMBOLISM	1.2478	5.5	6.5
79	04	MED		RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	1.5872	6.6	8.4

80	04	MED		RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	0.8497	4.3	5.4
81	04	MED	*	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	1.5311	6.1	6.1
82	04	MED		RESPIRATORY NEOPLASMS	1.3717	5.1	6.8
83	04	MED		MAJOR CHEST TRAUMA W CC	0.9806	4.3	5.3
84	04	MED		MAJOR CHEST TRAUMA W/O CC	0.5539	2.6	3.2
85	04	MED		PLEURAL EFFUSION W CC	1.2309	4.8	6.4
86	04	MED		PLEURAL EFFUSION W/O CC	0.6976	2.8	3.6
87	04	MED		PULMONARY EDEMA & RESPIRATORY FAILURE	1.3542	4.9	6.4
88	04	MED		CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.9089	4.1	5.0
89	04	MED		SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.0479	4.8	5.8
90	04	MED		SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.6172	3.3	3.9
91	04	MED		SIMPLE PNEUMONIA & PLEURISY AGE 0-17	0.6271	2.9	3.4
92	04	MED		INTERSTITIAL LUNG DISEASE W CC	1.1930	4.9	6.2
93	04	MED		INTERSTITIAL LUNG DISEASE W/O CC	0.7123	3.2	4.0
94	04	MED		PNEUMOTHORAX W CC	1.1476	4.6	6.2
95	04	MED		PNEUMOTHORAX W/O CC	0.6013	3.0	3.7
96	04	MED		BRONCHITIS & ASTHMA AGE >17 W CC	0.7439	3.6	4.4
97	04	MED		BRONCHITIS & ASTHMA AGE >17 W/O CC	0.5428	2.8	3.4
98	04	MED		BRONCHITIS & ASTHMA AGE 0-17	0.5534	2.7	3.1
99	04	MED		RESPIRATORY SIGNS & SYMPTOMS W CC	0.7178	2.4	3.2
100	04	MED		RESPIRATORY SIGNS & SYMPTOMS W/O CC	0.5445	1.8	2.1
101	04	MED		OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	0.8711	3.3	4.3
102	04	MED		OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.5473	2.0	2.5

103	PRE	SURG		HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM	19.5514	25.7	42.2
104	05	SURG		CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH	7.9180	12.4	14.6
105	05	SURG		CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH	5.7937	8.3	10.0
106	05	SURG		CORONARY BYPASS W PTCA	7.3062	9.6	11.3
107	05	SURG		CORONARY BYPASS W CARDIAC CATH	5.3757	9.3	10.6
108	05	SURG		OTHER CARDIOTHORACIC PROCEDURES	5.1702	6.9	9.6
109	05	SURG		CORONARY BYPASS W/O PTCA OR CARDIAC CATH	3.9450	6.8	7.8
110	05	SURG		MAJOR CARDIOVASCULAR PROCEDURES W CC	3.9587	6.1	8.7
111	05	SURG		MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.4488	2.8	3.7
112	05	SURG		NO LONGER VALID	0.0000	0.0	0.0
113	05	SURG		AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	3.1063	10.7	13.6
114	05	SURG		UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.6955	6.3	8.7
115	05	SURG		PRM CARD PACEM IMPL W AMI/HR/SHOCK OR AICD LEAD OR GNRTR	3.5928	4.6	7.0
116	05	SURG		OTHER PERMANENT CARDIAC PACEMAKER IMPLANT	2.3561	3.0	4.3
117	05	SURG		CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	1.3529	2.6	4.3
118	05	SURG		CARDIAC PACEMAKER DEVICE REPLACEMENT	1.6751	2.0	3.0
119	05	SURG		VEIN LIGATION & STRIPPING	1.4322	3.2	5.4
120	05	SURG		OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.3051	5.6	8.9

121	05	MED		CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	1.6200	5.3	6.6
122	05	MED		CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE	1.0127	2.9	3.6
123	05	MED		CIRCULATORY DISORDERS W AMI, EXPIRED	1.5421	2.9	4.7
124	05	MED		CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	1.4564	3.3	4.5
125	05	MED		CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	1.1146	2.2	2.8
126	05	MED		ACUTE & SUBACUTE ENDOCARDITIS	2.6051	9.0	11.5
127	05	MED		HEART FAILURE & SHOCK	1.0390	4.1	5.2
128	05	MED		DEEP VEIN THROMBOPHLEBITIS	0.7475	4.6	5.5
129	05	MED		CARDIAC ARREST, UNEXPLAINED	1.0346	1.7	2.7
130	05	MED		PERIPHERAL VASCULAR DISORDERS W CC	0.9566	4.5	5.6
131	05	MED		PERIPHERAL VASCULAR DISORDERS W/O CC	0.5655	3.3	4.0
132	05	MED		ATHEROSCLEROSIS W CC	0.6428	2.3	2.9
133	05	MED		ATHEROSCLEROSIS W/O CC	0.5411	1.8	2.2
134	05	MED		HYPERTENSION	0.6091	2.5	3.2
135	05	MED		CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	0.9264	3.4	4.5
136	05	MED		CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	0.5902	2.1	2.6
137	05	MED	*	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	0.8249	3.3	3.3
138	05	MED		CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.8413	3.1	4.0

139	05	MED		CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.5234	2.0	2.5
140	05	MED		ANGINA PECTORIS	0.5275	2.0	2.5
141	05	MED		SYNCOPE & COLLAPSE W CC	0.7617	2.8	3.5
142	05	MED		SYNCOPE & COLLAPSE W/O CC	0.5929	2.1	2.5
143	05	MED		CHEST PAIN	0.5643	1.7	2.1
144	05	MED		OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.2502	4.0	5.7
145	05	MED		OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.5850	2.0	2.6
146	06	SURG		RECTAL RESECTION W CC	2.6435	8.6	10.1
147	06	SURG		RECTAL RESECTION W/O CC	1.5194	5.4	6.0
148	06	SURG		MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	3.3871	10.0	12.2
149	06	SURG		MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.4352	5.6	6.1
150	06	SURG		PERITONEAL ADHESIOLYSIS W CC	2.7489	8.9	11.0
151	06	SURG		PERITONEAL ADHESIOLYSIS W/O CC	1.2960	4.3	5.4
152	06	SURG		MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.8812	6.6	8.0
153	06	SURG		MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.1129	4.6	5.1
154	06	SURG		STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC	4.0524	9.9	13.3
155	06	SURG		STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	1.2708	3.1	4.1
156	06	SURG	*	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	0.8495	6.0	6.0

157	06	SURG		ANAL & STOMAL PROCEDURES W CC	1.2914	4.0	5.6
158	06	SURG		ANAL & STOMAL PROCEDURES W/O CC	0.6564	2.1	2.6
159	06	SURG		HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	1.3836	3.8	5.1
160	06	SURG		HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	0.8225	2.2	2.7
161	06	SURG		INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.1824	3.0	4.4
162	06	SURG		INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	0.6643	1.6	2.0
163	06	SURG		HERNIA PROCEDURES AGE 0-17	1.0030	3.5	3.7
164	06	SURG		APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	2.2921	6.9	8.3
165	06	SURG		APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.1878	3.7	4.3
166	06	SURG		APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.4723	3.5	4.7
167	06	SURG		APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	0.8956	1.9	2.3
168	03	SURG		MOUTH PROCEDURES W CC	1.2425	3.2	4.7
169	03	SURG		MOUTH PROCEDURES W/O CC	0.7482	1.9	2.5
170	06	SURG		OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.8628	7.5	10.8
171	06	SURG		OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.1843	3.2	4.3
172	06	MED		DIGESTIVE MALIGNANCY W CC	1.3968	5.1	7.0
173	06	MED		DIGESTIVE MALIGNANCY W/O CC	0.7437	2.7	3.7
174	06	MED		G.I. HEMORRHAGE W CC	1.0109	3.8	4.8
175	06	MED		G.I. HEMORRHAGE W/O CC	0.5704	2.5	2.9

176	06	MED		COMPLICATED PEPTIC ULCER	1.1149	4.1	5.3
177	06	MED		UNCOMPLICATED PEPTIC ULCER W CC	0.9339	3.7	4.6
178	06	MED		UNCOMPLICATED PEPTIC ULCER W/O CC	0.6791	2.6	3.1
179	06	MED		INFLAMMATORY BOWEL DISEASE	1.1059	4.6	5.9
180	06	MED		G.I. OBSTRUCTION W CC	0.9753	4.2	5.4
181	06	MED		G.I. OBSTRUCTION W/O CC	0.5539	2.8	3.4
182	06	MED		ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	0.8255	3.4	4.4
183	06	MED		ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	0.5844	2.3	2.9
184	06	MED		ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	0.4851	2.5	3.3
185	03	MED		DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	0.9124	3.4	4.7
186	03	MED	*	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	0.3238	2.9	2.9
187	03	MED		DENTAL EXTRACTIONS & RESTORATIONS	0.8167	3.1	4.3
188	06	MED		OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.1137	4.1	5.6
189	06	MED		OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.5918	2.4	3.1
190	06	MED		OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	0.5210	3.3	4.3
191	07	SURG		PANCREAS, LIVER & SHUNT PROCEDURES W CC	4.0497	9.3	13.3
192	07	SURG		PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.6269	4.2	5.6
193	07	SURG		BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	3.4161	10.3	12.7
194	07	SURG		BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	1.5689	5.4	6.6

195	07	SURG		CHOLECYSTECTOMY W C.D.E. W CC	2.8886	8.5	10.2
196	07	SURG		CHOLECYSTECTOMY W C.D.E. W/O CC	1.5850	4.6	5.5
197	07	SURG		CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	2.5179	7.4	9.1
198	07	SURG		CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	1.1761	3.8	4.4
199	07	SURG		HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.3380	6.8	9.5
200	07	SURG		HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	2.9603	6.4	10.3
201	07	SURG		OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	3.7522	10.2	14.1
202	07	MED		CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3386	4.7	6.3
203	07	MED		MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.3825	5.0	6.7
204	07	MED		DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.1440	4.3	5.7
205	07	MED		DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	1.2122	4.5	6.1
206	07	MED		DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	0.7271	3.0	3.8
207	07	MED		DISORDERS OF THE BILIARY TRACT W CC	1.1870	4.1	5.3
208	07	MED		DISORDERS OF THE BILIARY TRACT W/O CC	0.6917	2.3	2.9
209	08	SURG		MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY	2.0332	4.3	4.8
210	08	SURG		HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	1.8817	6.1	7.0

211	08	SURG		HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.2675	4.4	4.8
212	08	SURG	*	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.4162	11.1	11.1
213	08	SURG		AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.8952	6.6	9.1
214	08	SURG		NO LONGER VALID	0.0000	0.0	0.0
215	08	SURG		NO LONGER VALID	0.0000	0.0	0.0
216	08	SURG		BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	1.8966	3.8	6.6
217	08	SURG		WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS	2.9339	9.0	13.0
218	08	SURG		LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC	1.5762	4.3	5.5
219	08	SURG		LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC	1.0191	2.7	3.2
220	08	SURG	*	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17	0.5885	5.3	5.3
221	08	SURG		NO LONGER VALID	0.0000	0.0	0.0
222	08	SURG		NO LONGER VALID	0.0000	0.0	0.0
223	08	SURG		MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	1.0764	2.2	3.1
224	08	SURG		SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC	0.7972	1.6	1.9
225	08	SURG		FOOT PROCEDURES	1.1979	3.7	5.2
226	08	SURG		SOFT TISSUE PROCEDURES W CC	1.5306	4.4	6.5

227	08	SURG		SOFT TISSUE PROCEDURES W/O CC	0.8339	2.1	2.7
228	08	SURG		MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC	1.1649	2.8	4.2
229	08	SURG		HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	0.7353	1.9	2.5
230	08	SURG		LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	1.3454	3.7	5.7
231	08	SURG		NO LONGER VALID	0.0000	0.0	0.0
232	08	SURG		ARTHROSCOPY	0.9964	1.8	2.8
233	08	SURG		OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.9542	5.4	7.6
234	08	SURG		OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	1.1643	2.5	3.4
235	08	MED		FRACTURES OF FEMUR	0.7512	3.7	4.8
236	08	MED		FRACTURES OF HIP & PELVIS	0.7544	3.9	4.7
237	08	MED		SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.6063	3.0	3.8
238	08	MED		OSTEOMYELITIS	1.3708	6.5	8.6
239	08	MED		PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	1.0811	5.0	6.3
240	08	MED		CONNECTIVE TISSUE DISORDERS W CC	1.3500	4.9	6.7
241	08	MED		CONNECTIVE TISSUE DISORDERS W/O CC	0.6679	3.0	3.7
242	08	MED		SEPTIC ARTHRITIS	1.1618	5.3	7.0
243	08	MED		MEDICAL BACK PROBLEMS	0.7712	3.7	4.6
244	08	MED		BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.7137	3.6	4.6
245	08	MED		BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.4741	2.6	3.3
246	08	MED		NON-SPECIFIC ARTHROPATHIES	0.5977	2.9	3.6
247	08	MED		SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	0.5825	2.6	3.3

248	08	MED		TENDONITIS, MYOSITIS & BURSITIS	0.8417	3.8	4.8
249	08	MED		AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.7006	2.6	3.8
250	08	MED		FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	0.6908	3.1	3.9
251	08	MED		FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	0.4830	2.3	2.8
252	08	MED	*	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	0.2555	1.8	1.8
253	08	MED		FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC	0.7664	3.7	4.6
254	08	MED		FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC	0.4555	2.5	3.1
255	08	MED	*	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	0.2976	2.9	2.9
256	08	MED		OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	0.8218	3.9	5.1
257	09	SURG		TOTAL MASTECTOMY FOR MALIGNANCY W CC	0.9117	2.1	2.7
258	09	SURG		TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.7155	1.6	1.8
259	09	SURG		SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	0.9816	1.8	2.8
260	09	SURG		SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.6982	1.2	1.4
261	09	SURG		BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	0.9725	1.6	2.1
262	09	SURG		BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	0.9711	3.2	4.7
263	09	SURG		SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	2.0413	8.3	11.3

264	09	SURG		SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	1.0679	4.9	6.5
265	09	SURG		SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.5980	4.2	6.8
266	09	SURG		SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	0.8616	2.3	3.2
267	09	SURG		PERIANAL & PILONIDAL PROCEDURES	0.9036	2.8	4.5
268	09	SURG		SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	1.2052	2.4	3.7
269	09	SURG		OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.7560	6.1	8.6
270	09	SURG		OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	0.8173	2.6	3.7
271	09	MED		SKIN ULCERS	1.0233	5.5	7.1
272	09	MED		MAJOR SKIN DISORDERS W CC	1.0219	4.5	5.9
273	09	MED		MAJOR SKIN DISORDERS W/O CC	0.5968	2.9	3.7
274	09	MED		MALIGNANT BREAST DISORDERS W CC	1.1249	4.6	6.3
275	09	MED		MALIGNANT BREAST DISORDERS W/O CC	0.5735	2.2	3.0
276	09	MED		NON-MALIGANT BREAST DISORDERS	0.7233	3.7	4.7
277	09	MED		CELLULITIS AGE >17 W CC	0.8877	4.7	5.7
278	09	MED		CELLULITIS AGE >17 W/O CC	0.5531	3.5	4.2
279	09	MED	*	CELLULITIS AGE 0-17	0.7785	4.2	4.2
280	09	MED		TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	0.7259	3.2	4.1
281	09	MED		TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	0.4944	2.3	2.9
282	09	MED	*	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	0.2588	2.2	2.2
283	09	MED		MINOR SKIN DISORDERS W CC	0.7570	3.5	4.7

284	09	MED		MINOR SKIN DISORDERS W/O CC	0.4291	2.3	3.0
285	10	SURG		AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS	2.0637	7.9	10.4
286	10	SURG		ADRENAL & PITUITARY PROCEDURES	1.9324	4.2	5.6
287	10	SURG		SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	1.9092	7.5	10.1
288	10	SURG		O.R. PROCEDURES FOR OBESITY	2.1291	3.5	4.5
289	10	SURG		PARATHYROID PROCEDURES	0.9629	1.7	2.6
290	10	SURG		THYROID PROCEDURES	0.9022	1.6	2.2
291	10	SURG		THYROGLOSSAL PROCEDURES	0.6948	1.3	1.5
292	10	SURG		OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.7222	7.1	10.3
293	10	SURG		OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.4162	3.3	4.7
294	10	MED		DIABETES AGE >35	0.7809	3.4	4.5
295	10	MED		DIABETES AGE 0-35	0.7686	2.9	3.8
296	10	MED		NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.8420	3.8	4.9
297	10	MED		NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.4992	2.6	3.2
298	10	MED		NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	0.5883	2.7	3.8
299	10	MED		INBORN ERRORS OF METABOLISM	0.9355	3.8	5.3
300	10	MED		ENDOCRINE DISORDERS W CC	1.0955	4.6	6.0
301	10	MED		ENDOCRINE DISORDERS W/O CC	0.6440	2.8	3.5
302	11	SURG		KIDNEY TRANSPLANT	3.1515	7.0	8.2
303	11	SURG		KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	2.3212	6.1	7.7

304	11	SURG		KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC	2.3479	6.0	8.6
305	11	SURG		KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	1.1662	2.7	3.3
306	11	SURG		PROSTATECTOMY W CC	1.2609	3.4	5.4
307	11	SURG		PROSTATECTOMY W/O CC	0.6143	1.7	2.0
308	11	SURG		MINOR BLADDER PROCEDURES W CC	1.5905	3.8	6.0
309	11	SURG		MINOR BLADDER PROCEDURES W/O CC	0.8995	1.6	2.0
310	11	SURG		TRANSURETHRAL PROCEDURES W CC	1.1659	3.0	4.4
311	11	SURG		TRANSURETHRAL PROCEDURES W/O CC	0.6287	1.5	1.8
312	11	SURG		URETHRAL PROCEDURES, AGE >17 W CC	1.0704	3.1	4.6
313	11	SURG		URETHRAL PROCEDURES, AGE >17 W/O CC	0.6575	1.7	2.2
314	11	SURG	*	URETHRAL PROCEDURES, AGE 0-17	0.4988	2.3	2.3
315	11	SURG		OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.0861	3.6	6.8
316	11	MED		RENAL FAILURE	1.2823	4.9	6.5
317	11	MED		ADMIT FOR RENAL DIALYSIS	0.8093	2.3	3.3
318	11	MED		KIDNEY & URINARY TRACT NEOPLASMS W CC	1.1486	4.2	5.8
319	11	MED		KIDNEY & URINARY TRACT NEOPLASMS W/O CC	0.6161	2.1	2.7
320	11	MED		KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.8776	4.3	5.3
321	11	MED		KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.5681	3.1	3.7
322	11	MED		KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	0.5257	3.0	3.7
323	11	MED		URINARY STONES W CC, &/OR ESW LITHOTRIPSY	0.8331	2.4	3.2
324	11	MED		URINARY STONES W/O CC	0.4924	1.6	1.9
325	11	MED		KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	0.6630	2.9	3.8

326	11	MED		KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	0.4374	2.1	2.6
327	11	MED	*	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	0.3730	3.1	3.1
328	11	MED		URETHRAL STRICTURE AGE >17 W CC	0.6783	2.5	3.4
329	11	MED		URETHRAL STRICTURE AGE >17 W/O CC	0.4551	1.6	2.2
330	11	MED	*	URETHRAL STRICTURE AGE 0-17	0.3212	1.6	1.6
331	11	MED		OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	1.0595	4.1	5.6
332	11	MED		OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.6032	2.4	3.2
333	11	MED		OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	0.9336	3.7	5.3
334	12	SURG		MAJOR MALE PELVIC PROCEDURES W CC	1.4275	3.7	4.5
335	12	SURG		MAJOR MALE PELVIC PROCEDURES W/O CC	1.0871	2.6	2.9
336	12	SURG		TRANSURETHRAL PROSTATECTOMY W CC	0.8542	2.5	3.3
337	12	SURG		TRANSURETHRAL PROSTATECTOMY W/O CC	0.5821	1.7	2.0
338	12	SURG		TESTES PROCEDURES, FOR MALIGNANCY	1.2137	3.4	5.7
339	12	SURG		TESTES PROCEDURES, NON-MALIGNANCY AGE >17	1.2121	3.2	5.3
340	12	SURG	*	TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	0.2855	2.4	2.4
341	12	SURG		PENIS PROCEDURES	1.2688	1.9	2.9
342	12	SURG		CIRCUMCISION AGE >17	0.7945	2.4	3.2
343	12	SURG	*	CIRCUMCISION AGE 0-17	0.1552	1.7	1.7
344	12	SURG		OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.2980	1.6	2.5

345	12	SURG		OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	1.1932	3.1	4.9
346	12	MED		MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	1.0888	4.5	6.0
347	12	MED		MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	0.5268	2.0	2.7
348	12	MED		BENIGN PROSTATIC HYPERTROPHY W CC	0.7290	3.2	4.1
349	12	MED		BENIGN PROSTATIC HYPERTROPHY W/O CC	0.4479	2.0	2.5
350	12	MED		INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.7478	3.6	4.5
351	12	MED	*	STERILIZATION, MALE	0.2381	1.3	1.3
352	12	MED		OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	0.7615	3.0	4.1
353	13	SURG		PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	1.8936	4.8	6.4
354	13	SURG		UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.5316	4.7	5.8
355	13	SURG		UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	0.8959	2.9	3.1
356	13	SURG		FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	0.7411	1.7	2.0
357	13	SURG		UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	2.2302	6.6	8.3
358	13	SURG		UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.1696	3.3	4.1
359	13	SURG		UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	0.8029	2.3	2.5

360	13	SURG		VAGINA, CERVIX & VULVA PROCEDURES	0.8674	2.1	2.7
361	13	SURG		LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	1.1250	2.3	3.6
362	13	SURG	*	ENDOSCOPIC TUBAL INTERRUPTION	0.3043	1.4	1.4
363	13	SURG		D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	0.9725	2.7	3.8
364	13	SURG		D&C, CONIZATION EXCEPT FOR MALIGNANCY	0.9850	3.1	4.4
365	13	SURG		OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	2.0636	5.2	7.9
366	13	MED		MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.2628	4.9	6.7
367	13	MED		MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	0.5495	2.3	3.2
368	13	MED		INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	1.1972	5.2	6.8
369	13	MED		MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	0.6213	2.4	3.3
370	14	SURG		CESAREAN SECTION W CC	0.8981	4.2	5.4
371	14	SURG		CESAREAN SECTION W/O CC	0.6221	3.2	3.5
372	14	MED		VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.5460	2.7	3.5
373	14	MED		VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.3601	2.0	2.2
374	14	SURG		VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.6642	2.7	3.3
375	14	SURG	*	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0.5810	4.4	4.4
376	14	MED		POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.5400	2.6	3.6
377	14	SURG		POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	1.1199	3.2	4.8
378	14	MED		ECTOPIC PREGNANCY	0.7809	1.9	2.2

379	14	MED		THREATENED ABORTION	0.3757	2.0	3.0
380	14	MED		ABORTION W/O D&C	0.3539	1.5	1.9
381	14	SURG		ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.6633	1.5	2.1
382	14	MED		FALSE LABOR	0.2345	1.5	2.0
383	14	MED		OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.5070	2.7	3.8
384	14	MED		OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.2913	1.6	2.0
385	15	MED	*	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.3865	1.8	1.8
386	15	MED	*	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	4.5721	17.9	17.9
387	15	MED	*	PREMATURITY W MAJOR PROBLEMS	3.1226	13.3	13.3
388	15	MED	*	PREMATURITY W/O MAJOR PROBLEMS	1.8841	8.6	8.6
389	15	MED	*	FULL TERM NEONATE W MAJOR PROBLEMS	3.2076	4.7	4.7
390	15	MED	*	NEONATE W OTHER SIGNIFICANT PROBLEMS	1.1352	3.4	3.4
391	15	MED	*	NORMAL NEWBORN	0.1537	3.1	3.1
392	16	SURG		SPLENECTOMY AGE >17	3.2387	6.7	9.4
393	16	SURG	*	SPLENECTOMY AGE 0-17	1.3581	9.1	9.1
394	16	SURG		OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	1.8868	4.4	7.2
395	16	MED		RED BLOOD CELL DISORDERS AGE >17	0.8399	3.2	4.4
396	16	MED		RED BLOOD CELL DISORDERS AGE 0-17	2.5293	5.3	10.9
397	16	MED		COAGULATION DISORDERS	1.2284	3.7	5.1
398	16	MED		RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	1.2347	4.6	5.9
399	16	MED		RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	0.6583	2.6	3.3
400	17	SURG		NO LONGER VALID	0.0000	0.0	0.0

401	17	SURG		LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.9598	8.0	11.5
402	17	SURG		LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	1.1533	2.8	4.1
403	17	MED		LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.8172	5.7	8.0
404	17	MED		LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.8923	3.0	4.1
405	17	MED	*	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	1.9255	4.9	4.9
406	17	SURG		MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	2.7644	6.8	9.7
407	17	SURG		MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	1.2158	3.3	4.0
408	17	SURG		MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	2.1980	4.9	8.3
409	17	MED		RADIOTHERAPY	1.3093	4.4	6.0
410	17	MED		CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	1.1163	3.1	4.0
411	17	MED	*	HISTORY OF MALIGNANCY W/O ENDOSCOPY	0.3951	4.7	4.7
412	17	MED		HISTORY OF MALIGNANCY W ENDOSCOPY	0.6424	1.2	1.6
413	17	MED		OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.3974	5.4	7.3
414	17	MED		OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	0.6494	2.9	3.8
415	18	SURG		O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.6291	10.2	14.1
416	18	MED		SEPTICEMIA AGE >17	1.5982	5.5	7.4
417	18	MED		SEPTICEMIA AGE 0-17	1.4132	3.8	5.4
418	18	MED		POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	1.0726	4.8	6.2

419	18	MED		FEVER OF UNKNOWN ORIGIN AGE >17 W CC	0.8898	3.6	4.6
420	18	MED		FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	0.6021	2.7	3.3
421	18	MED		VIRAL ILLNESS AGE >17	0.8107	3.2	4.2
422	18	MED		VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	0.5944	2.6	3.3
423	18	MED		OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.7834	5.8	8.1
424	19	SURG		O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	2.4327	7.6	13.0
425	19	MED		ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	0.6839	2.8	3.8
426	19	MED		DEPRESSIVE NEUROSES	0.4845	3.1	4.2
427	19	MED		NEUROSES EXCEPT DEPRESSIVE	0.5124	3.2	4.7
428	19	MED		DISORDERS OF PERSONALITY & IMPULSE CONTROL	0.7762	4.8	7.5
429	19	MED		ORGANIC DISTURBANCES & MENTAL RETARDATION	0.8248	4.4	5.9
430	19	MED		PSYCHOSES	0.6608	5.6	7.8
431	19	MED		CHILDHOOD MENTAL DISORDERS	0.4825	3.9	5.6
432	19	MED		OTHER MENTAL DISORDER DIAGNOSES	0.6486	3.1	4.5
433	20	MED		ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.2836	2.2	2.9
434	20	MED		NO LONGER VALID	0.0000	0.0	0.0
435	20	MED		NO LONGER VALID	0.0000	0.0	0.0
436	20	MED		NO LONGER VALID	0.0000	0.0	0.0
437	20	MED		NO LONGER VALID	0.0000	0.0	0.0
438	20			NO LONGER VALID	0.0000	0.0	0.0
439	21	SURG		SKIN GRAFTS FOR INJURIES	1.8778	5.2	8.6
440	21	SURG		WOUND DEBRIDEMENTS FOR INJURIES	1.8415	5.7	8.8
441	21	SURG		HAND PROCEDURES FOR INJURIES	0.8694	2.1	3.1
442	21	SURG		OTHER O.R. PROCEDURES FOR INJURIES W CC	2.4839	5.8	8.8

443	21	SURG		OTHER O.R. PROCEDURES FOR INJURIES W/O CC	1.0074	2.6	3.4
444	21	MED		TRAUMATIC INJURY AGE >17 W CC	0.7705	3.1	4.1
445	21	MED		TRAUMATIC INJURY AGE >17 W/O CC	0.5121	2.2	2.8
446	21	MED	*	TRAUMATIC INJURY AGE 0-17	0.2985	2.4	2.4
447	21	MED		ALLERGIC REACTIONS AGE >17	0.5431	1.9	2.6
448	21	MED	*	ALLERGIC REACTIONS AGE 0-17	0.0982	2.9	2.9
449	21	MED		POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	0.8515	2.6	3.7
450	21	MED		POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	0.4314	1.6	2.0
451	21	MED	*	POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	0.2650	2.1	2.1
452	21	MED		COMPLICATIONS OF TREATMENT W CC	1.0418	3.5	5.0
453	21	MED		COMPLICATIONS OF TREATMENT W/O CC	0.5226	2.2	2.8
454	21	MED		OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	0.8494	3.0	4.3
455	21	MED		OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	0.4804	1.8	2.4
456	22			NO LONGER VALID	0.0000	0.0	0.0
457	22	MED		NO LONGER VALID	0.0000	0.0	0.0
458	22	SURG		NO LONGER VALID	0.0000	0.0	0.0
459	22	SURG		NO LONGER VALID	0.0000	0.0	0.0
460	22	MED		NO LONGER VALID	0.0000	0.0	0.0
461	23	SURG		O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	1.2114	2.2	3.6
462	23	MED		REHABILITATION	0.8865	8.9	11.0
463	23	MED		SIGNS & SYMPTOMS W CC	0.7073	3.1	4.0
464	23	MED		SIGNS & SYMPTOMS W/O CC	0.5123	2.4	3.0

465	23	MED		AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.5976	2.0	2.9
466	23	MED		AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.6416	2.4	4.1
467	23	MED		OTHER FACTORS INFLUENCING HEALTH STATUS	0.5604	2.0	3.2
468				EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	3.9472	9.6	13.2
469		*	*	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0.0000	0.0	0.0
470		*	*	UNGROUPABLE	0.0000	0.0	0.0
471	08	SURG		BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	3.0523	4.6	5.3
472	22	SURG		NO LONGER VALID	0.0000	0.0	0.0
473	17	MED		ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	3.5386	7.6	13.1
474	04	SURG		NO LONGER VALID	0.0000	0.0	0.0
475	04	MED		RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	3.6166	8.0	11.3
476		SURG		PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.2487	7.8	10.8
477		SURG		NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.0181	5.6	8.4
478	05	SURG		OTHER VASCULAR PROCEDURES W CC	2.3989	4.8	7.3
479	05	SURG		OTHER VASCULAR PROCEDURES W/O CC	1.4402	2.3	3.0
480	PRE	SURG		LIVER TRANSPLANT AND/OR INTESTINAL TRANSPLANT	9.8696	13.2	18.9
481	PRE	SURG		BONE MARROW TRANSPLANT	6.4851	19.1	22.5
482	PRE	SURG		TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES	3.1977	9.3	11.8

483	PRE	SURG		NO LONGER VALID	0.0000	0.0	0.0
484	24	SURG		CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.0869	8.8	12.9
485	24	SURG		LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRA	3.1808	7.9	9.8
486	24	SURG		OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	4.7311	8.7	12.7
487	24	MED		OTHER MULTIPLE SIGNIFICANT TRAUMA	1.9715	5.3	7.4
488	25	SURG		HIV W EXTENSIVE O.R. PROCEDURE	4.8891	11.9	17.0
489	25	MED		HIV W MAJOR RELATED CONDITION	1.7764	5.9	8.3
490	25	MED		HIV W OR W/O OTHER RELATED CONDITION	1.0543	3.8	5.3
491	08	SURG		MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	1.7028	2.7	3.3
492	17	MED		CHEMOTHERAPY W ACUTE LEUKEMIA OR W USE OF HI DOSE CHEMOAGENT	3.8509	9.4	15.0
493	07	SURG		LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.8368	4.5	6.1
494	07	SURG		LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.0218	2.1	2.7
495	PRE	SURG		LUNG TRANSPLANT	8.8440	13.9	16.9
496	08	SURG		COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	5.8072	6.6	8.9
497	08	SURG		SPINAL FUSION EXCEPT CERVICAL W CC	3.5251	5.2	6.3
498	08	SURG		SPINAL FUSION EXCEPT CERVICAL W/O CC	2.6527	3.6	3.9
499	08	SURG		BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.4409	3.2	4.4

500	08	SURG		BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	0.9436	1.9	2.3
501	08	SURG		KNEE PROCEDURES W PDX OF INFECTION W CC	2.4285	8.0	10.1
502	08	SURG		KNEE PROCEDURES W PDX OF INFECTION W/O CC	1.4275	5.1	6.0
503	08	SURG		KNEE PROCEDURES W/O PDX OF INFECTION	1.2167	2.9	3.8
504	22	SURG		EXTEN. BURNS OR FULL THICKNESS BURN W/MV 96+HRS W/SKIN GFT	13.0063	23.1	29.3
505	22	MED		EXTEN. BURNS OR FULL THICKNESS BURN W/MV 96+HRS W/O SKIN GFT	1.8727	2.3	4.4
506	22	SURG		FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA	4.0604	11.6	16.2
507	22	SURG		FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA	1.8618	6.6	9.1
508	22	MED		FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA	1.3358	5.1	7.3
509	22	MED		FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA	0.6859	3.4	4.7
510	22	MED		NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	1.2739	4.5	6.8
511	22	MED		NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	0.7058	2.9	4.1
512	PRE	SURG		SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	6.0202	11.4	13.9
513	PRE	SURG		PANCREAS TRANSPLANT	6.3212	8.9	10.0
514	05	SURG		NO LONGER VALID	0.0000	0.0	0.0
515	05	SURG		CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	5.4339	2.7	4.7
516	05	SURG		PERCUTANEOUS CARDIOVASC PROC W AMI	2.6457	3.7	4.6

517	05	SURG		PERC CARDIO PROC W NON-DRUG ELUTING STENT W/O AMI	2.1106	1.8	2.5
518	05	SURG		PERC CARDIO PROC W/O CORONARY ARTERY STENT OR AMI	1.7509	2.3	3.5
519	08	SURG		CERVICAL SPINAL FUSION W CC	2.4146	3.1	4.9
520	08	SURG		CERVICAL SPINAL FUSION W/O CC	1.6300	1.6	2.1
521	20	MED		ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	0.6988	4.2	5.6
522	20	MED		ALC/DRUG ABUSE OR DEPEND W REHABILITATION THERAPY W/O CC	0.4947	7.6	9.5
523	20	MED		ALC/DRUG ABUSE OR DEPEND W/O REHABILITATION THERAPY W/O CC	0.3885	3.2	3.9
524	01	MED		TRANSIENT ISCHEMIA	0.7414	2.6	3.3
525	05	SURG		OTHER HEART ASSIST SYSTEM IMPLANT	11.3749	8.2	15.8
526	05	SURG		PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W AMI	2.9741	3.3	4.3
527	05	SURG		PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W/O AMI	2.3282	1.6	2.1
528	01	SURG		INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE	6.8481	13.8	17.0
529	01	SURG		VENTRICULAR SHUNT PROCEDURES W CC	2.2165	5.2	8.2
530	01	SURG		VENTRICULAR SHUNT PROCEDURES W/O CC	1.1945	2.5	3.3
531	01	SURG		SPINAL PROCEDURES W CC	3.0980	6.5	9.7
532	01	SURG		SPINAL PROCEDURES W/O CC	1.4676	2.9	3.9
533	01	SURG		EXTRACRANIAL PROCEDURES W CC	1.6498	2.6	4.0
534	01	SURG		EXTRACRANIAL PROCEDURES W/O CC	1.0515	1.6	1.9

535	05	SURG		CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK	7.6973	6.2	9.2
536	05	SURG		CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	6.2417	3.5	5.4
537	08	SURG		LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W CC	1.7961	4.7	6.9
538	08	SURG		LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W/O CC	0.9940	2.1	2.9
539	17	SURG		LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W CC	3.3809	7.4	11.4
540	17	SURG		LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W/O CC	1.2864	2.9	4.0
541	17	SURG		TRACH W MV 96+HRS OR PDX EXC FACE,MOUTH, & NECK DX W/MAJ OR	20.0414	38.7	45.9
542	17	SURG		TRACH W MV 96+HRS OR PDX EXC FACE, MOUTH, & NECK DX W/O MJ OR	12.0286	27.5	34.0
543	01	SURG		CRANIOTOMY W/IMPLANT OF CHEMO AGENT OR ACUTE COMPLEX CNS PDX	4.4579	8.7	12.4

Exhibit 2

Base Rates and Cost-to-Charge Ratios

Medicare #	Hospital Name	Base Rate	Cost to Charge
60036	Arkansas Valley Reg. Med. Ctr.	$5,116.57	0.530
60103	Porter Avista Adventist Hospital	$5,558.09	0.384
60027	Boulder Community Hospital	$5,219.61	0.419
60044	Colorado Plains Medical Center	$5,480.02	0.329
60054	Community Hospital - GJ	$4,960.87	0.723
60071	Delta County Memorial Hospital	$5,066.92	0.591
60011	Denver Health Medical Center	$8,684.88	0.522
60009	Exempla Lutheran Medical Ctr	$5,305.75	0.314
60028	Exempla Saint Joseph Hospital	$5,866.12	0.289
60043	Keefe Memorial Hospital	$12,847.77	1.050
60003	Longmont United Hospital	$5,351.43	0.438
60027	Mapleton Center For Rehabilitation- Boulder Community Hospital	$5,219.61	0.419
60030	McKee Medical Center	$5,064.19	0.490
60100	Medical Center Of Aurora (System)	$5,779.57	0.291
60022	Memorial Hospital	$5,497.31	0.337
60013	Mercy Medical Center - Durango	$4,975.87	0.498
60001	North Colorado Medical Center	$5,775.30	0.479
60065	North Suburban Medical Ctr	$6,090.79	0.304
60020	Parkview Medical Center	$5,334.96	0.306

60031	Penrose-St Francis Health Services	$4,942.95	0.303
60004	Platte Valley Medical Center	$5,920.78	0.373
60113	Porter - Littleton Adventist Hospital	$5,293.39	0.369
60114	Porter Adventist Hospital - Parker	$5,302.70	0.643
60010	Poudre Valley Hospital	$5,263.36	0.503
60014	Presbyterian St Lukes Medical Ctr	$6,444.79	0.332
60032	Rose Medical Center	$6,062.86	0.278
60008	San Luis Valley Reg Med Ctr	$5,295.06	0.563
60112	Sky Ridge Medical Center	$4,838.88	0.369
60018	Southwest Memorial Hospital	$5,312.56	0.538
60015	St Anthony Hospital Central	$6,005.45	0.295
60104	St Anthony Hospital North	$5,613.82	0.303
60012	St Mary-Corwin Medical Center	$5,399.37	0.328
60023	St Marys Hospital & Medical Ctr	$5,587.66	0.424
	St Marys Rehabilitation Center	$5,587.66	**0.424**
60016	St Thomas More Hospital	$4,999.07	0.437
60076	Sterling Regional MedCenter	$5,088.51	0.630
60034	Swedish Medical Center	$5,461.63	0.288
60024	University Hospital	$8,544.86	0.333
60096	Vail Valley Medical Center	$5,635.64	0.666
60075	Valley View Hospital	$6,128.67	0.585
60049	Yampa Valley Medical Center	$5,599.19	0.769
60041	Pioneers Hospital of Rio Blanc	$8,994.62	0.832
60107	National Jewish	$9,194.25	0.369
60006	Montrose Memorial	$5,073.23	0.447

60064	Portercare	$5,311.64	0.345
60116	Good Samaritan	$4,568.50	0.369

Exhibit 3

Critical Access Hospitals

Name	***Location in Colorado***
Aspen Valley Hospital	Aspen
Conejos County Hospital	La Jara
East Morgan County Hospital	Brush
Estes Park Medical Center	Estes Park
Family Health West Hospital	Fruita
Grand River Medical Center	Rifle
Gunnison Valley Hospital	Gunnison
Haxtun Hospital District	Haxtun
Heart of the Rockies Regional Medical Center	Salida
Kit Carson County Memeorial Hospital	Burlington
Kremmling Memorial Hospital	Kremmling
Lincoln Community Hospital	Hugo
Melissa Memorial Hospital	Holyoke
The Memorial Hospital	Craig
Mt. San Rafael Hospital	Trinidad
Prowers Medical Center	Lamar
Rangeley District Hospital	Rangely
Rio Grande Hospital	Del Norte
Sedgwick County Memorial Hospital	Julesburg
Southeast Colorado Hospital	Springfield

Spanish Peaks Regional Helath Center	Walsenburg
St. Vincent General Hospital	Leadville

Exhibit 4

Outpatient Surgery Facility Codes and Fees		
Codes	**CPT Code Description**	**Dollar Value**
10140	INCISION AND DRAINAGE OF HEMATOMA, SEROMA OR FLUID COLLECTION	$1,418.84
10180	INCISION AND DRAINAGE, COMPLEX, POSTOPERATIVE WOUND INFECTION	$1,418.84
11043	DEBRIDEMENT, SKIN, SUBCUTANEOUS TISSUE, AND MUSCLE.	$1,338.00
11044	DEBRIDEMENT; SUBCUTANEOUS TISSUE, MUSCLE AND BONE.	$1,338.00
14001	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, TRUNK; DEFECT 10.1 SQ CM TO 30 SQ CM	$1,918.68
14020	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, SCALP, ARMS, AND/OR LEGS; DEFECT 10 SQ CM OR LESS	$1,918.68
14021	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, SCALP, ARMS, AND/OR LEGS; DEFECT 10 SQ CM TO 30 SQ CM	$1,918.68
14040	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS AND/OR FEET; DEFECT 10 SQ CM OR LESS	$1,918.68
14041	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS AND/OR FEET; DEFECT 10 SQ CM TO 30 SQ CM	$1,918.68
14060	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, EYELIDS, NOSE, EARS AND/OR LIPS; DEFECT 10 SQ CM OR LESS	$1,918.68
14061	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, EYELIDS, NOSE, EARS AND/OR LIPS; DEFECT 10 SQ CM TO 30 SQ CM	$1,918.68
14300	ADJACENT TISSUE TRANSFER OR REARRANGEMENT; DEFECT MORE THAN 30 SQ CM, UNUSUAL OR COMPLICATED, ANY AREA	$1,918.68
14350	FILLETED FINGER OR TOE FLAP, INCLUDING PREPARATION OF RECIPIENT SITE	$1,918.68
15000	SURG PREP RECIP SITE; 1ST 100 CM/1%	$1,338.00
15001	SURG PREP RECIP SITE; EA ADD 100 CM	$539.24
15050	PINCH GFT 1/MX-SM AREA UP TO 2 CM	$1,338.00
15100	SPLIT GFT TRUNK; 1ST 100 SQ CM/</1%	$1,918.68
15101	SPLIT GFT TRUNK, EA ADD 100 SQ CM/1%	$1,918.68
15120	SPLIT GFT FACE; 1ST 100 SQ CM/</1%	$1,918.68
15121	SPLIT GFT FACE; EA ADD 100 SQ CM/1%	$1,918.68
15200	FULL THICK GFT TRUNK; 20 SQ CM/LESS	$1,918.68

15201	FULL THICK GFT TRUNK; EA ADD 20 SQ	$1,338.00
15220	FTG SCLP ARM&/LEG; 20 SQ CM/LESS	$1,918.68
15221	FTG SCLP ARM&/LEG; EA ADD 20 SQ CM	$1,338.00
15240	FTG FOREHEAD CHN AX&/FT; 20 SQ CM/<	$1,918.68
15241	FTG FOREHEAD CHN AX&/FT, EA ADD 20CM	$1,530.00
15260	FTG NOSE EAR EYELD/&LIPS, 20 SQ CM/<	$1,918.68
15261	FTG NOSE EAR EYELD/&LPS, EA ADD 20CM	$1,338.00
15342	APPLICATION OF BILAMINATE SKIN SUBSTITUTE/NEODERMIS; 25 SQ CM	$202.20
15343	APPLICATION OF BILAMINATE SKIN SUBSTITUTE/NEODERMIS; 25 SQ CM; EACH ADDITIONAL 25 SQ CM	$202.20
15350	APPLIC ALLOGFT SKIN; 100 SQ CM/LESS	$1,338.00
15351	APPLIC ALLOGFT SKN, EA ADD 100 SQ CM	$1,918.68
15400	APPLIC XENOGFT SKIN; 100 SQ CM/LESS	$1,338.00
15401	APPLIC XENOGFT SKN, EA ADD 100 SQ CM	$1,338.00
15570	FORM DIR PEDICLE W/WO TRANSF; TRUNK	$1,918.68
15572	FORM DIR PEDICLE W/WO TRANSF; SCLP	$1,918.68
15574	FORM DIR PEDICLE; CHEEKS CHIN AX/FT	$1,918.68
15576	FORM DIR PEDICLE; EYELDS NOSE/EARS	$1,918.68
15600	DELAY FLAP/SECTION FLAP; AT TRUNK	$1,918.68
15610	DELAY FLP/SECT FLP, SCLP ARMS/LEGS	$1,918.68
15620	DELAY FLAP/SECT; CHIN AX GENIT/FT	$1,918.68
15630	DELAY FLAP/SECT, EYELID NOSE EAR/LIP	$1,918.68
15650	TRNSF INTERMED PEDICLE FLP LOCATION	$2,151.00
15732	MUSC MYOCUT/FASCIOCUT FLP; HEAD&NCK	$1,918.68
15734	MUSCLE MYOCUT/FASCIOCUT FLAP; TRUNK	$1,918.68
15736	MUSC MYOCUT/FASCIOCUT FLP; UP EXTRM	$1,918.68
15738	MUSC MYOCUT/FASCIOCUT FLP; LW EXTRM	$1,918.68
15740	FLAP; ISLAND PEDICLE	$1,918.68
15750	FLAP; NEUROVASCULAR PEDICLE	$1,918.68
15760	GFT; COMPOS INCL PRIM CLO DONR AREA	$1,918.68
15770	GRAFT; DERMA-FAT-FASCIA	$1,918.68
15775	PUNCH GFT HAIR TPLNT; 1-15 GFTS	$1,530.00
15776	PUNCH GFT HAIR TPLNT; > 15 GFTS	$1,530.00
15850	REMOVAL OF SUTURES UNDER ANESTHESIA (OTHER AN LOCAL), SAME SURGEON	$322.76
15851	REMOVAL OF SUTURES UNDER ANESTHESIA (OTHER AN LOCAL), SAME SURGEON	$322.76
15852	DRESSING CHANGE (FOR OTHER AN BURNS) UNDER ANESTHESIA (OTHER THAN LOCAL)	$72.12

16010	DRESSING AND/OR DEBRIDEMENT, INITIAL OR SUBSEQUENT; UNDER ANESTHESIA, SMALL	$322.76
16015	DRESSING AND/OR DEBRIDEMENT, INITIAL OR SUBSEQUENT; UNDER ANESTHESIA, MEDIUM OR LARGE, OR WITH MAJOR DEBRIDEMENT	$1,981.80
16030	DRESSING AND/OR DEBRIDEMENT, INITIAL OR SUBSEQUENT; WITHOUT ANESTHESIA, LARGE, (MORE THAN ONE EXTREMITY	$196.56
20610	ARTHROCENTESIS ASPIR&/INJ; MAJ JNT	$372.69
20650	INSRT WIRE/PIN W/TRAC-SEP PROC	$2,302.64
20670	REMOVAL OF IMPLANT; SUP SEP PROC	$1,696.64
20680	REMOVAL OF IMPLANT; DEEP	$2,207.52
20690	APPLIC UNIPLANE UNILAT EXT FIX SYS	$2,803.58
20692	APPLIC MXIPLANE UNILAT EXT FIX SYS	$2,803.58
20693	ADJ/REV EXT FIX SYS RQR ANESTHESIA	$2,302.64
20694	REMOVAL UNDER ANES-EXT FIX SYSTEM	$2,302.64
20900	BONE GRAFT ANY DONOR AREA; MINOR/SM	$2,803.58
20902	BONE GRAFT ANY DONOR AREA; MAJOR/LG	$2,803.58
20910	CARTILAGE GRAFT; COSTOCHONDRAL	$1,918.68
20912	CARTILAGE GRAFT; NASAL SEPTUM	$1,918.68
20920	FASCIA LATA GRAFT; BY STRIPPER	$1,918.68
20922	FASCIA LATA GRAFT; INCI&AREA EXPOS	$1,918.68
20924	TENDON GRAFT FROM A DISTANCE	$2,803.58
20926	TISSUE GRAFTS OTHER	$1,918.68
20931	ALLOGRAFT SPINE ONLY, STRUCTURAL	$2,803.58
20936	ALLOGRAFT SPINE ONLY, LOCAL (HARVEST/GRAFT INCLUDED)	$2,803.58
20937	AUTOGRAFT SPINE ONLY, MORSELIZED	$2,803.58
20938	AUTOGRAFT SPINE ONLY, STRUCTURAL, BICORTICAL OR TRICORTICAL	$2,803.58
21010	ARTHROTOMY TEMPOROMANDIBULAR JOINT	$2,660.44
21235	GRAFT; EAR CARTILAGE, AUTOGENOUS, TO NOSE OR EAR (INCLUDES OBTAINING GRAFT)	$2,660.44
21270	MALAR AUGMENTATION, PROSTHETIC MATERIAL	$4,208.74
21330	OPEN TREATMENT OF NASAL FRACTURE, COMPLICATED WITH INTERNAL AND OR EXTERNAL SKELETAL FIXATION	$2,660.44
21335	OPEN TREATMENT OF NASAL FRACTURE, COMPLICATED WITH INTERNAL AND OR EXTERNAL SKELETAL FIXATION; WITH CONCOMITANT OPEN TREATMENT OF FRACURED SEPTUM	$2,660.44
22505	MANIPULATION OF SPINE REQUIRING ANESTHESIA, ANY REGION	$809.68
22520	PERQ VERTPLSTY 1 UNI/BIL INJ; THOR	$2,803.58
22521	PERQ VERTPLSTY 1 UNI/BIL INJ; LUMB	$2,803.58

22522	PERQ VERTPLSTY 1 UNI/BIL INJ;EA ADD	$2,803.58
22532	ARTHRDSIS LATERAL EXTRACAVITARY TECHNIQUE, INCLUDING A MINI DISKECT; THORACIC	$5,579.27
22533	ARTHRDSIS LATERAL EXTRACAVITARY TECHNIQUE, INCLUDING A MINI DISKECT; LUMBAR	$5,579.27
22554	ARTHRODESIS ANTERIOR INTERBODY TECHNIQUE, INCLUDING MINIMAL DISKECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION) BELOW C2	$5,579.27
22556	ARTHRODESIS ANTERIOR INTERBODY TECHNIQUE, INCLUDING MINIMAL DISKECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION) THORACIC	$5,579.27
22585	ARTHRODESIS ANTERIOR INTERBODY TECHNIQUE, INCLUDING MINIMAL DISKECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION); EACH ADDITIONAL INTERSPACE	$5,579.27
22600	ARTHRDSIS POST/POSTEROLAT 1; below C2 segment, Cervical	$5,579.27
22610	ARTHRDSIS POST/POSTEROLAT 1;thoracic	$5,579.27
22612	ARTHRDSIS POST/POSTEROLAT 1; LUMB	$5,579.27
22614	ARTHRDSIS POST/POSTEROLAT 1;EA ADD VERTEBRAL SEGMENT	$5,579.27
22630	ARTHRDSIS POSTERIOR INTERBODY TECHNIQUE, W/LAMINECT OR DISKECTOMY 1; LUMB	$5,579.27
22632	ARTHRDSIS POST W/LAMINECT 1; EA ADD	$5,579.27
22830	EXPLORATION OF SPINAL FUSION	$5,579.27
22840	POSTERIOR NON-SEGMENTAL INSTRUMENTATION 9EG, HARRINGOTN ROD TECHNIQUE, PEDICLE FIXATION ACROSS ONE INTERSPACE, ATLANTOAXIAL TRANARTICULAR SCREW FIXATION, SUBLAMINAR WIRING AT C1, FACET SCREQ FIXATION)	$5,579.27
22842	POSTERIOR SEGMENTAL INSTRUMENTATION (E PEDICULE FIXATION, DURAL RODS WITH MULTIPLE HOOKS AND SUBLAMINAL WIRE(S) 3 TO 6 VERTEBRAL SEGMENTS	$5,579.27
22845	ANTERIOR INSTRUMENTATION; 2 TO 3 VERTEBRAL SEGMENTS	$5,579.27
22849	REINSERTION OF SPINAL FIXATION DEVICE	$5,579.27
22850	REMOVAL OF POSTERIOR NONSEGMENTAL INSTRUMENTATION (EG HARRINGTON ROD)	$5,579.27
22851	APPLICATION OF INTEVERTEBRAL BIOMECHANICAL DEVICE(S) (EG SYNTHETIC CAGE(S), THREADED BONE DOWEL(S) METHYLEMETHACRYLATE) TO VERTEBRAL DEFECT OR INTERSPACE	$5,579.27
22855	REMOVAL OF ANTERIOR INSTRUMENTATION	$5,579.27
23000	REMOVAL OF SUBDELTOID CALCAREDOUS DEPOSITS, OPEN	$1,696.64
23020	CAPSULAR CONTRACTURE RELEASE	$4,086.90
23030	I&D SHOULDER AREA; DEEP ABSC/HEMAT	$2,206.06

23031	I&D SHOULDER AREA; INFECTED BURSA	$2,206.06
23035	INCISION BONE CORTEX SHOULDER AREA	$2,302.64
23040	ARTHROT GLENOHUM JNT EXPL/REMV FB	$2,803.58
23044	ARTHROT AC SC JNT INCL EXPL/REMV FB	$2,803.58
23065	BX SOFT TISSUE SHLDR AREA; SUP	$1,696.64
23066	BX SOFT TISSUE SHOULDER AREA; DEEP	$2,207.52
23075	EXC SFT TISS TUMR SHLDR AREA; SUBQ	$1,696.64
23076	EXC SFT TISS TUMR SHLDR; DEEP/IM	$2,207.52
23077	RADL RES TUMR SFT TISSUE SHLDR AREA	$2,207.52
23100	ARTHROT GLENOHUM JOINT INCLUDING BX	$2,302.64
23101	ARTHROT AC/SC JNT INCL BX&/EXC CART	$2,985.00
23105	ARTHROT; GLENOHUM JNT W/SYNOVECT	$2,803.58
23106	ARTHROT; SC JNT W/SYNOVECT W/WO BX	$2,803.58
23107	ARTHROT GLENOHUM JNT W/JNT EXPL	$2,803.58
23120	CLAVICULECTOMY; PARTIAL	$4,086.90
23125	CLAVICULECTOMY; TOTAL	$4,086.90
23130	ACROMPLSTY/ACROMNECT PART W/WO RLSE	$4,086.90
23170	SEQUESTRECTOMY CLAVICLE	$2,803.58
23172	SEQUESTRECTOMY SCAPULA	$2,803.58
23174	SEQECT HUM HEAD SURGICAL NECK	$2,803.58
23180	PARTIAL EXCISION BONE CLAVICLE	$2,803.58
23182	PARTIAL EXCISION BONE SCAPULA	$2,803.58
23184	PARTIAL EXCISION BONE PROXIMAL HUM	$2,803.58
23190	OSTECTOMY OF SCAPULA PARTIAL	$2,803.58
23195	RESECTION HUMERAL HEAD	$2,803.58
23395	MUSC TRNSF ANY TYPE SHLDR/UP ARM; 1	$4,086.90
23397	MUSC TRNSF TYPE SHLDR/UP ARM; MX	$4,966.12
23400	SCAPULOPEXY	$2,985.00
23405	TENOTOMY SHLDR AREA; SINGLE TENDON	$2,803.58
23406	TENOT SHLDR; MX TENDONS-SAME INCS	$2,803.58
23410	REP RUP MUSCULOTENDINUS CUFF OPN, AC	$4,966.12
23412	REP RUP MUSCLOTENDNUS CUFF OPN, CHRN	$4,966.12
23415	CORACOACROM LIG REL W/WO ACROMPLSTY	$4,086.90
23420	RECNSTR CMPL SHLDR CUFF AVUL CHRON	$4,966.12
23430	TENODESIS OF LONG TENDON OF BICEPS	$4,966.12
23440	RESECTION/TPLNT LONG TENDON BICEPS	$4,966.12
23450	CAPSULORRHAPHY ANT PUTTI-PLATT TYPE	$4,966.12
23455	CAPSULORRHAPHY ANT; W/LABRAL REPAIR	$4,966.12
23460	CPSLORR ANT ANY TYPE; W/BONE BLOCK	$4,966.12
23462	CPSLORR ANT; W/CORACOID PRC TRNSF	$4,966.12

23465	CPSLORR GLENOHUM JNT POST BN BLOCK	$4,966.12
23466	CPSLORR GLENOHUM JNT MX INSTABILITY	$4,966.12
23470	ARTHPLSTY GLENHUM JNT;HEMIARTHPLSTY w/pros	$4,966.12
23472	ARTHPLSTY GLENOHUM JNT; TOT SHLDR	$4,966.12
23480	OSTEOTOMY CLAV W/WO INTERNAL FIX;	$4,086.90
23485	OSTEOT CLAV W/WO INTRL FIX; W/GFT	$4,086.90
23490	PROPHYLACTIC TX W/WO MMC; CLAV	$4,086.90
23491	PROPH TX W/WO MMC; PROXIMAL HUM	$4,086.90
23550	OPEN TREATMENT OF ACROMIOCLAVICULAR DISLOCATION, ACUTE OR CHRONIC;	$4,001.40
23585	OPEN TREATMENT OF SCAPULAR FRACTURE (BODY, GLENOID OR ACROMION) WITH OR WITHOUT INTERNAL FIXATION	$4,001.40
23615	OPEN TREATMENT OF PROXIMAL HUMERAL (SURGICAL OR ANATOMICAL NECK) FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, WITH OR WITHOUT REPAIR OF TUBEROSITY(S)	$4,001.40
23700	MANIP W/ANES SHLDR JNT INCL APPLICATION OF FIXATION DEVICE	$809.68
23800	ARTHRODESIS GLENOHUMERAL JOINT;	$4,086.90
23802	ARTHRDSIS GLENOHUM JNT;W/AUTOGN GFT	$4,086.90
23921	AMPUTATION - DISARTIC SHLDR; SEC CLOS/SCAR REV	$1,530.00
23930	I&D UP ARM/ELB AREA; DP ABSC/HEMAT	$2,206.06
23931	I&D UPPER ARM OR ELBOW AREA; BURSA	$1,418.84
23935	INCI DP W/OPENING BN CORTX HUM/ELB	$2,302.64
24000	ARTHROT ELB INCL EXPL DRN/REMOVL FB	$2,803.58
24006	ARTHROTOMY ELB W/CAP EXC-SEP PROC	$2,803.58
24100	ARTHROT ELBOW; W/SYNOVIAL BX ONLY	$2,302.64
24101	ARTHROTOMY ELBOW; W/JOINT EXPL	$2,803.58
24102	ARTHROTOMY ELBOW; WITH SYNOVECTOMY	$2,803.58
24105	EXCISION OLECRANON BURSA	$2,302.64
24130	EXCISION RADIAL HEAD	$2,803.58
24134	SEQUESTRECTOMY SHAFT/DISTAL HUMERUS	$2,803.58
24136	SEQUESTRECTOMY RADIAL HEAD OR NECK	$2,803.58
24138	SEQUESTRECTOMY OLECRANON PROCESS	$2,803.58
24140	PARTIAL EXCISION BONE HUMERUS	$2,803.58
24145	PART EXCISION BONE RADIAL HEAD/NECK	$2,803.58
24147	PART EXCISION BONE OLECRN PROCESS	$2,803.58
24155	RESECTION OF ELBOW JOINT	$4,086.90
24160	IMPLANT REMOVAL; ELBOW JOINT	$2,803.58
24164	IMPLANT REMOVAL; RADIAL HEAD	$2,803.58

24300	MANIPULATION ELBOW UNDER ANESTHESIA	$1,619.36
24301	MUSC/TEND TRNSF TYPE UP ARM/ELB 1	$2,803.58
24305	TENDON LEN UPPER ARM/ELB EA TENDON	$2,803.58
24310	TENOTOMY OPEN ELB SHLDR EA TENDON	$2,302.64
24320	TENPLSTY W/MUSC TRNSF ELB-SHLDR 1	$4,086.90
24330	FLEXOR-PLASTY ELBOW;	$4,086.90
24331	FLEX-PLASTY ELB; W/EXT ADVANCEMENT	$4,086.90
24332	TENOLYSIS TRICEPS	$2,302.64
24340	TENODESIS OF BICEPS TENDON AT ELBOW	$4,086.90
24341	REPR TEND/MUSC ARM/ELB EA PRIM/SEC	$4,086.90
24342	REINS RUP BICEPS/TRICEPS TEND DIST	$4,086.90
24343	REPR LAT COLLAT LIG ELB W/LOC TISS	$2,803.58
24344	RECON LAT COLLAT LIG ELB W/TEND GFT	$4,086.90
24345	REPAIR MCL ELBOW WITH LOCAL TISSUE	$2,803.58
24346	RECONSTRUCT MCL ELB W/TENDON GRAFT	$4,086.90
24350	FASCIOTOMY LATERAL OR MEDIAL;	$2,803.58
24351	FASCOT LAT/MED; W/EXT ORIGIN DETACH	$2,803.58
24352	FASCOT LAT/MED; W/ANNULAR LIG RES	$2,803.58
24354	FASCOT LATERAL/MEDIAL; W/STRIPPING	$2,803.58
24356	FASCOT LAT/MED; W/PARTIAL OSTECTOMY	$2,803.58
24360	ARTHROPLASTY ELBOW; WITH MEMBRANE	$3,538.56
24361	ARTHROPLSTY ELB; W/DIST HUM PROSTH	$3,538.56
24362	ARTHROPLSTY ELB; W/IMPL & LIG RECON	$3,538.56
24363	ARTHROPLASTY ELBOW; TOTAL ELBOW	$3,538.56
24365	ARTHROPLASTY RADIAL HEAD;	$3,538.56
24366	ARTHROPLASTY RADIAL HEAD; W/IMPLANT	$3,538.56
24400	OSTEOTOMY HUMERUS W/WO INTERNAL FIX	$2,803.58
24410	MX OSTEOT W/REALIGN ROD HUM SHAFT	$2,803.58
24420	OSTEOPLASTY HUMERUS	$4,086.90
24430	REPR NONUNION/MALUNION HUM; W/O GFT	$4,086.90
24435	REPR NON/MALUNION HUM; W/AUTOGFT	$4,086.90
24470	HEMIEPIPHYSEAL ARREST	$4,086.90
24495	DECOMP FASCIOT FOREARM W/BRACH ART	$2,803.58
24515	OPEN TREATMENT OF HUMERAL SHAFT FRACTURE WITH PLATE/SCREWS, WITH OR WITHOUT CERCLAGE	$4,001.40
24516	TREATMENT OF HUMERAL SHAFT FRACTURE WITH INSERTION OF INTRAMEDULLARY IMPLANT, WITH OR WITHOUT CERCLAGE AND OR LOCKING SCREWS	$4,001.40

24635	CLOSED TREATMEN OF SUPRACONDYLAR OR TRANSCOLDYLAR HUMERAL FRACTURE, WITH OR WITHOUT INTERCONDYLAR EXTNSION; WITH MANIPULATION, WITH OR WITHOUT SKIN OR SKETLETAL TRACTION	$4,001.40
24665	OPEN TREATMENT RADIAL HEAD OR NECK FRACTURE, WITH OR WITHOUT INTERNAL FIXATION OR RADIAL HEAD EXCISION	$4,001.40
24666	OPEN TREATMENT RADIAL HEAD OR NECK FRACTURE, WITH OR WITHOUT INTERNAL FIXATION OR RADIAL HEAD EXCISION; WITH RADIAL HEAL PROSTHETIC REPLACEMENT	$4,001.40
24685	OPEN TREATMENT OF ULNAR FRACTURE PROXIMAL END (OLECRANON PROCESS), WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION	$4,001.40
24800	ARTHRODESIS ELBOW JOINT; LOCAL	$4,086.90
24802	ARTHRDSIS ELB JOINT; W/AUTOGEN GFT	$4,086.90
24925	AMP ARM THRU HUM; SEC CLOS/SCAR REV	$2,302.64
24935	STUMP ELONGATION UPPER EXTREMITY	$4,966.12
25000	INCISION EXT TENDON SHEATH WRIST	$2,302.64
25001	INCISION FLEXOR TENDON SHEATH WRIST	$2,302.64
25020	DECOMP FASC FORARM FLX/EXT NO DEBRD	$2,302.64
25023	DECOMP FASC FORARM FLX/EXT W/DEBRID	$2,803.58
25024	DECOMP FASC FORARM FLX&EXT NO DEBRD	$2,803.58
25025	DECOMP FASC FORARM FLX&EXT W/DEBRID	$2,803.58
25028	I&D FOREARM &OR WRST; DP ABSC/HEMAT	$2,302.64
25031	I&D FOREARM AND/OR WRIST; BURSA	$2,302.64
25035	INCI DP BN CORTX FORARM &OR WRST	$2,302.64
25040	ARTHROT RADIO/MIDCARPAL W/EXPL/DRN	$2,803.58
25085	CAPSULOTOMY WRIST	$2,302.64
25100	ARTHROTOMY WRIST JOINT; WITH BIOPSY	$2,302.64
25101	ARTHROT WRIST JNT; W/EXPL W/WO BX	$2,803.58
25105	ARTHROT WRIST JOINT; W/SYNOVECTOMY	$2,803.58
25107	ARTHROT DIST RADIOULNAR JNT REPR CA	$2,803.58
25110	EXC LES TEND SHEATH FORARM &/ WRST	$2,302.64
25111	EXCISION OF GANGLION WRIST; PRIMARY	$1,767.58
25112	EXCISION GANGLION WRIST; RECURRENT	$1,890.00
25115	RADL EXC BURSA WRIST TENDON; FLEXOR	$2,302.64
25116	RADL EXC BURSA WRIST TEND; EXTENSOR	$2,302.64
25118	SYNOVECTOMY EXTENSOR TEND WRIST 1	$2,803.58
25119	SYNOVECT EXT WRIST 1; RES DIST ULNA	$2,803.58
25145	SEQUESTRECTOMY FOREARM AND/OR WRIST	$2,803.58
25150	PARTIAL EXCISION OF BONE; ULNA	$2,803.58
25151	PARTIAL EXCISION OF BONE; RADIUS	$2,803.58

25210	CARPECTOMY; ONE BONE	$2,834.68
25215	CARPECTOMY; ALL BONES PROXIMAL ROW	$2,834.68
25230	RADIAL STYLOIDECTOMY	$2,803.58
25240	EXCISION DIST ULNA PARTIAL/COMPLETE	$2,803.58
25248	EXPL W/REMOVAL DEEP FB FOREARM/WRST	$2,302.64
25250	REMOVAL OF WRIST PROSTHESIS;	$2,803.58
25251	REMV WRST PROSTH; COMP W/TOT WRST	$2,803.58
25260	REPR TEND/MUSC FLX WRIST; PRIM 1 EA	$2,803.58
25263	REPR TEND/MUSC FLX WRIST; 2ND 1 EA	$2,803.58
25265	REPR TEND/MUSC FLX WRIST; 2ND W/GFT	$2,803.58
25270	REPR TEND/MUSC EXT WRIST; PRIM 1 EA	$2,803.58
25272	REPR TEND/MUSC EXT WRIST; 2ND 1 EA	$2,803.58
25274	REP TEND/MUSC EXT FORARM; SEC W/GFT	$2,803.58
25275	REP TEND EXT FORARM&/WRST FREE GFT	$2,803.58
25280	LEN/SHRT TEND FOREARM&/WRIST 1 EA	$2,803.58
25290	TENOT OPEN FLX/EXT FOREARM&/WRIST 1	$2,803.58
25295	TENOLYSIS FLEX/EXT FOREARM&/WRIST 1	$2,302.64
25300	TENODESIS WRIST; FLEXORS OF FINGERS	$2,803.58
25301	TENODESIS WRIST; EXTENSORS FINGERS	$2,803.58
25310	TEND TPLNT/TRNSF FOREARM&/WRIST 1;	$4,086.90
25312	TEND TPLNT/TRNSF FORARM&/WRST;W/GFT	$4,086.90
25315	FLEX ORIGIN SLIDE FOREARM &OR WRST;	$4,086.90
25316	FLX SLIDE FORARM&/WRST;W/TEND TRNSF	$4,086.90
25320	CPSLORR/RECNSTR WRST OPN CARPAL	$4,086.90
25332	ARTHROPLASTY WRIST W/WO INTERPSTN	$3,538.56
25335	CENTRALIZATION OF WRIST ON ULNA	$4,086.90
25337	RECON DIST ULNA/RADIOULNAR 2ND	$4,086.90
25350	OSTEOTOMY RADIUS; DISTAL THIRD	$4,086.90
25355	OSTEOT RADIUS; MID/PROXIMAL THIRD	$4,086.90
25360	OSTEOTOMY; ULNA	$2,803.58
25365	OSTEOTOMY; RADIUS AND ULNA	$2,803.58
25370	MX OSTEOTOMIES; RADIUS/ULNA	$4,086.90
25375	MX OSTEOTOMIES; RADIUS & ULNA	$4,086.90
25390	OSTEOPLASTY RADIUS/ULNA; SHORTENING	$2,803.58
25391	OSTEPLSTY RADUS/ULNA; LEN W/AUTOGFT	$4,086.90
25392	OSTEOPLASTY RADIUS&ULNA; SHORTENING	$2,803.58
25393	OSTEPLSTY RADUS&ULNA; LEN W/AUTOGFT	$4,086.90
25394	OSTEOPLASTY CARPAL BONE SHORTENING	$1,767.58
25400	REPR NON/MALUNION RAD/ULNA; W/O GFT	$2,803.58
25405	REP NON/MALUNION RADUS/ULNA; W/GFT	$2,803.58

25415	REPR NON/MALUNION RAD&ULNA; W/O GFT	$2,803.58
25420	REP NON/MALUNION RADUS&ULNA; W/GFT	$4,086.90
25425	REPR DEFECT W/AUTOGFT; RADIUS/ULNA	$4,086.90
25426	REPR DEFECT W/AUTOGFT; RADIUS&ULNA	$4,086.90
25430	INSRTION VASC PEDICLE IN CARPAL BN	$2,834.68
25431	REPAIR NONUNION CARPAL BONE EA BONE	$2,834.68
25440	REP NONUNION SCAPHOID CARPAL BN	$4,086.90
25441	ARTHPLSTY W/PROSTH REPL; DIST RADUS	$3,538.56
25442	ARTHROPLSTY W/PROSTH REPL DIST ULNA	$3,538.56
25443	ARTHPLSTY W/REPL; SCAPHOID CARPAL	$3,538.56
25444	ARTHROPLASTY W/PROSTH REPL; LUNATE	$3,298.30
25445	ARTHPLSTY W/PROSTH REPL TRAPEZIUM	$3,298.30
25446	ARTHPLSTY W/PROSTH REPL; TOT WRIST	$3,538.56
25447	ARTHPLSTY INTERPSTN INTERCARPAL/CMC	$3,538.56
25449	REV ARTHROPLSTY REMV IMPL WRIST JNT	$3,538.56
25450	EPIPHYSEAL ARREST; DIST RADIUS/ULNA	$4,086.90
25455	EPIPHYSEAL ARREST; DIST RADIUS&ULNA	$4,086.90
25525	TREAT FRACTURE OF RADIUS	$4,001.40
25526	OPEN TREATMENT OF RADIAL SHAFT FRACTURE, WITH INTERNAL AND/OR EXTERNAL FIXATION AND OPEN TREATMENT , WITH OR WITHOUT INTERNAL FIXATION OF DITAL RADIOULNAR JOINT (GALEAZZI FRACTURE/DISLOCATION), INCLUDES REPAIR FO TRIANGULAR FIRBROCARTILAGE COMPLEX	$4,001.40
25545	OPEN TREATMENT OF ULNAR SHAFT FRACTURES; WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION	$4,001.40
25575	OPEN TREATMENT OF RADIAL AND ULNAR SHAFT FRACTURE , WITH INTERNAL OR EXTERNAL FIXATION OF RADIUS AND ULNA	$4,001.40
25611	PERCUTANEOUS SKELETAL FIXATION OF DISTAL RADIAL FRACTURE (EG, COLLES OR SMITH TYPE) OR EPIPHYSEAL SEPARATION, WITH OR WITHOUT FRACTURE OF ULNAR STYOLID, REQUIRING MANIPULATION, WITH OR WITHOUT EXTERNAL FIXATION	$4,001.40
25620	TREAT FRACTURE RADIUS/ULNA	$4,001.40
25695	OPEN TREATMENT LUNATE DISLOCATION	$4,001.40
25800	ARTHRDSIS WRST; CMPL W/O BN GRAFT	$4,086.90
25805	ARTHRODESIS WRIST; W/SLIDING GRAFT	$4,086.90
25810	ARTHRDSIS WRST; W/ILIAC/OTH AUTOGFT	$4,086.90
25820	ARTHRDSIS WRST; LTD W/O BONE GRAFT	$1,890.00
25825	ARTHRODESIS WRIST; WITH AUTOGRAFT	$2,834.68
25830	ARTHRDSIS DIST RADIOULNA RES ULNA	$4,086.90

26037	DECOMPRESSIVE FASCIOTOMY HAND	$1,767.58
26040	FASCIOTOMY PALMAR; PERCUTANEOUS	$2,834.68
26045	FASCIOTOMY PALMAR; OPEN PARTIAL	$2,834.68
26055	TENDON SHEATH INCISION	$1,767.58
26060	TENOTOMY PERCUT SINGLE EA DIGIT	$1,767.58
26070	ARTHROT W/EXPL DRN/REMV FB; CMC JNT	$1,767.58
26075	ARTHROT W/EXPL DRN/REMV FB; MCP JNT	$1,890.00
26080	ARTHROT W/EXPL DRN/REMV FB; IP JNT	$1,890.00
26100	ARTHROT W/BX; CMC JOINT EA	$1,767.58
26105	ARTHROT W/BX; MCP JOINT EA	$1,767.58
26110	ARTHROT W/BX; IP JOINT EA	$1,767.58
26115	EXC TMR/MALF SFT TISS HND/FNGR SUBQ	$2,207.52
26116	EXC TMR/MALF SFT TISS HND/FNGR DEEP	$2,207.52
26117	RADL RES TUMR SOFT TISSUE HND/FNGR	$2,207.52
26121	FASCECT PALM W/WO Z-PLASTY/GFT	$2,834.68
26123	FASCECT PART PALMAR W/REL 1 DIGIT;	$2,834.68
26125	FASCECT PART PALMAR W/REL; EA ADD	$2,834.68
26130	SYNOVECTOMY CARPOMETACARPAL JOINT	$1,767.58
26135	SYNOVECT MCP JNT REL&RECON EA DIGIT	$2,834.68
26140	SYNOVECT PROX IP JNT W/EXT RECON EA	$1,767.58
26145	SYNOVECT FLEX TEND PALM&/FINGR EA	$1,767.58
26160	EXC LES TEND SHETH/JNT CAP HND/FNGR	$1,767.58
26170	EXCISION TENDON PALM FLEX SINGLE EA	$1,767.58
26180	EXC TENDON FINGER FLEX EA TENDON	$1,767.58
26185	SESAMOIDECTOMY THUMB OR FINGER	$1,890.00
26230	PARTIAL EXCISION BONE; METACARPAL	$2,985.00
26235	PART EXC BN; PROX/MID PHALNX FINGER	$1,767.58
26236	PART EXC BN; DIST PHALNX FINGER	$1,767.58
26250	RADICAL RESECTION METACARPAL;	$1,767.58
26255	RADICAL RESECTION MC; W/AUTOGRAFT	$2,834.68
26260	RADL RES PROX/MID PHALNX FNGR;	$1,767.58
26261	RADL RES PROX/MID FINGER; W/AUTOGFT	$1,767.58
26262	RADL RESECTION DIST PHALNX FINGER	$1,767.58
26320	REMOVAL IMPLANT FROM FINGER OR HAND	$1,696.64
26350	REP FLX TEND NOT ZONE 2 DIGT NO GFT	$2,834.68
26352	REP FLX TEND NO ZONE 2 DIGT SEC GFT	$2,834.68
26356	REP FLX TEND ZONE 2 DIGTL; W/O GFT	$2,834.68
26357	REP FLX TEND ZONE 2 DIGT SEC NO GFT	$2,834.68
26358	REP FLX TEND ZONE 2 DIGTL SEC W/GFT	$2,834.68
26370	REPR PROFUNDUS TENDON; PRIM EA TEND	$2,834.68

26372	REPR PROFUND TEND; SEC FREE GFT EA	$2,834.68
26373	REPR PROFUND TEND; SEC W/O GFT EA	$2,834.68
26390	EXC FLX TEND IMPL ROD GFT HND/FNGR	$2,834.68
26392	REMV ROD&INSRT FLX TND GFT HND/FNGR	$2,834.68
26410	REPR EXT TEND HAND PRIM/SEC; WO GFT	$1,767.58
26412	REPR EXT TEND HAND PRIM/SEC; W/GFT	$2,834.68
26415	EXC EXT TEND IMPL ROD GFT HND/FNGR	$2,834.68
26416	REMV ROD&INSRT EXT TND GFT HND/FNGR	$2,834.68
26418	REPR EXT TEND FNGR PRIM/SEC W/O GFT	$1,890.00
26420	REPR EXT TEND FNGR PRIM/SEC; W/GFT	$2,834.68
26426	REP EXT TEND CNTRL SLP SEC LOC TISS	$2,834.68
26428	REP EXT TEND CNTRL SLP SEC FREE GFT	$2,834.68
26433	REPR EXT TEND DIST INSRT; W/O GFT	$1,767.58
26434	REPR EXT TEND DIST INSRT; W/GFT	$2,834.68
26437	REALIGNMENT EXT TEND HND EA TEND	$1,767.58
26440	TENOLYS FLX TEND; PALM/FNGR EA TEND	$1,767.58
26442	TENOLYSIS FLEX; PALM&FINGER EA TEND	$2,834.68
26445	TENOLYSIS EXT TEND HND/FNGR EA TEND	$1,767.58
26449	TENOLYSIS CMPLX EXT FINGER FOREARM	$2,834.68
26450	TENOTOMY FLEXOR PALM OPEN EA TENDON	$1,767.58
26455	TENOTOMY FLEX FINGER OPEN EA TENDON	$1,767.58
26460	TENOT EXT HAND/FINGER OPN EA TENDON	$1,767.58
26471	TENODESIS; PROX IP JOINT EA JOINT	$1,767.58
26474	TENODESIS; DISTAL JOINT EACH JOINT	$1,767.58
26476	LEN TENDON EXT HAND/FNGR EA TENDON	$1,767.58
26477	SHRT TENDON EXT HAND/FNGR EA TENDON	$1,767.58
26478	LEN TENDON FLEX HAND/FNGR EA TENDON	$1,767.58
26479	SHRT TENDON FLX HAND/FNGR EA TENDON	$1,767.58
26480	TRNSF/TPLNT TEND DORSUM HND; WO GFT	$2,834.68
26483	TRNSF/TPLNT TEND DORSUM HND; W/GFT	$2,834.68
26485	TRNSF/TPLNT TEND PALMAR; WO GFT EA	$2,834.68
26489	TRNSF/TPLNT TEND PALMAR; W/GFT EA	$2,834.68
26490	OPPONENSPLASTY; SUPERFICIALIS TRNSF	$2,834.68
26492	OPPONENSPLASTY; TEND TRNSF GFT EA	$2,834.68
26494	OPPONENSPLSTY;HYPOTHENAR MUSC TRNSF	$2,834.68
26496	OPPONENSPLASTY; OTHER METHODS	$2,834.68
26497	TRNSF TEND TO RESTORE; RING&SM FNGR	$2,834.68
26498	TRNSF TEND TO RESTORE; ALL 4 FNGR	$2,834.68
26499	CORRECTION CLAW FINGER OTH METHODS	$2,834.68
26500	RECON TEND PULLEY EA; LOC-SEP PROC	$1,890.00

26502	RECON TEND PULLEY EA; GFT-SEP PROC	$2,834.68
26504	RECON TEND PULLY EA;PROSTH-SEP PROC	$2,834.68
26508	RELEASE OF THENAR MUSCLE	$1,767.58
26510	CROSS INTRINSIC TRANSFER EA TENDON	$2,834.68
26516	CAPSLDSIS MCP JOINT; SINGLE DIGIT	$2,834.68
26517	CAPSLDSIS MCP JOINT; 2 DIGITS	$2,834.68
26518	CAPSLDSIS MCP JOINT; 3/4 DIGITS	$2,834.68
26520	CAPCTOMY/CAPSULOT; MCP JNT EA JNT	$1,767.58
26525	CAPCTOMY/CAPSULOT; IP JNT EA JNT	$1,767.58
26530	ARTHPLSTY MCP JOINT; EA JOINT	$3,538.56
26531	ARTHROPLASTY MCP JNT; PROSTH EA JNT	$3,298.30
26535	ARTHPLSTY IP JOINT; EA JOINT	$3,538.56
26536	ARTHROPLASTY IP JNT; PROSTH EA JNT	$3,298.30
26540	REPAIR COLLAT LIGAMENT MCP/IP JOINT	$1,890.00
26541	RECON COLLAT LIG MCP JNT 1; W/GFT	$2,985.00
26542	RECON LIG MCP JNT 1; W/LOC TISS	$1,890.00
26545	RECON LIG IP JNT 1 INCL GFT EA JNT	$2,834.68
26546	REPAIR NON-UNION METACARPAL/PHALANX	$2,834.68
26548	REPR&RECNSTR FNGR VOLAR PLAT IP JNT	$2,834.68
26550	POLLICIZATION OF A DIGIT	$2,834.68
26555	TRNSF FINGER OTH PSTN W/O ANASTOM	$2,834.68
26560	REPR SYNDACTYLY EA WEB; W/SKIN FLAP	$1,767.58
26561	REPR SYNDACTYLY EA; W/SKIN FLPS&GFT	$2,834.68
26562	REPR SYNDACTYLY EA WEB SPACE; CMPLX	$2,834.68
26565	OSTEOTOMY; METACARPAL EACH	$2,834.68
26567	OSTEOTOMY; PHALANX OF FINGER EACH	$2,834.68
26568	OSTEOPLASTY LEN METACARPAL/PHALANX	$2,834.68
26580	REPAIR CLEFT HAND	$2,834.68
26587	RECON POLYDACTYLUS DIGT SFT TISS&BN	$2,151.00
26590	REPAIR MACRODACTYLIA EACH DIGIT	$2,834.68
26591	REPAIR INTRIN MUSC HAND EA MUSCLE	$2,834.68
26593	RELEASE INTRIN MUSC HAND EA MUSCLE	$1,767.58
26596	EXC CONSTRICT RING FNGR W/Z-PLSTIES	$2,834.68
26735	OPEN TREATMENT OF PHALANGEAL SHAFT FRACTURE, PROXIMAL OR MIDDLE PHALANX, FINGER OR THUMB, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, EACH	$4,001.40
26756	PERCUTANEOUS SKELETAL FIXATION OF DISTAL PHALANGEAL FRACTURE, FINGER OR THUMB, EACH	$4,001.40
26765	TREAT FINGER FRACTURE, EACH	$4,001.40
26841	ARTHRODESIS CMC JNT THUMB W/WO FIX	$2,834.68

26842	ARTHRODESIS CMC JNT THUMB;W/AUTOGFT	$2,834.68
26843	ARTHRDSIS CMC JOINT DIGIT EACH;	$2,834.68
26844	ARTHRDSIS CMC JNT DIGT EA;W/AUTOGFT	$2,834.68
26850	ARTHRDSIS MCP JOINT W/WO INTRL FIX;	$2,834.68
26852	ARTHRDSIS MCP JNT W/WO FIX;W/AUTOGF	$2,834.68
26860	ARTHRDSIS IP JOINT W/WO INTRL FIX;	$2,834.68
26861	ARTHRODESIS IP JNT W/WO FIX; EA ADD	$2,834.68
26862	ARTHRODESIS IP JNT W/WO FIXW/AUTOGF	$2,834.68
26863	ARTHRDSIS IP JNT; W/AUTOGFT EA ADD	$2,834.68
26910	AMP MC 1 W/WO INTEROSSEOUS TRNSF	$2,834.68
26951	AMP FNGR/THUMB ANY JNT; W/DIR CLOS	$1,767.58
26952	AMP FNGR/THUMB ANY JNT; W/ADV FLAP	$1,890.00
27096	INJECTION PROCEDURE FOR SI JOINT, ARTHROGRAPHY AND/OR ANESTHETIC/STEROID	$999.00
27275	MANIPULATION , HIP JOINT, REQUIRING GENERAL ANESTHESIA	$809.68
27330	ARTHROT KNEE; W/SYNOVIAL BX ONLY	$2,803.58
27331	ARTHROT KNEE; JNT EXPL BX/REMV FB	$2,803.58
27332	ARTHROT EXC SEMILUNAR KNEE; MED/LAT	$2,803.58
27333	ARTHROT EXC SEMILUNAR KNEE; MED&LAT	$2,803.58
27334	ARTHROT W/SYNOVECT KNEE; ANT/POST	$2,803.58
27335	ARTHROT-SYNOVECT KNEE; ANT-POST-POP	$2,803.58
27340	EXCISION PREPATELLAR BURSA	$2,302.64
27345	EXCISION SYNOVIAL CYST POP SPACE	$2,302.64
27347	EXCISION LESION MENISCUS/CAP KNEE	$2,302.64
27350	PATELLECTOMY OR HEMIPATELLECTOMY	$2,803.58
27360	PART EXC BN FEM PROX TIB &/ FIB	$2,803.58
27372	REMOVAL FB DP THI REGION/KNEE AREA	$2,985.00
27380	SUTURE INFRAPATR TENDON; PRIMARY	$2,302.64
27381	SUT INFRAPATELLAR TEND; SEC RECON	$2,302.64
27403	ARTHROTOMY W/MENISCUS REPAIR KNEE	$2,803.58
27405	REPR PRIM TORN LIG&/CAP KNEE;COLLAT	$4,086.90
27407	REPR PRIM TORN LIG KNEE; CRUCIATE	$4,086.90
27409	REPR TORN LIG KNEE; COLLAT&CRUCIATE	$4,086.90
27412	AUTOL CHONDROCYTE IMPLANTATION KNEE	$4,966.66
27415	OSTEOCHONDRAL ALLOGRAFT KNEE OPEN	$4,966.66
27418	ANTERIOR TIBIAL TUBERCLEPLASTY	$4,086.90
27420	RECONSTRUCTION DISLOCATING PATELLA;	$4,086.90
27422	RECON DISLOC PATELLA; EXT REALIGN	$4,086.90
27424	RECNSTR DISLOC PAT; W/PATELLECTOMY	$4,086.90
27425	LATERAL RETINACULAR RELEASE OPEN	$2,985.00

27427	LIG RECONSTRUCT KNEE; EXTRA-ARTICLR	$4,966.12
27428	LIG RECONSTRUCT KNEE; INTRA-ARTICLR	$4,966.12
27429	LIG RECON KNEE; INTRA/EXTRA-ARTICLR	$4,966.12
27430	QUADRICEPSPLASTY	$4,086.90
27435	CAPSULOT POST CAPSULAR RELEASE KNEE	$4,086.90
27437	ARTHPLSTY PAT; WITHOUT PROSTHESIS	$3,538.56
27438	ARTHROPLASTY PATELLA; W/PROSTHESIS	$3,298.30
27440	ARTHROPLASTY KNEE TIBIAL PLATEAU;	$3,538.56
27441	ARTHROPLASTY TIB; W/DEBRID&SYNOVECT	$3,538.56
27442	ARTHROPLASTY FEM CONDYLE/TIB KNEE;	$3,538.56
27443	ARTHPLSTY FEM CONDYLE KNEE; DEBRID	$3,538.56
27446	ARTHROPLASTY KNEE CONDYLE; MED/LAT	$3,733.50
27447	TOTAL KNEE ARTHROPLASTY	$3,733.50
27524	OPEN TREATMENT OF PATELLAR FRACTURE, WITH INTERNAL FIXATION AND/OR PARTIAL OR COMPLETE PATELLECTOMY AND SOFT TISSUE REPAIR	$4,001.40
27570	MANIP KNEE JNT UNDER GEN ANESTHESIA	$1,619.36
27603	I&D LEG/ANKLE; DEEP ABSC/HEMATOMA	$1,418.84
27604	I&D LEG OR ANKLE; INFECTED BURSA	$2,302.64
27612	ARTHROT POST CAPSULAR RELASE ANK	$2,803.58
27620	ARTHROTOMY ANK W/JNT EXPL W/WO BX	$2,803.58
27625	ARTHROTOMY WITH SYNOVECTOMY ANKLE;	$2,803.58
27626	ARTHROT W/SYNOVECT ANK;TENOSYNOVECT	$2,803.58
27630	EXC LES TEND SHEATH/CAP LEG &/ ANK	$2,302.64
27640	PARTIAL EXCISION BONE; TIBIA	$4,086.90
27641	PARTIAL EXCISION BONE; FIBULA	$2,803.58
27647	RADL RES TUMR BN; TALUS/CALCAN	$4,086.90
27650	REPR PRIM OPN/PERQ RUP ACHILLES	$4,086.90
27652	REPR PRIM OP EN RUP ACHILLES; W/GFT	$4,086.90
27654	REPR SEC ACHILLES TENDON W/WO GRAFT	$4,086.90
27656	REPAIR FASCIAL DEFECT OF LEG	$2,302.64
27658	REPR FLEX TEND LEG; PRIM W/O GFT EA	$2,302.64
27659	REPR FLEX TEND LEG; SEC EA TENDON	$2,302.64
27664	REPR EXT TEND LEG; PRIM WO GFT EA	$2,302.64
27665	REPR EXT TEND LEG; SEC EA TEND	$2,803.58
27675	REPR DISLOC PERONEAL TEND, WO OSTEOT	$2,302.64
27676	REPR DISLOC PERONEAL TEND; W/OSTEOT	$2,803.58
27680	TENOLYSIS FLEX/EXT LEG&/ANK, 1 EA	$2,803.58
27681	TENOLYSIS FLEX/EXT LEG&/ANK, MX TEND	$2,803.58
27685	LEN/SHRT TEND LEG/ANK; 1 SEP PROC	$2,803.58

27686	LEN/SHRT TENDON LEG/ANK; MX TEND EA	$2,803.58
27687	GASTROCNEMIUS RECESSION	$2,803.58
27690	TRANSFER/TRANSPLANT 1 TENDON; SUP	$4,086.90
27691	TRANSFER/TRANSPLANT 1 TENDON; DEEP	$4,086.90
27692	TRNSF/TPLNT 1 TEND; EA ADD TEND	$4,086.90
27695	REPR PRIM DISRUPTED LIG ANK; COLLAT	$2,803.58
27696	REPR PRIM DISRUPTED LIG ANK; BOTH	$2,803.58
27698	REPR SEC DISRUPTED LIG ANK COLLAT	$2,803.58
27700	ARTHROPLASTY ANKLE;	$3,538.56
27704	REMOVAL OF ANKLE IMPLANT	$2,302.64
27756	PERCUTANEOUS SKELETAL FIXATION OF TIBIAL SHAFT FRACTURE (WITH OR WITHOUT FIBULAR FRACTURE) (EG PINS OR SCREWS)	$4,001.40
27758	OPEN TREATMENT OF TIBIAL SHAFT FRACTURE, (W OR W/O FIBULAR FRACTURE) (EG, PINS OR SCREWS)	$4,001.40
27759	TREATMETN OF TIBIAL SHAFT FRACURE (W OR W/O FIBULAR FRACTURE) BUY INTRAMEDULLARY IMPLANT, WITH OR WITHOUT INTERLOCKING SCREWS AND/OR CERCLAGE	$4,001.40
27766	OPEN TREATMENT OF MEDICAL MALLEOLUS FRACTURE , WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION	$4,001.40
27784	OPEN TREATMENT OF PROXIMAL FIBULA OR SHAFT FRACTURE, W OR W/O INTERNAL OR EXTERNAL FIXATION	$4,001.40
27792	OPEN TREATMENT OF DISTAL FIBULAR FRACTURE (LATERAL MALLEOLUS); WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION.	$4,001.40
27814	OPEN TREATMENT OF BIMALLEOLAR ANKLE FRACTURE , WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION	$4,001.40
27822	OPEN TREATMENT OF TRIMALLEOLAR ANKLE FRACTURE, W OR W/O INTERNAL OR EXTERNAL FIXATION, MEDIAL AND/OR LATERAL MALLEOLUS; WO FIXATION OF POSTERIOR LIP	$4,001.40
27823	OPEN TREATMENT OF TRIMALLEOLAR ANKLE FRACTURE, W OR W/O INTERNAL OR EXTERNAL FIXATION, MEDIAL AND/OR LATERAL MALLEOLUS; W FIXATION OF POSTERIOR LIP	$4,001.40
27829	OPEN TREATMENT OF DISTAL TIBIOFIULAR JOINT (SYNDESMOIS DISRUPTIONM W OR W/O INTERNALOR EXTERNAL FIXATION	$4,001.40
27842	CLOSED TREATMNET OF ANKLE DILCATION, WITH OR WITHOUT PERCUTANEOUS SKELETAL FIXATION; REQUIRING ANESTHESIA, WITH OR WITHOUT PERCUANEOUS SKELTAL FIXATION.	$1,619.36

27860	MANIPULATION OF ANKLE UNDER GENERAL ANESTHESIA (INCLUDES APPLICATION OF TRACTION OR OTHER FIXATION APPARATUS)	$1,619.36
27870	ARTHRODESIS, ANKLE OPEN	$4,086.90
27871	ARTHRODESIS IBIOFIBULAR JOINT, PROXIMAL OR DISTAL	$4,086.90
28005	INCISION BONE CORTEX FOOT	$2,204.60
28008	FASCIOTOMY FOOT AND/OR TOE	$2,204.60
28010	TENOTOMY PERCUT TOE; SINGLE TENDON	$2,204.60
28011	TENOTOMY PERCUT TOE; MX TENDONS	$2,204.60
28020	ARTHROT EXPL/DRN; INTERTARSAL JNT	$2,204.60
28022	ARTHROT EXPL DRN/REMV FB; MTP JNT	$2,204.60
28024	ARTHROT EXPL DRN/REMV FB; IP JNT	$2,204.60
28030	NEURECTOMY INTRIN MUSCULATURE FOOT	$1,971.20
28035	RELEASE TARSAL TUNNEL	$1,971.20
28043	EXCISION TUMOR FOOT; SUBCUT TISSUE	$1,696.64
28045	EXCISION TUMR FOOT; DP SUBFASCL IM	$2,204.60
28046	RADL RES TUMR SOFT TISSUE FOOT	$2,204.60
28050	ARTHROT W/BX; INTERTARSAL/TMT JNT	$2,204.60
28052	ARTHROT W/BX; METATARSOPHALANG JNT	$2,204.60
28054	ARTHROT W/BX; INTERPHALANGEAL JOINT	$2,204.60
28060	FASCIECTOMY PLANTAR FASCIA; PARTIAL	$3,029.36
28062	FASCIECTOMY PLANTAR FASCIA; RADICAL	$3,029.36
28070	SYNOVECTOMY; INTERTARSAL/TMT JNT EA	$3,029.36
28072	SYNOVECT; METATARSOPHALANG JOINT EA	$3,029.36
28080	EXC INTERDIGTL NEUROMA SINGLE EA	$2,204.60
28086	SYNOVECT TENDON SHEATH FOOT; FLEX	$2,204.60
28088	SYNOVECTOMY TENDON SHEATH FOOT; EXT	$2,204.60
28090	EXC LES TEND TEND SHEATH/CAP; FOOT	$2,204.60
28092	EXC LES TEND SHEATH/CAPSULE; TOE EA	$2,204.60
28108	EXC BONE CYST/TUMR PHALANGES FOOT	$2,204.60
28110	OSTEC PARTIAL EXCISION 1/5 MT HEAD	$3,029.36
28111	OSTEC COMPLETE EXCISION; 1 MT HEAD	$2,204.60
28112	OSTEC CMPL EXCISION; OTH MT HEAD	$2,204.60
28113	OSTEC CMPL EXCISION; 1/5 MT HEAD	$2,204.60
28114	OSTEC CMPL; ALL MT HEADS EXCLD 1ST	$2,204.60
28116	OSTECTOMY EXCISION TARSAL COALITION	$2,204.60
28118	OSTECTOMY CALCANEUS;	$2,204.60
28119	OSTEC CALCAN; SPUR W/WO PLANTAR REL	$2,204.60
28120	PARTIAL EXCISION BONE; TALUS/CALCAN	$2,985.00
28122	PART EXC BONE; TARSAL/MT EX TALUS	$2,204.60

28124	PARTIAL EXCISION BONE; PHALANX TOE	$2,204.60
28126	RES PART/CMPL PHALANG BASE EA TOE	$2,204.60
28130	TALECTOMY	$2,204.60
28140	METATARSECTOMY	$2,204.60
28150	PHALANGECTOMY TOE EACH TOE	$2,204.60
28153	RES CONDYLE DIST END PHALNX EA TOE	$2,204.60
28160	HEMIPHALANGECT/TOE PROX PHALANX EA	$2,204.60
28171	RADL RESECTION TUMOR BONE; TARSAL	$2,204.60
28173	RADICAL RESECTION TUMOR BONE; MT	$2,204.60
28175	RADL RESECTION TUMR BN; PHALNX TOE	$2,204.60
28192	REMOVAL OF FOREIGN BODY FOOT; DEEP	$1,696.64
28193	REMOVAL FOREIGN BODY FOOT; COMP	$1,890.00
28200	REPR TEND FLEX FOOT; PRIM/SEC EA	$2,204.60
28202	REPR TENDON FLEX FOOT; SEC W/GFT EA	$3,029.36
28208	REPR TEND EXT FOOT;PRIM/SEC EA TEND	$2,204.60
28210	REPR TEND EXT FOOT; SEC W/GRAFT EA	$3,029.36
28220	TENOLYSIS FLEX FOOT; SINGLE TENDON	$2,204.60
28222	TENOLYSIS FLEX FOOT; MX TENDONS	$2,204.60
28225	TENOLYSIS EXT FOOT; SINGLE TENDON	$2,204.60
28226	TENOLYSIS EXT FOOT; MX TENDONS	$2,204.60
28230	TENOT OPN TEND FLX; FT 1/MX TEND	$2,204.60
28232	TENOT OPN TENDON FLX; TOE 1 TENDON	$2,204.60
28234	TENOT OPEN EXT FOOT/TOE EA TENDON	$2,204.60
28238	RECON POST TIBL TEND W/EXC TARSL BN	$3,029.36
28240	TENOT LEN/RLSE ABDUCT HALLUCIS MUSC	$2,204.60
28250	DIVISION OF PLANTAR FASCIA&MUSCLE	$3,029.36
28260	CAPSULOT MIDFOOT; MED RELEASE ONLY	$3,029.36
28261	CAPSULOT MIDFOOT; W/TENDON LEN	$3,029.36
28262	CAPSULOT MIDFOOT; EXT TALOTIB LEN	$3,029.36
28264	CAPSULOTOMY MIDTARSAL	$3,029.36
28270	CAPSULOT; MTP JNT EA JT SEP PROC	$2,204.60
28272	CAPSULOT; IP JNT EA JNT SEP PROC	$2,204.60
28280	SYNDACTYLIZATION TOES	$2,204.60
28285	CORRECTION HAMMERTOE	$2,204.60
28286	CORRECT COCK-UP 5TH TOE PLSTC CLOS	$2,204.60
28288	OSTEC PART EXOSTECT MT HEAD EA	$3,029.36
28289	HALLUX RIGIDIS CORR W/CHEILECT MTP	$3,029.36
28290	HALLUX VALGUS; SIMPL EXOSTECTOMY	$3,029.36
28292	HALLUX VALGUS; KELLER/MAYO TYPE	$3,077.42
28293	HALLUX VALGUS; RES JOINT W/IMPLANT	$3,077.42

28294	HALLUX VALGUS; W/TENDON TRANSPLANT	$3,029.36
28296	HALLUX VALGUS; W/METATARSAL OSTEOT	$3,029.36
28297	HALLUX VALGUS; LAPIDUS TYPE PROC	$3,077.42
28298	HALLUX VALGUS; PHALANX OSTEOTOMY	$3,029.36
28299	CORR HALLUX VALGUS; DBL OSTEOT	$3,077.42
28300	OSTEOTOMY; CALCAN W/WO INTERNAL FIX	$3,029.36
28302	OSTEOTOMY; TALUS	$3,029.36
28304	OSTEOT TARSAL BNS NOT CALCAN/TALUS;	$3,029.36
28305	OSTEOT TARSAL BONES; W/AUTOGFT	$3,029.36
28306	OSTEOT METATARSAL; 1ST METATARSAL	$3,029.36
28307	OSTEOT METATARSAL; 1ST MT W/AUTOGFT	$3,029.36
28308	OSTEOTOMY METATARSAL; NOT 1ST MT EA	$3,029.36
28309	OSTEOTOMY METATARSAL; MULTIPLE	$3,029.36
28310	OSTEOT;PROX PHALNX 1ST TOE SEP PROC	$2,204.60
28312	OSTEOTOMY;OTH PHALANGES ANY TOE	$2,204.60
28313	RECON ANGULAR DEFORM TOE SOFT TISS	$2,204.60
28315	SESAMOIDECTOMY FIRST TOE	$2,204.60
28320	REPR NONUNION/MALUNION; TARSAL BNS	$3,029.36
28322	REP NON/MALUNION; MT W/WO BN GFT	$3,029.36
28340	RECON TOE MACRODACTYLY; TISS RES	$2,204.60
28341	RECON TOE MACRODACTYLY; REQ BN RES	$2,204.60
28344	RECONSTRUCTION TOE; POLYDACTYLY	$3,029.36
28345	RECON TOE; SYNDACTYLY W/WO GFT EA	$3,029.36
28415	OPN TX CALCAN FX W/WO INTRL/EXT FIX	$4,001.40
28615	OPEN TX TARSOMT JNT DISLOC W/WO FIX	$4,001.40
28705	ARTHRODESIS; PANTALAR	$3,029.36
28715	ARTHRODESIS; TRIPLE	$3,029.36
28725	ARTHRODESIS; SUBTALAR	$3,029.36
28730	ARTHRDSIS MIDTARSAL/TARSOMT MX/TRNS	$3,029.36
28735	ARTHRDSIS MIDTARSAL MX; W/OSTEOT	$3,029.36
28737	ARTHRDSIS W/TEND LEN&ADV MIDTARSAL	$3,029.36
28740	ARTHRDSIS MIDTARSAL/TARSOMT 1 JNT	$3,029.36
28750	ARTHRODESIS GREAT TOE; MTP JNT	$3,029.36
28755	ARTHRDSIS GREAT TOE; IP JOINT	$2,204.60
28760	ARTHRDSIS EXT HALLUCIS TRNSF IP JNT	$3,029.36
28810	AMPUTATION METATARSAL W/TOE SINGLE	$2,204.60
28820	AMP TOE; METATARSOPHALANGEAL JOINT	$2,204.60
28825	AMP TOE; INTERPHALANGEAL JOINT	$2,204.60
29800	SCOPE TMJ DX W/WO SYNOVIAL BX	$4,966.66
29804	ARTHROSCOPY TMJ SURGICAL	$3,193.94

29805	SCOPE SHLDR DX W/WO SYN BX SEP PROC	$3,193.94
29806	SCOPE SHOULDER SURGICAL; CPSLORR	$4,966.66
29807	SCOPE SHLDR SURG; REPR SLAP LESION	$4,966.66
29819	SCOPE SHLDR SURG; REMV LOOSE/FB	$3,193.94
29820	SCOPE SHLDR SURG; SYNOVECTOMY PART	$3,193.94
29821	SCOPE SHLDR SURG; SYNOVECT COMPLETE	$3,193.94
29822	SCOPE SHOULDER SURGICAL; DEBRID LTD	$3,193.94
29823	SCOPE SHOULDER SURGICAL; DEBRID EXT	$3,193.94
29824	SCOPE SHLDR SURG;DIST CLAVICULECT	$4,966.66
29825	SCOPE SHOULDER; W/LYSIS ADHESIONS	$3,193.94
29826	SCOPE SHOULDER; DECOMP SUBACROM	$4,966.66
29827	SCOPE SHLDR SURG; W/ROTOR CUFF REP	$4,966.66
29830	SCOPE ELBOW DX W/WO SYNOVIAL BX	$3,193.94
29834	SCOPE ELBOW SURG; W/REMV LOOSE/FB	$3,193.94
29835	SCOPE ELB SURG; SYNOVECTOMY PART	$3,193.94
29836	SCOPE ELB SURG; SYNOVECT COMPLETE	$3,193.94
29837	SCOPE ELBOW SURGICAL; DEBRID LTD	$3,193.94
29838	SCOPE ELB SURGICAL; DEBRID EXT	$3,193.94
29840	SCOPE WRIST DX W/WO SYN BX SEP PROC	$3,193.94
29843	SCOPE WRIST SURG; INF LAVAGE&DRAIN	$3,193.94
29844	SCOPE WRIST SURG; SYNOVECTOMY PART	$3,193.94
29845	SCOPE WRIST SURG; SYNOVECT COMPLETE	$3,193.94
29846	SCOPE WRIST SURG; EXC&/REPR CART	$3,193.94
29847	SCOPE WRIST SURG; INTERNAL FIX	$4,966.66
29848	ENDO WRST SURG REL TRNS CARP LIG	$4,017.00
29850	ARTHSCPY AIDED TX KNEE; W/O FIX	$3,193.94
29851	ARTHSCPY AIDED TX KNEE; W/FIX	$4,966.66
29855	ARTHSCPY AIDED TX TIB FX; UNICOND	$4,966.66
29856	ARTHSCPY AIDED TX TIB FX; BICOND	$4,966.66
29860	SCOPE HIP DX W/WO SYN BX SEP PROC	$3,193.94
29861	ARTHROSCOPY HIP SURG; W/REMV FB	$4,966.66
29862	SCOPE HIP SURG; DEBRID/SHAV CART	$4,966.66
29863	SCOPE HIP SURGICAL; W/SYNOVECTOMY	$4,966.66
29866	SCOPE KNEE; OSTEOCHONDRAL AUTOGRAFT	$4,966.66
29867	SCOPE KNEE; OSTEOCHONDRAL ALLOGRAFT	$4,966.66
29868	SCOPE KNEE; MENISCAL TPLNT MED/LAT	$4,966.66
29870	SCOPE KNEE DX W/WO SYN BX SEP PROC	$3,193.94
29871	SCOPE KNEE SURG; INF LAVAGE&DRAIN	$3,193.94
29873	SCOPE KNEE SURGICAL; W/LAT RELEASE	$3,193.94
29874	SCOPE KNEE SURG; REMV LOOSE BDY/FB	$3,193.94

29875	SCOPE KNEE; SYNOVECT LTD SEP PROC	$3,193.94
29876	SCOPE KNEE SURG; SYNOVECTOMY MAJOR	$3,193.94
29877	SCOPE KNEE SURG; DEBRID/SHAVE CART	$3,193.94
29879	SCOPE KNEE SURG; ABRASION ARTHPLSTY	$3,193.94
29880	SCOPE KNEE SURG;W/MENISCECT MED&LAT	$3,193.94
29881	SCOPE KNEE SURG;W/MENISCECT MED/LAT	$3,193.94
29882	SCOPE KNEE; W/MENISCUS REPR MED/LAT	$3,193.94
29883	SCOPE KNEE; W/MENISCUS REPR MED&LAT	$3,193.94
29884	SCOPE KNEE; W/LYSIS ADHES SEP PROC	$3,193.94
29885	SCOPE KNEE; DRILLING W/GFT W/WO FIX	$4,966.66
29886	SCOPE KNEE; DRILLING OSTEOCHNDRITIS	$3,193.94
29887	SCOPE KNEE; DRILLING W/INTERNAL FIX	$3,193.94
29888	ARTHSCPY AIDED ACL REPR/AUG/RECON	$4,966.66
29889	ARTHSCPY AIDED PCL REPR/AUG/RECON	$4,966.66
29891	SCOPE ANKLE EXC DEFECT TALUS &/ TIB	$3,193.94
29892	ARTHROS AIDED REPR OSTEO LES-TAL FX	$3,193.94
29893	ENDOSCOPIC PLANTAR FASCIOTOMY	$4,017.00
29894	ARTHROSCOPY ANK SURG; W/REMV FB	$3,193.94
29895	SCOPE ANK SURG; SYNOVECTOMY PART	$3,193.94
29897	SCOPE ANK SURGICAL; DEBRIDEMENT LTD	$3,193.94
29898	SCOPE ANK SURGICAL; DEBRID EXT	$3,193.94
29899	SCOPE ANKLE SURG; W/ANK ARTHRODESIS	$4,966.66
29900	SCOPE MCP JOINT DX INCL SYNOVIAL BX	$1,767.58
29901	SCOPE MCP JOINT SURGICAL; W/DEBRID	$1,767.58
29902	SCOPE MCP JNT;RDUC ULNAR COLLAT LIG	$1,767.58
30140	SUBMUCOS RES TURBINATE PART/CMPLT	$2,660.44
30400	RHINO PRIM; LAT&ALAR CART&/ELEV TIP	$4,208.74
30410	RHINO PRIM; CMPLT EXTERNAL PARTS	$4,208.74
30420	RHINO PRIM; INCL MAJ SEPTAL REPAIR	$4,208.74
30465	REPAIR OF NASAL VESTIBULAR STENOSIS	$4,208.74
30520	SEPTOPLASTY/SUBMUCOS RES W/GFT	$2,660.44
30540	REPAIR CHOANAL ATRESIA; INTRANASAL	$4,208.74
30545	REPR CHOANAL ATRESIA; TRANSPALATINE	$4,208.74
30580	REPAIR FISTULA; OROMAXILLARY	$4,208.74
30600	REPAIR FISTULA; ORONASAL	$4,208.74
30620	SEPTAL/OTH INTRANASAL DERMATOPLASTY	$4,208.74
30630	REPAIR NASAL SEPTAL PERFORATIONS	$2,985.00
30801	CAUT&/ABLAT MUCOS TURB SEP PROC;SUP	$999.00
30802	CAUT MUCOS TURB SEP PROC; INTRMURL	$999.00
31254	NASAL/SINUS ENDO; W/PART ETHMOECT	$2,386.02

31255	NASAL/SINUS ENDO; W/TOT ETHMOECT	$2,386.02
31256	NASL/SINUS ENDO SURG W/MAX ANTROST;	$2,386.02
31267	NASL/SINUS ENDO; W/TISS REMV MAXIL	$2,386.02
31276	NASL/SINUS ENDO W/FRNTL SINUS EXPL	$2,386.02
31287	NASL/SINUS ENDO SURG W/SPHENOIDOT;	$2,386.02
31288	NASAL ENDO W/SPHENOIDOT; REMV TISS	$2,386.02
31541	LARYNGOSCOPY, DIRECT OPERATIVE, WITH EXCISION OF TUMOR AND/OR STRIPPING OF VOCAL CORDS WITH OPERATING MICROSCOPE	$2,386.02
31571	LARYNGOSCOPY, DIRECT WITH INJECTION INTO VOCAL CORD(S) THERAPUTIC WITH OPERATING MICROSCOPE	$2,386.02
31575	LARYNGOSCOPY, FILEXIBLE OR FIBEROPTIC; DIAGNOSTIC	$158.44
31579	LARYNGOSCOPY, FILEXIBLE OR RIGID FIEBEROPTIC, WITH STROBOSCOPY	$471.52
31622	BRONCHOSCOPY, RIGID OR FLEXIBLE, WIH OR WITHOUT FLUORSCOPIC GUIDANCE;DIAGNOSTIC WITH OR WITHOUT CELL WASHINGS(SEPARATE PROCEDURE)	$1,075.52
31624	BRONCHOSCOPY, RIGID OR FLEXIBLE, WIH OR WITHOUT FLUORSCOPIC GUIDANCE;DIAGNOSTIC WITH OR WITHOUT CELL WASHING, WITH BRONCHIAL ALVEOLAR LAVAGE	$1,075.52
31628	BRONCHOSCOPY, RIGID OR FLEXIBLE, WIH OR WITHOUT FLUORSCOPIC GUIDANCE;DIAGNOSTIC WITH OR WITHOUT CELL WASHING, WITH TRANSBRONCIAL LUNG BIOPSY(S) , SINGLE LOBE	$1,075.52
31631	BRONCHOSCOPY, RIGID OR FLEXIBLE, WIH OR WITHOUT FLUORSCOPIC GUIDANCE;DIAGNOSTIC WITH OR WITHOUT CELL WASHINGS(SEPARATE PROCEDURE); WITH TRACHEAL DILATION AND PLACEMENT OF TRACHEAL STENT	$2,506.24
43248	UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS, STOMACH, AND EITHER THE DUODENUM AND /OR JEJUNUM OAS APPROPRAITEL DIAGNOSITC WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING OR WASHING;W/INSERTION OF GUIDE WIRE FOLLOWED	$920.00
49505	REPR INIT ING HERNIA 5YR/MORE; RDUC	$3,199.70
49507	REPR INIT ING HERNIA > 5YR; INCARC	$4,017.00
49520	REPR RECUR ING HERN ANY AGE; RDUC	$3,199.70
49521	REPR RECUR ING HERNIA; INCARC/STRAN	$4,017.00
49525	REPAIR ING HERNIA SLIDING ANY AGE	$3,199.70
49540	REPAIR LUMBAR HERNIA	$3,199.70
49550	REPR INIT FEM HERN ANY AGE; RDUC	$3,199.70
49553	REPR INIT FEM HERNIA; INCARC/STRANG	$4,017.00
49555	REPR RECUR FEM HERNIA; REDUCIBLE	$3,199.70

49557	REPR RECUR FEM HERNIA; INCARC/STRAN	$4,017.00
49560	REPR INIT INCS/VENT HERNIA; RDUC	$3,199.70
49561	REPR INIT INCS/VENT HERN; INCARCER	$4,017.00
49565	REPR RECUR INCS/VENT HERNIA; RDUC	$3,199.70
49566	REPR RECUR INCS/VENT HERNIA; INCARC	$4,017.00
49568	IMPLNT MESH/OTH-INCS/VENT HERN REPR	$3,199.70
49570	REPR EPIGASTRIC HERN; RDUC-SEP PROC	$3,199.70
49572	REPR EPIGAST HERNIA; INCARC/STRANG	$4,017.00
49585	REPR UMBIL HERNIA 5YR/OVER; RDUC	$3,199.70
49587	REPR UMBIL HERNIA 5YR/OVER; INCARCR	$4,017.00
49590	REPAIR SPIGELIAN HERNIA	$3,199.70
49600	REPR SMALL OMPHALOCELE W/PRIM CLOS	$3,199.70
49650	LAPARSCPY SURG; REPR INIT ING HERN	$4,872.34
49651	LAPARSCPY SURG; REP RECUR ING HERN	$4,872.34
50200	RENAL BIOPSY;PECUTANEOUS, BY TROCAR OR NEEDLE	$670.18
50590	LITHOTRIPSY, EXTRACORPOREAL SHOCK WAVE	$5,085.56
51726	COMPLEX CYSTOMETROGRAM (EG,M CALIBRATED ELECTRONIC EQUIPMENT)	$282.44
52005	CYSTOURETHROXCOPY, URETERAL CATHETERIZATION, W OR W/O IRRIGATION, INSTILLATION OR URETEROPYELOGRAPHY, EXCULSIVE OF RADIOLOGIC SERVICE	$2,038.30
62263	PERQ LYSIS EPIDURAL ADHESIONS USING SOLUTION INJECTION - OR MECHANICAL MEANS, INLCUDING RADIOLOGIC LOCATIZATION; 2 OR > PER DAY	$1,244.86
62264	PERQ LYSIS EPIDURAL ADHESIONS USING SOLUTION INJECTION - OR MECHANICAL MEANS, INLCUDING RADIOLOGIC LOCATIZATION; 1 OR > PER DAY	$1,244.86
62268	PERQ ASPIR SPINAL CORD CYST/SYRINX	$999.00
62270	SPINAL PUNCTURE, THERAPEUTIC, FOR DRAINAGE OF CEREBROSPINAL FLUID (BY NEEDLE OR CATHETER)	$999.00
62272	SP PUNCT TX FOR DRAIN CEREBROSP FL	$999.00
62273	INJECTION EPIDURAL BLOOD/CLOT PATCH	$999.00
62280	INJ NEUROLY W/WO OTH SUB; SUBARACH	$999.00
62281	INJ NEUROLY W/WO OTH SUBST;EPID C/T	$999.00
62282	INJ NEUROLY W/WO OTH SUBST;EPID L/S	$999.00
62287	ASPIR/DECOMPRESS-NUC PULPOS-LUMB	$4,017.00
62292	INJ PROC-CHEMONUCLEOLYSIS; 1/MX LUM	$335.80
62294	INJ PROC ART OCCL AV MALFORM SPINAL	$1,530.00
62310	INJ 1 NOT NEUROLYTIC-EPID;CERV/THOR	$999.00
62311	INJ 1 NOT NEUROLYTIC-EPID; LUMB/SAC	$999.00
62318	INJ NOT NEUROLYTIC-EPID; CERV/THOR	$999.00

62319	INJ NOT NEUROLYTIC-EPID; LUMB/SAC	$999.00
62350	IMPLANT EPID CATH-MEDS; W/O LAMINEC	$1,338.00
62351	IMPLANT EPID CATH-MEDS; W/LAMINECT	$4,851.54
62355	REMOV PREV IMPLNT INTHEC/EPID CATH	$1,338.00
62360	IMPLANT/REPLAC DEVICE-EPID; RESVOIR	$737.48
62361	IMPLANT/REPLC DEVICE-EPID; NONPROGM	$3,064.64
62362	IMPLANT/REPLAC DEVICE-EPID; PROGMBL	$3,064.64
62365	REMOV PREV IMPLNT SUBQ RESVOIR/PUMP	$3,271.74
63020	LAMINOT W/DECOMP; 1 INTERSPACE CERV	$4,851.54
63030	LAMINOT W/ DECOMP; 1 INTERSPACE LUM	$4,851.54
63035	LAMINOT; EA ADD INTERSPAC CERV/LUMB	$4,851.54
63040	LAMINOTOMY W/DECOMPOMPRESSION OF NERVE ROOTS, INCLUDING PARTIAL FACETECTOMY, FORAMINOTMY AND /OR EXCISION OF HERNIATED INTERVERTEBRAL DISK, RE-EXPLORATION, SINGLE CERVICAL	$4,851.54
63042	LAMINOTOMY W/DECOMPOMPRESSION OF NERVE ROOTS, INCLUDING PARTIAL FACETECTOMY, FORAMINOTMY AND /OR EXCISION OF HERNIATED INTERVERTEBRAL DISK, RE-EXPLORATION, SINGLE LUMBAR	$4,851.54
63043	LAMINOTOMY W/DECOMPOMPRESSION OF NERVE ROOTS, INCLUDING PARTIAL FACETECTOMY, FORAMINOTMY AND /OR EXCISION OF HERNIATED INTERVERTEBRAL DISK, RE-EXPLORATION, SINGLE EACH ADDITIONAL CERVICAL	$4,851.54
63044	LAMINOTOMY W/DECOMPOMPRESSION OF NERVE ROOTS, INCLUDING PARTIAL FACETECTOMY, FORAMINOTMY AND /OR EXCISION OF HERNIATED INTERVERTEBRAL DISK, RE-EXPLORATION, EACH ADDITIONAL LUMBAR	$4,851.54
63045	LAMINECT 1 VERT SEGMT-UNI/BIL; CERV	$4,851.54
63046	LAMINECT 1 VERT SEGMT-UNI/BIL; THOR	$4,851.54
63047	LAMINECT 1 VERT SEGMT-UNI/BIL; LUMB	$4,851.54
63048	LAMINECT 1 SEGMT-UNI/BIL; EA ADD	$4,851.54
63055	TRANSPEDIC W/DECOM 1 SEG; THORACIC	$4,851.54
63056	TRANSPEDIC W/DECOM 1 SEG; LUMBAR	$4,851.54
63057	TRANSPEDIC W/DECOM 1 SEG; EA ADD	$4,851.54
63064	COSTOVERTEBRAL THORACIC; SINGLE SEG	$4,851.54
63066	COSTOVERTEB THORACIC; EA ADD SEG	$4,851.54
63075	DISKECT ANT; CERVICAL 1 INTERSPACE	$4,851.54
63076	DISKECT ANT; CERV EA ADD INTERSPACE	$4,851.54
63081	VERTEBRAL CORPECTOMY; CERV 1 SEG	$4,851.54
63082	VERTEBRAL CORPECT; CERV EACH ADDITIONAL SEG	$4,851.54
63090	VERTEBRAL CORPECT; THORACIC, LUMBAR, OR SACRAL	$4,851.54

63091	VERTEBRAL CORPECT; THORACIC, LUMBAR, OR SACRAL EACH ADDITIONAL	$4,851.54
63610	STEREOTACT STIM-CORD PERQ-SEP PROC	$1,971.20
63615	STEREOTAC BX ASPIR/EXC LES SP CORD	$1,971.20
63650	PERQ IMPLANT ELECT ARRAY EPIDURAL	$2,396.16
63655	LAMINECT IMPLANT ELECTRODE EPIDURAL	$4,935.16
63660	REVIS/REMOV SPINAL ELECTRODE/ARRAY	$999.00
63685	INSRT/REPL SP NEUROSTIM GEN/RECV	$3,457.34
63688	REVIS IMPLANT SPINAL NEUROSTIM GEN	$999.00
64400	INJ ANES AGT; TRIGEMINL NERV DIV/BR	$372.69
64402	INJECTION ANESTHETIC AGT; FCE NERVE	$372.69
64405	INJECTION ANES AGT; GT OCCIP NERVE	$372.69
64408	INJECTION ANES AGT; VAGUS NERVE	$372.69
64410	INJECTION ANES AGT; PHRENIC NERVE	$999.00
64412	INJ ANES AGT; SPINAL ACSS NERVE	$928.44
64413	INJECTION ANES AGT; CERV PLEXUS	$372.69
64415	INJ ANESAGT; BRACH PLEXUS SINGLE	$999.00
64417	INJECTION ANESTHETIC AGT; AX NERVE	$999.00
64418	INJECTION ANES AGT; SUPRASCAP NERVE	$372.69
64420	INJ ANES AGT; INTERCOSTAL NERV 1	$999.00
64421	INJ ANES AGENT; INTERCOSTAL NERV-MX	$999.00
64425	INJ ANES AGENT; ILIOINGUINAL NERV	$372.69
64430	INJECTION ANES AGT; PUDENDAL NERVE	$999.00
64435	INJECTION ANES AGT; PARACERV NERVE	$372.69
64445	INJ ANESAGT; SCIATIC NERVE SINGLE	$372.69
64447	INJ ANES AGT, FEMORAL NERVE, SINGLE	$372.69
64450	INJ ANES AGT; OTH PERIPH NERVE/BR	$372.69
64470	INJ ANES FACET JT; CERV/THOR-1LEVEL	$999.00
64472	INJ ANES FACET JT; CERV/THOR-EA ADD	$999.00
64475	INJ ANES FACET JT; LUMB/SAC-1LEVEL	$999.00
64476	INJ ANES FACET JT; LUMB/SAC-EA ADD	$999.00
64479	INJ ANES EPIDURL; CERV/THOR 1 LEVEL	$999.00
64480	INJ ANES EPIDURL; CERV/THOR-EA ADD	$999.00
64483	INJ ANES EPIDURL; LUMB/SAC 1 LEVEL	$999.00
64484	INJ ANES EPIDURL; LUMB/SAC-EA ADD	$999.00
64505	INJ ANES, SPHENOPALATINE GANGLION	$372.69
64508	INJ ANES,CAROTID SINUS (SEPARATE PROCEDURE)	$372.69
64510	INJECTION ANES AGT; STELLATE GANG	$999.00
64520	INJECTION ANES AGT; LUMBAR/THOR	$999.00
64530	INJ ANES AGENT; CELIAC PLEXUS	$999.00

64553	PERQ IMPLNT ELECTRODE; CRANIAL NERV	$4,935.16
64555	PERQ IMPLNT ELECTRODES; PERIPHERAL	$2,396.16
64560	PERQ IMPLNT ELECTRODES; AUTONOMIC	$2,396.16
64561	PERQ IMPL NEUROSTIM ELEC; SAC NERV	$2,396.16
64565	PERQ IMPL NEUROSTIM ELEC; NEUROMUSC	$2,396.16
64573	INCI IMPLNT ELECTRODE; CRANIAL NERV	$4,935.16
64575	INCI IMPLNT ELECTRODES; PERIPHERAL	$2,396.16
64577	INCI IMPLNT ELECTRODES; AUTONOMIC	$4,935.16
64580	INCI IMPL NEUROSTIM ELEC; NEUROMUSC	$4,935.16
64581	INCISION FOR IMPLANTATION OF NEUROSTIMULARO ELECTRODES; SACRAL NERVE (TRANSFORAMINAL PLACEMENT)	$2,396.16
64585	REV/REMOVAL PERIPH NEUROSTIM ELEC	$2,288.00
64590	INSRT/REPL PERIPH NEUROSTM GEN/RECV	$3,417.34
64595	REV/REMV PERIPHERAL PULSE GEN	$4,755.58
64600	DESTRCT TRIGEMINAL; SUPRAORBITAL	$1,244.86
64605	DESTRCT TRIGEMOMAL; 2ND & 3RD DIV	$1,244.86
64610	DESTRCT TRIGEMINAL; W/RAD MONITOR	$1,244.86
64612	CHEMODENERV MUSC; INNERV FACIAL NRV	$248.46
64613	CHEMODENERVATION MUSC; CERV SP MUSC	$248.46
64614	CHEMODNERV MUSC; EXTREM&/TRUNK MUSC	$248.46
64620	DESTRUC NEURLYT AGT INTERCOSTAL NRV	$1,244.86
64622	DESTRUC FACET JT NRV; L/S-1 LEVEL	$1,244.86
64623	DESTRUC FACET JT NRV; L/S-EA AD LEV	$999.00
64626	DESTRUC FACET NRV; CERV/THOR 1 LEV	$1,244.86
64627	DESTRUC FACET NRV; CRV/THOR-EA ADD	$999.00
64630	DESTRUC NEURLYT AGT; PUDENDAL NERVE	$1,338.00
64640	DESTRUC NEUROLYTIC; OTH PERIPH NERV	$928.44
64680	DESTRCT W/WO RAD MON; CELIAC PLEXUS	$1,338.00
64681	DESTRUC NEURLYT;SUP HYPOGASTRC PLEX	$1,244.86
64702	NEURPLSTY; DIGTL 1/BOTH SAME DIGIT	$1,971.20
64704	NEUROPLASTY; NERVE OF HAND OR FOOT	$1,971.20
64708	NEUROPLSTY PERIPHRL NERV; NOT SPEC	$1,971.20
64712	NEUROPLSTY PERIPH NERV; SCIATC NERV	$1,971.20
64713	NEUROPLSTY PERIPH; BRACHIAL PLEXS	$1,971.20
64714	NEUROPLSTY PERIPH; LUMBAR PLEXUS	$1,971.20
64716	NEURPLSTY &OR TRANSPSTN; CRANIL NRV	$1,971.20
64718	NEUROPLASTY; ULNAR NERV AT ELBOW	$1,971.20
64719	NEUROPLASTY; ULNAR NERV AT WRIST	$1,971.20
64721	NEUROPLASTY; MEDIAN CARPAL TUNNEL	$1,971.20

64722	DECOMPRESSION; UNSPECIFIED NERVE	$1,971.20
64726	DECOMPRS; PLANTAR DIGITAL NERVE	$1,971.20
64727	INTRL NEUROLYSIS RQR USE OP MIC	$1,971.20
64774	EXCISION OF NEUROMA; CUTANEOUS NERVE SURGICALLY IDENTIFIABLE	$1,971.20
64776	EXCISION OF NEUROMA; DIGITAL NERVE, ONE OR BOTH, SAME DIGIT	$1,971.20
64778	EXCISION OF NEUROMA; DIGITAL NERVE, ONE OR BOTH, SAME DIGIT; EACH ADDITIONAL NERVE	$1,971.20
64782	EXCISION OF NEUROMA; HAND OR FOOT, EXCEPT DIGITAL NERVE	$1,971.20
64783	EXCISION OF NEUROMA; HAND OR FOOT, EACH ADDITIONAL NERVE, EXCEPT DIGITAL NERVE	$1,971.20
64784	EXCISION OF NEUROMA; MAJOR PERIPHERAL NERVE, EXCEPT SCIATIC	$1,971.20
64786	EXCISION OF NEUROMA; EXCEPT SCIATIC	$3,271.74
64787	IMPLANTATION OF NERVE END INTO BONE OR MUSCLE (LIST SEPARATELY IN ADDITION OT NEUROMA EXCISION)	$1,971.20
64831	SUT DIGTL NERVE HAND/FOOT; 1 NERVE	$3,271.74
64832	SUTURE DIGITAL NERV HAND/FT; EA ADD	$3,271.74
64834	SUT 1 NERV HND/FOOT; CMN SENSY NERV	$3,271.74
64835	SUTURE 1 NERV HAND/FT; MED MOTOR	$3,271.74
64836	SUT 1 NERVE HAND/FOOT; ULNAR MOTOR	$3,271.74
64837	SUTURE EA ADD NERVE HAND/FOOT	$3,271.74
64890	NERVE GRAFT(INCLUDES OBTAINING GRAFT), SINGLE STRAND, HAND, OR FOOT; > 4CM IN LENGTH	$3,271.74
64892	NERVE GRAFT(INCLUDES OBTAINING GRAFT), SINGLE STRAND, HAND, OR FOOT; UP TO 4CM IN LENGTH	$3,271.74
65105	ENUCLEATION OF EYE;WITH IMPLANT, MUSCLES ATTACHED OT IMPLANT	$3,446.84
65265	REMOVAL OF FOREIGN BODY INTRAOCULAR; FROM POSTERIOR SEGMENT, NONMAGNETIC EXTRACTION	$2,433.24
65280	REPAIR OF LACERATION CORNEA AND/OR SCLERA, PERFORATING, NOT INVOLVING UVEAL TISSUE	$2,433.24
65285	REPAIR OF LACERATION CORNEA AND/OR SCLERA, PERFORATING, WITH REPOSTIION OR RESECTION OF UVEAL TISSUE	$2,433.24
65770	KERATOPROSTHESIS	$2,433.24
66682	SUTURE IRIS, CILIARY BODY (SEPARATE PROCEDURE) WITH RETRIEVAL OF SUTURE THROUGH SMALL INCISION (EG MCCANNEL SUTURE)	$2,522.76

66825	REPOSITIONING OF INTRAOCULAR LENS PROSTHESIS REQUIRING AN INCISION (SEPARATE PROCEDURE)	$2,522.76
66920	REMOVAL OF LENS MATERIAL; INTRACAPSULAR	$3,243.66
66986	EXCHANGE OF INTRAOCULAR LENS	$2,658.96
67036	VITRECTOMY, MECHANICAL, PARS PLANA APPROACH;	$3,934.98
67038	VITRECTOMY, MECHANICAL, PARS PLANA APPROACH; WITH EPIRETINAL MEMBRANE STRIPPING	$3,934.98
67039	VITRECTOMY, MECHANICAL, PARS PLANA APPROACH; WITH FOCAL ENDOLASER PHOTOCOAGULATION	$3,934.98
67040	VITRECTOMY, MECHANICAL, PARS PLANA APPROACH; WITH ENDOLASER PANRETINAL PHOTOCOAGULATION	$4,550.58
67107	REPR RETINAL DETACH; SCLERAL BUCKL	$4,550.58
67108	REPR RETINAL DETACH; W/VITRECTOMY	$4,550.58
67110	REPR RET DETACH; INJ AIR/OTH GAS	$2,433.24
67400	ORBITOT W/O BONE FLP; EXPL W/WO BX	$2,682.18
67405	ORBITOT W/O BONE FLP; W/DRAIN ONLY	$2,682.18
67412	ORBITOT W/O BN FLP; W/REMOVAL LES	$2,682.18
67413	ORBITOT W/O BONE FLP; W/REMOVAL FB	$2,682.18
67414	ORBITOTOMY WO FLAP; W/REMV BONE	$3,446.84
67550	ORBITAL IMPLANT; INSERTION	$3,446.84
67560	ORBITAL IMPLANT; REMOVAL/REVISION	$2,682.18
67830	CORRECTION OF TRICHIASIS; INCISION OF LID MARGIN	$763.74
67835	CORRECTION OF TRICHIASIS; INCISION OF LID MARGIN, WITH FREE MUCOUS MEMBRANE GRAFTS	$2,059.54
67875	TEMPORARY CLOSURE OF EYELIDS BY SUTURE (EG FROST SUTURE)	$763.74
67914	REPAIR OF ECTOPION; SUTURE	$2,059.54
67917	REPAIR OF ECTOPION; EXTENSIVE (EG TARSAL STRIP OPERATIONS)	$2,059.54
67924	REPAIR OF ENTROPION; EXTENSIVE (EG, TARSAL STRIP OR CAPSULOPALPEBRAL FASCIA REPAIRS OPERATION)	$2,059.54
67950	CANTHOPLASTY	$2,059.54
67961	EXC & REPR LID; TO 1/4 LID MARGIN	$2,059.54
67966	EXCISION AND REPAIR OF EYELID, INVOLVING LID MARGIN, TARSUS, CONJUNCTIVA, CANTHUS, OR FULL THICKNESS, MAY INCLUDE PAREPARATION OF RSKIN GRAFT OR PEDICAL FLAP WITH ADJACENT TISSUE TRANSFER OR REARRANGEMENT; OVER ONE-FOURTH OF LID MARGIN	$2,059.54
68115	EXCISION OF LESION, CONJUNCTIVA; OVER 1 CM	$2,059.54
68325	CONJUNCITOPLASTY; WITH BUCCAL MUCOUS MEMBRANE GRAFT (INCLUDES OBTAINING GRAFT)	$3,446.84

68328	CONJUNCTIOPLASTY, WITH BUCCAL MUCOUS MEMBRANE GRAFT (INCLUDES OBTAINING GRAFT)	$2,682.18
68750	CONJUNCITORHIOSTOMY (FISTULIZATION OF CONJUNCTIVA TO NASAL CAVITY); WITH INSERTION OF TUBE OR STENT	$3,446.84
69440	MID EAR EXPLOR-POSTAURICULAR INCS	$2,660.44
69631	TYMP NO MASTOIDEC; NO OSSICUL CHAIN	$4,208.74
69643	TYMPANOPLSTY WITH MASTOIDECTOMY (INCLUDING CANAPLASTY, MIDDLE EAR SURGERY, TYMPANIC MEMBRANE REPAIR); WITH INTACT OR RECONSTRUCTED WALL, WITHOUT OSSICULAR CHAIN RECONSTRUCTION	$4,208.74
69666	REPAIR OVAL WINDOW FISTULA	$4,208.74
69667	REPAIR ROUND WINDOW FISTULA	$4,208.74
69990	MICROSURGICAL TECHNIQUES, REQUIREING USE OF OPERATING MICROSCOPE	$500.00

Exhibit 5

Rural Primary Care Facilities

BENT COUNTY NURSING SERVICE WOMENS HEALTH CLINIC
701 PARK AVE
LAS ANIMAS, CO 81054 - BENT COUNTY
Telephone: (719)456-0517, Fax: (719)456-0518

BRUSH FAMILY CLINIC
2400 W EDISON
BRUSH, CO 80723 - MORGAN COUNTY
Telephone: (970)842-2833, Fax: (970)842-6241

BUENA VISTA FAMILY PRACTICE CLINIC
836 U.S. HWY 24 SO
BUENA VISTA, CO 81211 - CHAFFEE COUNTY
Telephone: (719)395-9048, Fax: (719)395-9064

CONEJOS MEDICAL CLINIC
19021 STATE HWY 285
LA JARA, CO 81140 - CONEJOS COUNTY
Telephone: (719)274-5121, Fax: (719)274-6003

CUSTER COUNTY MEDICAL CLINIC
704 EDWARDS
WESTCLIFFE, CO 81252 - CUSTER COUNTY
Telephone: (719)783-2380, Fax: (719)783-2377

DOLORES MEDICAL CENTER
507 CENTRAL AVENUE
DOLORES, CO 81323 - MONTEZUMA COUNTY
Telephone: (970)882-7221, Fax: (970)882-4243

EADS MEDICAL CLINIC
1211 LUTHER STREET
EADS, CO 81036 - KIOWA COUNTY
Telephone: (719)438-2251, Fax: (719)438-2254

EASTERN PLAINS MEDICAL CLINIC OF CALHAN
555 COLORADO AVENUE

CALHAN, CO 80808 - EL PASO COUNTY
Telephone: (719)347-0100, Fax: (719)347-0551

FAMILY CARE CLINIC
615 FAIRHURST
STERLING, CO 80751 - LOGAN COUNTY
Telephone: (970)521-3223

FAMILY PRACTICE OF HOLYOKE
520 SOUTH INTEROCEAN
HOLYOKE, CO 80734 - PHILLIPS COUNTY
Telephone: (970)854-2500, Fax: (970)854-3440

FLEMING FAMILY HEALTH CENTER
104 W LARIMER ST
FLEMING, CO 80728 - LOGAN COUNTY
Telephone: (970)774-6123, Fax: (970)774-6158

FLORENCE MEDICAL CENTER
501 W 5TH ST
FLORENCE, CO 81226 - FREMONT COUNTY
Telephone: (719)784-4816, Fax: (719)784-6014

GRAND RIVER PRIMARY CARE
501 AIRPORT ROAD
RIFLE, CO 81650 - GARFIELD COUNTY
Telephone: (970)625-1100, Fax: (970)625-0725

GRAND RIVER PRIMARY CARE - BATTLEMENT MESA
73 SIPPERELLE DRIVE, SUITE K
PARACHUTE, CO 81635 - GARFIELD COUNTY
Telephone: (970)285-7046, Fax: (970)285-6064

HAVENS FAMILY CLINIC
109 LATIGO LN STE C
CANON CITY, CO 81212 - FREMONT COUNTY
Telephone: (719)276-3211, Fax: (719)276-3011

KIT CARSON CLINIC
102 EAST 2ND AVENUE
KIT CARSON, CO 80825 - CHEYENNE COUNTY
Telephone: (719)962-3501, Fax: (719)962-3403

LA CLINICA INC
24850 N ST HWY 69
GARDNER, CO 81040 - HUERFANO COUNTY
Telephone: (719)746-2244

LAKE CITY AREA MEDICAL CENTER
700 N HENSON STREET
LAKE CITY, CO 81235 - HINSDALE COUNTY
Telephone: (970)944-2331, Fax: (970)944-2320

MEEKER FAMILY HEALTH CENTER
345 CLEVELAND
MEEKER, CO 81641 - RIO BLANCO COUNTY
Telephone: (970)878-4014, Fax: (970)878-3285

MOUNTAIN MEDICAL CENTER OF BUENA VISTA, P.C
36 OAK ST
BUENA VISTA, CO 81211 - CHAFFEE COUNTY
Telephone: (719)395-8632, Fax: (719)395-4971

NORTH PARK MEDICAL CLINIC
521 5TH ST
WALDEN, CO 80480 - JACKSON COUNTY
Telephone: (970)723-4255, Fax: (970)723-4268

OLATHE MEDICAL CLINIC
308 MAIN ST
OLATHE, CO 81425 - MONTROSE COUNTY
Telephone: (970)323-6141, Fax: (970)323-6117

PARKE HEALTH CLINIC
182 16TH ST
BURLINGTON, CO 80807 - KIT CARSON COUNTY
Telephone: (719)346-9481, Fax: (719)346-9485

PEDIATRIC ASSOCIATION OF CANON CITY
1335 PHAY AVENUE
CANON CITY, CO 81212 - FREMONT COUNTY
Telephone: (719)269-1727, Fax: (719)269-1730

PRAIRIE VIEW RURAL HEALTH CLINIC

560 N 6 W STREET
CHEYENNE WELLS, CO 80810 - CHEYENNE COUNTY
Telephone: (719)767-5669, Fax: (719)767-8042

ROCKY FORD FAMILY HEALTH CENTER
1014 ELM AVENUE
ROCKY FORD, CO 81067 - OTERO COUNTY
Telephone: (719)254-7421, Fax: (719)254-6966

SANTA FE TRAIL MEDICAL CENTER
111 WAVERLY AVE
TRINIDAD, CO 81082 - LAS ANIMAS COUNTY
Telephone: (719)846-0123, Fax: (719)846-0121

SOUTHEAST COLORADO PHYSICIAN'S CLINIC
210 E TENTH AVE
SPRINGFIELD, CO 81073 - BACA COUNTY
Telephone: (719)523-6628, Fax: (719)523-4513

SOUTHEAST REGIONAL CLINIC
912 WALNUT
ROCKY FORD, CO 81067 - OTERO COUNTY
Telephone: (719)254-7891, Fax: (719)254-7907

ST VINCENTS PRIMARY CARE LLC
400 BENEDICTA STE A
TRINIDAD, CO 81082 - LAS ANIMAS COUNTY
Telephone: (719)846-2206, Fax: (719)846-7823

STRATTON MEDICAL CLINIC
500 NEBRASKA AVENUE
STRATTON, CO 80836 - KIT CARSON COUNTY
Telephone: (719)348-4650, Fax: (719)348-4653

SURFACE CREEK FAMILY PRACTICE
255 SW 8TH AVE
CEDAREDGE, CO 81413 - DELTA COUNTY
Telephone: (970)856-3146, Fax: (970)856-4385

TELLURIDE MEDICAL CENTER
500 W PACIFIC
TELLURIDE, CO 81435 - SAN MIGUEL COUNTY

Telephone: (970)728-3840, Fax: (970)728-3404

TRINIDAD FAMILY MEDICAL CENTER
1502 E MAIN ST
TRINIDAD, CO 81082 - LAS ANIMAS COUNTY
Telephone: (719)846-3305, Fax: (719)846-4922

TRINIDAD MEDICAL ASSOCIATES
400 BENEDICTA #B
TRINIDAD, CO 81082 - LAS ANIMAS COUNTY
Telephone: (719)845-0627, Fax: (719)845-0663

UNITED MEDICAL CENTER OF BERTHOUD
549 MOUNTAIN AVENUE
BERTHOUD, CO 80513 - LARIMER COUNTY
Telephone: (970)532-4644, Fax: (970)532-0608

VALLEY MEDICAL CLINIC
116 E NINTH STREET
JULESBURG, CO 80737 - SEDGWICK COUNTY
Telephone: (970)474-3376, Fax: (970)474-2461

WASHINGTON COUNTY CLINIC
482 ADAMS AVENUE
AKRON, CO 80720 - WASHINGTON COUNTY
Telephone: (970)345-2262, Fax: (970)345-2265

WILEY MEDICAL CLINIC
302 MAIN STREET
WILEY, CO 81092 - PROWERS COUNTY
Telephone: (719)829-4627, Fax: (719)829-4269

YUMA RURAL HEALTH CLINIC
910 S MAIN ST
YUMA, CO 80759 - YUMA COUNTY
Telephone: (970)848-4700, Fax: (970)848-0809

Exhibit 6

Dental Fee Schedule

Code	Description in Rule 18	VALUE
	Clinical Oral Evaluations	
D0120	Periodic oral evaluation	$40.10
D0140	Limited oral evaluation - problem focused	$54.99
D0150	Comprehensive oral evaluation - new or established patient	$75.62
D0160	Detailed and extensive oral evaluation - problem focused, by report	$97.39
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$48.12
D0180	Comprehensive periodontal evaluation - new or established patient	BR
	Radiographs/Diagnostic Imaging (including interpretation)	
D0210	Intraoral - complete series (including bitewings)	$120.00
D0220	Intraoral - periapical first film	$20.63
D0230	Intraoral - periapical each additional film	$17.18
D0240	Intraoral - occlusal film	$34.38
D0250	Extraoral - first film	$46.98
D0260	Extraoral - each additional film	$45.84
D0270	Bitewing - single film	$25.21
D0272	Bitewing - two films	$38.00
D0274	Bitewing - four films	$56.00
D0277	Vertical Bitewings-7-8 Films	$82.49
D0290	Posterior - anterior or lateral skull and facial bone survey film	$158.11
D0310	Sialography	$403.32
D0320	Temporomandibular joint arthrogram, including injection	$690.90
D0321	Other temporomandibular joint films	BR
D0322	Tomographic Survey	$554.56
D0330	Panoramic Film	$85.94
D0340	Cephalometric film	$116.87
D0350	Oral/Facial Photographic Images (Incl. Intra and extra-oral images)	$51.56
	Tests and Examinations	
D0415	Collection of microorganisms for culture and sensitivity	$45.84
D0416	Viral culture A diagnostic test to identify viral organisms, most often herpes virus.	BR
D0421	Genetic test for susceptibility to oral diseases	BR
D0425	Caries susceptibility tests	$29.79
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	BR
D0460	Pulp vitality tests	$51.56
D0470	Diagnostic casts	$85.94
	Oral Pathology Laboratory	
D0472	Accession Tissue-Gross Exam, Prep & Trans report	$77.91
D0473	Accession Tissue-Gross & Micro exam, prep & trans report	$151.24

D0474	Accession tissue-Gross & micro exam, Assess surgical margins, prep & trans report	$182.17
D0475	Decalcification procedure	BR
D0476	Special stains for microorganisms	BR
D0477	Special stains, not for microorganisms	BR
D0478	Immunohistochemical stains	BR
D0479	Tissue in-situ hybridization, including interpretation	BR
D0480	Process & interpret cytologica smears-Prep report	$110.00
D0481	Electron microscopy – diagnostic	BR
D0482	Direct immunofluorescence	BR
D0483	Indirect immunofluorescence	BR
D0484	Consultation on slides prepared elsewhere	BR
D0485	Consultation, including preparation of slides from biopsy material supplied by referring source	BR
D0502	Other oral pathology procedures	BR
D0999	Unspecified diagnostic procedure	BR
	Dental Prophylaxis	
D1110	Prophylaxis - adult	$74.48
D1120	Prophylaxis - child	$51.56
	Topical Fluoride Treatment	
D1201	Topical application of fluoride (including prophylaxis)- child	$69.89
D1203	Topical application of fluoride (prophylaxis not included)- child	$34.38
D1204	Topical application of fluoride (prophylaxis not included) - adult	$34.38
D1205	Topical application of fluoride (including prophylaxis) - adult	$85.94
	Other Preventive Services	
D1310	Nutritional counseling for the control of dental disease	$43.53
D1320	Tobacco counseling for the control and prevention of oral dis-ease	$45.84
D1330	Oral hygiene instruction	$58.44
D1351	Sealant - per tooth	$40.10
	Space Maintenance (Passive Appliances)	
D1510	Space maintainer - fixed (unilateral)	$257.80
D1515	Space maintainer - fixed (bilateral)	$331.13
D1520	Space maintainer - removable (unilateral)	$351.76
D1525	Space maintainer - removable (bilateral)	$482.37
D1550	Re-cementation of space maintainer	$61.87
	Amalgam Restorations (Including Polishing)	
D2140	Amalgam - one surface, primary or permanent	$97.39
D2150	Amalgam - two surface, primary or permanent	$126.04
D2160	Amalgam - three surfaces, primary or permanent	$162.70
D2161	Amalgam - four or more surfaces, primary or permanent	$189.05
	Resin-Based Composite Restorations -Direct	
D2330	Resin – based composite -one surface, anterior	$114.58
D2331	Resin – based composite - two surfaces, anterior	$158.11
D2332	Resin – based composite - three surfaces, anterior	$199.37
D2335	Resin - four or more surfaces or involving incisal angle, anterior	$234.88
D2390	Resin-based composite crown, anterior	$299.04
D2391	Resin-based composite - one surface, posterior	$155.82

D2392	Resin-based composite - two surfaces, posterior	$181.03
D2393	Resin-based composite - three surfaces, posterior	$248.64
D2394	Resin-based composite - four or more surfaces, posterior	$315.09
	Gold Foil Restorations	
D2410	Gold foil - one surface	$248.64
D2420	Gold foil - two surfaces	$414.77
D2430	Gold foil - three surfaces	$718.39
	Inlay/Onlay Restorations	
D2510	Inlay - metallic - one surface	$687.46
D2520	Inlay - metallic - two surfaces	$701.21
D2530	Inlay - metallic - three or more surfaces	$860.48
D2542	On-lay-metallic-2 surfaces	$843.29
D2543	On-lay - metallic - three surfaces	$811.21
D2544	On-lay - metallic - four or more surfaces	$917.76
D2610	Inlay - porcelain/ceramic - one surface	$774.54
D2620	Inlay - porcelain/ceramic - two surfaces	$716.10
D2630	Inlay - porcelain/ceramic -three or more surfaces	$816.93
D2642	On-lay - porcelain/ceramic - two surfaces	$894.84
D2643	On-lay - porcelain/ceramic - three surfaces	$894.84
D2644	On-lay - porcelain/ceramic - four or more surfaces	$968.18
D2650	Inlay – resin-based composite/resin - one surface (indirect tech)	$751.63
D2651	Inlay – resin-based composite/resin - two surfaces (indirect tech)	$751.63
D2652	Inlay – resin-based composite/resin - three or more surfaces (indirect tech)	$637.05
D2662	On-lay – resin-based composite/resin - two surfaces (indirect tech)	$553.40
D2663	On-lay – resin-based composite/resin - three surfaces (indirect tech)	$650.80
D2664	On-lay – resin-based composite/resin - four or more surfaces (indirect tech)	$696.63
	Crowns - Single Restorations Only	
D2710	Crown – resin-based composite (indirect)	$393.00
D2712	Crown – 3/4 resin-based composite (indirect)	BR
D2720	Crown - resin with high noble metal	$968.18
D2721	Crown - resin with predominantly base metal	$906.30
D2722	Crown - resin with noble metal	$926.93
D2740	Crown - porcelain/ceramic substrate	$894.84
D2750	Crown - porcelain fused to high noble metal	$902.87
D2751	Crown - porcelain fused to predominantly base metal	$721.84
D2752	Crown - porcelain fused to noble metal	$773.40
D2780	Crown-3/4 cast high noble metal	$939.54
D2781	Crown-3/4 cast predominantly base metal	$884.53
D2782	Crown-3/4 cast noble metal	$913.18
D2783	Crown-3/4 Porcelain/ceramic (without facial veneers)	$967.03
D2790	Crown - full cast high noble metal	$811.21
D2791	Crown - full cast predominantly base metal	$895.99
D2792	Crown - full cast noble metal	$912.04
D2794	Crown - titanium	BR
D2799	Provisional crown	$393.00
	Other Restorative Services	
D2910	Recement inlay, onlay, or partial coverage restoration	$96.25

D2915	Recement cast or prefabricated post and core	BR
D2920	Recement crown	$85.94
D2930	Prefabricated stainless steel crown - primary tooth	$230.30
D2931	Prefabricated stainless steel crown - permanent tooth	$271.54
D2932	Prefabricated resin crown	$338.01
D2933	Prefabricated stainless steel crown with resin window	$379.25
D2934	Prefabricated esthetic coated stainless steel crown – primary tooth	BR
D2940	Sedative filling	$103.12
D2950	Core buildup, including any pins	$211.97
D2951	Pin retention - per tooth, in addition to restoration	$54.99
D2952	Cast post & core in addition to crown	$387.27
D2953	Each add cast post-same tooth	$199.37
D2954	Prefabricated post and core in addition to crown	$331.13
D2955	Post removal (not in conjunction with endodontic therapy)	$248.64
D2957	Each additional prefabricated post-same tooth	$164.99
D2960	Labial veneer (resin laminate) - chairside	$612.99
D2961	Labial veneer (resin laminate) - laboratory	$907.45
D2962	Labial veneer (porcelain laminate) - laboratory	$984.00
D2971	Additional procedures to construct new crown under existing partial denture framework To be reported in addition to a crown code.	BR
D2975	Coping A thin covering of the remaining portion of a tooth, usually fabricated of metal and devoid of anatomic contour. This is to be used as a definitive restoration.	BR
D2980	Crown repair, by report	BR
D2999	Unspecified restorative procedure, by report	BR
	Pulp Capping	
D3110	Pulp cap - direct (excluding final restoration)	$82.49
D3120	Pulp cap - indirect (excluding final restoration)	$79.06
	Pulpotomy	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$169.57
D3221	Pulpal debridement, primary & permanent teeth	$170.72
	Endodontic Therapy or Primary Teeth	
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$163.85
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$176.45
	Endodontic Therapy (Including Treatment Plan, Clinical Procedures and Follow-up Care)	
D3310	Anterior (excluding final restoration)	$515.60
D3320	Bicuspid (excluding final restoration)	$617.58
D3330	Molar (excluding final restoration)	$952.00
D3331	Treatment root canal obstruction -non-surgical access	$221.13
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$568.31
D3333	Internal Root Repair of perforation defects	$189.05
	Endodontic Retreatment	

D3346	Retreatment of previous root canal therapy - anterior	$884.53
D3347	Retreatment of previous root canal therapy - bicuspid	$1,042.65
D3348	Retreatment of previous root canal therapy - molar	$1,253.47
	Apexification/Recalcification Procedures	
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$372.37
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	$162.70
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair or perforations, root resorption, etc.)	$549.97
	Apicoectomy/Periradicular Services	
D3410	Apicoectomy/periradicular surgery - anterior	$464.03
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$821.52
D3425	Apicoectomy/periradicular surgery - molar (first root)	$929.22
D3426	Apicoectomy/periradicular surgery - (each additional root)	$309.36
D3430	Retrograde filling - per root	$228.01
D3450	Root amputation - per root	$461.74
D3460	Endodontic endosseous implant	$2,214.78
D3470	Intentional re-implantation (including necessary splinting)	$920.05
	Other Endodontic Procedures	
D3910	Surgical procedure for isolation of tooth with rubber dam	$120.30
D3920	Hemisection (including any root removal,) not including root canal therapy	$359.77
D3950	Canal preparation and fitting of performed dowel or post	$163.85
D3999	Unspecific endodontic procedure, by report	BR
	Surgical Services (Including Usual Postoperative Care)	
D4210	Gingivectomy or gingivoplasty - four or more contiquous teeth or bounded teeth spaces per quadrant	$472.06
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	$270.00
D4240	Gngival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$865.06
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	$865.06
D4245	Apically positioned flap	$622.16
D4249	Clinical crown lengthening - hard tissue	$986.50
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	$916.62
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	$916.62
D4263	Bone replacement graft - first site in quadrant	$421.64
D4264	Bone replacement graft - each additional site in quadrant	$210.83
D4265	Biologic materials to aid in soft and osseous tissue regeneration	BR
D4266	Guided tissue regeneration - resorbable barrier, per site	$508.72
D4267	Guided tissue regeneration - nonresorbable barrier, per site, (includes membrane removal)	$654.23

D4268	Surgical revision procedure per tooth	BR
D4270	Pedicle soft tissue graft procedure	$1,032.34
D4271	Free soft tissue graft procedure (including donor site surgery)	$1,060.98
D4273	Subepithelial connective tissue graft procedures, per tooth	$1,132.02
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$319.67
D4275	Soft tissue allograft	BR
D4276	Combined connective tissue and double pedicle graft, per tooth	BR
	Non-Surgical Periodontal Service	
D4320	Provisional splinting - intracoronal	$413.62
D4321	Provisional splinting - extracoronal	$511.01
D4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$211.97
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant	$211.97
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$148.95
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	BR
	Other Periodontal Services	
D4910	Periodontal maintenance	$134.06
D4920	Unscheduled dressing change (by someone other than treating dentist)	$114.58
D4999	Unspecified periodontal procedure, by report	BR
	Complete Dentures (Including Routine Post-Delivery Care)	
D5110	Complete denture - maxillary	$1,374.93
D5120	Complete denture - mandibular	$1,374.93
D5130	Immediate denture - maxillary	$1,311.91
D5140	Immediate denture - mandibular	$1,311.91
	Partial Dentures (Including Routine Post-Delivery Care)	
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$1,122.85
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$1,122.85
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$1,374.93
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$1,374.93
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	BR
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	BR
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	$889.12
	Adjustments to Dentures	
D5410	Adjust complete denture - maxillary	$75.62
D5411	Adjust complete denture - mandibular	$75.62
D5421	Adjust partial denture - maxillary	$75.62

D5422	Adjust partial denture - mandibular	$75.62
	Repairs to Complete Dentures	
D5510	Repair broken complete denture base	$217.70
D5520	Replace missing or broken teeth - complete denture (each tooth)	$120.30
	Repairs to Partial Dentures	
D5610	Repair resin denture base	$171.87
D5620	Repair cast framework	$229.15
D5630	Repair replace broken clasp	$211.97
D5640	Replace broken teeth - per tooth	$120.30
D5650	Add tooth to existing partial denture	$171.87
D5660	Add clasp to existing partial denture	$223.43
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	BR
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	BR
	Denture Rebase Procedures	
D5710	Rebase complete maxillary denture	$418.21
D5711	Rebase complete mandibular denture	$535.08
D5720	Rebase maxillary partial denture	$528.20
D5721	Rebase mandibular partial denture	$528.20
	Denture Reline Procedures	
D5730	Reline complete maxillary denture (chairside)	$286.45
D5731	Reline complete mandibular denture (chairside)	$286.45
D5740	Reline maxillary partial denture (chairside)	$289.88
D5741	Reline mandibular partial denture (chairside)	$289.88
D5750	Reline complete maxillary denture (laboratory)	$343.73
D5751	Reline complete mandibular denture (laboratory)	$343.73
D5760	Reline maxillary partial denture (laboratory)	$415.92
D5761	Reline mandibular partial denture (laboratory)	$415.92
	Interim Prosthesis	
D5810	Interim complete denture (maxillary)	$666.84
D5811	Interim complete denture (mandibular)	$717.25
D5820	Interim partial denture (maxillary) (includes any necessary clasps and rests)	$515.60
D5821	Interim partial denture (mandibular) (includes any necessary clasps and rests)	$547.68
	Other Removable Prosthetic Services	
D5850	Tissue conditioning, maxillary	$131.76
D5851	Tissue conditioning, mandibular	$131.76
D5860	Overdenture - complete, by report	BR
D5861	Overdenture - partial, by report	BR
D5862	Precision attachment, by report	BR
D5867	Replacement of replaceable part of semi-precision or precision attachment (male or female component)	BR
D5875	Modification of removable prosthesis following implant surgery	BR
D5899	Unspecified removable prosthodontic procedure, by report	BR
	Maxillofacial Prosthetics	
D5911	Facial moulage (sectional)	$349.46
D5912	Facial moulage (complete)	$349.46
D5913	Nasal prosthesis	$7,369.61

D5914	Auricular prosthesis	$7,369.61
D5915	Orbital prosthesis	$9,972.80
D5916	Ocular prosthesis	$2,658.90
D5919	Facial prosthesis	BR
D5922	Nasal spetal prosthesis	BR
D5923	Ocular prosthesis, interim	$2,608.92
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	$3,967.81
D5932	Obturator prosthesis, definitive	$7,421.17
D5933	Obturator prosthesis, modification	BR
D5934	Mandibular resection prosthesis with guide flange	$6,763.49
D5935	Mandibular resection prosthesis without guide flange	$5,884.68
D5936	Obturator prosthesis, interim	$6,609.96
D5937	Trismus appliance (not for TMD treatment)	$830.68
D5951	Feeding aid	$1,080.46
D5952	Speech aid prosthesis, pediatric	$3,507.20
D5953	Speech aid prosthesis, adult	$6,660.37
D5954	Palatal augmentation prosthesis	$6,172.28
D5955	Palatal lift prosthesis, definitive	$5,708.23
D5958	Palatal lift prosthesis, interim	BR
D5959	Palatal lift prosthesis, modification	BR
D5960	Speech aid prosthesis, modification	BR
D5982	Surgical stent	$686.32
D5983	Radiation carrier	$1,661.37
D5984	Radiation shield	$1,661.37
D5985	Radiation cone locator	$1,661.37
D5986	Fluoride gel carrier	$140.93
D5987	Commissure splint	$2,493.20
D5988	Surgical splint	BR
D5999	Unspecified maxillofacial prosthesis	BR
	Implant Services (Local anesthesia is considered to be part of implant service procedures)	
D6010	Surgical placement of implant body: endosteal implant	$2,305.29
D6040	Surgical placement: eposteal implant	$10,601.83
D6050	Surgical placement: transosteal implant	$6,580.17
	Implant Supported Prosthetics	
D6053	Implant/abutment supported removable denture for complete edentulous arch	BR
D6054	Implant/abutment supported removable denture for partially edentuous arch	BR
D6055	Dental implant supported connecting bar	$585.49
D6056	Prefabricated abutment – includes placement	BR
D6057	Custom Abutment - includes placemen	BR
D6058	Abutment supported porcelain/ceramic crown	$1,326.80

D6059	Abutment support porcelain fused to metal crown (high noble metal)	$1,309.62
D6060	Abutment support porcelain fused metal crown (predominantly base metal)	$1,237.43
D6061	Abutment support porcelain fused to metal crown (noble metal)	$1,262.64
D6062	Abutment supported cast metal crown (high noble metal)	$1,258.06
D6063	Abutment supported cast metal crown (predominantly base metal)	$1,073.58
D6064	Abutment supported cast metal crown (noble metal)	$1,144.63
D6094	Abutment supported crown – (titanium)	BR
D6065	Implant supported porcelain/ceramic crown	$1,305.04
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$1,271.81
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$1,234.00
D6068	Abutment supported retainer for porcelain/ceramic FPD	$1,326.80
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal))	$1,309.62
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$1,237.43
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal	$1,262.64
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$1,288.99
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$1,166.40
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$1,258.06
D6194	Abutment supported retainer crown for FPD – (titanium)	BR
D6075	Implant supported retainer for ceramic FPD	$1,305.04
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, high noble metal)	$1,271.81
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, high noble metal)	$1,234.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch	BR
D6079	Implant/abut supported fixed denture for partially edentulous arch	BR
	Other Implant Services	
D6080	Implant maintenance procedures, including: removal of prosthesis, cleansing of prosthesis and abutments, reinsertion of prosthesis	BR
D6090	Repair implant supported prosthesis, by report	BR
D6095	Repair implant abutment, by report	BR
D6100	Implant removal, by report	BR
D6190	Radiographic/surgical implant index, by report	BR
D6199	Unspecified implant procedure, by report	BR
	Prosthodontics, fixed	
D6205	Pontic – indirect resin based composite Not to be used as a temporary or provisional prosthesis.	BR
D6210	Pontic - cast high noble metal	$811.21
D6211	Pontic - cast predominantly base metal	$870.78
D6212	Pontic - cast noble metal	$906.30
D6214	Pontic – titanium	BR
D6240	Pontic - porcelain fused to high noble metal	$830.68

D6241	Pontic - porcelain fused to predominantly base metal	$744.76
D6242	Pontic - porcelain fused to noble metal	$894.84
D6245	Pontic-porcelain/ceramic	$947.55
D6250	Pontic - resin with high noble metal	$906.30
D6251	Pontic - resin with predominantly base metal	$836.42
D6252	Pontic - resin with noble metal	$863.10
D6253	Provisional pontic	BR
	Fixed Partial Denture Retainers - Inlays/Onlays	
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$830.68
D6548	Retainer-porcelain/ceramic for resin bonded fixed prosthesis	$423.93
D6600	Inlay - procelain/ceramic for resin bonded fixed prosthesis	$859.33
D6601	Inlay - porcelain/ceramic, three or more surfaces	$917.76
D6602	Inlay - cast high noble metal, two surfaces	$800.90
D6603	Inlay - cast high noble metal, three or more surfaces	$981.93
D6604	Inlay - cast predominantly base metal, two surfaces	$800.90
D6605	Inlay - cast predominantly base metal, three or more surfaces	$917.76
D6606	Inlay - cast noble metal, two surfaces	$800.90
D6607	Inlay - cast noble metal, three or more surfaces	$981.93
D6624	Inlay - titanium	BR
D6608	Onlay - porcelain/Ceramic, two surfaces	$859.33
D6609	Only - porcelain/ceramic, three or more surfaces	$981.93
D6610	Onlay - cast high noble metal, two surfaces	$800.90
D6611	Onlay - cast high noble metal, three or more surfaces	$917.76
D6612	Onlay - cast predominantly base metal, two surfaces	$800.90
D6613	Onlay - cast predominantly base metal, three or more surfaces	$917.76
D6614	Onlay - cast noble metal, two surfaces	$940.68
D6615	Onlay - cast noble metal, three or more surfaces	$940.68
D6634	Onlay - titanium	BR
	Fixed Partial Denture Retainers - Crowns	
D6710	Crown – indirect resin based composite Not to be used as a temporary or provisional prosthesis.	BR
D6720	Crown - resin with high noble metal	$779.12
D6721	Crown - resin with predominantly base metal	$970.47
D6722	Crown - resin with noble metal	$987.66
D6740	Crown-porcelain/ceramic	$1,075.89
D6750	Crown - porcelain fused to high noble metal	$830.68
D6751	Crown - porcelain fused to predominantly base metal	$773.40
D6752	Crown - porcelain fused to noble metal	$1,001.41
D6780	Crown - 3/4 cast high noble metal	$773.40
D6781	Crown - ¾ cast predominately base metal	$987.66
D6782	Crown - ¾ cast noble metal	$917.76
D6783	Crown - 3/4 porcelain/ceramic	$1,017.45
D6790	Crown - full cast high noble metal	$790.58
D6791	Crown - full cast predominantly base metal	$959.01
D6792	Crown - full cast noble metal	$993.38
D6793	Provisional retainer crown	BR
D6794	Crown - titanium	BR

	Other Fixed Partial Denture Services	
D6920	Connector bar	$175.31
D6930	Recement fixed partial denture	$143.22
D6940	Stress breaker	$278.42
D6950	Precision attachment	$544.24
D6970	Cast post and core in addition to fixed partial denture retainer	$339.15
D6971	Cast post as part of fixed partial denture retainer	$297.90
D6972	Prefabricated post and core in addition to fixed partial denture retainer	$276.13
D6973	Core build up for retainer, including any pins	$222.27
D6975	Coping - metal	$608.41
D6976	Each additional cast post - same tooth	$144.36
D6977	Each additional prefabricated post - same tooth	$137.49
D6980	Fixed partial denture repair, by report	BR
D6985	Pediatric partial denture, fixed	BR
D6999	Unspecified fixed prosthodontic procedure, by report	BR
	Oral and Maxillofacial Surgery	
	Extractions (Includes Local Anesthesia, Suturing, If Needed, and Routine Postoperative Care)	
D7111	Extraction, coronal remnants - deciduous tooth	BR
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	BR
	Surgical Extractions (Includes Local Anesthesia, Suturing, If Needed, and Routine Postoperative Care)	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$206.24
D7220	Removal of impacted tooth - soft tissue	$230.30
D7230	Removal of impacted tooth - partially bony	$270.40
D7240	Removal of impacted tooth - completely bony	$318.52
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$446.85
D7250	Surgical removal of residual tooth roots (cutting procedure)	$229.15
	Other Surgical Procedures	
D7260	Oroantral fistual closure	$2,305.29
D7261	Primary closure of a sinus perforation	BR
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$477.79
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	$679.44
D7280	Surgical access of an unerupted tooth	$523.62
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	BR
D7283	Placement of device to facilitate eruption of impacted tooth	BR
D7285	Biopsy of oral tissue – hard (bone, tooth)	$926.93
D7286	Biopsy of oral tissue – soft	$380.40
D7287	Exfoliative cytological sample collection	BR
D7288	Brush biopsy – transepithelial sample collection	BR
D7290	Surgical repositioning of teeth	$431.96
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$65.31
	Alveoloplasty - Surgical Preparation of Ridge For Dentures	
D7310	Alveoloplasty in conjunction with extractions - per quadrant	$252.07

D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	BR
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	$343.73
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	BR
	Vestibuloplasty	
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	$2,065.82
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$6,478.20
	Surgical Excision of Soft Tissue Lesions	
D7410	Excision or benign lesion up to 1.25 cm	$1,440.23
D7411	Excision of benign lesion greater than 1.25 cm	BR
D7412	Excision of benign lesion, complicated	BR
D7413	Excision of malignant lesion up to 1.25 cm	BR
D7414	Excision of malignant lesion greater than 1.25 cm	BR
D7415	Excision of malignant lesion, complicated	BR
D7465	Destruction of lesion(s) by physical or chemical method, by report	BR
	Surgical Excision of Intra-Osseous Lesions	
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	$1,458.57
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	$2,266.34
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$826.10
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$1,297.02
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$826.10
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$1,330.24
	Excision of Bone Tissue	
D7471	Removal of exostosis (maxilla or mandible)	$855.89
D7472	Removal of torus palatinus	BR
D7473	Removal of torus mandibularis	BR
D7485	Surgical reduction of osseous tuberosity	BR
D7490	Radical resection of mandible with bone graft	$6,910.15
	Surgical Incision	
D7510	Incision and drainage of abscess - intraoral soft tissue	$247.48
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	BR
D7520	Incision and drainage of abscess - extraoral soft tissue	$1,179.00
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	BR
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$425.08
D7540	Removal of reaction-producing foreign bodies - musculoskeletal system	$470.91
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$293.32
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$2,332.79
	Treatment of Fractures - Simple	

D7610	Maxilla - open reduction (teeth immobilized, if present)	$3,771.88
D7620	Maxilla - closed reduction (teeth immobilized, if present)	$2,828.91
D7630	Mandible - open reduction (teeth immobilized, if present)	$4,903.90
D7640	Mandible - closed reduction (teeth immobilized, if present)	$3,111.91
D7650	Malar and/or zygomatic arch - open reduction	$2,358.00
D7660	Malar and/or zygomatic arch - closed reduction	$1,389.82
D7670	Alveolus -closed reduction may include stabilization of teeth	$1,085.04
D7671	Alveolus - open reduction, may include stabilization of teeth	BR
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	$7,072.86
	Treatment of Fractures - Compound	
D7710	Maxilla - open reduction	$4,432.99
D7720	Maxilla - closed reduction	$3,111.91
D7730	Mandible - open reduction	$6,412.89
D7740	Mandible - closed reduction	$3,172.64
D7750	Malar and/or zygomatic arch - open reduction	$4,035.41
D7760	Malar and/or zygomatic arch - closed reduction	$1,618.97
D7770	Alveolus - open reduction stabilization of teeth	$2,194.15
D7771	Alveolus - closed reduction stabilization of teeth	BR
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches	$9,430.85
	Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions	
D7810	Open reduction of dislocation	$4,148.84
D7820	Closed reduction of dislocation	$679.44
D7830	Manipulation under anesthesia	$389.57
D7840	Condylectomy	$5,655.53
D7850	Surgical discectomy, with/without implant	$4,883.28
D7852	Disc repair	$5,591.37
D7854	Synovectomy	$5,770.11
D7856	Myotomy	$4,094.99
D7858	Joint reconstruction	$11,670.84
D7860	Arthrotomy	$4,974.94
D7865	Arthroplasty	$8,015.82
D7870	Arthrocentesis	$264.68
D7871	Non-arthroscopic lysis & lavage	$529.35
D7872	Arthroscopy - diagnosis, with or without biopsy	$2,827.76
D7873	Arthroscopy - surgical: lavage & lysis of adhesions	$3,404.08
D7874	Arthroscopy - surgical: disc repositioning and stabilization	$4,883.28
D7875	Arthroscopy - surgical: synovectomy	$5,349.61
D7876	Arthroscopy - surgical: discectomy	$5,767.82
D7877	Arthroscopy - surgical: debridement	$5,090.67
D7880	Occlusal orthotic device, by report	$1,604.08
D7899	Unspecified TMD therapy, by report	BR
	Repair of Traumatic Wounds	
D7910	Suture of recent small wounds up to 5 cm	$229.15
	Complicated Suturing	

	(Reconstruction Requiring Delicate Handling of Tissues and Wide Undermining for Meticulous Closure)	
D7911	Complicated suture - up to 5 cm	$942.97
D7912	Complicated suture - greater than 5 cm	$1,698.03
	Other Repair Procedures	
D7920	Skin graft (identify defect covered, location, and type of graft)	$2,781.94
D7940	Osteoplasty - for orthognathic deformities	$8,327.47
D7941	Osteotomy – mandibular rami	$8,327.47
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	$8,672.35
D7944	Osteotomy - segmented or subapical - per sextant or quadrant	$7,732.81
D7945	Osteotomy - body of mandible	$8,580.69
D7946	LeFort I (maxilla - total)	$10,602.98
D7947	LeFort I (maxilla - segmented)	$8,932.44
D7948	LeFort II or LeFort III (osteoplasty of facial bone for midface hypoplasia or retrusion) - without bone graft	$13,909.68
D7949	LeFort II or LeFort III - with bone graft	$19,568.64
D7950	Osseous, osteoperiosteal or cartilage graft of the mandible or facial bones - autogenous or nonautogenous, by report	BR
D7953	Bone replacement graft for ridge preservation – per site	BR
D7955	Repair of maxillofacial soft and/or hard tissue defect	BR
D7960	Frenulectomy (frenectomy or frenotomy), separate procedure	$317.38
D7963	Frenulplasty	BR
D7970	Excision of hyperplastic tissue - per arch	$472.06
D7971	Excision of pericoronal gingiva	$178.74
D7972	Surgical reduction of fibrous tuberosity	BR
D7980	Sialolithotomy	$800.90
D7981	Excision of salivary gland, by report	BR
D7982	Sialodochoplasty	$2,154.05
D7983	Closure of salivary fistula	$2,055.51
D7990	Emergency tracheotomy	$1,885.94
D7991	Coronoidectomy	$4,667.88
D7995	Synthetic graft - mandible or facial bones, by report	BR
D7996	Implant - mandible for augmentation purposes (excluding alveolar ridge), by report	BR
D7997	Appliance Removal (not by dentist who placed appliance), includes removal of archbar	$288.74
D7999	Unspecified oral surgery procedure, by report	BR
	Orthodontics	
	Limited Orthodontic Treatment	
D8010	Limited orthodontic treatment of the primary dentition	BR
D8020	Limited orthodontic treatment of the transitional dentition	BR
D8030	Limited orthodontic treatment of the adolescent dentition	BR
D8040	Limited orthodontic treatment of the adult dentition	BR
	Interceptive Orthodontic Treatment	
D8050	Interceptive orthodontic treatment of the primary dentition	BR
D8060	Interceptive orthodontic treatment of the transitional dentition	BR
	Comprehensive Orthodontic Treatment	

D8070	Comprehensive orthodontic treatment of the transitional dentition	BR
D8080	Comprehensive orthodontic treatment of the adolescent dentition	BR
D8090	Comprehensive orthodontic treatment of the adult dentition	BR
	Minor Treatment to Control Harmful Habits	
D8210	Removable appliance therapy	BR
D8220	Fixed appliance therapy	BR
	Other Orthodontic Services	
D8660	Pre-orthodontic treatment visit	$79.06
D8670	Periodic orthodontic treatment visit (as part of contract)	$380.40
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$836.42
D8690	Orthodontic treatment (alternative billing to a contract fee)	$395.29
D8691	Repair of orthodontic appliance	$207.38
D8692	Replacement of lost or broken retainer	$413.62
D8999	Unspecified orthodontic procedure, by report	BR
	Adjunctive General Services	
	Unclassified Treatment	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$127.18
	Anesthesia	
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$63.02
D9211	Regional block anesthesia	$51.56
D9212	Trigeminal division block anesthesia	$95.09
D9215	Local anesthesia	$51.56
D9220	Deep sedation/general anesthesia - first 30 minutes	$421.64
D9221	Deep sedation/general anesthesia - each additional 15 minutes	$177.60
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$82.49
D9241	Intravenous conscious sedation/analgesia - first 30 min	$332.27
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	$138.64
D9248	Non-intravenous conscious sedation	$71.04
	Professional Consultation	
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	$222.27
	Professional Visits	
D9410	House/extended care facility call	$293.32
D9420	Hospital call	$403.32
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$74.48
D9440	Office visit - after regularly scheduled hours	$114.58
D9450	Case presentation, detailed and extensive treatment planning	BR
	Drugs	
D9610	Therapeutic drug injection, by report	BR
D9630	Other drugs and/or medicaments, by report	BR
	Miscellaneous Services	
D9910	Application of desensitizing medicament	$48.12
D9911	Applic desenzt resin-cerv &/or root surf/tooth	$74.48
D9920	Behavior management, by report	BR

D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	BR
D9940	Occlusal guard, by report	$681.74
D9941	Fabrication of athletic mouthguard	$315.09
D9942	Repair and/or reline of occlusal guard	BR
D9950	Occlusion analysis - mounted case	$294.46
D9951	Occlusal adjustment - limited	$229.15
D9952	Occlusal adjustment - complete	$810.06
D9970	Enamel microabrasion	$51.56
D9971	Odontoplasty 1-2 Teeth-includes removal of enamel projections	$72.19
D9972	External Bleaching – Per Arch	$331.13
D9973	External Bleaching-Per Tooth	$36.67
D9974	Internal Bleaching-Per Tooth	$281.86
D9999	Unspecified adjunctive procedure, by report	BR