

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD  
APPLICATION FOR PERMIT**

**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

**This Section must be completed for all projects.**

**Facility/Project Identification**

Facility Name: Illinois Bone & Spine Institute		
Street Address: 300 W. Butterfield Road		
City and Zip Code: Elmhurst 60126		
County: DuPage	Health Service Area: VII	Health Planning Area: A-05

**Applicant(s)** [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: Illinois Back & Neck Institute, PLLC d/b/a Illinois Bone & Spine Institute
Street Address: 360 W. Butterfield Road, Suite 100
City and Zip Code: Elmhurst 60126
Name of Registered Agent: Neema Bayran
Registered Agent Street Address: 360 W. Butterfield Road, Suite 100
Registered Agent City and Zip Code: Elmhurst 60126
Name of Chief Executive Officer: Neema Bayran, M.D.
CEO Street Address: 360 W. Butterfield Road, Suite 100
CEO City and Zip Code: Elmhurst 60126
CEO Telephone Number: 847-501-0730

**Type of Ownership of Applicants**

<input type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership	
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental	
<input checked="" type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Other
<ul style="list-style-type: none"> <li>○ Corporations and limited liability companies must provide an <b>Illinois certificate of good standing</b>.</li> <li>○ Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.</li> </ul>		
<b>APPEND DOCUMENTATION AS <u>ATTACHMENT 1</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>		

**Primary Contact** [Person to receive ALL correspondence or inquiries]

Name: Juan Morado Jr. and Mark J. Silberman
Title: CON Counsel
Company: Benesch Friedlander Coplan and Aronoff LLP
Address: 71 South Wacker Drive, Suite 1600, Chicago, Illinois 60606
Telephone Number: 312-212-4967 and 312-212-4952
E-mail Address: jmorado@beneschlaw.com and msilberman@beneschlaw.com
Fax Number: 312-767-9192

**Additional Contact** [Person who is also authorized to discuss the application for permit]

Name:
Title:
Company Name:
Address:
Telephone Number:
E-mail Address:
Fax Number:

**Post Permit Contact**

[Person to receive all correspondence subsequent to permit issuance-**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960**]

Name: Neema Bayran, M.D.
Title: Chief Executive Officer
Company Name: Illinois Back & Neck Institute, PLLC d/b/a Illinois Bone & Spine Institute
Address: 360 W. Butterfield Road, Suite 100, Elmhurst 60126
Telephone Number: (847)-367-8100 ext. 7231
E-mail Address: Neema@paincenteril.com
Fax Number: (866)-998-0186

**Site Ownership**

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Menaj, LLC
Address of Site Owner: 300 West Butterfield Road, Elmhurst, Illinois 60126
Street Address or Legal Description of the Site: <b>Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.</b>
<b>APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>

**Operating Identity/Licensee**

[Provide this information for each applicable facility and insert after this page.]

Exact Legal Name: Illinois Back and Neck Institute, PLLC d/b/a Illinois Bone & Spine Institute			
Address: 360 W. Butterfield Road, Suite 100, Elmhurst 60126			
<input type="checkbox"/>	Non-profit Corporation	<input type="checkbox"/>	Partnership
<input type="checkbox"/>	For-profit Corporation	<input type="checkbox"/>	Governmental
<input checked="" type="checkbox"/>	Limited Liability Company	<input type="checkbox"/>	Sole Proprietorship
		<input type="checkbox"/>	Other
<ul style="list-style-type: none"> <li>Corporations and limited liability companies must provide an Illinois Certificate of Good Standing</li> <li>Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.</li> <li><b>Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.</b></li> </ul>			
<b>APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>			

**Organizational Relationships**

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

**APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**Flood Plain Requirements**

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at [www.FEMA.gov](http://www.FEMA.gov) or [www.illinoisfloodmaps.org](http://www.illinoisfloodmaps.org). **This map must be in a readable format.** In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 (<http://www.hfsrb.illinois.gov>). **NOTE: A SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM has been added at the conclusion of this Application for Permit that must be completed to deem a project complete.**

**APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**Historic Resources Preservation Act Requirements**

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

**APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**DESCRIPTION OF PROJECT****1. Project Classification**

[Check those applicable - refer to Part 1110.20 and Part 1120.20(b)]

Part 1110 Classification :

☒ Substantive☐ Non-substantive

**2. Narrative Description**

In the space below, provide a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

The Illinois Back & Neck Institute, PLLC d/b/a Illinois Bone & Spine Institute seeks authority from the Illinois Health Facilities and Services Review Board to relocate Illinois Bone & Spine Institute, presently located at 360 W. Butterfield Rd., Suite 100, Elmhurst, Illinois 60126 to 300 W. Butterfield Rd., Elmhurst, Illinois 60126

This project is classified as substantive, in that it involves the establishment of an ambulatory surgical treatment center to serve as a replacement for the existing facility pursuant to 77 Ill. Admin. Code 1110.20(c)(1)(A)(i). The facility will continue to offer the same categories of service as approved by the Board in Permit #17-073, for the Illinois Back and Neck Institute, which include Orthopedics and Pain Management. If approved, the Applicant intends to file a CON application to discontinue Illinois Back and Neck Institute effective upon completion of this project.



### Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must be equal.

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	-	-	-
Site Survey and Soil Investigation	-	-	-
Site Preparation	-	-	-
Off Site Work	-	-	-
New Construction Contracts	\$791,438	\$1,030,286	\$1,821,724
Modernization Contracts			
Contingencies	\$78,932	\$134,977	\$213,909
Architectural/Engineering Fees	\$67,204	\$87,643	\$154,847
Consulting and Other Fees	\$75,365	\$98,287	\$173,652
Movable or Other Equipment (not in construction contracts)	\$466,750	\$88,250	\$555,000
Bond Issuance Expense (project related)	-	-	-
Net Interest Expense During Construction (project related)	\$31,625	\$41,244	\$72,869
Fair Market Value of Leased Space or Equipment	\$464,997	\$606,425	\$1,071,422
Other Costs to Be Capitalized	\$124,558	\$162,442	\$287,000
Acquisition of Building or Other Property (excluding land)	-	-	-
<b>TOTAL USES OF FUNDS</b>	\$2,100,869	\$2,249,554	\$4,350,423
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	\$65,100	\$84,900	\$150,000
Pledges	-	-	-
Gifts and Bequests	-	-	-
Bond Issues (project related)	-	-	-
Mortgages	\$1,357,986.43	\$1,771,014.57	\$3,129,001
Leases (fair market value)	\$464,997	\$606,425	\$1,071,422
Governmental Appropriations	-	-	-
Grants	-	-	-
Other Funds and Sources	-	-	-
<b>TOTAL SOURCES OF FUNDS</b>	<b>\$1,888,084</b>	<b>\$2,462,339</b>	<b>\$4,350,423</b>
<b>NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>			

**Related Project Costs**

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Purchase Price: \$ <u>          N/A          </u> Fair Market Value: \$ <u>          N/A          </u>
The project involves the establishment of a new facility or a new category of service <div style="text-align: center;"><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <p>If yes, provide the dollar amount of all <b>non-capitalized</b> operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.</p> <p>Estimated start-up costs and operating deficit cost is \$ <u>3,652,288</u></p>

**Project Status and Completion Schedules**

<b>For facilities in which prior permits have been issued please provide the permit numbers.</b>
Indicate the stage of the project's architectural drawings:  <div style="display: flex; justify-content: space-around;"> <div><input type="checkbox"/> None or not applicable</div> <div><input type="checkbox"/> Preliminary</div> </div> <div style="display: flex; justify-content: space-around;"> <div><input checked="" type="checkbox"/> Schematics</div> <div><input type="checkbox"/> Final Working</div> </div>
Anticipated project completion date (refer to Part 1130.140): <u>December 31, 2023</u>
Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140):  <div style="list-style-type: none;"> <input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed.  <input type="checkbox"/> Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies  <input checked="" type="checkbox"/> Financial Commitment will occur after permit issuance.         </div>
<b>APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>

**State Agency Submittals** [Section 1130.620(c)] –

Are the following submittals up to date as applicable? <div style="list-style-type: none;"> <input type="checkbox"/> Cancer Registry – Not applicable  <input type="checkbox"/> APORS- Not applicable  <input checked="" type="checkbox"/> All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted  <input checked="" type="checkbox"/> All reports regarding outstanding permits         </div> <p><b>Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.</b></p>
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## Cost Space Requirements

Provide in the following format, the **Departmental Gross Square Feet (DGSF)** or the **Building Gross Square Feet (BGSF)** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

**Not Reviewable Space [i.e. non-clinical]:** means an area for the benefit of the patients, visitors, staff or employees of a health care facility and not directly related to the diagnosis, treatment, or rehabilitation of persons receiving services from the health care facility. "Non-clinical service areas" include, but are not limited to, chapels; gift shops; newsstands; computer systems; tunnels, walkways, and elevators; telephone systems; projects to comply with life safety codes; educational facilities; student housing; patient, employee, staff, and visitor dining areas; administration and volunteer offices; modernization of structural components (such as roof replacement and masonry work); boiler repair or replacement; vehicle maintenance and storage facilities; parking facilities; mechanical systems for heating, ventilation, and air conditioning; loading docks; and repair or replacement of carpeting, tile, wall coverings, window coverings or treatments, or furniture. Solely for the purpose of this definition, "non-clinical service area" does not include health and fitness centers. [20 ILCS 3960/3]

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
<b>REVIEWABLE</b>							
Operating Rooms (1)	\$2,100,869	-	2,737	2,737	-	-	-
Total Clinical	\$2,100,869	-	2,737	2,737	-	-	-
<b>NON-REVIEWABLE</b>							
Administrative		-	3,563	3,563		-	-
Total Non-clinical	\$2,249,554	-	3,563	3,563		-	-
<b>TOTAL</b>	<b>\$4,350,423</b>	<b>-</b>	<b>6,300</b>	<b>6,300</b>		<b>-</b>	<b>-</b>

APPEND DOCUMENTATION AS ATTACHMENT 9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

**Facility Bed Capacity and Utilization- NOT APPLICABLE**

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert the chart after this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which data is available**. Include observation days in the patient day totals for each bed service. Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

<b>FACILITY NAME:</b>		<b>CITY:</b>			
<b>REPORTING PERIOD DATES:</b>					
		<b>From:</b>	<b>to:</b>		
<b>Category of Service</b>	<b>Authorized Beds</b>	<b>Admissions</b>	<b>Patient Days</b>	<b>Bed Changes</b>	<b>Proposed Beds</b>
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long-Term Care					
Specialized Long-Term Care					
Long Term Acute Care					
Other ((identify))					
<b>TOTALS:</b>					

**CERTIFICATION**

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- in the case of a corporation, any two of its officers or members of its Board of Directors.
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist).
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist).
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

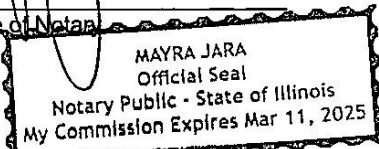
**This Application is filed on the behalf of Illinois Back & Neck Institute, PLLC d/b/a Illinois Bone & Spine Institute in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.**

Neema Bayran  
 SIGNATURE  
Neema Bayran  
 PRINTED NAME  
CEO  
 PRINTED TITLE

\_\_\_\_\_  
 SIGNATURE  
 \_\_\_\_\_  
 PRINTED NAME  
 \_\_\_\_\_  
 PRINTED TITLE

Notarization:  
 Subscribed and sworn to before me  
 this 25 day of October, 2022

Notarization:  
 Subscribed and sworn to before me  
 this \_\_\_\_ day of \_\_\_\_\_

Mayra Jara  
 Signature of Notary  
 Seal, 

\_\_\_\_\_  
 Signature of Notary  
 Seal

\*Insert the EXACT legal name of the applicant

### SECTION III. BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

#### 1110.110(a) – Background of the Applicant

READ THE REVIEW CRITERION and provide the following required information:

##### BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility.
3. For the following questions, please provide information for each applicant, including corporate officers or directors, LLC members, partners and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.
  - a. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant, directly or indirectly, during the three years prior to the filing of the application.
  - b. A certified listing of each applicant, identifying those individuals that have been cited, arrested, taken into custody, charged with, indicted, convicted or tried for, or pled guilty to the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or the subject of any juvenile delinquency or youthful offender proceeding. Unless expunged, provide details about the conviction and submit any police or court records regarding any matters disclosed.
  - c. A certified and detailed listing of each applicant or person charged with fraudulent conduct or any act involving moral turpitude.
  - d. A certified listing of each applicant with one or more unsatisfied judgements against him or her.
  - e. A certified and detailed listing of each applicant who is in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order or directive of any court or governmental agency.
4. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
5. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant can submit amendments to previously submitted information, as needed, to update and/or clarify data.

**APPEND DOCUMENTATION AS ATTACHMENT 11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.**

**Criterion 1110.110(b) & (d)****PURPOSE OF PROJECT**

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

For projects involving modernization, describe the conditions being upgraded, if any. For facility projects, include statements of the age and condition of the project site, as well as regulatory citations, if any. For equipment being replaced, include repair and maintenance records.

**NOTE:** Information regarding the "Purpose of the Project" will be included in the State Board Staff Report.

**APPEND DOCUMENTATION AS ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.**

**ALTERNATIVES**

- 1) Identify **ALL** the alternatives to the proposed project:

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost;
- B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;
- C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
- D) Provide the reasons why the chosen alternative was selected.

- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**
- 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

**APPEND DOCUMENTATION AS ATTACHMENT 13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**SECTION IV. PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE****Criterion 1110.120 - Project Scope, Utilization, and Unfinished/Shell Space**

READ THE REVIEW CRITERION and provide the following information:

**SIZE OF PROJECT:**

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative and it shall include the basis used for determining the space and the methodology applied.**
2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:
  - a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies and certified by the facility's Medical Director.
  - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.
  - c. The project involves the conversion of existing space that results in excess square footage.
  - d. Additional space is mandated by governmental or certification agency requirements that were not in existence when Appendix B standards were adopted.

**Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.**

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
ASTC (1 Operating Room)	2,737 GSF	2,750 GSF per treatment room	-13 GSF	YES

**APPEND DOCUMENTATION AS ATTACHMENT 14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**PROJECT SERVICES UTILIZATION:**

This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

**A table must be provided in the following format with Attachment 15.**

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MET STANDARD?
YEAR 1	ASTC Operating Room	266 Patients (2021)	1836 Procedures	77%	Yes
YEAR 2	ASTC Operating Room	1102 Patients (2022 YTD)	1928 Procedures	80%	Yes

**APPEND DOCUMENTATION AS ATTACHMENT 15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**



**UNFINISHED OR SHELL SPACE:**

Provide the following information:

1. Total gross square footage (GSF) of the proposed shell space.
2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area or function.
3. Evidence that the shell space is being constructed due to:
  - a. Requirements of governmental or certification agencies; or
  - b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.
4. Provide:
  - a. Historical utilization for the area for the latest five-year period for which data is available; and
  - b.
  - c. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

**APPEND DOCUMENTATION AS ATTACHMENT 16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**ASSURANCES:**

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.
2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and
3. The anticipated date when the shell space will be completed and placed into operation.

**APPEND DOCUMENTATION AS ATTACHMENT 17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

The following Sections DO NOT need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18-month period prior to the submittal of the application):

- Section 1120.120 Availability of Funds – Review Criteria
- Section 1120.130 Financial Viability – Review Criteria
- Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)

## VII. 1120.120 - AVAILABILITY OF FUNDS

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable [Indicate the dollar amount to be provided from the following sources]:

<b>\$150,000</b>	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: <ol style="list-style-type: none"> <li>1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and</li> <li>2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;</li> </ol>
<b>0</b>	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated timetable of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
<b>0</b>	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated timetable of receipts;
<b>\$4,200,423</b>	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: <ol style="list-style-type: none"> <li>1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated;</li> <li>2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate;</li> <li>3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.;</li> <li>4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment;</li> <li>5) For any option to lease, a copy of the option, including all terms and conditions.</li> </ol>

0	e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
0	f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
0	g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
<b>\$4,350,423</b>	<b>TOTAL FUNDS AVAILABLE</b>

APPEND DOCUMENTATION AS ATTACHMENT 34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

**SECTION VIII. 1120.130 - FINANCIAL VIABILITY**

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

**Financial Viability Waiver**

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better
2. All the project's capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third-party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

**APPEND DOCUMENTATION AS ATTACHMENT 35, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.** When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

	Historical 3 Years			Projected
<b>Enter Historical and/or Projected Years:</b>				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

**Variance**

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

**APPEND DOCUMENTATION AS ATTACHMENT 36, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**SECTION IX. 1120.140 - ECONOMIC FEASIBILITY**

This section is applicable to all projects subject to Part 1120.

**A. Reasonableness of Financing Arrangements**

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

- 1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
- 2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
  - A) A portion or all the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
  - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

**B. Conditions of Debt Financing**

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

- 1) That the selected form of debt financing for the project will be at the lowest net cost available;
- 2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;
- 3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

**C. Reasonableness of Project and Related Costs**

Read the criterion and provide the following:

- 1) Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)	
Operating Room	\$289.16	-	-	-	2,737	-	\$791,438	-	\$791,438
Contingency	\$28.83	-	-	-	3,563	-	\$78,932	-	\$78,932
TOTALS	\$317.99	-	-	-	6,300	-	\$870,370	-	\$870,370
* Include the percentage (%) of space for circulation									
<p><b>D. Projected Operating Costs</b></p> <p>The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.</p> <p><b>E. Total Effect of the Project on Capital Costs</b></p> <p>The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.</p>									
APPEND DOCUMENTATION AS <u>ATTACHMENT 37</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.									

**SECTION X. SAFETY NET IMPACT STATEMENT**

**SAFETY NET IMPACT STATEMENT that describes all the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:**

1. The project's material impact, if any, on essential safety net services in the community, *including the impact on racial and health care disparities in the community*, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

**Safety Net Impact Statements shall also include all of the following:**

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

**A table in the following format must be provided as part of Attachment 37.**

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	2019	2020	2021
Inpatient	-	-	-
Outpatient	-	-	-
<b>Total</b>	-	-	-
Charity (cost in dollars)	2019	2020	2021
Inpatient	-	-	-
Outpatient	-	-	-
<b>Total</b>	-	-	-
MEDICAID			
Medicaid (# of patients)	2019	2020	2021
Inpatient	-	-	-
Outpatient	-	-	-
<b>Total</b>	-	-	-
Medicaid (revenue)	2019	2020	2021
Inpatient	-	-	-
Outpatient	-	-	-
<b>Total</b>	-	-	-

**APPEND DOCUMENTATION AS ATTACHMENT 38, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**SECTION X. CHARITY CARE INFORMATION**

Charity Care information **MUST** be furnished for **ALL** projects [1120.20(c)].

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity Care **must** be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 39.

CHARITY CARE			
	2019	2020	2021
Net Patient Revenue	-	-	-
Amount of Charity Care (charges)	-	-	-
Cost of Charity Care	-	-	-

APPEND DOCUMENTATION AS **ATTACHMENT 39**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.




## SECTION XI -SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM

In accordance with Executive Order 2006-5 (EO 5), the Health Facilities & Services Review Board (HFSRB) must determine if the site of the CRITICAL FACILITY, as defined in EO 5, is located in a mapped floodplain (Special Flood Hazard Area) or a 500-year floodplain. All state agencies are required to ensure that before a permit, grant or a development is planned or promoted, the proposed project meets the requirements of the Executive Order, including compliance with the National Flood Insurance Program (NFIP) and state floodplain regulation.

1. Applicant: Illinois Back & Neck Institute, PLLC d/b/a Illinois Bone & Spine Institute, 300 W. Butterfield Rd., Elmhurst, IL 60126, 847-501-0730
2. Project Location: Illinois Back & Neck Institute, PLLC d/b/a Illinois Bone & Spine Institute, 300 W. Butterfield Rd, Elmhurst, IL 60126, DuPage County, York Township.
3. You can create a small map of your site showing the FEMA floodplain mapping using the FEMA Map Service Center website (<https://msc.fema.gov/portal/home>) by entering the address for the property in the Search bar. If a map, like that shown on page 2 is shown, select the **Go To NFHL Viewer** tab

above the map. You can print a copy of the floodplain map by selecting the  icon in the top

corner of the page. Select the pin tool icon  and place a pin on your site. Print a FIRMETTE size image.

If there is no digital floodplain map available select the **View/Print FIRM** icon above the aerial photo. You will then need to use the Zoom tools provided to locate the property on the map and use the **Make a FIRMette** tool to create a pdf of the floodplain map.

**IS THE PROJECT SITE LOCATED IN A SPECIAL FLOOD HAZARD AREA: Yes \_\_\_ No X**

**IS THE PROJECT SITE LOCATED IN THE 500-YEAR FLOOD PLAIN? NO**

If you are unable to determine if the site is in the mapped floodplain or 500-year floodplain, contact the county or the local community building or planning department for assistance.

If the determination is being made by a local official, please complete the following:

FIRM Panel Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Name of Official: \_\_\_\_\_ Title: \_\_\_\_\_

Business/Agency: \_\_\_\_\_ Address: \_\_\_\_\_

(City)

(State)

(ZIP Code)

(Telephone Number)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE:** This finding only means that the property in question is or is not in a Special Flood Hazard Area or a 500-year floodplain as designated on the map noted above. It does not constitute a guarantee that the property will or will not be flooded or be subject to local drainage problems.

**If you need additional help, contact the Illinois Statewide Floodplain Program at 217/782-4428**

INDEX OF ATTACHMENTS			
ATTACHMENT NO.			PAGES
1	Applicant Identification including Certificate of Good Standing		23-25
2	Site Ownership		26-28
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.		29-30
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.		31
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10	Discontinuation		n/a
11	Background of the Applicant		46-50
12	Purpose of the Project		51
13	Alternatives to the Project		52-53
14	Size of the Project		54
15	Project Service Utilization		55-59
16	Unfinished or Shell Space		60
17	Assurances for Unfinished/Shell Space		61
<b>Service Specific:</b>			
18	Medical Surgical Pediatrics, Obstetrics, ICU		n/a
19	Comprehensive Physical Rehabilitation		n/a
20	Acute Mental Illness		n/a
21	Open Heart Surgery		n/a
22	Cardiac Catheterization		n/a
23	In-Center Hemodialysis		n/a
24	Non-Hospital Based Ambulatory Surgery		62-111
25	Selected Organ Transplantation		n/a
26	Kidney Transplantation		n/a
27	Subacute Care Hospital Model		n/a
28	Community-Based Residential Rehabilitation Center		n/a
29	Long Term Acute Care Hospital		n/a
30	Clinical Service Areas Other than Categories of Service		n/a
31	Freestanding Emergency Center Medical Services		n/a
32	Birth Center		n/a
<b>Financial and Economic Feasibility:</b>			
34	Availability of Funds		112-113
35	Financial Waiver		n/a
36	Financial Viability		n/a
37	Economic Feasibility		114-116
38	Safety Net Impact Statement		117
39	Charity Care Information		118
40	Flood Plain Information		119-120

**Attachment 1**  
**Type of Ownership of Applicant**

Included with this attachment are:

1. The Certificate of Good Standing for the applicant, Illinois Back & Neck Institute, PLLC d/b/a Illinois Bone & Spine Institute.
2. A filed application to adopt an assumed name for Illinois Bone & Spine Institute.

**Attachment 1**  
**Certificate of Good Standing**  
**Illinois Back & Neck Institute, PLLC**

File Number                      0456293-3



***To all to whom these Presents Shall Come, Greeting:***

*I, Jesse White, Secretary of State of the State of Illinois, do hereby  
certify that I am the keeper of the records of the Department of  
Business Services. I certify that*

ILLINOIS BACK & NECK INSTITUTE, PLLC, HAVING ORGANIZED IN THE STATE OF  
ILLINOIS ON OCTOBER 01, 2013, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS  
OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS  
IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF  
ILLINOIS.



Authentication #: 2222303432 verifiable until 08/11/2023  
Authenticate at: <https://www.ilsos.gov>

***In Testimony Whereof, I hereto set  
my hand and cause to be affixed the Great Seal of  
the State of Illinois, this    11TH  
day of    AUGUST    A.D.    2022    .***

*Jesse White*

SECRETARY OF STATE

## ATTACHMENT 1

## **Attachment 2 Site Ownership**

The property is currently owned by Menaj, LLC who has entered into an LOI with Illinois Bone & Spine Institute. A copy of the LOI is enclosed as evidence of control over the site.

## Attachment 2 Letter of Intent

Dear Illinois Bone & Spine Institute,

This letter of intent ("LOI") with an effective date of September 15, 2022 is between Menaj, LLC and Illinois Back & Neck Institute, PLLC d/b/a Illinois Bone & Spine Institute. This LOI does not constitute a contract between the parties and is not intended to be binding on either party.

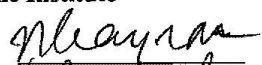
<b>Total Area Required:</b>	6,300 SF
<b>Use:</b>	Ambulatory Surgical Treatment Center
<b>Lease Commencement:</b>	1 <sup>st</sup> day of the month following CON approval date
<b>Lease Rate:</b>	\$148,700 with annual 3% increase each year
<b>Lease Term:</b>	10 Years

This LOI does not constitute a contract between the parties and is not intended to be binding on either party. This LOI is intended to solely as an expression of terms upon which the parties will endeavor to negotiate a formal and binding lease agreement which meets with the approval of both parties respective counsel. In shall either party incur any liability whatsoever of its failure to execute a formal and binding lease agreement or for any other reason.

## Attachment 2 Letter of Intent

IN WITNESS WHEREOF, this Agreement been executed by **Illinois Bone & Spine Institute** and **Menaj, LLC** on the date first above written.

### Illinois Back & Spine Institute

By:   
Printed Name: N. Bayran  
Title: CEO

### Menaj, LLC

By:   
Printed Name: Neema Bayran  
Title: Managing Member



### **Attachment 3 Operating Entity/Licensee**

The Illinois Back & Neck Institute, PLLC d/b/a Illinois Bone & Spine Institute is licensed by the Illinois Department of Public Health and will remain the licensee following this project. Attached as evidence of the owner entity's good standing is a Certificate of Good Standing issued by Illinois Secretary of State.

**Attachment 3  
Operating Entity/Licensee  
Certificate of Good Standing For  
Illinois Back & Neck Institute, PLLC**

File Number                      0456293-3



***To all to whom these Presents Shall Come, Greeting:***

*I, Jesse White, Secretary of State of the State of Illinois, do hereby  
certify that I am the keeper of the records of the Department of  
Business Services. I certify that*

ILLINOIS BACK & NECK INSTITUTE, PLLC, HAVING ORGANIZED IN THE STATE OF  
ILLINOIS ON OCTOBER 01, 2013, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS  
OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS  
IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF  
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Authentication #: 2222303432 verifiable until 08/11/2023  
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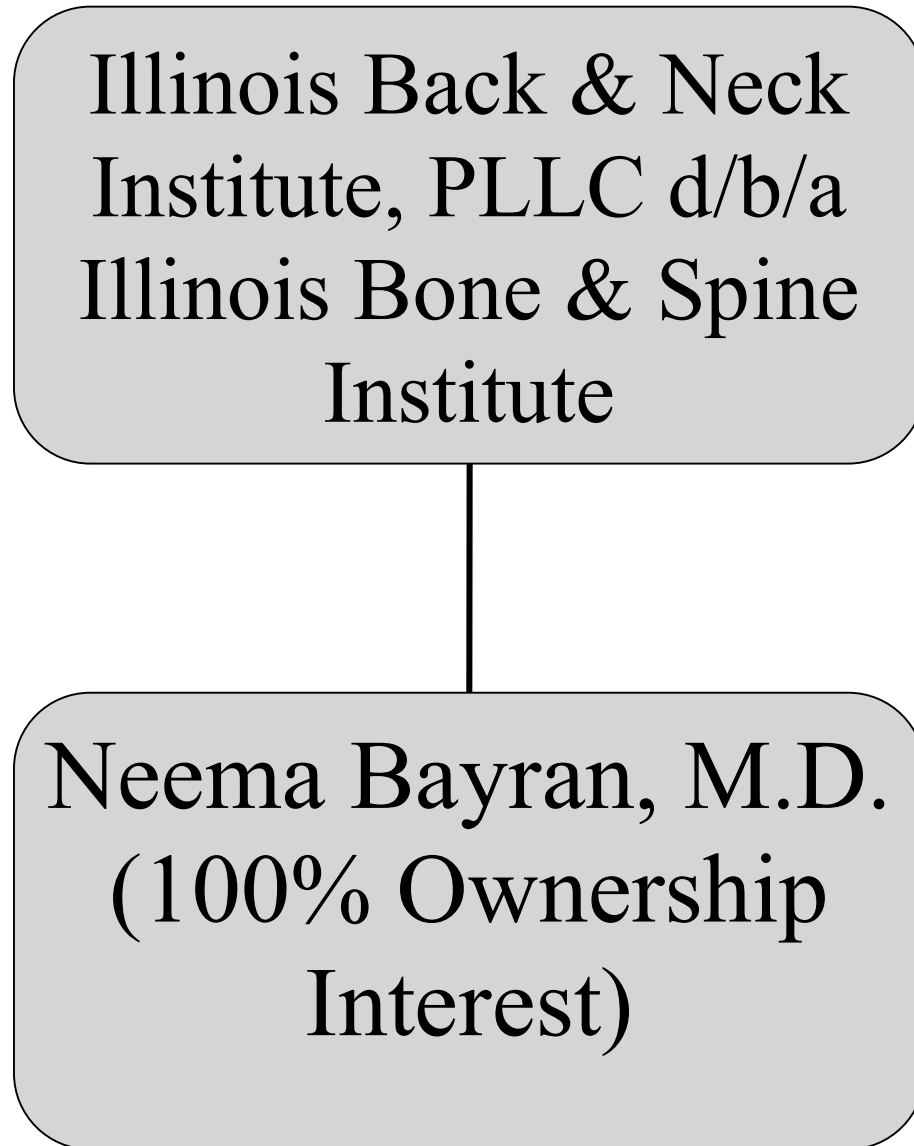
***In Testimony Whereof, I hereto set  
my hand and cause to be affixed the Great Seal of  
the State of Illinois, this    11TH  
day of    AUGUST    A.D.    2022    .***

*Jesse White*

SECRETARY OF STATE

**Attachment 4**  
**Organizational Relationships**

The facility will be owned by the CEO of Applicant, Neema Bayran, M.D., as identified in the organizational chart below.



## Attachment 5 Flood Plain Requirements

October 19, 2022

John P. Kniery  
Board Administrator  
Illinois Health Facilities and Services Review Board  
525 W Jefferson Street, Floor 2  
Springfield, IL 62761

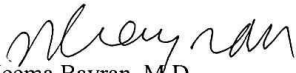
**Re: Illinois Bone & Spine Institute- Flood Plain Requirements**

Dear Mr. Kniery:

As representative of Illinois Back and Neck Institute, PLLC d/b/a Illinois Back & Spine Institute, I, Neema Bayran, M.D., affirm that the proposed relocation for the facility complies with Illinois Executive Order #2005-5. The facility location at 300 Butterfield Road, Elmhurst IL 60126 is not located in a flood plain, as evidence please find enclosed a map from the Federal Emergency Management Agency ("FEMA").

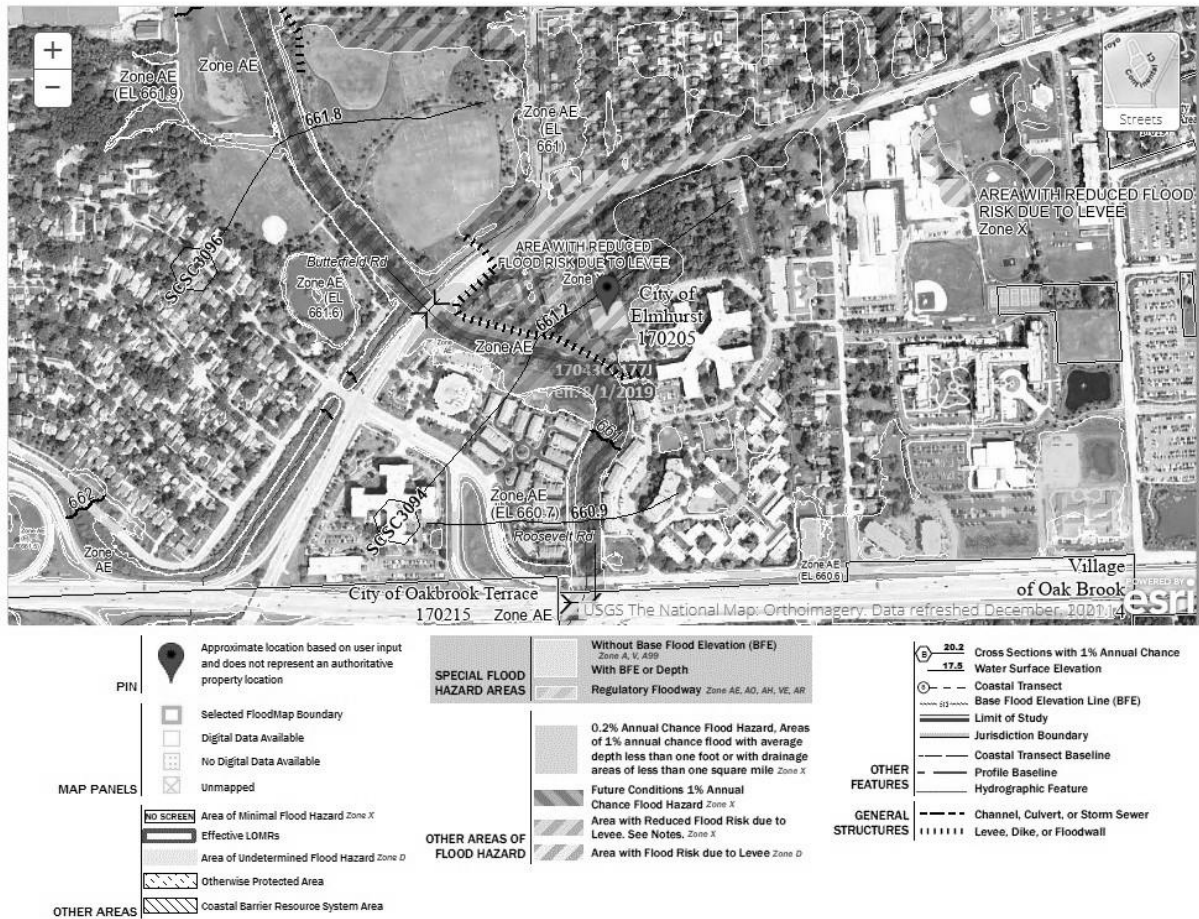
I hereby certify this true and is based upon my personal knowledge under penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely,



Neema Bayran, M.D.  
Chief Executive Officer  
Illinois Back & Spine Institute

## Attachment 5 Flood Plain Requirements



## **Attachment 6**

### **Historic Preservation Act Requirements**

The applicant submitted a request for determination to the Illinois Department of Natural Resources- Preservation Services Division on August 26, 2022. A final determination has been received, and is included with this attachment.

## Attachment 6 Historic Preservation Act Requirements



### Illinois Department of Natural Resources

One Natural Resources Way Springfield, Illinois 62702-1271  
www.dnr.illinois.gov

JB Pritzker, Governor  
Colleen Callahan, Director

**DuPage County  
Elmhurst**

**CON - Relocation of Ambulatory Surgical Treatment Center, Illinois Back and Neck Institute  
300 W. Butterfield Rd.  
SHPO Log #004082622**

**September 29, 2022**

**Juan Morado  
Benesch, Friedlander, Coplan and Aronoff LLP  
71 S. Wacker Dr., Suite 1600  
Chicago, IL 60606**

**Dear Mr. Morado:**

This letter is to inform you that we have reviewed the information provided concerning the referenced project.

Our review of the records indicates that no historic, architectural or archaeological sites exist within the project area.

Please retain this letter in your files as evidence of compliance with Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). This clearance remains in effect for two years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the Illinois Human Skeletal Remains Protection Act (20 ILCS 3440).

If you have any further questions, please contact Rita Baker, Cultural Resources Manager, at 217/785-4998 or at [Rita.E.Baker@illinois.gov](mailto:Rita.E.Baker@illinois.gov).

Sincerely,

A handwritten signature in cursive script that reads "Carey L. Mayer".

Carey L. Mayer, AIA  
Deputy State Historic  
Preservation Officer

**Attachment 6**  
**Historic Preservation Act Requirements**



Juan Morado, Jr.  
71 South Wacker Drive, Suite 1600  
Chicago, IL 60606  
Direct Dial: 312.212.4967  
Fax: 312.757.9192  
jmorado@beneschlaw.com

August 26, 2022

**VIA E-MAIL**

Jeffrey Kruchten  
Chief Archaeologist  
Preservation Services Division  
Illinois Historic Preservation Office Illinois Department of Natural Resources  
1 Natural Resources Way  
Springfield, IL 62702  
[SHPO.Review@illinois.gov](mailto:SHPO.Review@illinois.gov)

Re: Certificate of Need Application for Ambulatory Surgical Treatment Center

Dear Jeffrey:

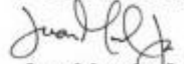
I am writing on behalf of my client, Illinois Back and Neck Institute, PLLC d/b/a Illinois Bone and Spine Institute ("IBSI") to request a review of the project area under Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). IBSI is submitting an application for a Certificate of Need from the Illinois Health Facilities and Services Review Board. IBSI currently holds a Certificate of Need (Permit #17-073), and intends to offer the same categories of services, which includes Orthopedics and Pain Management.

IBSI intends to cease operation of their existing ambulatory surgical center and relocate to 300 W. Butterfield Rd., Elmhurst, Illinois 60126. The ambulatory surgical treatment center at the new location will contain a patient waiting room, physician office space, nursing station, examination rooms, mechanical space, and one operating room.

For your reference, we have enclosed pictures of the existing lot and topographic maps showing the general location of the project. We respectfully request review of the project area and a determination letter at your earliest convenience. Thank you in advance for all of the time and effort that will be going into this review.

Very truly yours,

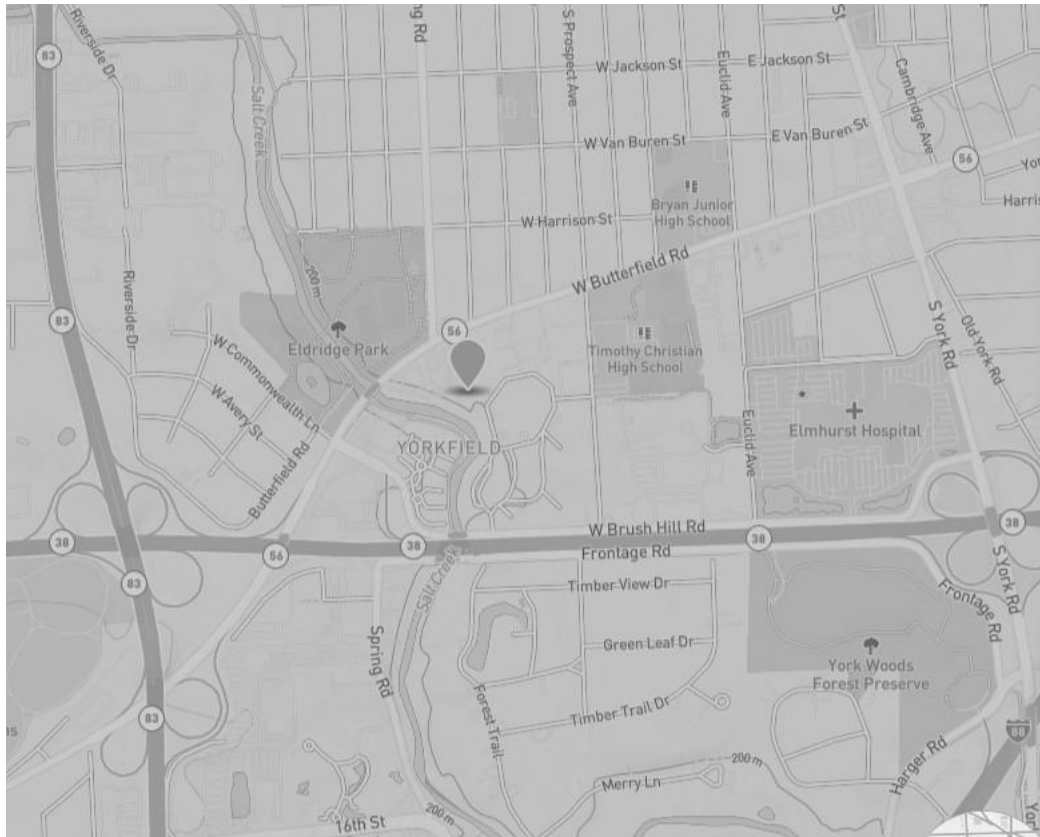
BENESCH, FRIEDLANDER,  
COPLAN & ARONOFF, LLP

  
Juan Morado, Jr.



## Attachment 6 Historic Preservation Act Requirements

Topographic Map (300 W. Butterfield Rd., blue pinpoint)



## Attachment 6 Historic Preservation Act Requirements

3D Aerial Map of 300 W Butterfield Rd, Elmhurst, IL 60126



**Attachment 6**  
**Historic Preservation Act Requirements**

**Street View of 300 W Butterfield Rd, Elmhurst, IL 60126, building in rear**



## Attachment 6 Historic Preservation Act Requirements

Parking Lot View of 300 W Butterfield Rd, Elmhurst, IL 60126



## Attachment 7

### Project Costs and Sources of Funds

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	-	-	-
Site Survey and Soil Investigation	-	-	-
Site Preparation	-	-	-
Off Site Work	-	-	-
New Construction Contracts	\$791,438	\$1,030,286	\$1,821,724
Modernization Contracts			
Contingencies	\$78,932	\$134,977	\$213,909
Architectural/Engineering Fees	\$67,204	\$87,643	\$154,847
Consulting and Other Fees	\$75,365	\$98,287	\$173,652
Movable or Other Equipment (not in construction contracts)	\$466,750	\$88,250	\$555,000
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)	\$31,625	\$41,244	\$72,869
Fair Market Value of Leased Space or Equipment	\$464,997	\$606,425	\$1,071,422
Other Costs to Be Capitalized	\$124,558	\$162,442	\$287,000
Acquisition of Building or Other Property (excluding land)	-	-	-
<b>TOTAL USES OF FUNDS</b>	<b>\$2,100,869</b>	<b>\$2,249,554</b>	<b>\$4,350,423</b>
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	\$65,100	\$84,900	\$150,000
Pledges	-	-	-
Gifts and Bequests	-	-	-
Bond Issues (project related)	-	-	-
Mortgages	\$1,357,986.43	\$1,771,014.57	\$3,129,001
Leases (fair market value)	\$464,997	\$606,425	\$1,071,422
Governmental Appropriations	-	-	-
Grants	-	-	-
Other Funds and Sources	-	-	-
<b>TOTAL SOURCES OF FUNDS</b>	<b>\$1,888,084</b>	<b>\$2,462,339</b>	<b>\$4,350,423</b>

## Attachment 7

### Project Costs and Sources of Funds

New Construction Costs	<ul style="list-style-type: none"> <li>General Contractor cost, material, and labor cost</li> <li>Miscellaneous Equipment</li> </ul>	\$1,821,724
Contingencies	<ul style="list-style-type: none"> <li>Unexpected costs associated with matter not covered under construction contract</li> </ul>	\$213,909
Architectural/Engineering Fees	<ul style="list-style-type: none"> <li>A/E Site Plans Preparation, Review Process</li> </ul>	\$154,847
Consulting and Other Fees	<ul style="list-style-type: none"> <li>CON and Permit Related Fees- \$90,000</li> <li>Testing Services-\$30,000</li> <li>Builder Permit Fees \$15,000</li> <li>Project Management-\$38,652</li> </ul>	\$173,652
Moveable or Other Equipment (not in construction contracts)	<ul style="list-style-type: none"> <li>Instrument Allowance- \$250,000</li> <li>OR Table and Jackson Table- \$135,000</li> <li>Nurse Calling System- \$35,000</li> <li>Anesthesia Machine/Setup- \$60,000</li> <li>Furniture- \$55,000</li> <li>Miscellaneous Office Equipment- \$20,000</li> </ul>	\$555,000
Net Interest Expense During Construction	<ul style="list-style-type: none"> <li>Interest related to loan</li> </ul>	\$72,869
FMV of Leased Space	<ul style="list-style-type: none"> <li>Cost of Leased Space Annually- \$148,700 with a 3% annual increase, multiplied over 10 years for life of the lease term</li> </ul>	\$1,071,422
Other Costs to Capitalized	<ul style="list-style-type: none"> <li>IT Related Upgrades to Data room, Software- \$120,000</li> <li>Re-location Costs-\$87,000</li> <li>HVAC System Commissioning-\$35,000</li> <li>Miscellaneous Fees- \$45,000</li> </ul>	\$287,000
<b>Total Project Cost</b>		<b>\$4,350,423</b>

**New Construction Contracts-** The proposed project will be constructed in a existing office building previously used for medical services. The projected building costs are based on national architectural and construction standards and adjusted to compensate for several factors. The clinical construction costs are estimated to be \$791,438 or \$289.16 per clinical square foot.

## **Attachment 7**

### **Project Costs and Sources of Funds**

**Contingencies-** The Project's contingencies costs are designed to allow the construction team an amount of funding for unforeseeable event related to construction. Clinical construction costs for contingencies are estimated to be \$78,932 or 9.9% percent of projected clinical new construction costs.

**Architectural/Engineering Fees-** The clinical project cost for architectural/engineering fees are projected to be \$67,204 or 7.72% of the new construction and contingencies costs.

**Consulting and Other Fees-** The Project's consulting fees are primarily comprised of various project related fees, additional state/local fees, and other CON related costs.

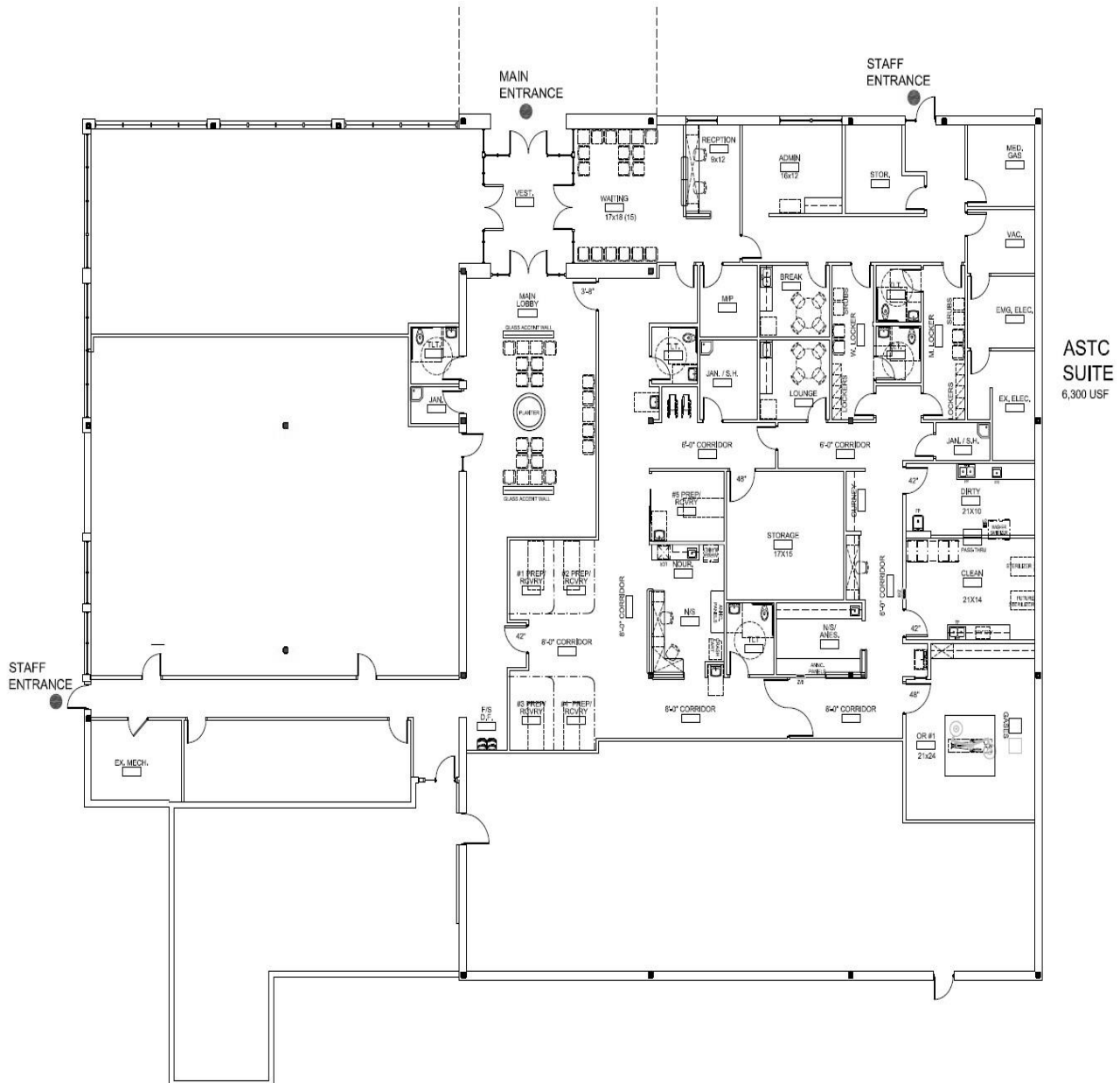
**Moveable Equipment Costs-** The moveable equipment costs are necessary for the operation of the ASTC, and proposed operating rooms and below the state standard per operating room.

**Fair Market Value of Leased Space-** The initial lease for the space will be for 10 years, and the annual rent will be \$148,700. There will be an annual increase, each year over the 10-year term. Over 10 years, the total lease value is \$1,071,422.

## Attachment 8

### Project Status and Completion Schedules

The proposed project plans are still at a schematic stage. The proposed project completion date is December 31, 2023. Financial commitment for the project will occur following permit issuance, but in accordance with HFSRB regulations.





## Attachment 9 Cost Space Requirements

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
<b>REVIEWABLE</b>							
Operating Rooms (1)	\$2,100,869	-	2,737	2,737	-	-	-
Total Clinical	\$2,100,869	-	2,737	2,737	-	-	-
<b>NON-REVIEWABLE</b>							
Administrative		-	3,563	3,563		-	-
Total Non-clinical	\$2,249,554	-	3,563	3,563		-	-
<b>TOTAL</b>	<b>\$4,350,423</b>	<b>-</b>	<b>6,300</b>	<b>6,300</b>		<b>-</b>	<b>-</b>


## Attachment 11

### Background of the Applicant

The following information is provided to illustrate the qualifications, background and character of the Applicants, and to assure the Health Facilities and Services Review Board that the proposed hospital will provide a proper standard of health care services for the community.

#### **Illinois Back & Neck Institute, PLLC dba Illinois Bone & Spine Institute**

1. The proposed project is brought forth by Illinois Back & Neck Institute, PLLC, doing business as Illinois Bone & Spine Institute. Neema Bayran, M.D., is the sole and majority owner of Illinois Back & Neck Institute, LLC. The ownership of facility is reflected in Attachment 4.
2. Dr. Bayran does have a direct ownership interest in one existing ASTC. The Applicant certifies that there have been no adverse actions taken during the three (3) years prior to filing of this application. A letter certifying to the above information is included at Attachment 11.
3. We have included a letter authorizing access to the HFSRB and IDPH to verify information contained in the application at Attachment 11.

 <b>Illinois Department of PUBLIC HEALTH</b>		HF 125554
<b>LICENSE, PERMIT, CERTIFICATION, REGISTRATION</b>		
The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.		
<b>Amaal V.E. Tokars</b> Acting Director		Issued under the authority of the Illinois Department of Public Health
EXPIRATION DATE	CATEGORY	I.D. NUMBER
5/2/2023		7003238
<b>Ambulatory Surgery Treatment Center</b>  Effective: 05/03/2022		
Illinois Back & Neck Institute LLC 360 W Butterfield Rd Ste 100 Elmhurst, IL 60126		
The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #19-493-001 10M 9/18		

**Attachment 11**  
**Background of the Applicant**

October 19, 2022

John P. Kniery  
Illinois Health Facilities and Service Review Board  
525 West Jefferson Street, 2<sup>nd</sup> Floor  
Springfield, Illinois 62761

**Re: Illinois Bone & Spine Institute – Certification and Authorization**

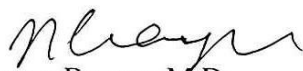
Dear Mr. Kniery,

As a representative of Illinois Back and Neck Institute, PLLC d/b/a Illinois Bone & Spine Institute, I, Neema Bayran, M.D., give authorization to the Health Facilities and Services Review Board and the Illinois Department of Public Health (“IDPH”) to access documents necessary to verify the information submitted including, but not limited to: official records of IDPH or other state agencies, the licensing or certification records of other states, and the records of nationally recognized accreditation organizations.

I further verify that I have an ownership interest in one other healthcare facility, Illinois Back and Neck Institute (“IBNI”). There are no adverse actions to report for the past three (3) years at IBNI.

I hereby certify this is true and based upon my personal knowledge under penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely,

  
Neema Bayran, M.D.  
CEO  
Illinois Bone & Spine Institute

## Attachment 11 Background of the Applicant

*Neema Bayran, MD*

*Board Certified Interventional Pain Management Physician  
Diplomate of the American Board of Anesthesiology and Pain Management  
Board Certified Independent Medical Examiner*

### The Pain Center of Illinois

Chicago and Elmhurst, Illinois  
830 N Ashland Ave. C-1N  
Chicago, Illinois 60622  
Ph: (312) 624-8364 Fax: (312) 929-3323

### CERTIFICATION

Board Certified Anesthesiologist- The American Board of Anesthesiology

Board Certified Interventional Pain Management- The American Board of Anesthesiology

American Board of Independent Medical Examiners – Board Certified Independent Medical Examiner

American Medical Association Guides to evaluation of Permanent Impairment, Sixth Edition- ABIME  
Board Certified

### CLINICAL PRACTICE

The Pain Center of Illinois Ltd. 01/2008-Present

University of Illinois at Chicago (Assistant Professor) 07/2002 to 2010

Advanced Pain Centers 04/2007 to 06/2008

Advanced Pain and Anesthesia Consultant 07/2002 to 03/2007

### Hospital Affiliation

Alexian Brothers Medical Center- Elk Gove Village, Illinois

Presence St. Joseph Hospital – Joliet, Illinois

West Lake Hospital- Melrose Park, Illinois

### Education

University of Illinois at Chicago – Chicago, Illinois

## Attachment 11

### Background of the Applicant

Fellowship in Pain Management: 2001-2002

Cleveland Clinic- Cleveland, Ohio

Special Fellowship in Pain Management: 03/2002-04/2002

University of Illinois at Chicago – Chicago, Illinois

Anesthesiology Residency- 1997-2001

Timisoara University of Medicine and Pharmacy, Timisoara, Romania

Doctor of Medicine: 1985-1991

University of Timisoara, Timisoara, Romania

Pre-Medicine: 1984-1985

#### Post-Doctoral Training:

Transitional Year

Teheran University of Medicine Science

Teheran, Iran

1992-1993

General Practitioner

Teheran, Iran

1993-1996

#### PROFESSIONAL ORGANIZATIONS

American Society of Anesthesiology- Member

American Society of Regional Anesthesia- Member

American Medical Association- Member

#### RESIDENCY ACTIVITIES AND HONORS

Chief Resident- Anesthesiology, University of Illinois at Chicago

Midwestern Anesthesiology Resident Conference (MARC), Jeopardy Tournament Award-First Place

#### LICENSURE

2002-present: Illinois Physician and Surgeon's No: 036-103729

#### CERTIFICATION

Jun-1996

USMLE step 1

Aug-1996

USMLE step 2

Sep-2000

USMLE step 3

## Attachment 11

### Background of the Applicant

Apr-03	American Board of Anesthesiology
Sep-03	American Board of Pain Medicine
July-13	American Board of Anesthesiology-Recertification
Sep-13	American Board of Pain Medicine-Recertification

#### LANGUAGES

Fluent in conversational and medical English, Romanian, Persian

#### PUBLICATIONS

- 1) Lu, Y; Laurito, C.; Beyranvand, N.; Sadoughi, A.R.;  
Yeomans, D.C.; (2001) Antinociceptive Pharmacology  
Produced by Noradrenergic Descending Modulation for Responses to Different  
Rates of Noxious Radiant Heating,  
Regional Anesthesia and Pain Medicine, Vol. 26, pp.114

#### PRESENTATIONS

- 1) Beyranvand, N.; Lu, Y; Laurito, C. ;Yeomans, D.C.;  
Antihyperalgesia induced by Exposure of Mouse Skin to Herpes Simplex Virus, which  
encodes Antisense For CGRP;  
MARC Meeting-2000
- 2) Beyranvand, N.; Lu, Y; Laurito, C. ; Sadoughi, A.R.;  
Yeomans, D.C.; Antinociceptive Pharmacology Produced  
By Noradrenergic Descending Modulation for Responses to  
Different Rates of Noxious Radiant Heating;  
MARC Meeting  
(2001)



## **Attachment 12**

### **Purpose of the Project**

This project proposes to move an existing surgery center from 360 W. Butterfield Rd., Suite 100, Elmhurst, IL 60162 and move it to 300 W. Butterfield Rd. Elmhurst, Illinois 60162. Approximately 0.3 miles. Upon approval of this application, the Applicant will file a CON application to discontinue the existing facility, established by HFSRB Permit 17-073.

The rationale is simple. The posture of the landlord has called into question the long-term viability of this ASTC continuing to operate and, based upon the success that the facility has enjoyed and the patient population dependent upon this facility for necessary and quality medical care, it is too important to Dr. Bayran to allow to chance. Therefore, Dr. Bayran has acquired a space which he will own and control at which the facility can be re-established and continue to operate without impediment.

The services provided will remain the same. The approved categories of service include pain management, orthopedic, podiatry, and gastroenterology. Those will remain unchanged.

The market area will remain, virtually, unchanged, but for the travel time of the 0.3 miles. The market area as defined by regulation is 45 minutes from the location which the ASTC will be established. The utilization this facility has enjoyed over the past several years reflects the need for the facility to continue to be available to care for the patient population. While the increased stability and control will allow for further expansion, the overwhelming majority of the expected patients are already being treated by the applicant physician and the facility at which he is currently operating.

All of the rationales that previously existed to justify the Board's approval of Illinois Back and Neck Institute, Permit, 17-073, continue to exist. The trends in healthcare (both by government and private payers) are encouraging physicians and facilities to relocate procedures that can safely and efficiently be performed in an ambulatory setting from the hospital setting because of quality, infection control, and cost. There are multiple payors that are driving the provision of care from the hospital into an ambulatory setting by adjusting the reimbursement available or strongly encouraging the relocation of the procedure. With the future of the existing facility an unknown, coupled with the current trends of healthcare to utilize ASTC, the approval of this application is timely and necessary for the patients of this population to ensure ongoing access to quality care.

## Attachment 13 Alternatives

### **Alternative #1: Maintain the Status Quo**

**No financial cost**

This alternative has no capital costs associated with it but it will likely result in the closure of the ASTC. Doing nothing would not address the issue that Illinois Back & Spine Institute can no longer remain at its current location long-term. Illinois Back & Spine Institute has been serving this community for several years now, is already familiar with this patient population, and is a key component to the healthcare delivery system. Maintaining the status quo and allowing the facility to close would run the very high risk that patients will no longer have access to these services and would likely force patients into a more restrictive and more costly setting for the provision of care that also includes a greater likelihood of resulting in suffering from prolonged chronic pain or greater reliance upon opioid dependent care. For these reasons, this alternative was not selected.

### **Alternative #2: Utilize Other Existing Facilities**

**No financial cost**

When this project was originally envisioned, it was determined that Elmhurst, Illinois was the best site for this surgery center to be located. There was an established patient base in the area. The physicians involved in the project had admitting privilege at West Lake, St. Joseph, Alexian Brothers, and Elmhurst Hospitals where they were well-established and where patients were already familiar with their services. The existing facilities did not have then, nor do they now, the capacity necessary to provide for this patient population. Accordingly, this was rejected as an alternative.

### **Alternative #3: Pursue a Joint Venture (Existing or New Facility)**

**Similar cost**

Would entering a joint venture with one or more providers or entities instead of establishing a new ASTC in the local geographic area make sense? Ultimately for the reasons stated below, the answer was no. The total projected cost of this alternative is unknown. The applicant determined that this alternative is unreasonable because the applicant already has an existing medical office and ASTC in the exact geographic location where its current ASTC exists and the proposed ASTC will be located. As such the applicant already has an established patient base in the area. Moreover, the applicant recognizes entering a joint venture would not allow the applicant the ability to design and create a center that would best fit the needs of its patients and practice autonomously, which is how the applicant has been serving this patient population for years. It is also more likely to yield circumstances of competing interests (like those with the current landlord requiring the relocation of this facility). This is a pattern worthy of avoiding repeating. For these reasons, this alternative was not selected.

### **Alternative #4: Propose a Project of Greater or Lesser Scope**

**Increased / Decreased cost**

Creating a large-scope project would undoubtedly increase the capital expenditure associated with such project. The costs associated with a smaller project would be reduced, but would not sufficiently reduce, the capital expenditures in a meaningful way. Adding additional specialties or surgical suites and thus increasing the scope of this project is not necessary, as it is not reflective of the current needs of this market area or the patient population. Creating a smaller scope project or removing a specialty would leave an unmet need which has been established as necessary based on the approval of the prior project. Neither option appears to offer sufficient financial benefit or sufficiently address access to care issues and for these reasons, this alternative was not selected.



## **Attachment 13 Alternatives**

### **Alternative #5: Refer Patient Procedures to Hospital Surgical Suites**

#### **No cost to business / Significant cost to patient and payer**

Utilizing a hospital for this market area, instead of allowing for the approval of this application to establish an ASTC, would increase access to care and cost for the payors and the patients. Hospital settings have proven to increase costs while procedures in an ASTC setting be performed at a lower cost and with the same results. Moreover, it would be inconsistent with the trends being advanced by patients and payers alike – increased utilization of outpatient settings over hospital settings to reduce cost, risk of infection, and improve patient experience. For these reasons, this alternative was rejected.

## Attachment 14

### Size of the Project

The square footage identified in this application for the proposed projects, includes one operating room, recovery stations is necessary, not excessive, and consistent with the standards identified in Appendix B of 77 Illinois Admin. Code Section 1110, as documented below.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
ASTC (1 Operating Room)	2,737 GSF	2,750 GSF per treatment room	-13 GSF	YES

## Attachment 15

### Project Services Utilization

The annual utilization expected of an ASTC is 1,500 hours per surgical or procedure room. The proposal for this facility is to establish two surgical rooms, making the objective for demonstrating utilization in excess of 1,500 hours. Based upon historical utilization and proposed patient volume, the facility should meet the state standard by its second year of operation.

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MEET STANDARD?
<b>YEAR 1</b>	ASTC Operating Room	<b>570 Patients (2021)</b>	<b>1,836 Procedures</b>	<b>77%</b>	<b>Yes</b>
<b>YEAR 2</b>	ASTC Operating Room	<b>1102 Patients (2022 YTD)</b>	<b>1,928 Procedures</b>	<b>80%</b>	<b>Yes</b>

The number of 1,836 predicted referrals are derived from patients and procedures emanating directly from current patients of Illinois Back and Neck Institute ("IBNI"), the facility to be replaced. In the last 12 months there have been 1,368 patients served at IBNI for a total of 1004 utilized surgical hours. IBNI was only recently licensed last year, and the facility only recently obtained Joint Commission Accreditation which is being used with Medicare for deemed status. Since obtaining deemed status, it has resulted in a significant increase in patient volume.

## Attachment 15 Project Services Utilization

Physician Name	Illinois Back and Neck Institute- January - August 2022	Illinois Back and Neck Institute- September - December 2021
Bayran	363	118
Bekerman	159	92
Candido	412	6
Kusper	35	0
Mohiuddin	5	0
Chundurik	11	0
Tu	25	9
Giannoulis	10	4
Park	10	4
MacGillis	7	3
Goldberg	2	1
Sompali	8	1
Poepping	6	0
Wolin	1	0
Markarian	2	2
Melkhail	22	2
Neckrysh	12	9
Erickson	3	4
Sampat	5	1
Salehi	4	0
Hussain	0	10
<b>Total</b>	<b>1102</b>	<b>266</b>
<b>Grand Total- 1368 Patients (Last 12 months)</b>		

In 2022 alone the facility has treated more than 1,102 patients. When the number of patients served in 2022 is annualized it is expected that IBNI will treat 1,836 patients in this calendar year.

## Attachment 15 Project Services Utilization

	2022 Annualized	
Physician Name	Pain Procedures	Orthopedic Procedures
Bayran	545	0
Bekerman	239	0
Candido	618	0
Kusper	53	0
Mohiuddin	8	8
Chundurik	17	0
Tu	38	38
Giannoulis	15	15
Park	15	15
MacGillis	11	11
Goldberg	3	3
Sompali	12	12
Poepping	9	9
Wolin	2	2
Markarian	3	3
Melkhail	33	33
Neckrysh	18	18
Erickson	5	5
Sampat	8	8
Salehi	6	6
Hussain	0	0
<b>Total</b>	<b>1653</b>	<b>183</b>
<b>Grand Total- 1,836 Total Patients</b>		

Utilizing the expected 1,836 patients that will be treated in 2022 and evaluating the types of procedures performed by each physician, it is expected that IBNI will utilize 1,434 surgical hours or put another way, the facility will be at 77% of target utilization (See chart below). It is expected that in the second year of operation there will be a modest 5% increase in patient volume resulting in the facility operating at 80% of target utilization.

## Attachment 15

### Project Services Utilization

The facility is approved for Pain Management and Orthopedics procedures, and the average procedure time for pain procedure at IBNI is 40 minutes including room prep, procedure time, and clean up. This is based on the facility's experience through the last 12 months of operation. The average procedure time for orthopedic procedures is 109 minutes which is based on the facility's experience through the last 12 months of operation.

Physician Name	Average Procedure Time	
	Pain - 40 Minutes	Spine- 110 minutes
Bayran	21780	0
Bekerman	9540	0
Candido	24720	0
Kusper	2100	0
Mohiuddin	300	818
Chundurik	660	0
Tu	1500	4088
Giannoulis	600	1635
Park	600	1635
MacGillis	420	1145
Goldberg	120	327
Sompali	480	1308
Poepping	360	981
Wolin	60	164
Markarian	120	327
Melkhail	1320	3597
Neckrysh	720	1962
Erickson	180	491
Sampat	300	818
Salehi	240	654
Hussain	0	0
Total Minutes	66120	19947
Total Hours	1102	332

### Attachment 15 Project Services Utilization

State Standard for One Operating Room	1500
Proposed Facility Utilization in Minutes	86067
Proposed Facility Utilization in Hours	1434
Total Projected Refferals in Year 1	1836
Total Facility Project Use in Minutes	86067
Percentage of Utilization	77%
State Standard for One Operating Room	1500
Proposed Facility Utilization in Minutes	90370
Proposed Facility Utilization in Hours	1506
Total Projected Refferals in Year 2	1928
Total Facility Project Use in Minutes	90370
Percentage of Utilization	80%

<b>Utilization Calculation</b>	
Operational Days	250
Average Hours of Operation	7.5
Procedures Hours Per Operating Room	1875
Number of Operating Rooms	1
First Year Proposed Procedures	1836
First Year Utilization	77%
Second Year Proposed Proceudres	1928
Second Year Utilization	80%

**Attachment 16**  
**Unfinished or Shell Space**

NOT APPLICABLE- The proposed project does not include plans for shell space.



**Attachment 17**  
**Assurances**

NOT APPLICABLE- The proposed project does not include plans for shell space.

**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
**Service to GSA Residents- 1110.235(c)(2)(B)**

The proposed project is necessary to meet the needs of the residents of the planning area. As noted in this application, this project involves the replacement of an existing ASTC in Elmhurst and the relocation of the facility down the block on the same street as existing ASTC. The physicians from Illinois Back and Neck Institute intend to continue referring patient to other area facilities, but ultimately patient choice will determine where procedures will take place.

With one operating room, the ASTC will have ample capacity to meet the needs of patients in the area and the demand of existing physician's patients. The facility will continue to offer time in the operating room to area providers under their open staff policy. While area hospitals have surgical capacity, it has been proven by multiple studies, articles, and actions of the Centers of Medicare and Medicaid Services (CMS) that outpatient procedures in an ASTC setting is less costly when medically appropriate. There are huge cost incentives, and ASTCs offer more patients better access to care at a lower cost.

The primary purpose of this project is to provide necessary health care to residents of the geographic service area ("GSA") in which the ASTC will be located. Listed on the following pages, in accordance with 77 Illinois Admin Code Section 1110.235(c)(2)(8) is the GSA consisting of all zip codes areas that are located within a 10 mile radius of the proposed site of the ASTC. The zip codes and area within a 10 mile radius of the proposed facility is listed below. We have included a map of the multi-directional travel radii's of the proposed ASTC site.

**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
**Service to GSA Residents- 1110.235(c)(2)(B)**

**10 Mile Radius from 300 West Butterfield Road, Elmhurst, IL 60126**



**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
**Service to GSA Residents- 1110.235(c)(2)(B)**

ZIP	CITY	2020 POPULATION
60629	Chicago	107,930
60623	Chicago	77,732
60639	Chicago	88,515
60632	Chicago	86,715
60804	Cicero	81,505
60634	Chicago	75,604
60402	Berwyn	62,729
60651	Chicago	63,679
60638	Chicago	57,057
60453	Oak Lawn	55,515
60440	Bolingbrook	52,440
60148	Lombard	52,057
60644	Chicago	45,919
60126	Elmhurst	48,928
60540	Naperville	43,887
60188	Carol Stream	41,472
60707	Elmwood Park	42,434
60565	Naperville	39,261
60101	Addison	39,261
60624	Chicago	35,054
60563	Naperville	38,785
60139	Glendale Heights	33,946
60137	Glen Ellyn	37,857
60302	Oak Park	31,568
60189	Wheaton	30,419
60525	La Grange	30,274
60517	Woodridge	32,099
60527	Willowbrook	26,800

**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
**Service Demand- Establishment of an ASTC- 1110.235(c)(3)**

We are submitting a referral letter from the Dr. Bayran on behalf of the physicians practicing at Illinois Back and Neck Institute the facility to be replaced. The letter includes zip code specific patient origin analysis of the individual's historical caseload and the patient origin to be serviced at the proposed facility is identical to that identified in the letter.

**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
**Service Demand- Establishment of an ASTC- 1110.235(c)(3)**

October 19, 2022

John P. Kniery  
 Board Administrator  
 Illinois Health Facilities and Services Review Board  
 525 W. Jefferson Street, Floor 2  
 Springfield, IL 62761

**Re: Referral Letter- Illinois Bone & Spine Institute**

Dear Mr. Kniery,

My name is Neema Bayran, M.D. and I am an orthopedic surgeon and CEO of Illinois Back and Neck Institute, PLLC d/b/a Illinois Bone & Spine Institute, an existing ASTC performing surgical procedures in the orthopedic and pain management categories of service. This letter contains the referral documentation required per 77 Ill. Admin. Code Section 1110.235(c)(3)(A)-(B). During the 12-month period prior to submission of this letter, Illinois Bone & Spine Institute through it's Drs. Bayran, Hussain, Bekerman, Candido, Chundurik, Tu, Shan, Giannolias, Park, MacGillis, Goldberg, Sompali, Markarian, Melkhail, Neckrysh, and Erickson have referred a total of 1,368 cases to the Illinois Bone & Spine Institute healthcare facility.

Historical Caseload by Licensed setting:

<b>Name of Healthcare Facility</b>	<b>Number of cases in past 12 months</b>	<b>Annualized 2022 Patient Volume</b>	<b>Illinois Bone &amp; Spine Institute</b>
Illinois Bone & Spine Institute	1,368	1,836	1,836
<b>Total</b>	<b>1,368</b>	<b>1,836</b>	<b>1,836</b>

Based on my historical referrals, I anticipate Illinois Bone & Spine Institute Physicians referring 1,836 surgical cases in year 1 of operation to Illinois Bone & Spine Institute. Enclosed with this letter is a list of patient origin by zip code of residence. I certify that the patients I propose to refer reside within the applicant's proposed geographic service area.

I further certify that the aforementioned referrals have not been used to support another pending or approved certificate of need permit application. The information provided in this letter is true and accurate to the best of my knowledge.

*Signature Page and Notary on Following Page*

**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
**Service Demand- Establishment of an ASTC- 1110.235(c)(3)**

Thank you,

Neema Bayran, M.D.

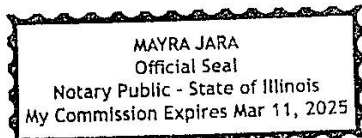
Physician's Signature Neema Bayran

Date 10/25/22

(Please Print/Type Name) Mayra Jara [Signature]  
Signature of Notary

Subscribed and sworn to before me

this 25 day of October, 2022



Seal

**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
**Service Demand- Establishment of an ASTC- 1110.235(c)(3)**

**Historical Patient Origin By Zip Code of Residence**

<b>Zip Code Area</b>	<b>County Name</b>	<b>Number of Patients</b>
60607	Cook County	74
60619	Cook County	45
60615	Cook County	34
60620	Cook County	22
60415	Cook County	57
60628	Cook County	51
64610	Lake County	22
60629	Cook County	51
60436	Will County	28
60644	Cook County	570
60155	Cook County	11



**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
**Treatment Room Assessment- 1110.235(c)(4)**

The annual utilization expected of an ASTC is 1,500 hours per surgical or procedure room. The proposal for this facility is to establish two surgical rooms, making the objective for demonstrating utilization in excess of 1,500 hours. Based upon historical utilization and proposed patient volume, the facility should meet the state standard by its second year of operation.

<b>UTILIZATION</b>					
	<b>DEPT./ SERVICE</b>	<b>HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.</b>	<b>PROJECTED UTILIZATION</b>	<b>STATE STANDARD</b>	<b>MEET STANDARD?</b>
<b>YEAR 1</b>	ASTC Operating Room	<b>570 Patients (2021)</b>	<b>1,836 Procedures</b>	<b>80%</b>	<b>Yes</b>
<b>YEAR 2</b>	ASTC Operating Room	<b>1102 Patients (2022 YTD)</b>	<b>1,928 Procedures</b>	<b>80%</b>	<b>Yes</b>

The number of 1,836 predicted referrals are derived from patients and procedures emanating directly from current patients of Illinois Back and Neck Institute ("IBNI"), the facility to be replaced. In the last 12 months there have been 1,368 patients served at IBNI for a total of 1004 utilized surgical hours. IBNI was only recently licensed last year, and the facility only recently obtained Joint Commission Accreditation which is being used with Medicare for deemed status. Since obtaining deemed status, it has resulted in a significant increase in patient volume.

Physician Name	Illinois Back and Neck Institute- January - August 2022	Illinois Back and Neck Institute- September - December 2021
Bayran	363	118
Bekerman	159	92
Candido	412	6
Kusper	35	0
Mohiuddin	5	0
Chundurik	11	0
Tu	25	9
Giannoulis	10	4
Park	10	4
MacGillis	7	3
Goldberg	2	1
Sompali	8	1
Poepping	6	0
Wolin	1	0
Markarian	2	2
Melkhail	22	2
Neckrysh	12	9
Erickson	3	4
Sampat	5	1
Salehi	4	0
Hussain	0	10
Total	1102	266
Grand Total- 1368 Patients (Last 12 months)		

**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
**Treatment Room Assessment- 1110.235(c)(4)**

In 2022 alone the facility has treated more than 1,102 patients. When the number of patients served in 2022 is annualized it is expected that IBNI will treat 1,836 patients

	2022 Annualized	
Physician Name	Pain Procedures	Orthopedic Proce
Bayran	545	0
Bekerman	239	0
Candido	618	0
Kusper	53	0
Mohiuddin	8	8
Chundurik	17	0
Tu	38	38
Giannoulis	15	15
Park	15	15
MacGillis	11	11
Goldberg	3	3
Sompali	12	12
Poepping	9	9
Wolin	2	2
Markarian	3	3
Melkhail	33	33
Neckrysh	18	18
Erickson	5	5
Sampat	8	8
Salehi	6	6
Hussain	0	0
Total	1653	183
Grand Total- 1,836 Total Patients		

**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
**Treatment Room Assessment- 1110.235(c)(4)**

Utilizing the expected 1,836 patients that will be treated in 2022 and evaluating the types of procedures performed by each physician, it is expected that IBNI will utilize 1,434 surgical hours or put another way, the facility will be at 77% of target utilization (See chart below). The facility is approved for Pain Management and Orthopedics procedures, and the average procedure time for pain procedure at IBNI is 40 minutes including room prep, procedure time, and clean up. This is based on the facility's experience through the last 12 months of operation. The average procedure time for orthopedic procedures is 109 minutes which is based on the facility's experience through the last 12 months of operation.

Physician Name	Average Procedure Time	
	Pain - 40 Minutes	Spine- 110 minutes
Bayran	21780	0
Bekerman	9540	0
Candido	24720	0
Kusper	2100	0
Mohiuddin	300	818
Chundurik	660	0
Tu	1500	4088
Giannoulis	600	1635
Park	600	1635
MacGillis	420	1145
Goldberg	120	327
Sompali	480	1308
Poepping	360	981
Wolin	60	164
Markarian	120	327
Melkhail	1320	3597
Neckrysh	720	1962
Erickson	180	491
Sampat	300	818
Salehi	240	654
Hussain	0	0
<b>Total Minutes</b>	<b>66120</b>	<b>19947</b>
<b>Total Hours</b>	<b>1102</b>	<b>332</b>

**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
**Treatment Room Assessment- 1110.235(c)(4)**

State Standard for One Operating Room	1500
Proposed Facility Utilization in Minutes	86067
Proposed Facility Utilization in Hours	1434
Total Projected Refferals in Year 1	1836
Total Facility Project Use in Minutes	86067
Percentage of Utilization	77%
State Standard for One Operating Room	1500
Proposed Facility Utilization in Minutes	90370
Proposed Facility Utilization in Hours	1506
Total Projected Refferals in Year 2	1928
Total Facility Project Use in Minutes	90370
Percentage of Utilization	80%

**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
**Treatment Room Assessment- 1110.235(c)(4)**

<b>Utilization Calculation</b>	
Operational Days	250
Average Hours of Operation	7.5
Procedures Hours Per Operating Room	1875
Number of Operating Rooms	1
First Year Proposed Procedures	1836
First Year Utilization	77%
Second Year Proposed Procedures	1928
Second Year Utilization	80%

**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
**Service Accessibility- 1110.235(c)(6)**

Facility Name	City	Number of Operating/Procedure Rooms	Distance from Proposed Facility (in miles)
Eye Surgery Center of Hinsdale	Hinsdale	2	3
Aiden Center for Day Surgery	Addison	4	6
Ambulatory Surgicenter of Downers Grove	Downers Grove	3	4
Chicago Prostate Cancer Surgery Center	Westmont	2	6
DMG Surgical Center	Lombard	8	3
DuPage Eye Surgery Center	Wheaton	3	3
Elmhurst Outpatient Surgery Center	Elmhurst	4	4
Hinsdale Surgical Center	Hinsdale	4	4
Illinois Back and Neck Institute	Elmhurst	1	3
Loyola University ASC	Oakbrook Terrace	3	1
Midwest Center for Day Surgery	Downers Grove	5	4
Rush Oak Brook Surgery Center	Oak Brook	6	4
Salt Creek Surgery Center	Westmont	4	6
OrthoTec Surgery Center	Elmhurst	1	3

As discussed throughout the application, the proposed facility will replace the Illinois Back and Neck Institute. There are fourteen other ASTCs operating within the GSA currently. Of those fourteen facilities, ten offer similar services to the facility being proposed by this project. Illinois Back and Neck Institute is one of the ten facilities in the GSA that offer these services. Two of fourteen existing surgery centers within 10 miles of the proposed facility are associated or owned by hospital systems and serve patients from those facilities.<sup>1</sup> The DMG Surgical Center is operating at or above the state standard for utilization of their facility and is not currently a destination for Illinois Back and Neck patients.

The other facilities that have available capacity are also multi-specialty facilities that are not currently serving Illinois Back and Neck patients, and offer a wide range of surgical services. Hinsdale Surgical Center is nearing the state standard for four operating rooms (74% utilization in 2020) and offers procedures in 11 categories of service, and finally Midwest Center for Day Surgery does have some available capacity (64% utilization in 2020) but has not been a facility that has served Illinois Back and Neck Institute patients in the past and has served no Medicaid patients according to their last several annual surveys while offering procedures in 6 different categories of service.

<sup>1</sup> Elmhurst Outpatient Surgery Center, Loyola University ASC

**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
**Unnecessary Duplication/Maldistribution, Impact on Area Providers-**  
**1110.235(c)(7)(a)-(c)**

The project is designed as a replacement facility for an existing ASC located down the block and on the same street as the proposed facility. The total population for the geographic service area is 1,459,442. The names and locations of the existing health care facilities can be found in the attachment addressing service accessibility. Upon approval of this CON application, the Applicant will file a CON application to discontinue Illinois Back and Neck Institute and thus avoid any unnecessary duplication.

Some of licensed ASTCs in the geographic service area are either operating at or near target utilization, some do not offer the same services that are proposed by this project, others are affiliated with hospital institutions and serve patients from those facilities. While there is available surgical capacity in the GSA, the proposed facility seeks to replace an existing facility and will not increase Maldistribution in the GSA.

Because this project will serve as a replacement of an existing facility it makes the likelihood of maldistribution minimal and will have little to no effect on other health care facilities in the GSA.



**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
**Staffing- 1110.235(c)(8)**

The facility will appoint, Neema Bayran, M.D. who is a Surgeon as Medical Director for the facility. The applicant has not traditionally had any difficulties in staffing their existing offices nor do they anticipate difficult in staffing the proposed ASTC. As needed additional staff will be identified and employed utilizing existing job search sites and professional placement services.

**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
**Charge Commitment- 1110.235(c)(9)**

October 19, 2022

John P. Kniery  
Illinois Health Facilities and Service Review Board  
525 West Jefferson Street, 2<sup>nd</sup> Floor  
Springfield, Illinois 62761


**Re: Illinois Bone & Spine Institute -Charge Commitment**

Dear Mr. Kniery,

As a representative of Illinois Back and Neck Institute, PLLC d/b/a Illinois Bone & Spine Institute, I, Neema Bayran, M.D., hereby attest that a peer review program exists or will be implemented that evaluates whether patient outcomes are consistent with quality standards established by professional organizations for ASTC services, and if outcomes do not meet or exceed those standards, that a quality improvement plan will be initiated.

Furthermore, I hereby attest that in order to meet the objectives of the Illinois Health Facilities Planning Act, which are to improve the financial ability of the public to obtain necessary health services; and to establish an orderly and comprehensive health care delivery system that will guarantee the availability of quality health care to the general public; and cost containment and support for safety net services that we have enclosed a list of CPT codes and a proposed fee schedule. We hereby commit that the charges will not increase, at a minimum, for the first 2 years of operation unless a permit is first obtained pursuant to 77 Ill. Admin. Code. 1130.310(a).

Sincerely,

  
Neema Bayran, M.D.  
CEO  
Illinois Bone & Spine Institute

## Attachment 24

### Non-Hospital Based Ambulatory Surgery Charge Commitment- 1110.235(c)(9)

A list of the relevant CPT codes, procedures and charge for the proposed ASTC is outlined below. In submitting this information, the applicant verifies that it will not increase these charges for a minimum of 24 months.

CPT Code	CPT Description	Proposed Fee Schedule
10060	INCISION & DRAINAGE ABSCESS SIMPLE/SINGLE	1,000
10061	INCISION & DRAINAGE ABSCESS COMPLICATED/MULTIPLE	1,000
10120	INCISION & REMOVAL FOREIGN BODY SUBQ TISS SIMPLE	1,000
10121	INCISION & REMOVAL FOREIGN BODY SUBQ TISS COMPL	3,395
10140	I&D HEMATOMA SEROMA/FLUID COLLECTION	2,508
10160	PUNCTURE ASPIRATION ABSCESS HEMATOMA BULLA/CYST	1,000
10180	INCISION & DRAINAGE COMPLEX PO WOUND INFECTION	3,936
11000	DBRDMT EXTENSV ECZEMA/INFECT SKN UP 10% BDY SURF	1,000
11010	DBRDMT W/RMVL FM FX&/DISLC SKIN&SUBQ TISSUS	1,088
11011	DBRDMT W/RMVL FM FX&/DISLC SKN SUBQ T/M/F MUSC	1,361
11012	DBRDMT FX&/DISLC SUBQ T/M/F BONE	3,382
11040	DEBRIDEMENT; SKIN, PARTIAL THICKNESS	1,000
11041	Debridement, skin, full thickness	1,000
11042	DEBRIDEMENT SUBCUTANEOUS TISSUE 20 SQ CM/<	2,124
11043	DEBRIDEMENT MUSCLE & FASCIA 20 SQ CM/<	2,832
11044	DEBRIDEMENT BONE MUSCLE &/FASCIA 20 SQ CM/<	3,540
11046	DEBRIDEMENT MUSCLE &/FASCIA EA ADDL 20 SQ CM	1,000
11100	BPSY OF SKIN, SUBCUT TISS &/OR MUC MEMB, UNLESS OTHERWISE LISTED; SINGLE LESION	1,000
11200	REMOVAL SKN TAGS MLT FIBRQ TAGS ANY AREA UPW/15	1,000
11305	SHAVING SKIN LESION 1 S/N/H/F/G DIAM 0.5 CM/<	1,000
11400	EXC B9 LESION MRGN XCP SK TG T/A/L 0.5 CM/<	1,000
11401	EXC B9 LESION MRGN XCP SK TG T/A/L 0.6-1.0 CM	1,000
11402	EXC B9 LESION MRGN XCP SK TG T/A/L 1.1-2.0 CM	1,000
11403	EXC B9 LESION MRGN XCP SK TG T/A/L 2.1-3.0 CM	1,531
11404	EXC B9 LESION MRGN XCP SK TG T/A/L 3.1-4.0 CM	3,395
11406	EXC B9 LESION MRGN XCP SK TG T/A/L >4.0 CM	3,395
11420	EXC B9 LESION MRGN XCP SK TG S/N/H/F/G 0.5 CM/<	1,532
11421	EXC B9 LESION MRGN XCP SK TG S/N/H/F/G 0.6-1.0CM	1,531
11422	EXC B9 LESION MRGN XCP SK TG S/N/H/F/G 1.1-2.0CM	1,532
11423	EXC B9 LESION MRGN XCP SK TG S/N/H/F/G 2.1-3.0CM	3,395
11424	EXC B9 LESION MRGN XCP SK TG S/N/H/F/G 3.1-4.0CM	3,429
11426	EXC B9 LESION MRGN XCP SK TG S/N/H/F/G > 4.0CM	4,511
11440	EXC B9 LESION MRGN XCP SK TG F/E/E/N/L/M 0.5CM/<	1,000

**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
**Charge Commitment- 1110.235(c)(9)**

<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
11441	EXC B9 LES MRGN XCP SK TG F/E/E/N/L/M 0.6-1.0CM	1,000
11442	EXC B9 LES MRGN XCP SK TG F/E/E/N/L/M 1.1-2.0CM	1,531
11443	EXC B9 LES MRGN XCP SK TG F/E/E/N/L/M 2.1-3.0CM	1,531
11444	EXC B9 LES MRGN XCP SK TG F/E/E/N/L/M 3.1-4.0CM	1,961
11446	EXC B9 LESION MRGN XCP SK TG F/E/E/N/L/M > 4.0CM	4,511
11600	EXCISION MAL LESION TRUNK/ARM/LEG 0.5 CM/<	1,000
11601	EXCISION MAL LESION TRUNK/ARM/LEG 0.6-1.0 CM	1,000
11602	EXCISION MAL LESION TRUNK/ARM/LEG 1.1-2.0 CM	1,000
11603	EXCISION MAL LESION TRUNK/ARM/LEG 2.1-3.0 CM	1,531
11604	EXCISION MAL LESION TRUNK/ARM/LEG 3.1-4.0 CM	1,531
11606	EXCISION MALIGNANT LESION TRUNK/ARM/LEG > 4.0 CM	3,395
11620	EXCISION MALIGNANT LESION S/N/H/F/G 0.5 CM/<	1,531
11621	EXCISION MALIGNANT LESION S/N/H/F/G 0.6-1.0 CM	1,000
11622	EXCISION MALIGNANT LESION S/N/H/F/G 1.1-2.0 CM	1,532
11623	EXCISION MALIGNANT LESION S/N/H/F/G 2.1-3.0 CM	3,395
11624	EXCISION MALIGNANT LESION S/N/H/F/G 3.1-4.0 CM	3,395
11626	EXCISION MALIGNANT LESION S/N/H/F/G >4.0 CM	4,511
11640	EXCISION MALIGNANT LESION F/E/E/N/L 0.5 CM/<	1,531
11641	EXCISION MALIGNANT LESION F/E/E/N/L 0.6-1.0 CM	1,531
11642	EXCISION MALIGNANT LESION F/E/E/N/L 1.1-2.0 CM	1,531
11643	EXCISION MALIGNANT LESION F/E/E/N/L 2.1-3.0 CM	1,531
11644	EXCISION MALIGNANT LESION F/E/E/N/L 3.1-4.0 CM	3,395
11646	EXCISION MALIGNANT LESION F/E/E/N/L >4.0 CM	4,511
11720	DEBRIDEMENT NAIL ANY METHOD 1-5	1,000
11730	AVULSION NAIL PLATE PARTIAL/COMPLETE SIMPLE 1	1,000
11732	AVULSION NAIL PLATE PARTIAL/COMP SIMPLE EA ADDL	1,000
11740	EVACUATION SUBUNGUAL HEMATOMA	2,653
11750	EXCISION NAIL MATRIX PERMANENT REMOVAL	1,878
11752	EXCIS OF NAIL & NAIL MATRIX, PRTL OR CMPLT, FOR PERM RMVL; W/ AMPUT OF TUFT OF DISTAL PHALANX	4,511
11755	BIOPSY NAIL UNIT SEPARATE PROCEDURE	1,822
11760	REPAIR NAIL BED	1,878
11762	RECONSTRUCTION NAIL BED W/GRAFT	1,000
11981	INSJ NON-BIODEGRADABLE DRUG DELIVERY IMPLANT	2,351

**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
**Charge Commitment- 1110.235(c)(9)**

<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
11982	REMOVAL NON-BIODEGRADABLE DRUG DELIVERY IMPLANT	1,000
12001	SIMPLE REPAIR SCALP/NECK/AX/GENIT/TRUNK 2.5CM/<	1,000
12002	SMPL REPAIR SCALP/NECK/AX/GENIT/TRUNK 2.6-7.5CM	1,000
12020	TX SUPERFICIAL WOUND DEHISCENCE SIMPLE CLOSURE	1,000
12032	REPAIR INTERMEDIATE S/A/T/E 2.6-7.5 CM	1,000
12035	REPAIR INTERMEDIATE S/A/T/E 12.6-20.0CM	1,000
12041	REPAIR INTERMEDIATE N/H/F/XTRNL GENT 2.5CM/<	1,000
12042	REPAIR INTERMEDIATE N/H/F/XTRNL GENT 2.6-7.5 CM	1,000
12052	REPAIR INTERMEDIATE F/E/E/N/L&MUC 2.6-5.0 CM	1,000
13101	REPAIR COMPLEX TRUNK 2.6-7.5 CM	1,183
13120	REPAIR COMPLEX SCALP/ARM/LEG 1.1-2.5 CM	1,000
13121	REPAIR COMPLEX SCALP/ARM/LEG 2.6-7.5 CM	4,526
13122	REPAIR COMPLEX SCALP/ARM/LEG EA ADDL 5 CM/<	1,824
13131	REPAIR COMPLEX F/C/C/M/N/AX/G/H/F 1.1-2.5 CM	4,528
13132	REPAIR COMPLEX F/C/C/M/N/AX/G/H/F 2.6-7.5 CM	1,000
13133	REPAIR COMPLEX F/C/C/M/N/AX/G/H/F EA ADDL 5 CM/<	1,000
13160	SECONDARY CLOSURE SURG WOUND/DEHSN EXTSV/COMPLIC	4,818
14001	ADJNT TIS TRANSFR/REARRANGE TRUNK 10.1-30.0 SQCM	4,818
14020	ADJT TIS TRNSFR/REARGMT SCALP/ARM/LEG 10 SQ CM/<	6,036
14021	ADJT/REARRGMT SCALP/ARM/LEG 10.1-30.0 SQ CM	9,776
14040	ADJT TIS TRNS/REARGMT F/C/C/M/N/A/G/H/F 10SQCM/<	3,176
14041	ADJT/REARGMT F/C/C/M/N/AX/G/H/F 10.1-30.0 SQ CM	11,315
14060	ADJT TIS TRNSFR/REARRGMT E/N/E/L DFCT 10 SQ CM/<	3,176
14061	ADJT TIS REARGMT EYE/NOSE/EAR/LIP 10.1-30.0 SQCM	3,176
14301	ADJNT TIS TRNSFR/REARGMT ANY AREA 30.1-60 SQ CM	5,117
14302	ADJT TIS TRNSFR/REARGMT DEFEC EA ADDL 30 SQCM	3,493
15002	PREP SITE TRUNK/ARM/LEG 1ST 100 SQ CM/1PCT	3,272
15004	PREP SITE F/S/N/H/F/G/M/D GT 1ST 100 SQ CM/1PCT	1,183
15040	HARVEST SKIN TISSUE CLTR SKIN AGRFT 100 CM/<	2,789
15050	PINCH GRAFT 1/MLT SM ULCER TIP/OTH AREA 2CM	3,019
15100	SPLIT AGRFT T/A/L 1ST 100 CM/&1% BDY INFT/CHLD	4,818
15120	SPLIT AGRFT F/S/N/H/F/G/M/D GT 1ST 100 CM/<1 %	5,117
15200	FTH/GFT FREE W/DIRECT CLOSURE TRUNK 20 CM/<	3,725

**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
**Charge Commitment- 1110.235(c)(9)**

<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
15201	FTH/GFT FR W/DIR CLSR TRNK EA ADDL 20 CM/<	1,863
15220	FTH/GFT FREE W/DIRECT CLOSURE S/A/L 20 CM/<	3,725
15221	FTH/GFT FR W/DIR CLSR S/A/L EA ADDL 20 CM/<	1,863
15240	FTH/GFT FR W/DIR CLSR F/C/C/M/N/AX/G/H/F 20 CM/<	3,725
15241	FTH/GT FR W/DIR CLSR F/C/C/M/N/AX/G/H/F EA20CM/<	1,863
15260	FTH/GFT FREE W/DIRECT CLOSURE N/E/E/L 20 SQ CM/<	3,725
15261	FTH/GFT FREE W/DIR CLSR N/E/E/L EA 20 SQ CM/<	1,863
15273	APP SKN SUBGRFT T/A/L AREA/100SQ CM 1ST 100SQ CM	5,117
15274	APP SKN SUB GRFT T/A/L AREA>=100SCM ADL 100SQCM	2,524
15275	SUB GRFT F/S/N/H/F/G/M/D <100SQ CM 1ST 25 SQ CM	2,789
15276	SUB GRFT F/S/N/H/F/G/M/D<100SQ CM EA ADDL25SQ CM	1,269
15277	SUB GRFT F/S/N/H/F/G/M/D >= 100SCM 1ST 100SQ CM	2,789
15572	FRMJ DIRECT/TUBE PEDICLE W/WO TR SCALP ARMS/LEGS	10,562
15574	FRMJ DIR/TUBE PEDCL W/WOTR FH/CH/CH/M/N/AX/G/H/F	12,071
15620	DELAY FLAP/SECTIONING FLAP F/C/C/N/AX/G/H/F	4,818
15769	GRAFTING of autologous soft tissue, other, harvested by direct excision (e.g. FAT, dermis, fascia)	5,847
15836	EXCISION EXCESSIVE SKIN & SUBQ TISSUE ARM	3,507
15837	EXC EXCESSIVE SKIN &SUBQ TISSUE FOREARM/HAND	3,395
15850	REMOVAL SUTURES UNDER ANESTHESIA SAME SURGEON	1,000
15851	REMOVAL SUTURES UNDER ANESTHESIA OTHER SURGEON	1,000
15852	DRESSING CHANGE UNDER ANESTHESIA	1,000
17000	DESTRUCTION PREMALIGNANT LESION 1ST	1,000
20005	INCISION OF SOFT TISSUE ABSCESS (EG, SECONDARY TO OSTEOMYELITIS); DEEP OR COMPLICATED	4,691
20103	EXPLORATION PENETRATING WOUND SPX EXTREMITY	2,161
20205	BIOPSY MUSCLE DEEP	3,395
20220	BIOPSY BONE TROCAR/NEEDLE SUPERFICIAL	1,961
20225	BIOPSY BONE TROCAR/NEEDLE DEEP	1,961
20240	BIOPSY BONE OPEN SUPERFICIAL	4,511
20245	BIOPSY BONE OPEN DEEP	4,511
20520	REMOVAL FOREIGN BODY MUSCLE/TENDON SHEATH SIMPLE	1,000
20525	RMVL FOREIGN BODY MUSCLE/TENDON SHEATH DEEP/COMP	6,399
20526	INJECTION THERAPEUTIC CARPAL TUNNEL	1,000

**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
**Charge Commitment- 1110.235(c)(9)**

<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
20550	INJECTION 1 TENDON SHEATH/LIGAMENT APONEUROSIS	2,653
20551	INJECTION SINGLE TENDON ORIGIN/INSERTION	1,000
20552	INJECTION SINGLE/MLT TRIGGER POINT 1/2 MUSCLES	1,000
20600	ARTHROCENTESIS ASPIR&/INJ SMALL JT/BURSA W/O US	1,000
20605	ARTHROCENTESIS ASPIR&/INJ INTERM JT/BURS W/O US	1,000
20610	ARTHROCENTESIS ASPIR&/INJ MAJOR JT/BURSA W/O US	1,000
20612	ASPIRATION&/INJECTION GANGLION CYST ANY LOCATJ	1,000
20650	INSERTION WIRE/PIN W/APPL SKELETAL TRACTION SPX	4,692
20670	REMOVAL IMPLANT SUPERFICIAL SEPARATE PROCEDURE	3,446
20680	REMOVAL IMPLANT DEEP	4,578
20690	APPLICATION UNIPLANE EXTERNAL FIXATION SYSTEM	12,775
20692	APPLICATION MULTIPLANE EXTERNAL FIXATION SYSTEM	27,677
20693	ADJUSTMENT/REVJ XTRNL FIXATION SYSTEM REQ ANES	9,534
20694	REMOVAL EXTERNAL FIXATION SYSTEM UNDER ANES	6,399
20696	XTRNL FIXJ W/STEREOTACTIC ADJUSTMENT 1ST & SUBQ	40,371
20697	XTRNL FIXJ W/STRTCTC ADJUSTMENT EXCHANGE STRUT	5,690
20900	BONE GRAFT ANY DONOR AREA MINOR/SMALL	9,534
20902	BONE GRAFT ANY DONOR AREA MAJOR/LARGE	9,534
20924	TENDON GRAFT FROM A DISTANCE	9,534
20926	TISSUE GRAFTS OTHER	5,234
20931	ALLOGRAFT FOR SPINE SURGERY ONLY STRUCTURAL	2,166
20999	UNLISTED PROCEDURE MUSCSKELETAL SYSTEM GENERAL	4,692
22513	PERQ VERT AGMNTJ CAVITY CRTJ UNI/BI CANNULATION	11,250
22514	PERQ VERT AGMNTJ CAVITY CRTJ UNI/BI CANNULJ LMBR	11,250
22515	PERQ VERT AGMNTJ CAVITY CRTJ UNI/BI CANNULJ EACH	5,626
22521	PERCUTANEOUS VERTEBROPLASTY, ONE VERTEBRAL BODY, UNILATERAL OR BILATERAL INJECTION; LUMBAR	5,965
22551	ARTHRD ANT INTERBODY DECOMPRESS CERVICAL BELW C2	28,634
22552	ARTHRD ANT INTERDY CERVCL BELW C2 EA ADDL NTRSPC	7,774
22554	ARTHRD ANT MIN DISCECT INTERBODY CERV BELOW C2	28,659
22612	ARTHRODESIS POSTERIOR/POSTEROLATERAL LUMBAR	29,273
22845	ANTERIOR INSTRUMENTATION 2-3 VERTEBRAL SEGMENTS	14,353
22856	TOT DISC ARTHRP ART DISC ANT APPRO 1 NTRSPC CRV	46,194
22858	TOT DISC ARTHRP ANT APPR DISC 2ND LEVEL CERVICAL	14,630

**Attachment 24**  
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<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
23066	BIOPSY SOFT TISSUE SHOULDER DEEP	6,211
23071	EXCISION TUMOR SOFT TISSUE SHOULDER SUBQ 3 CM/>	4,003
23073	EXC TUMOR SOFT TISSUE SHOULDER SUBFASCIAL 5 CM/>	4,022
23075	EXCISION TUMOR SOFT TISSUE SHOULDER SUBQ <3CM	5,290
23076	EXC TUMOR SOFT TISS SHOULDER SUBFASC <5CM	7,405
23120	CLAVICULECTOMY PARTIAL	11,386
23125	CLAVICULECTOMY TOTAL	12,421
23130	PARTIAL REPAIR OR REMOVAL OF SHOULDER BONE	12,421
23182	PARTIAL EXCISION BONE SCAPULA	9,534
23350	INJECTION SHOULDER ARTHROGRAPHY/ CT/MRI ARTHG	1,000
23395	MUSCLE TRANSFER SHOULDER/UPPER ARM SINGLE	14,916
23405	TENOTOMY SHOULDER AREA 1 TENDON	9,534
23410	OPEN REPAIR OF ROTATOR CUFF ACUTE	9,534
23412	OPEN REPAIR OF ROTATOR CUFF CHRONIC	10,351
23415	CORACOACROMIAL LIGAMENT RELEAS WWOACROMIOPLASTY	9,534
23420	RECONSTRUCTION ROTATOR CUFF AVULSION CHRONIC	12,421
23430	TENODESIS LONG TENDON BICEPS	9,534
23450	CAPSULORRHAPHY ANTERIOR PUTTI-PLATT/MAGNUSON	14,966
23455	CAPSULORRHAPHY ANTERIOR W/LABRAL REPAIR	14,966
23460	CAPSULORRHAPHY ANTERIOR WITH BONE BLOCK	15,065
23462	CAPSULORRHAPHY ANTERIOR W/CORACOID PROCESS TR	9,534
23465	CAPSULORRHAPHY GLENOHUMERAL JT PST WWO BONE BLK	14,966
23466	CAPSULORRHAPHY GLENOHUMRL JT MULTI-DIRIONAL INS	9,534
23470	ARTHROPLASTY GLENOHUMRL JT HEMIARTHROPLASTY	24,096
23472	ARTHROPLASTY GLENOHUMERAL JOINT TOTAL SHOULDER	29,692
23473	REVIS SHOULDER ARTHRPLSTY HUMERAL/GLENOID COMPNT	33,542
23474	REVIS SHOULDER ARTHRPLSTY HUMERAL&GLENOID COMPNT	36,508
23480	OSTEOTOMY CLAVICLE WWO INTERNAL FIXATION	9,534
23515	OPEN TX CLAVICULAR FRACTURE INTERNAL FIXATION	13,083
23550	OPEN TX ACROMIOCLAVICULAR DISLC ACUTE/CHRONIC	9,534
23552	OPTX ACROMCLAV DISLC ACUTE/CHRONIC W/FASCIAL GRF	12,999
23585	OPEN TX SCAPULAR FX W/INTERNAL FIXATION IF PFRMD	12,989
23615	OPEN TREATMENT PROXIMAL HUMERAL FRACTURE	28,192



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<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
23630	OPEN TREATMENT GRTER HUMERAL TUBEROSITY FRACTURE	12,862
23655	CLSD TX SHOULDER DISLC W/MANIPULATION REQ ANES	3,281
23670	OPEN TX SHOULDER DISLC W/HUMERAL TUBEROSITY FX	12,862
23675	CLTX SHOULDER DISLC W/SURG/ANTMCL NECK FX W/MANJ	4,232
23700	MANJ W/ANES SHOULDER JOINT W/FIXATION APPARATUS	4,142
23929	UNLISTED PROCEDURE SHOULDER	4,244
23930	I&D UPPER ARM/ELBOW DEEP ABSCESS/HEMATOMA	4,313
23931	INCISION&DRAINAGE UPPER ARM/ELBOW BURSA	3,936
24000	ARTHRT ELBOW W/EXPLORATION DRAINAGE/REMOVAL FB	7,246
24006	ARTHRT ELBOW CAPSULAR EXCISION CAPSULAR RLS SPX	5,649
24065	BIOPSY SOFT TISSUE UPPER ARM/ELBOW SUPERFICIAL	3,395
24066	BIOPSY SOFT TISSUE UPPER ARM/ELBOW AREA DEEP	6,211
24071	EXC TUMOR SOFT TISSUE UPPER ARM/ELBOW SUBQ 3CM/>	4,008
24073	EXC TUMOR SOFT TISS UPPER ARM/ELBW SUBFASC 5CM/>	3,451
24075	EXC TUMOR SOFT TISS UPPER ARM/ELBOW SUBQ <3CM	5,290
24076	EXC TUMOR SOFT TISS UPR ARM/ELBOW SUBFASC <5CM	7,246
24077	RAD RESECT TUMOR SOFT TISS UPPER ARM/ELBOW <5CM	8,282
24100	ARTHROTOMY ELBOW W/SYNOVIAL BIOPSY ONLY	6,211
24101	ARTHRT ELBOW W/JNT EXPL W/WOBX W/WORMVL LOOSE/FB	8,282
24102	ARTHROTOMY ELBOW W/SYNOVECTOMY	8,282
24105	EXCISION OLECRANON BURSA	7,246
24110	EXCISION/CURTG BONE CYST/BENIGN TUMOR HUMERUS	4,692
24120	EXC/CURTG BONE CYST/BENIGN TUMOR H/N RDS/OLECRN	4,692
24130	EXCISION RADIAL HEAD	9,316
24140	PARTIAL EXCISION BONE HUMERUS	10,351
24145	PARTIAL EXCISION BONE RADIAL HEAD/NECK	10,351
24147	PARTIAL EXCISION BONE OLECRANON PROCESS	10,351
24149	RAD RESCJ CAPSL TISS&HTRTPC BONE ELBW CONTRCT	10,351
24155	RESECTION ELBOW JOINT ARTHRECTOMY	9,316
24200	RMVL FOREIGN BODY UPPER ARM/ELBOW SUBCUTANEOUS	1,000
24201	REMOVAL FOREIGN BODY UPPER ARM/ELBOW DEEP	6,211
24300	MANIPULATION ELBOW UNDER ANESTHESIA	4,142
24301	MUSCLE/TENDON TRANSFER UPPER ARM/ELBOW SINGLE	9,534

**Attachment 24**  
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<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
24305	TENDON LENGTHENING UPPER ARM/ELBOW EA TENDON	8,282
24310	TENOTOMY OPEN ELBOW TO SHOULDER EACH TENDON	8,282
24332	TENOLYSIS TRICEPS	4,692
24340	TENODESIS BICEPS TENDON ELBOW SEPARATE PROCEDURE	9,534
24341	REPAIR TENDON/MUSCLE UPPER ARM/ELBOW EA	10,351
24342	RINSJ RPTD BICEPS/TRICEPS TDN DSTL W/WO TDN GRF	10,351
24343	REPAIR LATERAL COLLATERAL LIGAMENT ELBOW	10,351
24344	RCNSTJ LAT COLTRL LIGM ELBOW W/TENDON GRAFT	15,187
24345	REPAIR MEDIAL COLLATERAL LIGAMENT ELBOW	10,351
24346	RCNSTJ MEDIAL COLTRL LIGM ELBW W/TDN GRF	19,477
24350	FASCIOTOMY, LATERAL OR MEDIAL (EG, TENNIS ELBOW OR EPICONDYLITIS);	6,211
24351	FASCIOTOMY, LATERAL OR MEDIAL (EG, TENNIS ELBOW OR EPICONDYLITIS); WITH EXTENSOR ORIGIN DETACHMENT	7,246
24352	FASCIOTOMY, LATERAL OR MEDIAL (EG, TENNIS ELBOW OR EPICONDYLITIS); WITH ANNULAR LIGAMENT RESECTION	7,246
24354	FASCIOTOMY, LATERAL OR MEDIAL (EG, TENNIS ELBOW OR EPICONDYLITIS); WITH STRIPPING	7,246
24356	FASCIOTOMY, LATERAL OR MEDIAL (EG, TENNIS ELBOW OR EPICONDYLITIS); WITH PARTIAL OSTECTOMY	8,282
24357	TENOTOMY ELBOW LATERAL/MEDIAL PERCUTANEOUS	6,211
24358	TNOT ELBOW LATERAL/MEDIAL DEBRIDE OPEN	7,405
24359	TNOT ELBOW LATERAL/MEDIAL DEBRIDE OPEN TDN RPR	8,463
24360	ARTHROPLASTY ELBOW W/MEMBRANE	9,534
24361	ARTHROPLASTY ELBOW W/DISTAL HUMRL PROSTC RPLCMT	41,538
24363	ARTHRP ELBOW W/DISTAL HUM&PROX UR PROSTC RPLCM	51,437
24365	ARTHROPLASTY RADIAL HEAD	29,202
24366	ARTHROPLASTY RADIAL HEAD W/IMPLANT	31,046
24430	REPAIR NON/MALUNION HUMERUS W/O GRAFT	27,290
24435	REPAIR NON/MALUNION HUMERUS W/ILIAC/OTH AGRFT	29,019
24538	PRQ SKEL FIXJ SPRCONDYL/TRANSCONDYL HUMERAL FX	9,534
24545	OPEN TX HUMERAL SUPRACONDYLAR FRACTURE W/O XTN	27,906
24546	OPEN TX HUMERAL SUPRACONDYLAR FRACTURE W/XTN	46,223
24575	OPEN TX HUMERAL EPICONDYLAR FRACTURE	25,209
24576	CLTX HUMERAL CONDYLAR FX MEDIAL/LAT W/O MANJ	1,000

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<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
24579	OPEN TREATMENT HUMERAL CONDYLAR FRACTURE	25,640
24586	OPTX PERIARTICULAR FRACTURE &/DISLOCATION ELBO	20,887
24605	TREATMENT CLOSED ELBOW DISLOCATION REQ ANES	3,281
24615	OPEN TX ACUTE/CHRONIC ELBOW DISLOCATION	12,862
24635	OPEN TX MONTEGGIA FRACTURE DISLOCATION ELBOW	13,306
24655	CLOSED TX RADIAL HEAD/NECK FX W/MANIPULATION	4,142
24665	OPEN TX RADIAL HEAD/NECK FRACTURE	9,534
24666	OPEN TX RADIAL HEAD/NECK FRACTURE PROSTHETIC	30,888
24670	CLOSED TX ULNAR FRACTURE PROXIMAL END W/O MANJ	1,150
24675	CLOSED TX ULNAR FRACTURE PROXIMAL END W/MANJ	2,755
24685	OPEN TREATMENT ULNAR FRACTURE PROXIMAL END	12,527
25000	INCISION EXTENSOR TENDON SHEATH WRIST	5,331
25001	INCISION FLEXOR TENDON SHEATH WRIST	6,554
25028	I&D FOREARM&WRIST DEEP ABSCESS/HEMATOMA	5,176
25035	INCISION DEEP BONE CORTEX FOREARM&WRIST	9,534
25040	ARTHRT RDCRPL/MIDCARPL JT W/EXPL DRG/RMVL FB	10,923
25065	BIOPSY SOFT TISSUE FOREARM&WRIST SUPERFICIAL	1,531
25066	BIOPSY SOFT TISSUE FOREARM&WRIST DEEP	5,331
25071	EXC TUMOR SOFT TISS FOREARM AND/WRIST SUBQ 3CM/>	4,008
25073	EXC TUMOR SFT TISS FOREARM&WRIST SUBFASC 3CM/>	4,008
25075	EXC TUMOR SOFT TISSUE FOREARM &/WRIST SUBQ <3CM	5,331
25076	EXC TUMOR SOFT TISS FOREARM&WRIST SUBFASC <3CM	7,106
25077	RAD RESECT TUMOR SOFT TISS FOREARM&WRIST <3 CM	7,996
25078	RAD RESCJ TUM SOFT TISSUE FOREARM&WRIST 3 CM/>	3,451
25085	CAPSULOTOMY WRIST	7,996
25100	ARTHROTOMY WRIST JOINT WITH BIOPSY	5,331
25101	ARTHRT WRST W/JT EXPL W/WO BX W/WO RMVL LOOSE/FB	7,996
25105	ARTHROTOMY WRIST JOINT WITH SYNOVECTOMY	8,884
25107	ARTHROTOMY DSTL RADIOULNAR JOINT RPR CARTILAGE	7,996
25109	EXC TENDON FOREARM&WRIST FLEXOR/EXTENSOR EA	5,331
25110	EXCISION LESION TENDON SHEATH FOREARM&WRIST	7,106
25111	EXCISION GANGLION WRIST DORSAL/VOLAR PRIMARY	7,106
25112	EXCISION GANGLION WRIST DORSAL/VOLAR RECURRENT	8,884

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<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
25115	RAD EXC BURSA SYNVA WRST/F/ARM TDN SHTHS FLXRS	7,996
25116	RAD EXC BURSA SYNVA WRST/F/ARM TDN SHTHS XTNSRS	7,996
25118	SYNOVECTOMY EXTENSOR TENDON SHTH WRIST 1 CMPRT	5,733
25119	SYNVCT XTNSR TDN SHTH WRST 1 RESCJ DSTL ULNA	5,649
25120	EXCISION/CURETTAGE CYST/TUMOR RADIUS/ULNA	5,649
25126	EXC/CURTG CYST/TUMOR RADIUS/ULNA W/ALLOGRAFT	8,884
25130	EXCISION/CURETTAGE CYST/TUMOR CARPAL BONES	5,649
25135	EXC/CURTG CYST/TUMOR CARPAL BONES W/AUTOGRAFT	9,534
25136	EXC/CURTG CYST/TUMOR CARPAL BONES W/ALLOGRAFT	12,631
25150	PARTIAL EXCISION BONE ULNA	8,739
25151	PARTIAL EXCISION BONE RADIUS	8,739
25210	CARPECTOMY 1 BONE	7,106
25215	CARPECTOMY ALL BONES PROXIMAL ROW	8,884
25230	RADICAL STYLOIDECTOMY SEPARATE PROCEDURE	7,996
25240	EXCISION DISTAL ULNA PARTIAL/COMPLETE	7,996
25246	INJECTION WRIST ARTHROGRAPHY	1,000
25248	EXPL W/REMOVAL DEEP FOREIGN BODY FOREARM/WRIST	7,107
25250	REMOVAL WRIST PROSTHESIS SEPARATE PROCEDURE	5,648
25251	REMOVAL WRIST PROSTH COMPLICATED W/TOTAL WRIST	5,648
25259	MANIPULATION WRIST UNDER ANESTHESIA	3,554
25260	RPR TDN/MUSC FLXR F/ARM&WRST PRIM 1 EA TDN/MU	7,996
25263	RPR TDN/MUSC FLXR F/ARM&WRIST SEC 1 EA TDN/MUS	9,534
25265	RPR TDN/MUSC FLXR F/ARM&WRISTSEC FR GRF EA	7,106
25270	RPR TDN/MUSC XTNSR F/ARM&WRIST PRIM 1 EA TDN	7,996
25272	RPR TDN/MUSC XTNSR F/ARM&WRIST SEC 1 EA TDN/MU	7,106
25274	RPR TDN/MUSC XTNSR F/ARM&WRST SEC FR GRF EA TDN	7,996
25275	RPR TENDON SHEATH EXTENSOR F/ARM&WRIST W/GRAFT	7,996
25280	LNGTH/SHRT FLXR/XTNSR TDN F/ARM&WRIST 1 EA TDN	7,996
25290	TNOT FLXR/XTNSR TENDON FOREARM&WRIST 1 EA	7,106
25295	TNOLS FLXR/XTNSR TENDON FOREARM&WRIST 1 EA	7,106
25300	TENODESIS WRIST FLEXORS FINGERS	7,106
25301	TENODESIS WRIST EXTENSORS FINGERS	7,106
25310	TDN TRNSPLJ/TR FLXR/XTNSR F/ARM&WRST 1 EA TDN	9,237

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<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
25312	TDN TRNSPLJ/TR FLXR/XTNSR F/ARM&WRST 1/TDN GR	9,237
25320	CAPSL-RHPHY/RCNSTJ WRST OPN CARPL INS	9,534
25332	ARTHRP WRST WWO INTERPOS WWO XTRNL/INT FIXJ	10,923
25337	RCNSTJ STABLJ DSTL U/DSTL JT 2 SOFT TISS STABLJ	9,534
25350	OSTEOTOMY RADIUS DISTAL THIRD	15,187
25360	OSTEOTOMY ULNA	9,831
25390	OSTEOPLASTY RADIUS/ULNA SHORTENING	13,424
25394	OSTEOPLASTY CARPAL BONE SHORTENING	7,662
25400	RPR NONUNION/MALUNION RADIUS/ULNA W/O AUTOGRAFT	13,449
25405	RPR NONUNION/MALUNION RADIUS/ULNA W/AUTOGRAFT	13,299
25420	RPR NONUNION/MALUNION RADIUS&ULNA W/AUTOGRAFT	14,966
25430	INSERTION VASCULAR PEDICLE CARPAL BONE	10,923
25431	REPAIR NONUNION CARPAL BONE EACH BONE	10,923
25440	RPR NONUNION SCAPHOID CARPAL BNE WWO RDL STYLEC	15,187
25443	ARTHROPLASTY W/PROSTHETIC RPLCMT SCAPHOID CARPAL	13,293
25446	ARTHRP W/PROSTC RPLCMT DSTL RDS&PRTL/CARPUS	43,711
25447	ARTHRP INTERPOS INTERCARPAL/METACARPAL JOINTS	8,884
25449	REVJ ARTHRP W/REMOVAL IMPLANT WRIST JOINT	9,534
25450	EPIPHYSL ARRSST EPIPHYSIOD/STAPLING DSTL RDS/U	9,237
25455	EPIPHYSL ARRSST EPIPHYSIOD/STAPLING DSTL RDS&ULNA	9,237
25505	CLOSED TX RADIAL SHAFT FRACTURE W/MANIPULATION	4,370
25515	OPEN TREATMENT RADIAL SHAFT FRACTURE	12,797
25520	CLTX RDL SHFT FX&CLTX DISLC DSTL RAD/ULN JT	3,554
25525	OPEN RDL SHAFT FX CLOSED RAD/ULN JT DISLOCATE	9,534
25526	OPEN RDL SHAFT FX OPEN RAD/ULN JT DISLOCATE	12,673
25530	CLOSED TX ULNAR SHAFT FRACTURE W/O MANIPULATION	1,000
25535	CLOSED TX ULNAR SHAFT FRACTURE W/MANIPULATION	3,554
25545	OPEN TREATMENT OF ULNAR SHAFT FRACTURE	12,553
25565	CLOSED TX RADIAL&ULNAR SHAFT FRACTURES W/MANJ	3,554
25574	OPEN TX RADIAL&ULNAR SHAFT FX W/FIXJ RADIUS/ULNA	13,501
25575	OPEN TX RADIAL&ULNAR SHAFT FX W/FIXJ RADIUS&ULNA	13,127
25600	CLTX DSTL RADIAL FX/EPIPHYSL SEP W/O MANJ	1,000
25605	CLTX DSTL RDL FX/EPIPHYSL SEP W/MANJ WHEN PERF	3,554

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<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
25606	PERQ SKEL FIXJ DISTAL RADIAL FX/EPIPHYSL SEP	7,106
25607	OPTX DSTL RADL X-ARTIC FX/EPIPHYSL SEP	13,730
25608	OPTX DSTL RADL I-ARTIC FX/EPIPHYSL SEP 2 FRAG	13,671
25609	OPTX DSTL RADL I-ARTIC FX/EPIPHYSL SEP 3 FRAG	13,727
25611	PERCUT SKEL FIX OF DIS RAD FX OR EPIPHYS SEP, W/ OR W/O FX OF ULN STYL, REQ MANIP, W/ OR W/O EXT FIX	4,443
25620	OP TRTMT OF DIS RAD FX OR EPIPHYS SEP, W/ OR W/O FX OF ULN STYL, W/ OR W/O INT OR EXT FIX	7,106
25622	CLOSED TX CARPAL SCAPHOID FRACTURE W/O MANJ	1,778
25624	CLOSED TX CARPAL SCAPHOID FRACTURE W/MANJ	3,554
25628	OPEN TX CARPAL SCAPHOID NAVICULAR FRACTURE	9,534
25630	CLTX CARPAL BONE FX W/O MANJ EACH BONE	1,000
25635	CLTX CARPAL BONE FX W/MANJ EACH BONE	3,554
25645	OPEN TX CARPAL BONE FRACTURE OTH/THN SCAPHOID EA	8,438
25650	CLOSED TREATMENT ULNAR STYLOID FRACTURE	1,350
25651	PRQ SKELETAL FIXATION ULNAR STYLOID FRACTURE	5,738
25652	OPEN TREATMENT ULNAR STYLOID FRACTURE	9,534
25660	CLTX RDCRPL/INTERCARPL DISLC 1/> BONES W/MANJ	3,554
25670	OPEN TX RADIOCARPAL/INTERCARPAL DISLC 1/> BONES	9,534
25671	PRQ SKELETAL FIXJ DISTAL RADIOULNAR DISLOCATION	5,738
25675	CLOSED TX DISTAL RADIOULNAR DISLOCATION W/MANJ	3,554
25676	OPEN TX DISTAL RADIOULNAR DISLC ACUTE/CHRONIC	9,534
25680	CLTX TRANS-SCAPHOPRILUNAR TYP FX DISLC W/MANJ	3,554
25685	OPEN TX TRANS-SCAPHOPERILUNAR FRACTURE DISLC	9,534
25690	CLOSED TX LUNATE DISLOCATION W/MANIPULATION	3,554
25695	OPEN TREATMENT LUNATE DISLOCATION	9,534
25800	ARTHRODESIS WRIST COMPLETE W/O BONE GRAFT	15,187
25805	ARTHRODESIS WRIST W/SLIDING GRAFT	14,916
25810	ARTHRODESIS WRIST W/ILIAC/OTHER AUTOGRAFT	27,048
25820	ARTHRODESIS WRIST LIMITED W/O BONE GRAFT	12,960
25825	ARTHRODESIS WRIST LIMITED W/AUTOGRAFT	12,885
25830	ARTHRO DSTL RAD/ULN JT SGM TL RSCJ ULNA W/WO BONE	14,966
26010	DRAINAGE FINGER ABSCESS SIMPLE	1,000
26011	DRAINAGE FINGER ABSCESS COMPLICATED	3,554

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<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
26020	DRAINAGE TENDON SHEATH DIGIT&/PALM EACH	5,331
26025	DRAINAGE OF PALMAR BURSA SINGLE BURSA	4,375
26030	DRAINAGE OF PALMAR BURSA MULTIPLE BURSA	5,331
26034	INCISION BONE CORTEX HAND/FINGER	7,106
26040	FASCIOTOMY PALMAR PERCUTANEOUS	7,996
26045	FASCIOTOMY PALMAR OPEN PARTIAL	7,996
26055	TENDON SHEATH INCISION	7,106
26060	TENOTOMY PERCUTANEOUS SINGLE EACH DIGIT	6,219
26070	ARTHRT EXPL DRG/RMVL LOOSE/FB CARP/MTCRPL JT	5,331
26075	ARTHRT EXPL DRG/RMVL LOOSE/FB MTCARPHLNGJL JT EA	5,331
26080	ARTHRT EXPL DRG/RMVL LOOSE/FB IPHAL JT EA	5,331
26100	ARTHROTOMY BIOPSY CARP/MTCRPL JOINT EACH	5,331
26105	ARTHROTOMY BIOPSY MTCARPHLNGJL JOINT EACH	4,443
26110	ARTHROTOMY BIOPSY INTERPHALANGEAL JOINT EACH	4,443
26111	EX TUM/VASC MALF SFT TISS HAND/FNGR SUBQ 1.5CM/>	3,005
26113	EX TUM/VASC MAL SFT TIS HAND/FNGR SUBFSC 1.5CM/>	4,008
26115	EXC TUM/VASC MAL SFT TISS HAND/FNGR SUBQ <1.5CM	4,578
26116	EXC TUM/VAS MAL SFT TIS HAND/FNGR SUBFASC<1.5CM	5,331
26117	RAD RESECT TUMOR SOFT TISSUE HAND/FINGER <3CM	7,106
26121	FASCT PALM W/WO Z-PLASTY TISSUE REARGMT/SKN GRFT	7,996
26123	FASCT PRTL PALMAR 1 DGT PROX IPHAL JT W/WO RPR	8,884
26125	FASCT PRTL PALMR ADDL DGT PROX IPHAL JT W/WO RPR	4,443
26130	SYNOVECTOMY CARPOMETACARPAL JOINT	7,996
26135	SYNVCT MTCARPHLNGJL JT W/INTRNSC RLS&XTNSR HOOD	7,106
26140	SYNVCT PROX IPHAL JT W/XTNSR RCNSTJ EA IPHAL JT	7,106
26145	SYNVCT TDN SHTH RAD FLXR TDN PALM&/FNGR EA TDN	7,106
26160	EXC LESION TDN SHTH/JT CAPSL HAND/FNGR	5,331
26170	EXCISION TENDON PALM FLEXOR/EXTENSOR SINGLE EACH	7,106
26180	EXCISION TENDON FINGER FLEXOR/EXTENSOR EACH	7,106
26185	SESAMOIDECTOMY THUMB/FINGER SEPARATE PROCEDURE	6,219
26200	EXCISION/CURETTAGE CYST/TUMOR METACARPAL	5,331
26205	EXC/CURETTAGE CYST/TUMOR METACARPAL W/AUTOGRAFT	9,534
26210	EXCISION/CURETTAGE CYST/TUMOR PHALANX FINGER	5,331



**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
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<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
26215	EXC/CURETTAGE CYST/TUMOR PHALANX FINGER W/AGRAFT	7,106
26230	PARTIAL EXCISION BONE METACARPAL	8,884
26235	PARTIAL EXCISION PROXIMAL/MIDDLE PHALANX FINGER	7,996
26236	PARTIAL EXCISION DISTAL PHALANX FINGER	7,996
26250	RADICAL RESECTION TUMOR METACARPAL	7,996
26255	RADICAL RESECTION, METACARPAL (EG, TUMOR); WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)	8,884
26260	RAD RESECTION TUMOR PROX/MIDDLE PHALANX FINGER	7,996
26261	RADICAL RESECTION, PROXIMAL OR MIDDLE PHALANX OF FINGER; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)	8,884
26262	RADICAL RESECTION TUMOR DISTAL PHALANX FINGER	7,106
26320	REMOVAL IMPLANT FROM FINGER/HAND	4,443
26340	MANIPULATION FINGER JOINT UNDER ANES EACH JOINT	2,425
26350	RPR/ADVMNT FLXR TDN N/Z/2 W/O FR GRAFT EA TENDON	6,219
26352	RPR/ADVMNT FLXR TDN N/Z/2 W/FR GRAFT EA TENDON	9,534
26356	RPR/ADVMNT FLXR TDN ZONE 2 W/O FR GRFT EA TENDON	7,996
26357	RPR/ADVMNT FLXR TDN ZONE 2 W/O FR GRFT EA TENDON	7,996
26358	RPR/ADVMNT FLXR TDN ZONE 2 W/FR GRAFT EA TENDON	9,534
26370	RPR/ADVMNT TDN W/NTC SUPFCIS TDN PRIM EA TDN	7,996
26372	RPR/ADVMNT TDN W/NTC SUPFCIS TDN W/FREE GRAFT EA	9,534
26373	RPR/ADVMNT TDN W/NTC SUPFCIS TDN W/O FREE GRF EA	7,106
26390	EXC FLXR TDN W/IMPLTJ SYNTH ROD DLYD TDN GRF H/F	12,651
26392	RMVL SYNTH ROD & INSJ FLXR TDN GRF H/F EA ROD	9,534
26410	REPAIR EXTENSOR TENDON HAND W/O GRAFT EACH	5,331
26412	REPAIR EXTENSOR TENDON HAND W/GRAFT EACH	7,106
26415	EXC XTNSR TDN W/IMPLTJ SYNTH ROD DLYD GRF H/F EA	8,884
26416	RMVL SYNTH ROD & INSJ XTNSR TDN GRF H/F EA ROD	7,106
26418	REPAIR EXTENSOR TENDON FINGER W/O GRAFT EACH	5,331
26420	REPAIR EXTENSOR TENDON FINGER W/GRAFT EACH	7,106
26426	RPR XTNSR TDN CNTRL SLIP TISS W/LAT BAND EA FNGR	6,219
26428	RPR XTNSR TDN CNTRL SLIP SEC W/FR GRFT EA FINGER	7,996
26432	CLTX DSTL XTNSR TDN INSJ W/WO PERCUTAN PINNING	5,331
26433	REPAIR EXTENSOR TENDON DISTAL INSERTION W/O GRF	5,331
26434	REPAIR EXTENSOR TENDON DISTAL INSERTION W/GRAFT	7,996



**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
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<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
26437	REALIGNMENT EXTENSOR TENDON HAND EACH TENDON	6,664
26440	TENOLYSIS FLEXOR TENDON PALM/FINGER EACH TENDON	5,776
26445	TENOLYSIS EXTENSOR TENDON HAND/FINGER EACH	4,375
26449	TENOLYSIS CPLX XTNSR TENDON FINGER W/FOREARM EA	7,647
26455	TENOTOMY FLEXOR FINGER OPEN EACH TENDON	3,632
26460	TENOTOMY EXTENSOR HAND/FINGER OPEN EACH TENDON	5,331
26471	TENODESIS PROXIMAL INTERPHALANGEAL JOINT EACH	5,169
26474	TENODESIS DISTAL JOINT EACH	3,668
26478	LENGTHENING TENDON FLEXOR HAND/FINGER EACH	5,776
26479	SHORTENING TENDON FLEXOR HAND/FINGER EACH	5,776
26480	TR/TRNSPL TDN CARP/MTCRPL HAND W/O FR GRF EA TDN	7,996
26483	TENDON TRANSFER TRANSPLANT CARP/MTCRPL GRAFT	8,884
26485	TRANSFER/TRANSPLANT TENDON PALMAR W/O GRAFT EACH	7,996
26500	RCNSTJ TENDON PULLEY EACH W/LOCAL TISSUES SPX	9,534
26502	RCNSTJ TDN PULLEY EA TDN W/TDN/FSCAL GRF SPX	7,106
26504	RECONSTRUCTION OF TENDON PULLEY, EACH TENDON; WITH TENDON PROSTHESIS (SEPARATE PROCEDURE)	8,884
26508	RELEASE THENAR MUSCLE	7,106
26510	CROSS INTRINSIC TRANSFER EACH TENDON	7,106
26516	CAPSULODESIS MTCARPHLNGJL JOINT SINGLE DIGIT	5,817
26517	CAPSULODESIS MTCARPHLNGJL JOINT 2 DIGITS	7,996
26518	CAPSULODESIS MTCARPHLNGJL JOINT 3/4 DIGITS	9,534
26520	CAPSULECTOMY/CAPSULOTOMY MTCARPHLNGJL JOINT EACH	7,106
26525	CAPSULECTOMY/CAPSULOTOMY IPHAL JOINT EACH	7,106
26530	ARTHROPLASTY METACARPOPHALANGEAL JOINT EACH	9,534
26531	ARTHRP MTCARPHLNGJL JT W/PROSTC IMPLT EA JT	13,676
26535	ARTHROPLASTY INTERPHALANGEAL JOINT EACH	7,520
26536	ARTHROPLASTY INTERPHALANGEAL JT W/PROSTHETIC EA	12,654
26540	RPR COLTRL LIGM MTCARPHLNGJL/IPHAL JT	7,996
26541	RCNSTJ COLTRL LIGM MTCARPHLNGJL 1 W/TDN/FSCAL GRF	9,772
26542	RCNSTJ COLTRL LIGM MTCARPHLNGJL 1 W/LOCAL TISS	9,772
26545	RCNSTJ COLTRL LIGM IPHAL JT 1 W/GRF EA JT	8,884
26546	RPR NON-UNION MTCRPL/PHALANX	9,534
26548	RPR & RCNSTJ FINGER VOLAR PLATE INTERPHALANGEAL	7,996

**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
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<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
26560	REPAIR SYNDACTYLY EACH SPACE W/SKIN FLAPS	7,106
26561	REPAIR SYNDACTYLY EACH SPACE W/SKIN FLAPS&GRAFT	8,884
26562	REPAIR SYNDACTYLY EACH SPACE COMPLEX	9,772
26565	OSTEOTOMY METACARPAL EACH	8,884
26567	OSTEOTOMY PHALANX FINGER EACH	8,884
26591	REPAIR INTRINSIC MUSCLES HAND EACH MUSCLE	5,817
26593	RELEASE INTRINSIC MUSCLES HAND EACH MUSCLE	7,996
26600	CLTX METACARPAL FX W/O MANIPULATION EACH BONE	1,000
26605	CLTX METACARPAL FX W/MANIPULATION EACH BONE	1,000
26608	PRQ SKELETAL FIXJ METACARPAL FX EACH BONE	5,823
26615	OPEN TX METACARPAL FRACTURE SINGLE EA BONE	8,563
26641	CLTX CARPO/METACARPAL DISLOCATION THUMB W/MANJ	1,778
26645	CLTX CARPO/METACARPAL FX DISLC THUMB W/MANJ	2,666
26650	PRQ SKELETAL FIX CARPO/METACARPAL FX DISLC THUMB	5,738
26665	OPEN TX CARPOMETACARPAL FRACTURE DISLOCATE THUMB	8,438
26670	CLTX CARPO/METACARPL DISLC THMB MANJ EA W/O ANES	1,000
26675	CLTX CARPO/MTCRPL DISLC THUMB MANJ EA JT W/ANES	3,554
26676	PRQ SKEL FIXJ CARPO/MTCRPL DISLC THMB MANJ EA JT	5,823
26685	OPEN TX CARPOMETACARPAL DISLOCATE NOT THUMB	8,438
26686	OPTX CARP/MTCRPL DISLC THMB CPLX MLT/DLYD RDCTJ	12,862
26705	CLTX METACARPOPHALANGEAL DISLC W/MANJ W/ANES	3,554
26706	PRQ SKEL FIXJ METACARPOPHALANGEAL DISLC W/MANJ	4,375
26715	OPEN TREATMENT METACARPOPHALANGEAL DISLOCATION	8,438
26720	CLTX PHLNGL FX PROX/MIDDLE PX/F/T W/O MANJ EA	1,000
26725	CLTX PHLNGL FX PROX/MIDDLE PX/F/T W/MANJ EA	2,666
26727	PRQ SKEL FIXJ PHLNGL SHFT FX PROX/MIDDLE PX/F/T	5,823
26735	OPEN TX PHALANGEAL SHAFT FRACTURE PROX/MIDDLE EA	8,563
26740	CLTX ARTCLR FX INVG MTCRPHLNGL/IPHAL JT W/O MANJ	1,000
26742	CLTX ARTCLR FX INVG MTCARPHLNGL/IPHAL JT W/MANJ	2,425
26746	OPEN TX ARTICULAR FRACTURE MCP/IP JOINT EA	8,438
26750	CLTX DSTL PHLNGL FX FNGR/THMB W/O MANJ EA	1,000
26755	CLTX DSTL PHLNGL FX FNGR/THMB W/MANJ EA	1,000
26756	PRQ SKEL FIXJ DSTL PHLNGL FX FNGR/THMB EA	5,823

**Attachment 24**  
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<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
26765	OPEN TX DISTAL PHALANGEAL FRACTURE EACH	8,563
26770	CLTX IPHAL JT DISLC W/MANJ W/O ANES	1,000
26775	CLTX IPHAL JT DISLC W/MANJ REQ ANES	3,281
26776	PRQ SKEL FIXJ IPHAL JT DISLC W/MANJ	5,738
26785	OPEN TX INTERPHALANGEAL JOINT DISLOCATION	6,219
26820	FUSION OPPOSITION THUMB W/AUTOGENOUS GRAFT	13,075
26841	ARTHRD CARPO/METACARPAL JT THUMB WWO INT FIXJ	9,534
26842	ARTHRD CRP/MTACRPL JT THMB WWO INT FIXJ W/AGRFT	9,534
26843	ARTHRD CARP/MTCRPL JT DGT OTHER THAN THUMB EACH	9,534
26844	ARTHRD CARP/MTCRPL JT DGT OTH/THN THMB W/AGRFT	9,534
26850	ARTHRODESIS METACARPOPHALANGEAL JT WWO INT FIXJ	9,534
26852	ARTHRODESIS MTCRPL JT WWO INT FIXJ W/AUTOGRAFT	9,534
26860	ARTHRODESIS INTERPHALANGEAL JT WWO INT FIXJ	7,996
26861	ARTHRODESIS IPHAL JT WWO INT FIXJ EA IPHAL JT	5,816
26862	ARTHRODESIS IPHAL JT WWO INT FIXJ W/AUTOGRAFT	8,884
26863	ARTHRODESIS IPHAL JT WWO INT FIXJ W/AGRFT EA JT	5,816
26910	AMP MTCRPL W/FINGER/THUMB WWO INTEROSS TRANSFER	5,817
26951	AMP F/TH 1/2 JT/PHALANX W/NEURECT W/DIR CLSR	5,331
26952	AMP F/TH 1/2 JT/PHALANX W/NEURECT LOCAL FLAP	6,219
27006	TENOTOMY ABDUCTORS&/EXTENSOR HIP OPEN SPX	7,243
27025	FASCIOTOMY HIP/THIGH ANY TYPE	5,169
27043	EXCISION TUMOR SOFT TISSUE PELVIS&HIP SUBQ 3CM/>	4,374
27048	EXC TUMOR SOFT TISSUE PELVIS & HIP SUBFASC <5CM	4,511
27060	EXCISION ISCHIAL BURSA	9,534
27062	EXCISION TROCHANTERIC BURSA/CALCIFICATION	4,692
27066	EXCISION BONE CYST/BENIGN TUMOR DEEP	5,656
27093	INJECTION HIP ARTHROGRAPHY W/O ANESTHESIA	1,000
27095	INJECTION HIP ARTHROGRAPHY W/ANESTHESIA	1,000
27096	INJECT SI JOINT ARTHRGRPHY&/ANES/STEROID W/IMA	1,000
27125	HEMIARTHROPLASTY HIP PARTIAL	24,004
27130	ARTHRP ACETBLR/PROX FEM PROSTC AGRFT/ALGRFT	31,615
27132	CONV PREV HIP TOT HIP ARTHRP WWO AGRFT/ALGRFT	34,468
27176	TX SLP FEM EPIPHYSIS SINGLE/MULTIPL PINNING SITU	7,662

**Attachment 24**  
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<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
27218	OPTX POST PEL BONE FX&DISLC INT FIXJ IF PFRMD	15,389
27235	PRQ SKEL FIXJ FEMORAL FX PROX END NECK	5,649
27275	MANIPULATION HIP JOINT GENERAL ANESTHESIA	3,281
27279	ARTHRODESIS SACROILIAC JOINT PERCUTANEOUS	53,263
27301	I&D DEEP ABSC BURSA/HEMATOMA THIGH/KNEE REGION	3,936
27305	FASCIOTOMY ILIOTIBIAL OPEN	4,692
27306	TENOTOMY PRQ ADDUCTOR/HAMSTRING 1 TENDON SPX	4,692
27307	TENOTOMY PRQ ADDUCTOR/HAMSTRING MULTIPLE TENDON	5,965
27310	ARTHRT KNE W/EXPL DRG/RMVL FB	9,218
27324	BIOPSY SOFT TISSUE THIGH/KNEE AREA DEEP	4,742
27327	EXCISION TUMOR SOFT TISSUE THIGH/KNEE SUBQ <3CM	4,511
27328	EXC TUMOR SOFT TISSUE THIGH/KNEE SUBFASC <5CM	5,532
27331	ARTHRT KNE W/JT EXPL BX/RMVL LOOSE/FB	7,112
27337	EXCISON TUMOR SOFT TISSUE THIGH/KNEE SUBQ 3 CM/>	3,451
27339	EXC TUMOR SOFT TISSUE THIGH/KNEE SUBFASC 5 CM/>	3,702
27340	EXCISION PREPATELLAR BURSA	5,532
27345	EXCISION SYNOVIAL CYST POPLITEAL SPACE	6,321
27347	EXCISION LESION MENISCUS/CAPSULE KNEE	6,321
27350	PATELLECTOMY/HEMIPATELLECTOMY	9,534
27355	EXCISION/CURETTAGE CYST/TUMOR FEMUR	5,733
27360	PRTL EXC BONE FEMUR PROX TIBIA&FIBULA	5,649
27372	REMOVAL FOREIGN BODY DEEP THIGH/KNEE	6,321
27380	SUTURE INFRAPATELLAR TENDON PRIMARY	9,534
27381	SUTR INFRAPATELLAR TDN 2 RCNSTJ W/FSCAL/TDN GRF	9,534
27385	SUTURE QUADRICEPS/HAMSTRING RUPTURE PRIMARY	9,534
27386	SUTR QUADRICEPS/HAMSTRING MUSC RPT RCNSTJ	9,534
27403	ARTHROTOMY W/MENISCUS REPAIR KNEE	12,596
27405	RPR PRIMARY TORN LIGM&CAPSULE KNEE COLLATERAL	13,167
27407	REPAIR PRIMARY TORN LIGM&CAPSULE KNEE CRUCIAT	14,966
27409	RPR 1 TORN LIGM&CAPSL KNE COLTRL&CRUCIATE	9,534
27412	AUTOLOGOUS CHONDROCYTE IMPLANTATION KNEE	10,229
27415	OSTEOCHONDRAL ALLOGRAFT KNEE OPEN	32,004
27416	OSTEOCHONDRAL ALLOGRAFT KNEE OPEN MOSAICPLASTY	9,534

**Attachment 24**  
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<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
27418	ANTERIOR TIBIAL TUBERCLEPLASTY	11,250
27420	RCNSTJ DISLOCATING PATELLA	9,534
27422	RCNSTJ DISLC PATELLA W/XTNSR RELIGNMT&/MUSC RL	9,534
27425	LATERAL RETINACULAR RELEASE OPEN	7,902
27427	LIGAMENOUS RECONSTRUCTION KNEE EXTRA-ARTICULAR	12,348
27428	LIGAMENOUS RECONSTRUCTION KNEE INTRA-ARTICULAR	26,245
27430	QUADRICEPSPLASTY	14,484
27438	ARTHROPLASTY PATELLA W/PROSTHESIS	26,752
27442	ARTHROPLASTY FEM CONDYLES/TIBIAL PLATEAU KNEE	28,823
27446	ARTHRP KNEE CONDYLE&PLATEAU MEDIAL/LAT CMPRT	46,234
27447	ARTHRP KNE CONDYLE&PLATU MEDIAL&LAT COMPARTMENTS	29,281
27455	OSTEOT PROX TIBIA FIB EXC/OSTEOT BEFORE EPIPHYSL	22,847
27457	OSTEOT PROX TIBIA FIB EXC/OSTEOT AFTER EPIPHYSL	22,847
27470	RPR NON/MAL FEMUR DSTL H/N W/O GRF	6,802
27475	ARREST EPIPHYSEAL DISTAL FEMUR	9,534
27477	ARREST EPIPHYSEAL TIBIA & FIBULA PROXIMAL	5,648
27479	ARRST EPIPHYSL CMBN DSTL FEMUR PROX TIBFIB	9,534
27485	ARRST HEMIEPIPHYSL DSTL FEMUR/PROX TIBIA/FIBULA	4,690
27487	REVJ TOT KNEE ARTHRP FEM&ENTIRE TIBIAL COMPONE	37,734
27511	OPEN TX FEMORAL SUPRACONDYLAR FRACTURE W/O XTN	4,231
27514	OPEN TX FEMORAL FRACTURE DISTAL MED/LAT CONDYLE	15,389
27524	OPTX PATLLR FX W/INT FIXJ/PATLLC&SOFT TISS RPR	13,167
27540	OPEN TX INTERCONDYLAR SPINE/TUBRST FRACTURE KNEE	11,234
27556	OPEN TX KNEE DISLOCATION W/O LIGAMENOUS REPAIR	8,357
27566	OPTX PATELLAR DISLC W/WO PRTL/TOT PATELLECTOMY	9,534
27570	MANIPULATION KNEE JOINT UNDER GENERAL ANESTHESIA	3,330
27600	DCMPRN FASCT LEG ANT&/LAT COMPARTMENTS ONLY	4,692
27602	DCMPRN FASCT LEG ANT&/LAT&PST CMPRT	4,738
27603	INCISION & DRAINAGE LEG/ANKLE ABSCESS/HEMATOMA	3,936
27605	TENOTOMY PRQ ACHILLES TENDON SPX LOCAL ANES	4,592
27606	TENOTOMY PRQ ACHILLES TENDON SPX GENERAL ANES	4,692
27610	ARTHROTOMY ANKLE W/EXPL DRAINAGE/REMOVAL FB	5,824
27612	ARTHRT PST CAPSUL RLS ANKLE W/WO ACHLL TDN LNTH	7,489

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<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
27613	BIOPSY SOFT TISSUE LEG/ANKLE AREA SUPERFICIAL	1,532
27614	BIOPSY SOFT TISSUE LEG/ANKLE AREA DEEP	4,993
27615	RAD RESECTION TUMOR SOFT TISSUE LEG/ANKLE <5CM	6,657
27618	EXC TUMOR SOFT TISSUE LEG/ANKLE SUBQ <3CM	4,161
27619	EXC TUMOR SOFT TISSUE LEG/ANKLE SUBFASCIAL <5CM	6,657
27620	ARTHRT ANKLE W/EXPL W/WO BX W/WO RMVL LOOSE/FB	6,657
27625	ARTHROTOMY W/SYNOVECTOMY ANKLE	5,649
27626	ARTHROTOMY W/SYNOVECTOMY ANKLE TENOSYNOVECTOMY	6,657
27630	EXCISION LESION TENDON SHEATH/CAPSULE LEG&/ANK	4,993
27632	EXCISION TUMOR SOFT TISSUE LEG/ANKLE SUBQ 3 CM/>	4,003
27634	EXC TUMOR SOFT TISSUE LEG/ANKLE SUBFASC 5 CM/>	3,937
27635	EXCISION/CURETTAGE BONE CYST/TUMOR TIBIA/FIBULA	6,657
27637	EXC/CURETTAGE CYST/TUMOR TIBIA/FIBULA W/AGRAFT	9,534
27638	EXC/CURETTAGE CYST/TUMOR TIBIA/FIBULA W/ALGRAFT	9,534
27640	PARTIAL EXCISION BONE TIBIA	9,373
27641	PARTIAL EXCISION BONE FIBULA	5,824
27648	INJECTION ANKLE ARTHROGRAPHY	1,000
27650	REPAIR PRIMARY OPEN/PRQ RUPTURED ACHILLES TENDON	9,534
27652	RPR PRIMARY OPEN/PRQ RUPTURED ACHILLES W/GRAFT	15,187
27654	REPAIR SECONDARY ACHILLES TENDON W/WO GRAFT	9,534
27656	REPAIR FASCIAL DEFECT LEG	6,657
27658	REPAIR FLEXOR TENDON LEG PRIMARY W/O GRAFT EACH	4,692
27659	RPR FLEXOR TENDON LEG SECONDARY W/O GRAFT EACH	9,534
27664	RPR EXTENSOR TENDON LEG PRIMARY W/O GRAFT EACH	9,534
27665	RPR EXTENSOR TENDON LEG SECONDARY W/WO GRAFT EACH	9,534
27675	RPR DISLOC PERONEAL TENDON W/O FIBULAR OSTEOTOMY	6,657
27676	REPAIR DISLOCATING PERONEAL TENDON W/FIB OSTEOT	9,534
27680	TENOLYSIS FLXR/XTNRSR TENDON LEG&/ANKLE 1 EACH	5,650
27681	TNOLS FLXR/XTNRSR TDN LEG&/ANKLE MLT TDN	7,489
27685	LNGTH/SHRT TENDON LEG/ANKLE 1 TENDON SPX	5,733
27686	LNGTH/SHRT TDN LEG/ANKLE MLT TDN SAME INC EA	7,489
27687	GASTROCNEMIUS RECESSION	7,489
27690	TR/TRNSPL 1 TDN W/MUSC REDIRION/REROUTING SUPFC	9,534

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<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
27691	TR/TRNSPL 1 TDN W/MUSC REDIRION/REROUTING DP	9,534
27692	TR/TRNSPL 1 TDN W/MUSC REDIRION/REROUTING EA TDN	9,235
27695	RPR PRIMARY DISRUPTED LIGAMENT ANKLE COLLATERAL	9,534
27696	RPR PRIM DISRUPTED LIGM ANKLE BTH COLTRL LIGMS	9,534
27698	REPAIR SECONDARY DISRUPTED LIGAMENT ANKLE COLTRL	9,534
27705	OSTEOTOMY TIBIA	13,732
27707	OSTEOTOMY FIBULA	6,657
27709	OSTEOTOMY TIBIA & FIBULA	19,477
27720	REPAIR NONUNION/MALUNION TIBIA W/O GRAFT	13,086
27724	RPR NON/MAL TIBIA W/ILIAC/OTH AGRFT	11,250
27726	REPAIR FIBULA NONUNION/MALUNION W/INT FIXATION	13,330
27730	ARREST EPIPHYSEAL OPEN DISTAL TIBIA	5,649
27732	ARREST EPIPHYSEAL OPEN DISTAL FIBULA	5,649
27734	ARREST EPIPHYSEAL OPEN DISTAL TIBIA&FIBULA	5,649
27752	CLTX TIBIAL SHAFT FX W/MANJ W/WO SKEL TRACJ	3,329
27756	PRQ SKELETAL FIXATION TIBIAL SHAFT FRACTURE	13,930
27758	OPTX TIBIAL SHFT FX W/PLATE/SCREWS W/WO CERCLAGE	27,522
27759	TX TIBL SHFT FX IMED IMPLT W/WO SCREWS&/CERCLA	27,173
27760	CLTX MEDIAL MALLEOLUS FX W/O MANIPULATION	1,666
27762	CLTX MEDIAL MALLS FX W/MANJ W/WO SKN/SKEL TRACJ	3,329
27766	OPEN TREATMENT MEDIAL MALLEOLUS FRACTURE	9,534
27780	CLTX PROX FIBULA/SHFT FX W/O MANJ	1,666
27781	CLTX PROX FIBULA/SHFT FX W/MANJ	3,329
27784	OPEN TREATMENT PROXIMAL FIBULA/SHAFT FRACTURE	9,534
27786	CLTX DSTL FIBULAR FX LAT MALLS W/O MANJ	1,666
27788	CLTX DSTL FIBULAR FX LAT MALLS W/MANJ	3,329
27792	OPEN TX DISTAL FIBULAR FRACTURE LAT MALLEOLUS	12,600
27808	CLOSED TX BIMALLEOLAR ANKLE FRACTURE W/O MANJ	1,666
27810	CLOSED TX BIMALLEOLAR ANKLE FRACTURE W/MANJ	3,329
27814	OPEN TREATMENT BIMALLEOLAR ANKLE FRACTURE	12,800
27816	CLTX TRIMALLEOLAR ANKLE FX W/O MANIPULATION	1,666
27818	CLTX TRIMALLEOLAR ANKLE FX W/MANIPULATION	3,329
27822	OPEN TX TRIMALLEOLAR ANKLE FX W/O FIXJ PST LIP	12,746

**Attachment 24**  
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<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
27823	OPEN TX TRIMALLEOLAR ANKLE FX W/FIXJ PST LIP	12,862
27824	CLTX FX W8 BRG ARTCLR PRTN DSTL TIBIA W/O MANJ	1,666
27825	CLTX FX W8 BRG ARTCLR PRTN DSTL TIB W/SKEL TRACJ	3,329
27826	OPEN TREATMENT FRACTURE DISTAL TIBIA FIBULA	13,317
27827	OPEN TREATMENT FRACTURE DISTAL TIBIA ONLY	27,265
27828	OPEN TREATMENT FRACTURE DISTAL TIBIA & FIBULA	27,742
27829	OPEN TX DISTAL TIBIOFIBULAR JOINT DISRUPTION	9,534
27830	CLTX PROX TIBFIB JT DISLC W/O ANES	1,666
27831	CLTX PROX TIBFIB JT DISLC REQ ANES	4,375
27832	OPEN TX PROX TIBFIB JOINT DISLOCATE EXC PROX FIB	9,534
27840	CLOSED TX ANKLE DISLOCATION W/O ANESTHESIA	1,666
27842	CLTX ANKLE DISLC REQ ANES WWO PRQ SKEL FIXJ	3,329
27846	OPTX ANKLE DISLOCATION W/O REPAIR/INTERNAL FIXJ	9,534
27848	OPTX ANKLE DISLOCATION W/REPAIR/INT/XTRNL FIXJ	14,045
27860	MANIPULATION ANKLE UNDER GENERAL ANESTHESIA	4,375
27892	DCMPRN FASCT LEG ANT&/LAT W/DBRDMT MUSC&/NERVE	4,792
28002	I&D BELOW FASCIA FOOT 1 BURSAL SPACE	5,824
28003	I&D BELOW FASCIA FOOT MULTIPLE AREAS	6,657
28005	INCISION BONE CORTEX FOOT	6,657
28008	FASCIOTOMY FOOT&/TOE	4,993
28011	TENOTOMY PERCUTANEOUS TOE MULTIPLE TENDON	4,592
28020	ARTHRT W/EXPL DRG/RMVL LOOSE/FB NTRTRSL/TARS JT	5,824
28022	ARTHRT W/EXPL DRG/RMVL LOOSE/FB MTTARPHLNGL JT	5,824
28024	ARTHRT W/EXPL DRG/RMVL LOOSE/FB IPHAL JT	5,824
28030	NEURECTOMY, INTRINSIC MUSCULATURE OF FOOT	5,824
28035	RELEASE TARSAL TUNNEL	6,657
28039	EXCISION TUMOR SOFT TIS FOOT/TOE SUBQ 1.5 CM/>	3,451
28041	EXC TUMOR SOFT TISSUE FOOT/TOE SUBFASC 1.5 CM/>	3,382
28043	EXCISION TUMOR SOFT TISSUE FOOT/TOE SUBQ <1.5CM	4,511
28045	EXC TUMOR SOFT TISSUE FOOT/TOE SUBFASC <1.5CM	5,824
28046	RAD RESECTION TUMOR SOFT TISSUE FOOT/TOE <3CM	6,657
28047	RAD RESECTION TUMOR SOFT TISSUE FOOT/TOE 3 CM/>	3,451
28050	ARTHRT W/BX INTERTARSAL/TARSOMETATARSAL JOINT	5,824



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<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
28052	ARTHRTOMY W/BX METATARSOPHALANGEAL JOINT	5,824
28054	ARTHRTOMY W/BX INTERPHALANGEAL JOINT	5,824
28055	NEURECTOMY INTRINSIC MUSCULATURE OF FOOT	4,013
28060	FASCIECTOMY PLANTAR FASCIA PARTIAL SPX	6,657
28062	FASCIOTOMY PLANTAR FASCIA RADICAL SPX	7,489
28070	SYNVCT INTERTARSAL/TARSOMETATARSAL JT EA SPX	9,534
28072	SYNOVECTOMY METATARSOPHALANGEAL JOINT EACH	5,169
28080	EXCISION INTERDIGITAL MORTON NEUROMA SINGLE EACH	4,993
28090	EXC LESION TENDON SHEATH/CAPSULE W/SYNVCT FOOT	4,993
28092	EXC LESION TENDON SHEATH/CAPSULE W/SYNVCT TOE EA	4,993
28100	EXCISION/CURETTAGE CYST/TUMOR TALUS/CALCANEUS	4,592
28103	EXC/CURETTAGE CYST/TUMOR TALUS/CALCANEUS ALGRFT	9,534
28104	EXC/CURTG BONE CYST/B9 TUMORTARSAL/METATARSAL	4,668
28106	EXC/CURTG CST/B9 TUM TARSAL/METAR W/ILIAC/AGRFT	9,534
28107	EXC/CURTG CST/B9 TUM TARSAL/METAR W/ALGRFT	9,534
28108	EXC/CURTG CST/B9 TUM PHALANGES FOOT	5,824
28110	OSTECTOMY PRTL 5TH METAR HEAD SPX	5,824
28111	OSTECTOMY COMPLETE 1ST METATARSAL HEAD	5,824
28112	OSTECTOMY COMPLETE OTHER METATARSAL HEAD 2/3/4	5,824
28113	OSTECTOMY COMPLETE 5TH METATARSAL HEAD	4,993
28114	OSTC COMPL ALL METAR HEADS W/PRTL PROX PHALANGC	8,321
28116	OSTECTOMY TARSAL COALITION	6,657
28118	OSTECTOMY CALCANEUS	6,885
28119	OSTECTOMY CALCANEUS SPUR W/WO PLNTAR FASCIAL RLS	6,657
28120	PARTIAL EXCISION BONE TALUS/CALCANEUS	7,489
28122	PRTL EXC B1 TARSAL/METAR B1 XCP TALUS/CALCANEUS	5,824
28124	PARTICAL EXCISION BONE PHALANX TOE	4,993
28126	RESECTION PARTIAL/COMPLETE PHALANGEAL BASE EACH	4,592
28153	RESECTION CONDYLE DISTAL END PHALANX EACH TOE	4,592
28160	HEMIPHALANGECTOMY/INTERPHALANGEAL JOINT EXC TOE	6,005
28190	REMOVAL FOREIGN BODY FOOT SUBCUTANEOUS	1,666
28192	REMOVAL FOREIGN BODY FOOT DEEP	3,446
28193	REMOVAL FOREIGN BODY FOOT COMPLICATED	4,993

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<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
28200	RPR TDN FLXR FOOT 1/2 W/O FREE GRAFG EACH TENDON	6,657
28202	RPR TENDON FLXR FOOT SEC W/FREE GRAFT EA TENDON	9,534
28208	REPAIR TENDON EXTENSOR FOOT 1/2 EACH TENDON	6,657
28210	RPR TENDON XTNSR FOOT SEC W/FREE GRAFT EA TENDON	11,274
28220	TENOLYSIS FLEXOR FOOT SINGLE TENDON	4,592
28230	TX OPN TENDON FLEXOR FOOT SINGLE/MULT TENDON SPX	4,592
28232	TX OPEN TENDON FLEXOR TOE 1 TENDON SPX	4,592
28234	TENOTOMY OPEN EXTENSOR FOOT/TOE EACH TENDON	4,592
28238	RCNSTJ PST TIBL TDN W/EXC ACCESSORY TARSL NAVCLR	9,534
28240	TENOTOMY LENGTHENING/RLS ABDUCTOR HALLUCIS MUSC	6,657
28250	DIVISION PLANTAR FASCIA & MUSCLE SPX	6,657
28264	CAPSULOTOMY MIDTARSAL	9,184
28270	CAPSUL MTTARPHLNGL JT W/WO TENORRHAPHY EA JT SPX	4,993
28280	SYNDACTYLIZATION TOES	6,657
28285	CORRECTION HAMMERTOES	9,438
28286	CORRECTION COCK-UP 5TH TOE W/PLASTIC CLOSURE	5,824
28288	OSTC PRTL EXOSTC/CONDYLC METAR HEAD	5,824
28289	HALLUX RIGIDUS W/CHEILECTOMY 1ST MP JT W/O IMPLT	5,824
28290	CORRECTION, HALLUX VALGUS (BUNION), WITH OR WITHOUT SESAMOIDECTOMY; SIMPLE EXOSTECTOMY	6,657
28292	CORRJ HALLUX VALGUS W/SESMD C W/RESCJ PROX PHAL	6,657
28293	CORRECTION, HALLUX VALGUS (BUNION), WITH OR WITHOUT SESAMOIDECTOMY; RESECTION OF JOINT WITH IMPLANT	7,489
28294	CORRECTION, HALLUX VALGUS (BUNION), WITH OR WITHOUT SESAMOIDECTOMY W/ TNDN TRNSPLNT	7,489
28295	CORRJ HALLUX VALGUS W/SESMD C W/PROX METAR OSTEOT	6,657
28296	CORRJ HALLUX VALGUS W/SESMD C W/DIST METAR OSTEOT	6,657
28297	CORRJ HALLUX VALGUS W/SESMD C W/1METAR MEDIAL CNF	13,675
28298	CORRJ HALLUX VALGUS W/SESMD C W/PROX PHLNX OSTEOT	9,534
28299	CORRJ HALLUX VALGUS W/SESMD C W/2 OSTEOT	9,534
28300	OSTEOTOMY CALCANEUS W/WO INTERNAL FIXATION	12,752
28302	OSTEOTOMY TALUS	9,534
28304	OSTEOTOMY TARSAL BONES OTH/THN CALCANEUS/TALUS	9,534
28305	OSTEOT TARSAL OTH/THN CALCANEUS/TALUS W/AGRFT	13,730

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<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
28306	OSTEOT W/WO LNGTH SHRT/CORRJ 1ST METAR	9,534
28307	OSTEOT W/WO LNGTH SHRT/CORRJ METAR XCP 1ST TOE	9,534
28308	OSTEOT W/WO LNGTH SHRT/CORRJ METAR XCP 1ST EA	5,824
28309	OSTEOT W/WO LNGTH SHRT/ANGULAR CORRJ METAR MLT	9,534
28310	OSTEOT SHRT CORRJ PROX PHALANX 1ST TOE	9,534
28312	OSTEOT SHRT CORRJ OTH PHALANGES ANY TOE	5,824
28313	RCNSTJ ANGULAR DFRM TOE SOFT TISS PX ONLY	5,824
28315	SESAMOIDECTOMY FIRST TOE SPX	5,824
28320	REPAIR NONUNION/MALUNION TARSAL BONES	30,192
28322	RPR NON/MALUNION METARSAL W/WO BONE GRAFT	13,004
28340	RCNSTJ TOE MACRODACTYLY SOFT TISSUE RESECTION	6,657
28341	RCNSTJ TOE MACRODACTYLY REQUIRING BONE RESECTION	7,489
28344	RECONSTRUCTION TOE POLYDACTYLY	7,489
28345	RCNSTJ TOE SYNDACTYLY W/WO SKIN GRAFT EACH WEB	7,489
28400	CLOSED TX CALCANEAL FRACTURE W/O MANIPULATION	1,666
28405	CLOSED TX CALCANEAL FRACTURE W/MANIPULATION	3,329
28406	PRQ SKELETAL FIXJ CALCANEAL FRACTURE W/MANJ	9,534
28415	OPEN TREATMENT CALCANEAL FRACTURE	13,178
28420	OPEN TREATMENT CALCANEAL FRACTURE W BONE GRAFT	28,058
28435	CLOSED TX TALUS FRACTURE W/MANIPULATION	3,329
28436	PRQ SKELETAL FIXATION TALUS FRACTURE W/MANJ	9,534
28445	OPEN TREATMENT TALUS FRACTURE	12,372
28450	TX TARSAL BONE FX XCP TALUS&CALCN W/O MANJ	1,000
28456	PRQ SKEL FIXJ TARSL FX XCP TALUS&CALCNS W/MANJ	9,534
28465	OPEN TX TARSAL FRACTURE XCP TALUS & CALCANEUS EA	13,030
28470	CLOSED TX METATARSAL FRACTURE W/O MANIPULATION	1,000
28475	CLTX METAR FX W/MANJ	3,329
28476	PRQ SKEL FIXJ METAR FX W/MANJ	5,738
28485	OPEN TREATMENT METATARSAL FRACTURE EACH	12,692
28496	PRQ SKEL FIXJ FX GRT TOE PHLX/PHLG W/MANJ	5,738
28505	OPEN TX FRACTURE GREAT TOE/PHALANX/PHALANGES	8,563
28510	CLTX FX PHLX/PHLG OTH/THN GRT TOE W/O MANJ	1,030
28515	CLTX FX PHLX/PHLG OTH/THN GRT TOE W/MANJ	1,000

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<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
28525	OPEN TX FRACTURE PHALANX/PHALANGES NOT GREAT TOE	8,563
28531	OPEN TX SESAMOID FRACTURE W/WO INTERNAL FIXATION	9,534
28545	CLTX TARSAI DISLC OTH/THN TALOTARSAL W/ANES	5,738
28546	PRQ SKEL FIXJ TARSL DISLC XCP TALOTARSAL W/MANJ	5,738
28555	OPEN TREATMENT TARSAI BONE DISLOCATION	9,534
28575	CLOSED TX TALOTARSAL JOINT DISLOCATION W/ANES	4,375
28576	PRQ SKEL FIXJ TALOTARSAL JT DISLC W/MANJ	9,534
28585	OPEN TREATMENT TALOTARSAL JOINT DISLOCATION	14,061
28605	CLOSED TX TARSOMETATARSAL DISLOCATION W/ANES	3,329
28606	PRQ SKEL FIXJ TARS JT DISLC W/MANJ	5,738
28615	OPEN TREATMENT TARSOMETATARSAL JOINT DISLOCATION	12,432
28635	CLTX METATARSOPHLNGL JT DISLC REQ ANES	3,329
28636	PRQ SKEL FIXJ METATARSOPHLNGL JT DISLC W/MANJ	5,738
28645	OPEN TX METATARSOPHALANGEAL JOINT DISLOCATION	8,438
28665	CLTX INTERPHALANGEAL JOINT DISLOCATION REQ ANES	3,281
28666	PRQ SKEL FIXJ INTERPHALANGEAL JOINT DISLC W/MANJ	5,738
28675	OPEN TREATMENT INTERPHALANGEAL JOINT DISLOCATION	8,438
28705	ARTHRODESIS PANTALAR	39,377
28715	ARTHRODESIS TRIPLE	30,059
28725	ARTHRODESIS SUBTALAR	27,610
28730	ARTHROD MIDTARSL/TARSOMETATARSAL MULT/TRANSVRS	29,706
28735	ARTHROD MIDTARSL/TARS MLT/TRANSVRS W/OSTEOT	30,003
28737	ARTHROD W/TDN LNGTH&ADVMNT TARSL NVCLR-CUNEIFOR	28,522
28740	ARTHRODESIS MIDTARSOMETATARSAL SINGLE JOINT	14,096
28750	ARTHRODESIS GREAT TOE METATARSOPHALANGEAL JOINT	13,837
28755	ARTHRODESIS GREAT TOE INTERPHALANGEAL JOINT	9,534
28760	ARTHROD W/XTNSR HALLUCIS LONGUS TR 1ST METAR NCK	9,534
28805	AMPUTATION FOOT TRANSMETARSAL	3,723
28810	AMPUTATION METATARSAL W/TOE SINGLE	4,993
28820	AMPUTATION TOE METATARSOPHALANGEAL JOINT	4,993
28825	AMPUTATION TOE INTERPHALANGEAL JOINT	4,993
28899	UNLISTED PROCEDURE FOOT/TOES	7,489
29065	APPLICATION CAST SHOULDER HAND LONG ARM	1,000

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<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
29075	APPLICATION CAST ELBOW FINGER SHORT ARM	1,000
29085	APPLICATION CAST HAND & LOWER FOREARM GAUNTLET	1,000
29105	APPLICATION LONG ARM SPLINT SHOULDER HAND	1,000
29125	APPLICATION SHORT ARM SPLINT FOREARM-HAND STATIC	1,000
29325	APPL HIP SPICA CAST ONE&ONE-HALF SPICA/BOTH LEGS	1,000
29425	APPLICATION SHORT LEG CAST WALKING/AMBULATORY	1,000
29515	APPLICATION SHORT LEG SPLINT CALF FOOT	1,000
29710	RMVL/BIVLV SHO/HIP SPICA MINERVA/RISSE JACKET	1,000
29805	ARTHROSCOPY SHOULDER DX WWO SYNOVIAL BIOPSY SPX	7,400
29806	ARTHROSCOPY SHOULDER SURGICAL CAPSULORRHAPHY	11,845
29807	ARTHROSCOPY SHOULDER SURGICAL REPAIR SLAP LESION	11,845
29819	ARTHROSCOPY SHOULDER SURGICAL REMOVAL LOOSE/FB	9,866
29820	ARTHROSCOPY SHOULDER SURG SYNOVECTOMY PARTIAL	9,866
29821	ARTHROSCOPY SHOULDER SURG SYNOVECTOMY COMPLETE	9,866
29822	ARTHROSCOPY SHOULDER SURG DEBRIDEMENT LIMITED	9,866
29823	ARTHROSCOPY SHOULDER SURG DEBRIDEMENT EXTENSIVE	17,510
29824	ARTHROSCOPY SHOULDER DISTAL CLAVICULECTOMY	9,866
29825	ARTHROSCOPY SHOULDER AHESIOLYSIS WWO MANIPJ	9,866
29826	ARTHROSCOPY SHOULDER W/CORACOACRM LIGMNT RELEASE	7,292
29827	ARTHROSCOPY SHOULDER ROTATOR CUFF REPAIR	10,380
29828	ARTHROSCOPY SHOULDER BICEPS TENODESIS	9,534
29830	ARTHROSCOPY ELBOW DIAG WWO SYNOVIAL BIOPSY SPX	7,400
29834	ARTHROSCOPY ELBOW SURGICAL W/REMOVAL LOOSE/FB	9,044
29835	ARTHROSCOPY ELBOW SURGICAL SYNOVECTOMY PARTIAL	9,044
29836	ARTHROSCOPY ELBOW SURGICAL SYNOVECTOMY COMPLETE	9,534
29837	ARTHROSCOPY ELBOW SURGICAL DEBRIDEMENT LIMITED	9,044
29838	ARTHROSCOPY ELBOW SURGICAL DEBRIDEMENT EXTENSIVE	9,044
29840	ARTHROSCOPY WRIST DIAG WWO SYNOVIAL BIOPSY SPX	6,530
29843	ARTHROSCOPY WRIST INFECTION LAVAGE&DRAINAGE	8,222
29844	ARTHROSCOPY WRIST SURGICAL SYNOVECTOMY PARTIAL	8,222
29845	ARTHROSCOPY WRIST SURGICAL SYNOVECTOMY COMPLETE	8,222
29846	ARTHRS WRST EXC&/RPR TRIANG FIBROCARD&JOINT	9,044
29847	ARTHROSCOPY WRIST SURG INT FIXJ FX/INSTABILITY	9,534

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<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
29848	NDSC WRST SURG W/RLS TRANSVRS CARPL LIGM	8,343
29850	ARTHROSCOPY AID TX SPINE&/FX KNEE W/O FIXJ	6,435
29851	ARTHROSCOPY AID TX SPINE&/FX KNEE W/FIXJ	10,229
29855	ARTHRS AID TIBIAL FRACTURE PROXIMAL UNICONDYLAR	14,633
29860	ARTHROSCOPY HIP DIAGNOSTIC W/WO SYNOVIAL BYP SPX	9,534
29861	ARTHROSCOPY HIP SURGICAL W/REMOVAL LOOSE/FB	9,534
29862	ARTHRS HIP DEBRIDEMENT/SHAVING ARTICULAR CRTLG	10,229
29863	ARTHROSCOPY HIP SURGICAL W/SYNOVECTOMY	10,229
29866	ARTHROSCOPY KNEE OSTEOCHONDRAL AGRFT MOSAICPLAST	10,229
29867	ARTHROSCOPY KNEE OSTEOCHONDRAL ALLOGRAFT	28,857
29868	ARTHROSCOPY KNEE MENISCAL TRNSPLJ MED/LAT	34,468
29870	ARTHROSCOPY KNEE DIAGNOSTIC W/WO SYNOVIAL BX SPX	7,400
29871	ARTHROSCOPY KNEE INFECTION LAVAGE & DRAINAGE	9,044
29873	ARTHROSCOPY KNEE LATERAL RELEASE	9,044
29874	ARTHROSCOPY KNEE REMOVAL LOOSE/FOREIGN BODY	9,044
29875	ARTHROSCOPY KNEE SYNOVECTOMY LIMITED SPX	9,044
29876	ARTHROSCOPY KNEE SYNOVECTOMY 2/>COMPARTMENTS	9,044
29877	ARTHRS KNEE DEBRIDEMENT/SHAVING ARTCLR CRTLG	9,044
29879	ARTHRS KNEE ABRASION ARTHRP/MLT DRLG/MICROFX	9,044
29880	ARTHRS KNEE W/MENISCECTOMY MED&LAT W/SHAVING	9,044
29881	ARTHRS KNE SURG W/MENISCECTOMY MED/LAT W/SHVG	9,044
29882	ARTHROSCOPY KNEE W/MENISCUS RPR MEDIAL/LATERAL	9,044
29883	ARTHROSCOPY KNEE W/MENISCUS RPR MEDIAL&LATERAL	9,044
29884	ARTHROSCOPY KNEE W/LYSIS ADHESIONS W/WO MANJ SPX	9,044
29885	ARTHRS KNEE DRILL OSTEOCHONDRITIS DISSECANS GRFG	10,229
29886	ARTHRS KNEE DRILLING OSTEOCHOND DISSECANS LESION	9,044
29887	ARTHRS KNEE DRLG OSTEOCHOND DISSECANS INT FIXJ	9,534
29888	ARTHRS AIDED ANT CRUCIATE LIGM RPR/AGMNTJ/RCNSTJ	13,173
29889	ARTHRS AIDED PST CRUCIATE LIGM RPR/AGMNTJ/RCNSTJ	26,056
29891	ARTHRS ANKLE EXC OSTCHNDRL DFCT W/DRLG DFCT	7,400
29892	ARTHRS AID RPR LES/TALAR DOME FX/TIBL PLAFOND FX	9,534
29893	ENDOSCOPIC PLANTAR FASCIOTOMY	5,976
29894	ARTHROSCOPY ANKLE W/REMOVAL LOOSE/FOREIGN BODY	7,400

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<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
29895	ARTHROSCOPY ANKLE SURGICAL SYNOVECTOMY PARTIAL	7,400
29897	ARTHROSCOPY ANKLE SURGICAL DEBRIDEMENT LIMITED	8,222
29898	ARTHROSCOPY ANKLE SURGICAL DEBRIDEMENT EXTENSIVE	8,222
29899	ARTHROSCOPY ANKLE SURGICAL W/ANKLE ARTHRODESIS	12,361
29900	ARTHROSCOPY METACARPOPHALANGEAL SYNOVIAL BIOPSY	4,375
29914	ARTHROSCOPY HIP W/FEMOROPLASTY	9,534
29915	ARTHROSCOPY HIP W/ACETABULOPLASTY	9,534
29916	ARTHROSCOPY HIP W/LABRAL REPAIR	9,534
35206	REPAIR BLOOD VESSEL DIRECT UPPER EXTREMITY	5,140
35207	REPAIR BLOOD VESSEL DIRECT HAND FINGER	8,609
37618	LIGATION MAJOR ARTERY EXTREMITY	5,308
38220	DIAGNOSTIC BONE MARROW ASPIRATIONS	1,000
62287	DCMPRN PERQ NUCLEUS PULPOSUS 1/> LEVELS LUMBAR	8,377
62310	INJ, SNGL, NOT INCL NEURO SUBST, W/ OR W/O CONTRAST, OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S)	1,971
62311	INJ, SNGL, NOT INCL NEURO SUBST, W/ OR W/O CONTRAST, OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S)	1,971
62321	NJX DX/THER SBST INTRLMNR CRV/THRC W/IMG GDN	1,163
62323	NJX DX/THER SBST INTRLMNR LMBR/SAC W/IMG GDN	1,163
62350	IMPLTJ REVJ/RPSG ITHCL/EDRL CATH PMP W/O LAM	9,856
62355	RMVL PREVIOUSLY IMPLTED ITHCL/EDRL CATH	3,132
62362	IMPLTJ/RPLCMT ITHCL/EDRL DRUG NFS PRGRBL PUMP	49,204
62365	RMVL SUBQ RSVR/PUMP INTRATHECAL/EPIDURAL INFUS	7,381
62368	ELECT ANALYS IMPLT ITHCL/EDRL PUMP W/REPRGRMG	1,000
62370	ELEC ANLYS IMPLT ITHCL/EDRL PMP W/REPR PHYS/QHP	2,421
63020	LAMNOTMY INCL W/DCMPRSN NRV ROOT 1 INTRSPC CERVC	10,498
63030	LAMNOTMY INCL W/DCMPRSN NRV ROOT 1 INTRSPC LUMBR	9,924
63035	LAMNOTMY W/DCMPRSN NRV EACH ADDL CRVCL/LMBR	7,541
63042	LAMOT PRTL FFD EXC DISC REEXPL 1 NTRSPC LUMBAR	9,924
63045	LAM FACETECTOMY & FORAMOTOMY 1 SEGMENT CERVICAL	9,924
63047	LAM FACETECTOMY & FORAMOTOMY 1 SEGMENT LUMBAR	9,924
63048	LAM FACETECTOMY&FORAMTOMY 1 SGM EA CRV THRC/LMBR	2,685
63056	TRANSPEDICULAR DCMPRN SPINAL CORD 1 SEG LUMBAR	9,924
63267	LAM EXC/EVAC ISPI LESION OTH/THN NEO XDRL LUMBAR	11,212



**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
**Charge Commitment- 1110.235(c)(9)**

<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
63650	PRQ IMPLTJ NSTIM ELECTRODE ARRAY EPIDURAL	15,355
63661	RMVL SPINAL NSTIM ELTRD PRQ ARRAY INCL FLUOR	2,807
63663	REVJ INCL RPLCMT NSTIM ELTRD PRQ RA INCL FLUOR	19,044
63685	INSJ/RPLCMT SPI NPGR DIR/INDUXIVE COUPLING	79,811
63688	REVJ/RMVL IMPLANTED SPINAL NEUROSTIM GENERATOR	6,278
64405	INJECTION ANESTHETIC AGENT GREATER OCCIPITAL NRV	1,000
64418	INJECTION ANESTHETIC AGENT SUPRASCAPULAR NERVE	2,051
64421	MULTIPLE NERVE BLOCK INJECTIONS RIB NERVES	1,396
64445	INJECTION ANESTHETIC AGENT SCIATIC NRV SINGLE	2,051
64450	INJECTION ANES OTHER PERIPHERAL NERVE/BRANCH	1,000
64455	NJX ANES&/STERIOD PLANTAR COMMON DIGITAL NERVE	1,997
64470	INJ, ANES AGENT &/OR STRD, PRVRTBL FCT JNT OR FCT JNT NRV; CRVCL OR THOR, SINGLE LVL	1,971
64472	INJ, ANES AGENT &/OR STRD, PRVRTBL FCT JNT OR FCT JNT NRV; CRVCL OR THOR, EA ADDTL LVL	1,971
64475	INJ, ANES AGENT &/OR STRD, PRVRTBL FCT JNT OR FCT JNT NRV; LUMBAR OR SACRAL, SINGLE LVL	1,971
64476	INJ, ANES AGENT &/OR STRD, PRVRTBL FCT JNT OR FCT JNT NRV; LUMBAR OR SACRAL, EA ADDTL LVL	1,971
64479	NJX ANES&/STRD W/IMG TFRML EDRL CRV/THRC 1 LVL	2,051
64483	NJX ANES&/STRD W/IMG TFRML EDRL LMBR/SAC 1 LVL	1,971
64484	NJX ANES&/STRD W/IMG TFRML EDRL LMBR/SAC EA LV	1,971
64490	NJX DX/THER AGT PVRT FACET JT CRV/THRC 1 LEVEL	1,396
64491	NJX DX/THER AGT PVRT FACET JT CRV/THRC 2ND LEVEL	1,000
64492	NJX DX/THER AGT PVRT FACET JT CRV/THRC 3+ LEVEL	1,000
64493	NJX DX/THER AGT PVRT FACET JT LMBR/SAC 1 LEVEL	1,396
64494	NJX DX/THER AGT PVRT FACET JT LMBR/SAC 2ND LEVEL	1,000
64495	NJX DX/THER AGT PVRT FACET JT LMBR/SAC 3+ LEVEL	1,000
64510	NJX ANES STELLATE GANGLION CRV SYMPATHETIC	1,465
64520	INJECTION ANES LMBR/THRC PARAVERTEBRL SYMPATHETIC	1,465
64622	DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE; LUMBAR OR SACRAL, SINGLE LEVEL	2,736
64623	DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE; LUMB OR SACR, EACH ADDTL LVL	1,000
64640	DSTRJ NEUROLYTIC AGENT OTHER PERIPHERAL NERVE	1,288



**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
**Charge Commitment- 1110.235(c)(9)**

<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
64702	NEUROPLASTY DIGITAL 1/BOTH SAME DIGIT	5,564
64704	NEUROPLASTY NERVE HAND/FOOT	5,564
64708	NEURP MAJOR PRPH NRV ARM/LEG OPN OTH/THN SPEC	11,126
64712	NEURP MAJOR PRPH NRV OPN ARM/LEG SCIATIC NRV	4,013
64718	NEUROPLASTY &/TRANSPOSITION ULNAR NERVE ELBOW	11,126
64719	NEUROPLASTY &/TRANSPOSITION ULNAR NERVE WRIST	11,126
64721	NEUROPLASTY &/TRANSPOS MEDIAN NRV CARPAL TUNNE	8,343
64722	DECOMPRESSION UNSPECIFIED NERVE	5,789
64726	DECOMPRESSION PLANTAR DIGITAL NERVE	4,013
64727	INTERNAL NEUROLYSIS REQ OPERATING MICROSCOPE	1,000
64772	TRANSECTION/AVULSION OTH SPINAL NRV XDRL	4,013
64774	EXC NEUROMA CUTAN NRV SURGLY IDENTIFIABLE	8,343
64776	EXC NEUROMA DIGITAL NERVE 1 OR BOTH SAME DIGIT	9,735
64778	EXCISION NEUROMA DIGITAL NRV EA ADDL DIGIT	4,012
64782	EXC NEUROMA HAND/FOOT XCP DIGITAL NERVE	9,735
64783	EXC NEUROMA HAND/FOOT EA NRV XCP SM DGT	5,564
64784	EXC NEUROMA MAJOR PERIPHERAL NRV XCP SCIATIC	10,134
64787	IMPLANTATION NERVE END BONE/MUSCLE	8,343
64788	EXC NEUROFIBROMA/NEUROLEMMOMA CUTAN NRV	4,013
64790	EXC NEUROFIBROMA/NEUROLEMMOMA MAJOR PRPH NRV	4,013
64820	SYMPATHECTOMY DIGITAL ARTERIES EACH DIGIT	4,053
64821	SYMPATHECTOMY RADIAL ARTERY	5,817
64831	SUTURE DIGITAL NERVE HAND/FOOT 1 NERVE	11,126
64832	SUTR DIGITAL NRV HAND/FOOT EA DGTAL NRV	7,450
64834	SUTURE 1 NERVE HAND/FOOT COMMON SENSORY NERVE	8,686
64835	SUTURE 1 NERVE MEDIAN MOTOR THENAR	10,134
64836	SUTURE 1 NERVE ULNAR MOTOR	7,452
64837	SUTURE EACH ADDITIONAL NERVE HAND/FOOT	5,578
64856	SUTR PRPH NRV ARM/LEG XCP SCIATIC W/TRPOS	7,452
64857	SUTR PRPH NRV ARM/LEG XCP SCIATIC W/O TRPOS	11,582
64890	NERVE GRAFT 1 STRAND HAND/FOOT <4 CM	7,452
64892	NERVE GRAFT 1 STRAND ARM/LEG <4 CM	7,452
64895	NERVE GRAFT MLT STRANDS HAND/FOOT <4 CM	7,452

**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
**Charge Commitment- 1110.235(c)(9)**

<b>CPT Code</b>	<b>CPT Description</b>	<b>Proposed Fee Schedule</b>
64910	NERVE REPAIR W/CONDUIT EACH NERVE	11,582
73115	RADEX WRIST ARTHROGRAPHY RS&I	1,000
76000	FLUOROSCOPY UP TO 1 HOUR PHYSICIAN/QHP TIME	1,000
76003	FLUOROSCOPIC GUIDANCE FOR NEEDLE PLACEMENT ASPIRATION, INJECTION	1,000
77002	FLUOROSCOPIC GUIDANCE NEEDLE PLACEMENT ADD ON	1,000
77003	FLUOR NEEDLE/CATH SPINE/PARASPINAL DX/THER ADDON	1,000
95861	NDL EMG 2 XTR WWO RELATED PARASPINAL AREAS	1,000
95938	SHORT-LATENCY SOMATOSENS EP STD UPR & LOW LIMB	1,365
95939	CTR MOTR EP STD TRANSCRNL MOTR STIM UPR&LOW LI	2,027
95940	IONM 1 ON 1 IN OR W/ATTENDANCE EACH 15 MINUTES	1,000
G0260	INJ PROC FOR SACRO JNT; PROV OF ANES, STROID AND/OR OTH THERAP AGNT & ARTHRO SPCL CVRG INSTR	1,000
G0289	ARTHROSCOPY, KNEE, SURGICAL CHONDROPLASTY	9,044

**Attachment 24**  
**Non-Hospital Based Ambulatory Surgery**  
**Assurances- 1110.235(c)(10)**

October 19, 2022


John P. Kniery  
Illinois Health Facilities and Service Review Board  
525 West Jefferson Street, 2<sup>nd</sup> Floor  
Springfield, Illinois 62761

**Re: Illinois Bone & Spine Institute -Assurances**

Dear Mr. Kniery,

As a representative of Illinois Back and Neck Institute, PLLC d/b/a Illinois Bone & Spine Institute, I, Neema Bayran, M.D., attest the Applicant's full anticipation that, by the end of the second year following the proposed ambulatory surgical treatment center's opening, the proposed facility will operate at or in excess of the utilization standards identified in 77 Ill. Admin. Code Section 1110, Appendix B.

Sincerely,

  
Neema Bayran, M.D.  
CEO  
Illinois Bone & Spine Institute

### **Attachment 34 Availability of Funds**

The total estimated project cost is \$4,350,423 and \$3,279,001 of that amount is attribute to construction and equipment purchases. The balance of the project cost is related to the leasing costs for the new facility. Neema Bayran, M.D. will fund the project costs with cash and a loan from Old National Bank. Dr. Bayran has sufficient internal resources to fund the cash portion of the project and letter of commitment from Old National Bank is enclosed to evidence his ability to obtain financing for the remainder of the project costs.

**Attachment 34  
Availability of Funds**



October 18, 2022

John P. Kniery  
Board Administrator  
Illinois Health Facilities and Service Review Board  
525 West Jefferson Street, 2<sup>nd</sup> Floor  
Springfield, Illinois 62761

Dear Mr. Kniery,

It is my understanding that Illinois Back & Neck Institute, PLLC is transferring their Certificate of Need from their existing facility located at 360 W. Butterfield, Elmhurst, IL 60126 to a newly purchased building located at 300 W. Butterfield, Elmhurst, IL 60126. Illinois Back & Neck Institute PLLC will require financing in the amount of approximately \$3,700,000.

Should the Illinois Health Facilities and Services Review Board approve the transfer and based upon a preliminary review of the financial information, Old National Bank is prepared to extend Illinois Back & Neck Institute, PLLC up to \$3,700,000.

I trust that this letter is sufficient for your needs. Should you, or the Illinois Health Facilities and Services Review Board have any questions or comments, please do not hesitate to contact me directly at 708-930-4612.

Sincerely,

A handwritten signature in black ink, appearing to read 'Kevin Burns'.

Kevin Burns  
Vice President  
Old National Bank

**Attachment 37  
Economic Feasibility  
Project Operating Costs and  
Total Effect of the Project on Capital Costs**

October 19, 2022

John P. Kniery  
Illinois Health Facilities and Service Review Board  
525 West Jefferson Street, 2<sup>nd</sup> Floor  
Springfield, Illinois 62761

**Re: Illinois Bone & Spine Institute**  
**Ill. Admin. Code Section 1120.120(a) Available Funds Certification**  
**Ill. Admin. Code Section 1120.140(a) Reasonableness of Financing Arrangements**

Dear Mr. Kniery,

As a representative of Illinois Back and Neck Institute, PLLC d/b/a Illinois Bone & Spine Institute, I, Neema Bayran, M.D., hereby attest that the project costs will be \$4,350,423. Dr. Troy will fund the entirety of the construction of the project and the necessary working capital and operating deficits through the first full fiscal year. Dr. Bayran will fund these costs with a loan from Old National Bank and existing cash. Dr. Bayran has sufficient and readily accessible internal resources to fund the obligation required by the project.

I further certify that our analysis of the funding options for this project reflected that the funding strategy outlined herein is the lowest net cost option available.

Sincerely,

  
Neema Bayran, M.D.  
CEO  
Illinois Bone & Spine Institute

**Attachment 37**  
**Economic Feasibility**  
**Cost and GSF by Service**

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE							
Department (list below)	A	B	C	D	E	F	G
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. \$ (A x C)
Operating Room	\$289.16	-	-	-	2,737		\$791,438
Contingency	\$28.83	-	-	-	3,563		\$78,932
TOTALS	\$317.99	-	-	-	6,300		\$870,370
* Include the percentage (%) of space for circulation							

Pursuant to Illinois Admin. Code Section 1120.Appendix A (a)(3) a project's cost must be at or below the RS Means for the new construction of an ASTC. At the time of this application the RS Means for the new construction of a ASTC in this area of the state is \$446.96 GSF. This project is slated to be completed in the 3rd quarter of 2023 and the applicable RS Means standard is \$460.37 per GSF. The proposed cost per GSF for this project is \$317.99, and thus this project meets the Board's criteria.

## Attachment 37 Economic Feasibility Proforma

Illinois Back and Neck Institute, LLC			
Proforma Analysis			
	2023	2024	
<b>Estimated Medical Receipts</b>	7,150,000	7,865,500	
<b>Expenses</b>			
<u>Projected 2022 w/ 10% increase 2023-2024</u>			
Employee Costs	880,000	968,000	
Advertising & Marketing	550,000	605,000	
Medical Supplies	825,000	907,500	
Other Medical Expenses	11,000	12,100	
Insurance	137,500	151,250	
Billing Service	220,000	242,000	
Meals & Entertainment	27,500	30,250	
Professional Fees	38,500	42,350	
Equipment Rental & Lease	22,000	24,200	
Outside Services   Independent Contractors	55,000	60,500	
Computer	44,000	48,400	
Bank Fees	5,500	6,050	
Office	55,000	60,500	
Repairs & Maintenance	11,000	12,100	
Licenses & Permits	16,500	18,150	
Travel	5,500	6,050	
Travel, Meeting, Supplies	11,000	12,100	
Continuing Education	5,500	6,050	
Telephone	5,500	6,050	
Utilities	16,500	18,150	
State Taxes & Other	99,000	108,900	
<u>Estimate based on buildout &amp; debt</u>			
Depreciation & Section 179	212,088	212,088	
Interest	150,000	210,000	
Real Estate Taxes	100,000	100,000	
Rent	148,700	153,161	
Expenses	3,652,288	4,020,899	
Net Income	\$ 3,497,712	\$ 3,844,101	
<u>Estimated Cash Flow</u>			
Net Income	\$ 3,497,712	\$ 3,844,101	
Depreciation	212,088	212,088	
Interest	150,000	210,000	
Distributions	(2,300,000)	(2,400,000)	
Loan P&I Payments	(205,000)	(375,000)	
Unfinanced CapX			
Cash Flow	\$ 1,354,800	\$ 1,491,189	



## **Attachment 38**

### **Safety Net Impact Statement**

Illinois Bone & Spine Institute is a new entity and has no applicable historical data for this section of the application. However, it is anticipated that the proposed facility will have a positive material impact on essential safety net services in the community.

Dr. Bayran and his practice have long maintained a commitment to serving diverse communities in Chicago and the Chicagoland area. That diversity has included both racial and economic diversity. This is evidenced by the location of their current physician practice sites, and the proposed business plan for the facility which intends to serve Medicaid patients and patients without regard to their ability to pay for procedures.

This project involves the replacement of an existing facility and should not have any impact on the ability of another provider to cross-subsidize safety net services.

### **Attachment 39**

### **Charity Care**

Illinois Bone & Spine Institute is a new entity and has no applicable historical data for this section of the application. The project patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net revenue by the end of its second year of operation are included below. These projections are based on the existing patient base seen at the Illinois Back and Neck Institute over the last 12 months.

<b>Payor Type</b>	<b>Estimated Number of Patients</b>
Commercial	67%
Medicare	23%
Medicaid/ Medicaid MCO	2%
Private Pay	5%
Charitable Care	3%

**Attachment 40  
Flood Zone Letter**

October 19, 2022

John P. Kniery  
Board Administrator  
Illinois Health Facilities and Services Review Board  
525 W Jefferson Street, Floor 2  
Springfield, IL 62761

**Re: Illinois Bone & Spine Institute- Flood Plain Requirements**

Dear Mr. Kniery:

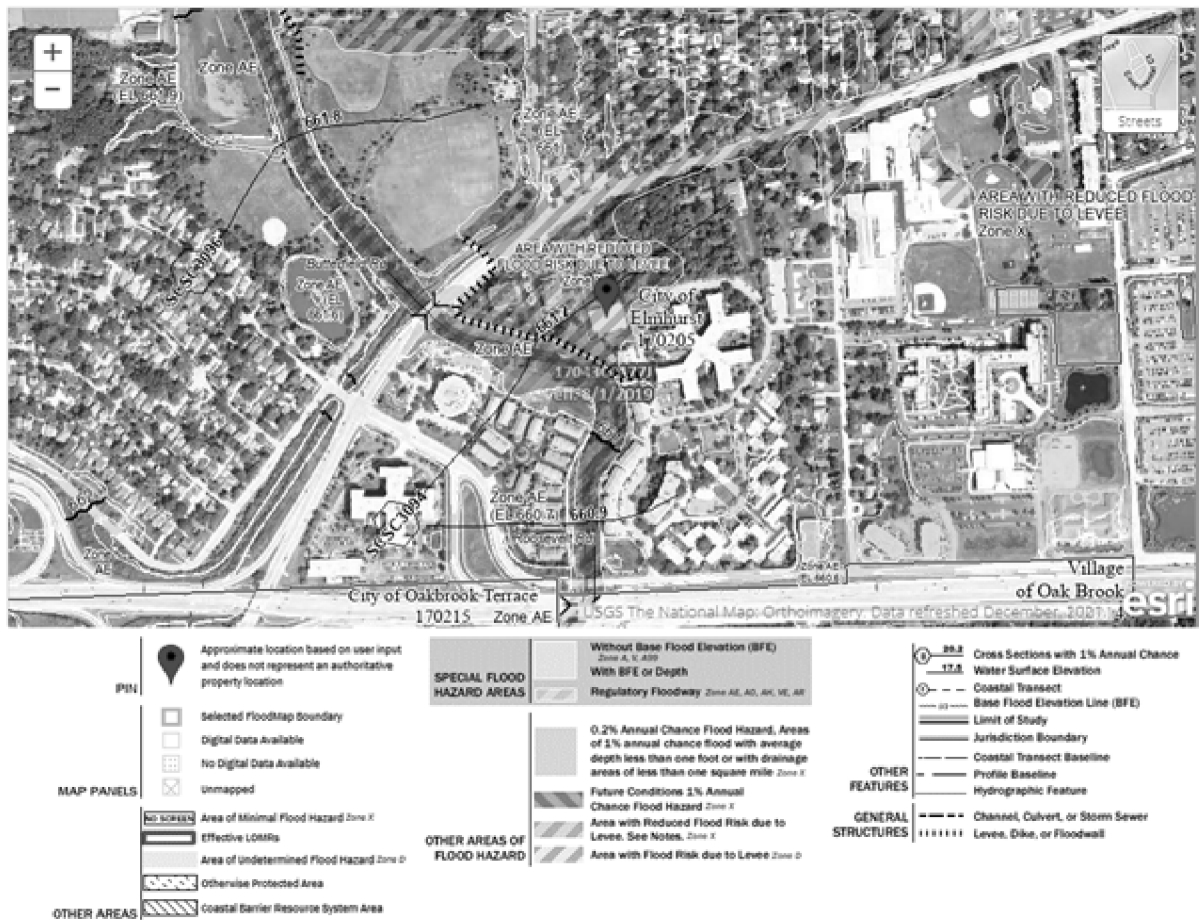
As representative of Illinois Back and Neck Institute, PLLC d/b/a Illinois Back & Spine Institute, I, Neema Bayran, M.D., affirm that the proposed relocation for the facility complies with Illinois Executive Order #2005-5. The facility location at 300 Butterfield Road, Elmhurst IL 60126 is not located in a flood plain, as evidence please find enclosed a map from the Federal Emergency Management Agency ("FEMA").

I hereby certify this true and is based upon my personal knowledge under penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely,

  
Neema Bayran, M.D.  
Chief Executive Officer  
Illinois Back & Spine Institute

## Attachment 40 Flood Zone Letter



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