25-034

RECEIVED
AUG 22 2025
HEALTH FACILITIES & SERVICES REVIEW BOARD

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: Prime Healthcare ASC – Joliet, LLC
Street Address: 301 Madison Street, Suite 100
City and Zip Code: Joliet, 60435-60435
County: Will Health Service Area: 009 Health Planning Area: 197, A-13

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

Exact Legal Name: Prime Healthcare ASC - Joliet, LLC
Street Address: 301 Madison Street, Suite 100
City and Zip Code: Joliet, 60435
Name of Registered Agent: Cogency Global Inc.
Registered Agent Street Address: 600 South Second Street, Suite 404
Registered Agent City and Zip Code: Springfield, 62704
Name of Chief Executive Officer: Sunny Bhatia, M.D.
CEO Street Address: 3480 E. Guasti Road
CEO City and Zip Code: Ontario, 91761
CEO Telephone Number: 909-235-4400

Type of Ownership of Applicants

- ☐ Non-profit Corporation
- ☐ For-profit Corporation
- ☒ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
- ☐ Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- 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.

APPEND DOCUMENTATION AS ATTACHMENT 1, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Juan Morado, Jr. and Mark J. Silberman
Title: Partner and CON Counsel
Company Name: Benesch Friedlander Coplan & Aronoff LLP
Address: 71 South Wacker Drive, 16th Floor, Chicago, IL 60606
Telephone Number: 312-212-4949
E-mail Address: jmorado@beneschlaw.com; msilberman@beneschlaw.com

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:

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

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City and Zip Code: Joliet, 60435
County: Will Health Service Area: 009 Health Planning Area: 197, A-13

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

Exact Legal Name: Saint Joseph Medical Center – Joliet, LLC d/b/a Saint Joseph Medical Center
Street Address: 3480 E. Guasti Road
City and Zip Code: Ontario, 91761
Name of Registered Agent: Cogency Global Inc.
Registered Agent Street Address: 600 South Second Street, Suite 404
Registered Agent City and Zip Code: Dover, 19904
Name of Interim Chief Executive Officer: Colleen Pawlik, MSN, BSN
Interim CEO Street Address: 301 Madison Street, Suite 100
Interim CEO City and Zip Code: Joliet, 60435
Interim CEO Telephone Number: 909-235-4400

Type of Ownership of Applicants

- ☐ Non-profit Corporation
- ☐ For-profit Corporation
- ☒ Limited Liability Company
- ☐ Partnership
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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: Prime Healthcare ASC – Joliet, LLC
Street Address: 301 Madison Street, Suite 100
City and Zip Code: Joliet, Illinois 60435
County: Will Health Service Area: 009 Health Planning Area: 197, A-13

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

Exact Legal Name: Prime Healthcare Services, Inc.
Street Address: 3480 E. Guasti Road
City and Zip Code: Ontario, 91761
Name of Registered Agent: Cogency Global Inc.
Registered Agent Street Address: 850 New Burton Road, Suite 201
Registered Agent City and Zip Code: Dover, 19904
Name of Chief Executive Officer: Dr. Prem Reddy
CEO Street Address: 3480 E. Guasti Road
CEO City and Zip Code: Ontario, 91761
CEO Telephone Number: 909-235-4400

Type of Ownership of Applicants

- ☐ Non-profit Corporation
- ☒ For-profit Corporation
- ☐ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
- ☐ Other

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Address: 71 South Wacker Drive, 16th Floor, Chicago, IL 60606
Telephone Number: 312-212-4949
E-mail Address: jmorado@beneschlaw.com; msilberman@beneschlaw.com

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 after permit issuance -**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960**]

Name: Colleen Pawlik, MSN, BSN
Title: Interim Chief Executive Officer
Company Name: Prime Saint Joseph Medical Center - Joliet
Address: 333 Madison Street, Joliet, IL 60435
Telephone Number: 708-945-8310
E-mail Address: Cpawlik@PrimeHealthcare.com
Fax Number:

Site Ownership [Provide this information for each applicable site]

Exact Legal Name of Site Owner: Prime Healthcare Services Inc.
Address of Site Owner: 3480 E. Guasti Road, Ontario, CA 91761
Street Address or Legal Description of the Site: **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.**
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee [Provide this information for each applicable facility and insert after this page.]

Exact Legal Name: Saint Joseph Medical Center – Joliet, LLC

Address: 333 Madison Street, Joliet, IL 60435

☐	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
☒	Limited Liability Company	☐	Sole Proprietorship	☐	Other

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- 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.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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** or **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.

Prime Healthcare ASC – Joliet, LLC ("Prime ASC") is submitting this application for a Certificate of Need to the Illinois Health Facilities and Services Review Board for the establishment of a multi-specialty ambulatory surgical treatment center ("ASTC") located at 301 Madison Street, Suite 100, Joliet, Illinois 60435.

This project is considered a substantive project because it will result in the establishment of a new facility, though the ASTC will be located in what is currently an outpatient pavilion on the hospital's campus.

Prime ASC will provide the following categories of services:

- Colon and Rectal Surgery
- General Surgery
- Gastroenterology
- Neurological
- Obstetrics/Gynecology
- Ophthalmology
- Orthopedic
- Otolaryngology
- Pain management
- Podiatric
- Cardiovascular
- Thoracic, and
- Urology.

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	558,407	173,593	732,000
Modernization Contracts	-	-	-
Contingencies	50,000	50,000	100,000
Architectural/Engineering Fees	30,000	30,000	60,000
Consulting and Other Fees	100,000	100,000	200,000
Movable or Other Equipment (not in construction contracts)	767,000	286,600	1,053,600
Bond Issuance Expense (project related)	-	-	-
Net Interest Expense During Construction (project related)	-	-	-
Fair Market Value of Leased Space or Equipment	2,534,681	787,962	3,322,643
Other Costs to Be Capitalized	-	-	-
Acquisition of Building or Other Property (excluding land)	-	-	-
TOTAL USES OF FUNDS	4,040,088	1,428,155	5,468,243
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	1,505,407	640,193	$2,145,600
Pledges			
Gifts and Bequests	-	-	-
Bond Issues (project related)	-	-	-
Mortgages	-	-	-
Leases (fair market value)	2,534,681	787,962	3,322,643
Governmental Appropriations	-	-	-
Grants	-	-	-
Other Funds and Sources	-	-	-
TOTAL SOURCES OF FUNDS	**4,040,088**	**1,428,155**	**5,468,243**
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

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 ☐ Yes ☒ No

Purchase Price: NOT APPLICABLE

Fair Market Value: NOT APPLICABLE

The project involves the establishment of a new facility or a new category of service

☒ Yes ☐ No

If yes, provide the dollar amount of all **non-capitalized** 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.

Estimated start-up costs and operating deficit cost is **$2,032,067**

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

☐ None or not applicable ☐ Preliminary

☒ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): July 1, 2026

Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140):

☐ Purchase orders, leases or contracts pertaining to the project have been executed.

☐ 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

☒ Financial Commitment will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable?

☒ Cancer Registry

☒ APORS

☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted

☒ All reports regarding outstanding permits

Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

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 departments 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]

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE		-			-	-	
ASC	$4,040,088	-	8,370	8,370	-	-	-
Total Clinical	$4,040,088	-	8,370	8,370	-	-	-
NON-REVIEWABLE							
Administrative	$1,428,155	-	2,602	2,602	-		-
Total Non-clinical	$1,428,155	-	2,602	2,602	-		-
TOTAL	**$5,468,243**	-	**10,972**	**10,972**	-		-

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**.

FACILITY NAME:		**CITY:**			
REPORTING PERIOD DATES:	**From:**		**to:**		
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
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)					
TOTALS:					

Saint Joseph Medical Center

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 Prime Healthcare ASC – Joliet, LLC * 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.

Colleen Pawlik, MSN
SIGNATURE

Colleen Pawlik, MSN
PRINTED NAME

Interim COO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 11th day of August

Signature of Notary

Seal

CHARLETTE COLEMAN
Official Seal
Notary Public - State of Illinois
My Commission Expires Nov 16, 2028

Sunil Patel
SIGNATURE

Sunil Patel
PRINTED NAME

CMO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 11th day of August

Signature of Notary

Seal

Official Seal
ERICA L BRODERICK
Notary Public, State of Illinois
Commission No. 906011
My Commission Expires December 18, 2027

*Insert the EXACT legal name of the applicant

Saint Joseph Medical Center

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- 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 Saint Joseph Medical Center – Joliet, LLC* 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.

SIGNATURE

Colleen Pawlik MSN

PRINTED NAME

Interim CEO

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 11th day of August

Signature of Notary

Seal

CHARLOTTE COLEMAN
Official Seal
Notary Public - State of Illinois
My Commission Expires Nov 18, 2024

SIGNATURE

Sunil Patel

PRINTED NAME

CMO

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 11th day of August

Signature of Notary

Seal

Official Seal
ERICA L BRODERICK
Notary Public, State of Illinois
Commission No. 906011
My Commission Expires December 18, 2027

*Insert the EXACT legal name of the applicant

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- 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 Prime Healthcare Services, Inc.* 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.

SIGNATURE

Ali Tavakoli MD

PRINTED NAME

VP ASC

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 18th day of July, 2025

Elena Manzo

Signature of Notary

Seal

Official Seal
ELENA MANZO
Notary Public, State of Illinois
Commission No. 597111
My Commission Expires March 14, 2028

SIGNATURE

Steve Aleman

PRINTED NAME

Chief Financial Officer

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this ____ day of _____

See attached CA Jurat

Signature of Notary

Seal

*Insert the EXACT legal name of the applicant

CERTIFICATION/NOTARIZATION

CALIFORNIA JURAT GOVERNMENT CODE § 8202

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California

County of San Bernardino

Subscribed and sworn to (or affirmed) before me on this 14th day of July, 2025, by

Date *Month* *Year*

(1) Steve Aleman

(and (2) _____).

Name(s) of Signer(s)

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

CATHERINE JARAMILLO
Notary Public - California
San Bernardino County
Commission # 2440092
My Comm. Expires Mar 28, 2027

Place Notary Seal and/or Stamp Above

Signature Catherine Jaramillo

Signature of Notary Public

OPTIONAL

Completing this information can deter alteration of the document or fraudulent reattachment of this form to an unintended document.

Description of Attached Document

Title or Type of Document: _____

Document Date: _____ Number of Pages: _____

Signer(s) Other Than Named Above: _____

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 (3 Operating Rooms 2 Procedure Rooms)	8,370 GSF	13,750 GSF	5,020 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**	**MEET STANDARD?**
YEAR 1	ASTC	17,588 Hours	7,543 Hours	6,000 Hours	YES
YEAR 2	ASTC	17,588 Hours	7,770 Hours	6,000 Hours	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. 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.

SECTION VI. SERVICE SPECIFIC REVIEW CRITERIA

This Section is applicable to all projects proposing the establishment, expansion, or modernization of categories of service that are subject to CON review, as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960]. It is comprised of information requirements for each category of service, as well as charts for each service, indicating the review criteria that must be addressed for each action (establishment, expansion, and modernization). After identifying the applicable review criteria for each category of service involved, read the criteria, and provide the required information APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:

G. Non-Hospital Based Ambulatory Surgery

Applicants proposing to establish, expand and/or modernize the Non-Hospital Based Ambulatory Surgery category of service must submit the following information.

ASTC Service
☒ **Cardiovascular**
☒ **Colon and Rectal Surgery**
☐ **Dermatology**
☐ **General Dentistry**
☒ **General Surgery**
☒ **Gastroenterology**
☒ **Neurological Surgery**
☐ **Nuclear Medicine**
☒ **Obstetrics/Gynecology**
☒ **Ophthalmology**
☐ **Oral/Maxillofacial Surgery**
☒ **Orthopedic Surgery**
☒ **Otolaryngology**
☒ **Pain Management**
☐ **Physical Medicine and Rehabilitation**
☐ **Plastic Surgery**
☒ **Podiatric Surgery**
☐ **Radiology**
☒ **Thoracic Surgery**
☒ **Urology**
☐ **Other**_____

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA	Establish New ASTC or Service	Expand Existing Service
1110.235(c)(2)(B) – Service to GSA Residents	X	
1110.235(c)(3) – Service Demand – Establishment of an ASTC or Additional ASTC Service	X	
1110.235(c)(4) – Service Demand – Expansion of Existing ASTC Service	N/A	
1110.235(c)(5) – Treatment Room Need Assessment	X	
1110.235(c)(6) – Service Accessibility	X	
1110.235(c)(7)(A) – Unnecessary Duplication/Maldistribution	X	
1110.235(c)(7)(B) – Maldistribution	X	
1110.235(c)(7)(C) – Impact to Area Providers	X	
1110.235(c)(8) – Staffing	X	
1110.235(c)(9) – Charge Commitment	X	
1110.235(c)(10) – Assurances	X	
APPEND DOCUMENTATION AS ATTACHMENT 24, 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)**

SECTION VII. 1120.120 - AVAILABILITY OF FUNDS

The applicant shall document those 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]:**

$4,040,088	a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 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 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.
	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.
	c) Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated timetable of receipts.
$3,322,643	d) Debt – a statement of the estimated terms and conditions (including the debt time, variable or permanent interest rates over the debt time, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 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. 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate. 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. 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. 5) For any option to lease, a copy of the option, including all terms and conditions.
	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.
	f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt.
	g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
$5,468,243	**TOTAL FUNDS AVAILABLE**
APPEND DOCUMENTATION AS ATTACHMENT 34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

SECTION VIII. 1120.130 - FINANCIAL VIABILITY - NOT APPLICABLE, WAIVER MET

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
Enter Historical and/or Projected Years:				
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 SEQUENTIAL 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 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		Gross Sq. Ft.		Gross Sq. Ft.		Const. $	Mod. $	
	New	Mod.	New	Circ.*	Mod.	Circ.*	(A x C)	(B x E)	
ASC	$66.72	-	8,370	-	-	-	$558,407	-	$558,407
Contingency	$19.22	-	2,602	-	-	-	$50,000	-	$50,000
TOTALS	$85.94	-	10,972	-	-	-	$608,407	-	$608,407

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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.

E. Total Effect of the Project on Capital Costs

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.

APPEND DOCUMENTATION AS ATTACHMENT 37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. Safety Net Impact Statement - NOT APPLICABLE

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 each community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all 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.

CHARITY CARE of Saint Joseph Medical Center – Joliet (as a reference)			
Charity (# of patients)	**2021**	**2022**	**2023**
Inpatient	299	267	183
Outpatient	5875	5936	4180
Total	**6174**	**6203**	**4363**
Charity (cost in dollars)			
Inpatient	$4,493,201	$3,436,556	$3,671,268
Outpatient	$5,208,329	$4,475,892	$5,301,876
Total	**$9,701,530**	**$7,912,448**	**$8,973,144**

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

SECTION X. Charity Care Information - NOT APPLICABLE

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 for Saint Joseph Medical Center – Joliet (as a reference)			
	2021	**2022**	**2023**
Net Patient Revenue	2.9%	2.2%	2.5%
Amount of Charity Care (charges)	6174	6203	4363
Cost of Charity Care	**$9,701,530**	**$7,912,448**	**$8,973,144**

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 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: Prime Healthcare ASC – Joliet, LLC (Name) 301 Madison St. Suite 100 (Address)

Joliet (City) IL (State) 60435 (ZIP Code) (Telephone Number)

2. Project Location: 301 Madison St. Suite 100 (Address) Joliet (City) IL (State)

Will (County) Joliet 9 (Township) (Section)

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 ☒

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

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

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ATTACHMENT 1
Type of Ownership of Applicants

Included with this attachment are the Certificates of Good Standing for:

1. Prime Healthcare ASC – Joliet, LLC;
2. Saint Joseph Medical Center – Joliet, LLC d/b/a Prime Saint Joseph Medical Center;
3. Prime Healthcare Services, Inc.

ATTACHMENT 1
Certificate of Good Standing
Prime Healthcare ASC – Joliet, LLC

File Number 1599251-4

STATE OF ILLINOIS
OFFICE OF
THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulias, *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*

PRIME HEALTHCARE ASC - JOLIET, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON MAY 28, 2025, 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 FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

SEAL OF THE STATE OF ILLINOIS
AUG. 26TH 1818

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 10TH *day of* JUNE *A.D.* 2025 .

Authentication #: 2516100648 verifiable until 06/10/2026
Authenticate at: https://www.ilsos.gov

Alexi Giannoulias
SECRETARY OF STATE

ATTACHMENT 1
Certificate of Good Standing
Saint Joseph Medical Center – Joliet, LLC

File Number 1431703-1

STATE OF ILLINOIS
OFFICE OF
THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulias, *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*

SAINT JOSEPH MEDICAL CENTER - JOLIET, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON MARCH 26, 2024, 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 FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 10TH *day of* JUNE *A.D.* 2025 .

Authentication #: 2516100664 verifiable until 06/10/2026
Authenticate at: https://www.ilsos.gov

SECRETARY OF STATE

ATTACHMENT 1
Certificate of Good Standing
Prime Healthcare Services, Inc.

Secretary of State
Certificate of Status

I, SHIRLEY N. WEBER, PH.D., California Secretary of State, hereby certify:

Entity Name:	PRIME HEALTHCARE SERVICES, INC.
Entity No.:	2333336
Registration Date:	02/08/2001
Entity Type:	Stock Corporation - Out of State - Stock
Formed In:	DELAWARE
Status:	Active

The above referenced entity is active on the Secretary of State's records and is qualified to transact intrastate business in California.

This certificate relates to the status of the entity on the Secretary of State's records as of the date of this certificate and does not reflect documents that are pending review or other events that may impact status.

No information is available from this office regarding the financial condition, status of licenses, if any, business activities or practices of the entity.

IN WITNESS WHEREOF, I execute this certificate and affix the Great Seal of the State of California this day of June 10, 2025.

SHIRLEY N. WEBER, PH.D.
Secretary of State

Certificate No.: 336284843

To verify the issuance of this Certificate, use the Certificate No. above with the Secretary of State Certification Verification Search available at bizfileOnline.sos.ca.gov.

ATTACHMENT 2
Site Ownership

Attached is a letter of attestation of ownership of the site by Prime Healthcare Services, Inc. from Saint Joseph Medical Center's Interim Chief Executive Officer, Colleen Pawlik.

Saint Joseph Medical Center

July 1, 2025

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

Re: Attestation of Site Ownership -Prime Healthcare ASC – Joliet, LLC

Dear Mr. Kniery:

As a representative of Saint Joseph Medical Center – Joliet, I, Colleen Pawlik, MSN, BSN, hereby attest that the site of the proposed Prime Healthcare ASC-Joliet, LLC, located at 301 Madison Street, Suite 100, Joliet, Illinois 60435 is owned by Prime Healthcare Services, Inc.

Furthermore, I attest that the proposed location for the Prime Healthcare ASC- Joliet, LLC is not located in a flood zone. I hereby certify this is true and is based upon my personal knowledge under penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely,

Colleen Pawlik, MSN, BSN
Interim Chief Executive Officer
Saint Joseph Medical Center – Joliet

ATTACHMENT 3
Operating Entity/Licensee

Prime Healthcare ASC – Joliet, LLC ("Prime ASC") will be licensed by the Illinois Department of Public Health. Attached as evidence of the operating entity's good standing is a Certificate of Good Standing issued by Illinois Secretary of State.

ATTACHMENT 3
Certificate of Good Standing
Licensee: Prime Healthcare ASC – Joliet, LLC

File Number 1599251-4

To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulias, *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*

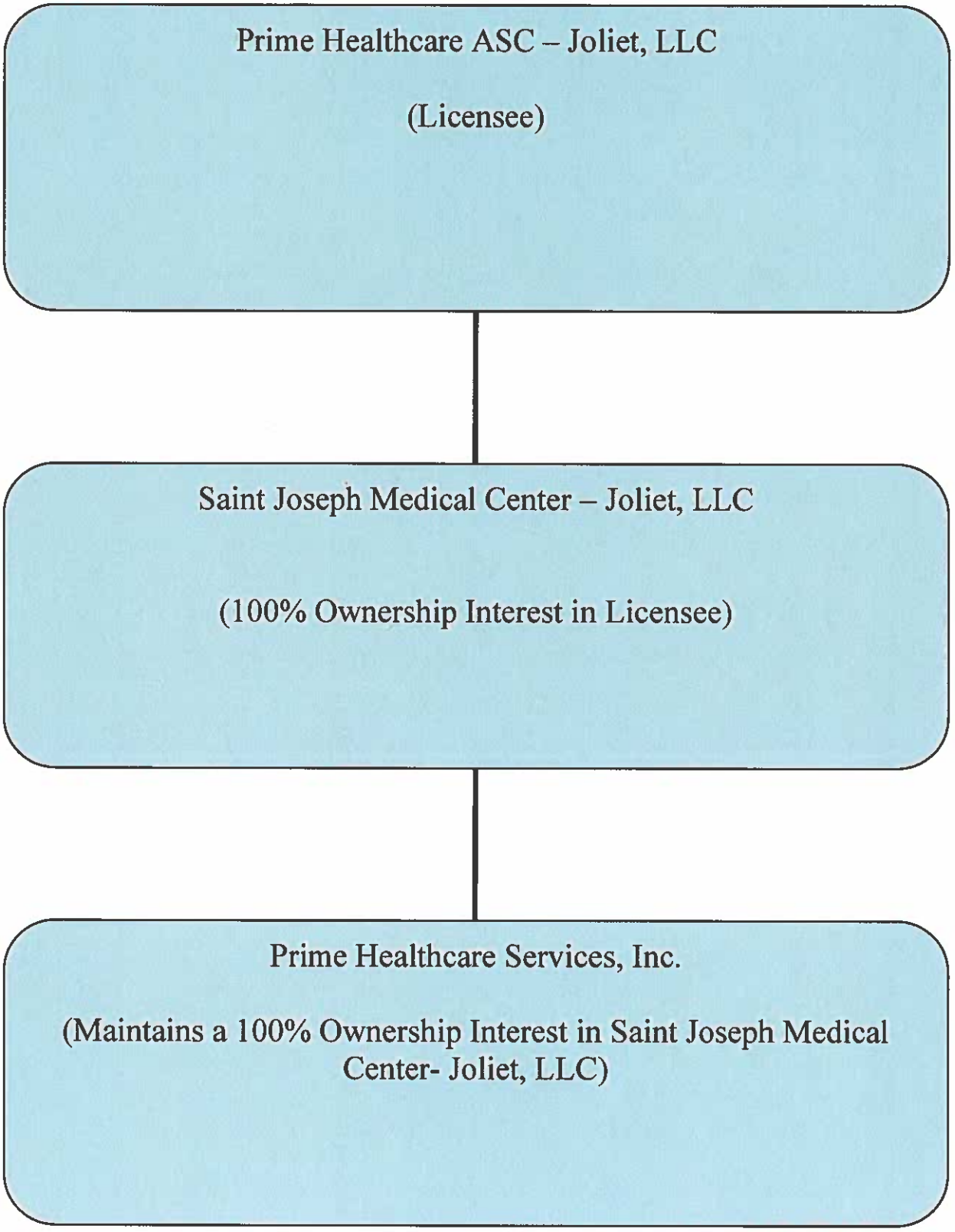
PRIME HEALTHCARE ASC - JOLIET, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON MAY 28, 2025, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 10TH *day of* JUNE *A.D.* 2025 .

Authentication #: 2516100648 verifiable until 06/10/2026
Authenticate at: https://www.ilsos.gov

Alexi Giannoulias
SECRETARY OF STATE

ATTACHMENT 4
Organizational Relationships



Saint Joseph Medical Center

July 1, 2025

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

Re: – Flood Plain Requirements -Prime Healthcare ASC – Joliet, LLC

Dear Mr. Kniery:

As a representative of Saint Joseph Medical Center – Joliet, I, Colleen Pawlik, MSN, BSN, affirm that the proposed location for the Prime Healthcare ASC – Joliet, LLC ("Prime ASC") ambulatory surgical treatment center complies with Illinois Executive Order #2005-5. The facility location at 301 Madison Street, Suite 100, Joliet, Illinois 60435 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 is true and is based upon my personal knowledge under penalty of perjury and in accordance with 735 ILCS 5/1-109.

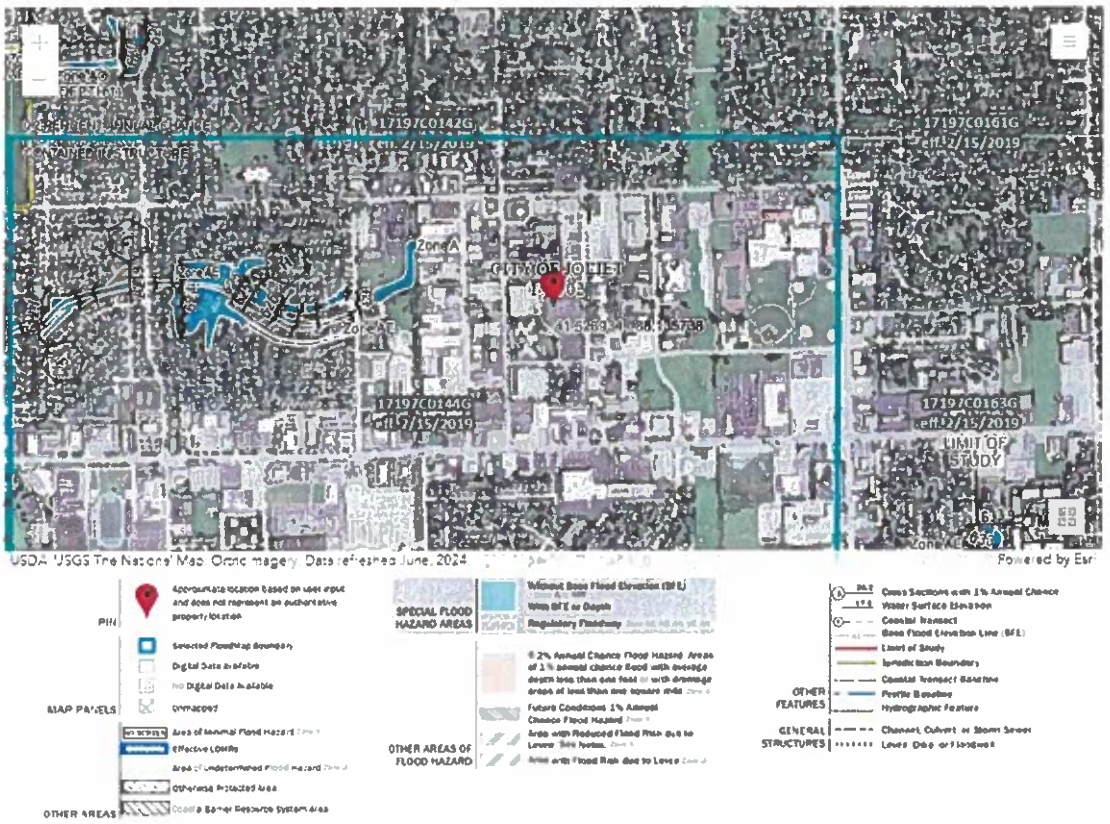
Sincerely,

Colleen Pawlik, MSN, BSN
Interim Chief Executive Officer
Saint Joseph Medical Center – Joliet

ATTACHMENT 5
Flood Plain Requirements

Saint Joseph Medical Center

Flood Plain Attestation
Page Two



ATTACHMENT 6
Historic Preservation Act Requirements

The applicant submitted a request for determination to the Illinois Department of Natural Resources - Preservation Services Division on June 11, 2025. A final determination has been received from the Department and the proposed site contains no historic, architectural, or archeological sites. A copy of the letter is enclosed as evidence with this attachment.

ATTACHMENT 6
Historic Preservation Act Requirements

Juan Morado, Jr.
71 South Wacker Drive, Suite 1600
Chicago, Illinois 60606-4637
Direct Dial: 312.212.4967
Fax: 312.767.9192
jmorado@beneschlaw.com

June 11, 2025

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

Re: Certificate of Need Application for Ambulatory Surgical Treatment Center

Dear Jeffrey:

I am writing on behalf of my client, Prime Healthcare ASC – Joliet, LLC, ("Prime ASC") 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.). Prime ASC is submitting an application for a Certificate of Need from the Illinois Health Facilities and Services Review Board. Prime ASC intends to establish an ambulatory surgical treatment center ("ASTC") at 301 Madison St. Suite 100 Joliet, IL 60435, and provide the following categories of services in an existing office building: colon and rectal surgery, general surgery, gastroenterology, neurological surgery, obstetrics/gynecology, ophthalmology, orthopedic surgery, otolaryngology, pain management, podiatric surgery, thoracic surgery, and urology.

The ASTC will contain a patient waiting room, a nursing station, five recovery rooms, four prep rooms, a pre-op room, three operating rooms, two post-op rooms, waste/disposal, decontamination, and sterilization spaces, and a post-recovery 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.

ATTACHMENT 6
Historic Preservation Act Requirements

Very truly yours,

BENESCH, FRIEDLANDER,
COPLAN & ARONOFF LLP

Juan Morado, Jr.

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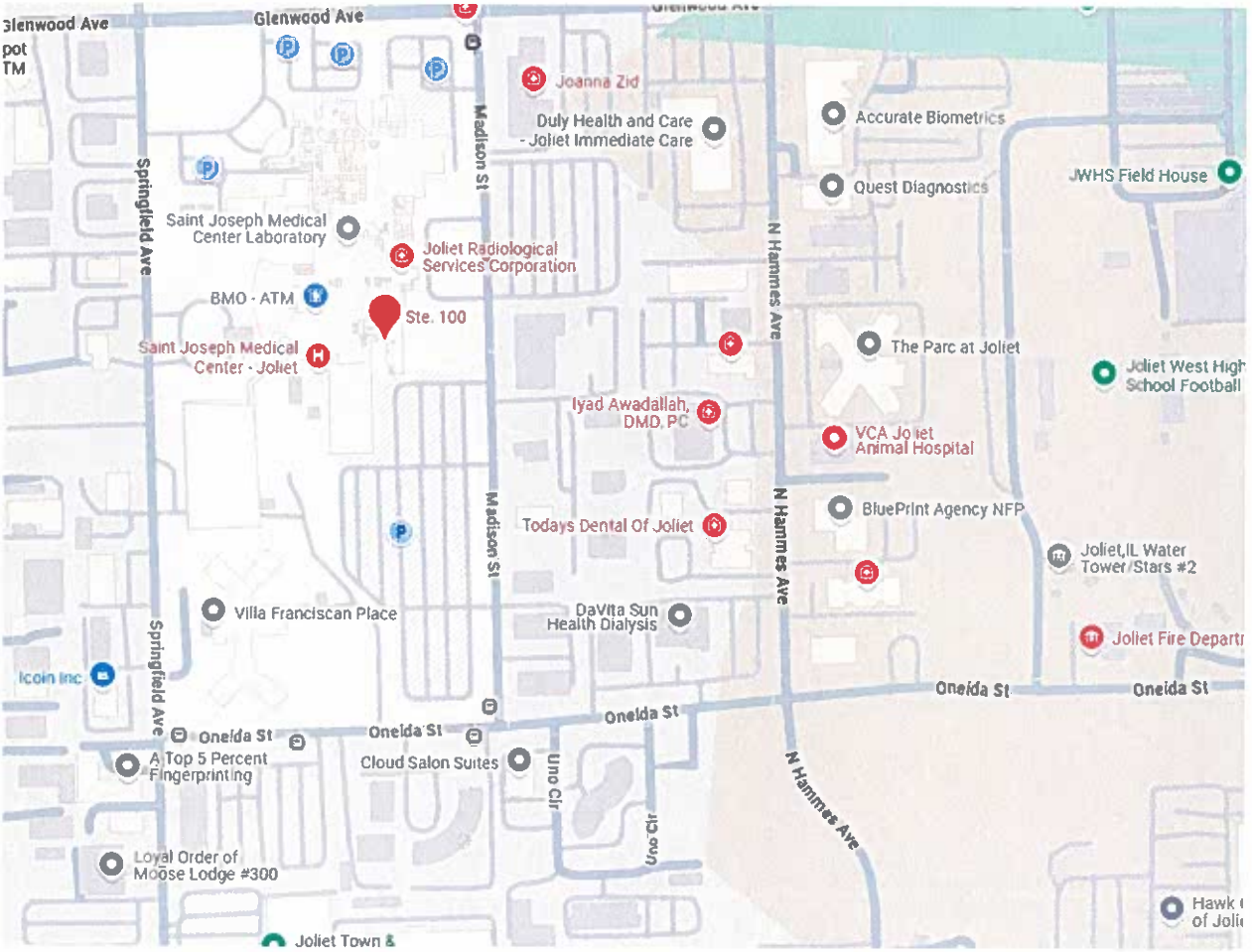
ATTACHMENT 6
Historic Preservation Act Requirements

Topographic Map (301 Madison St. Suite 100, red pinpoint)



ATTACHMENT 6
Historic Preservation Act Requirements

3D Aerial Map of 301 Madison St. Suite 100 Joliet, IL 60435

ATTACHMENT 6
Historic Preservation Act Requirements

Street View of 301 Madison St. Suite 100 Joliet, IL 60435

ATTACHMENT 6
Historic Preservation Act Requirements

Street View of 301 Madison St. Suite 100 Joliet, IL 60435

ATTACHMENT 6
Historic Preservation Act Requirements

Will County
Joliet
CON - Establishing an Ambulatory Surgical Treatment Center
301 Madison St., Suite 100

IHFSRB, SHPO Log #001061225

June 12, 2025

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

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 Remains Protection Act (20 ILCS 3440).

If you have any further questions, please contact Steve Dasovich, Cultural Resources Manager, at 217/782-7441 or at Steve.Dasovich@illinois.gov.

Sincerely,

Carey L. Mayer

Carey L. Mayer, AIA
Deputy State Historic Preservation Officer

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	558,407	173,593	732,000
Modernization Contracts	-	-	-
Contingencies	50,000	50,000	100,000
Architectural/Engineering Fees	30,000	30,000	60,000
Consulting and Other Fees	100,000	100,000	200,000
Movable or Other Equipment (not in construction contracts)	767,000	286,600	1,053,600
Bond Issuance Expense (project related)	-	-	-
Net Interest Expense During Construction (project related)	-	-	-
Fair Market Value of Leased Space or Equipment	2,534,681	787,962	3,322,643
Other Costs to Be Capitalized	-	-	-
Acquisition of Building or Other Property (excluding land)	-	-	-
TOTAL USES OF FUNDS	4,040,088	1,428,155	5,468,243
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	1,505,407	640,193	$2,145,600
Pledges			
Gifts and Bequests	-	-	-
Bond Issues (project related)	-	-	-
Mortgages	-	-	-
Leases (fair market value)	2,534,681	787,962	3,322,643
Governmental Appropriations	-	-	-
Grants	-	-	-
Other Funds and Sources	-	-	-
TOTAL SOURCES OF FUNDS	**4,040,088**	**1,428,155**	**5,468,243**

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ATTACHMENT 7
Project Costs and Sources of Funds (cont'd)

New Construction Contracts - The proposed project will utilize an existing outpatient surgical department at Saint Joseph Medical Center. The project's building cost are based on national architectural and construction standards and adjusted to compensate for several factors. The clinical costs are estimated to be $558,407 or $66.71 per GSF.

New Construction Costs	Cost
New counter tops / reception area, soil and dirty rooms	$40,000
Painting of the suite	$80,000
New flooring	$100,000
Lighting	$40,000
Automatic Closure	$52,000
New humidification	$50,000
HVAC Work	$200,000
Temp Trac	$50,000
Carpentry	$120,000
Total	**$732,000**

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 $100,000 or 1.4% percent of projected clinical new construction costs.

Architectural/Engineering Fees - The clinical project cost for architectural/engineering fees are projected to be $60,000 or 4.9% 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.

Equipment	Costs
(12) Stretchers	$75,000
(12) Lounge Chairs	$24,000
(2) Defibrators	$50,000
(6) GE Data Scopes	$35,000
(5) Colon Scopes	$100,000
(2) Endo Washers	$60,000
(5) Bovie Electrosurgical units	$40,000
(1) C - Arm	$454,600
(1) Anesthesia Machine	$80,000
(1) Sterrand Sterilization System	$50,000
(2) Endo Video	$50,000
(8) Office Chairs	$5,000
(1) Ice Machine	$30,000
Total	**$1,053,600**

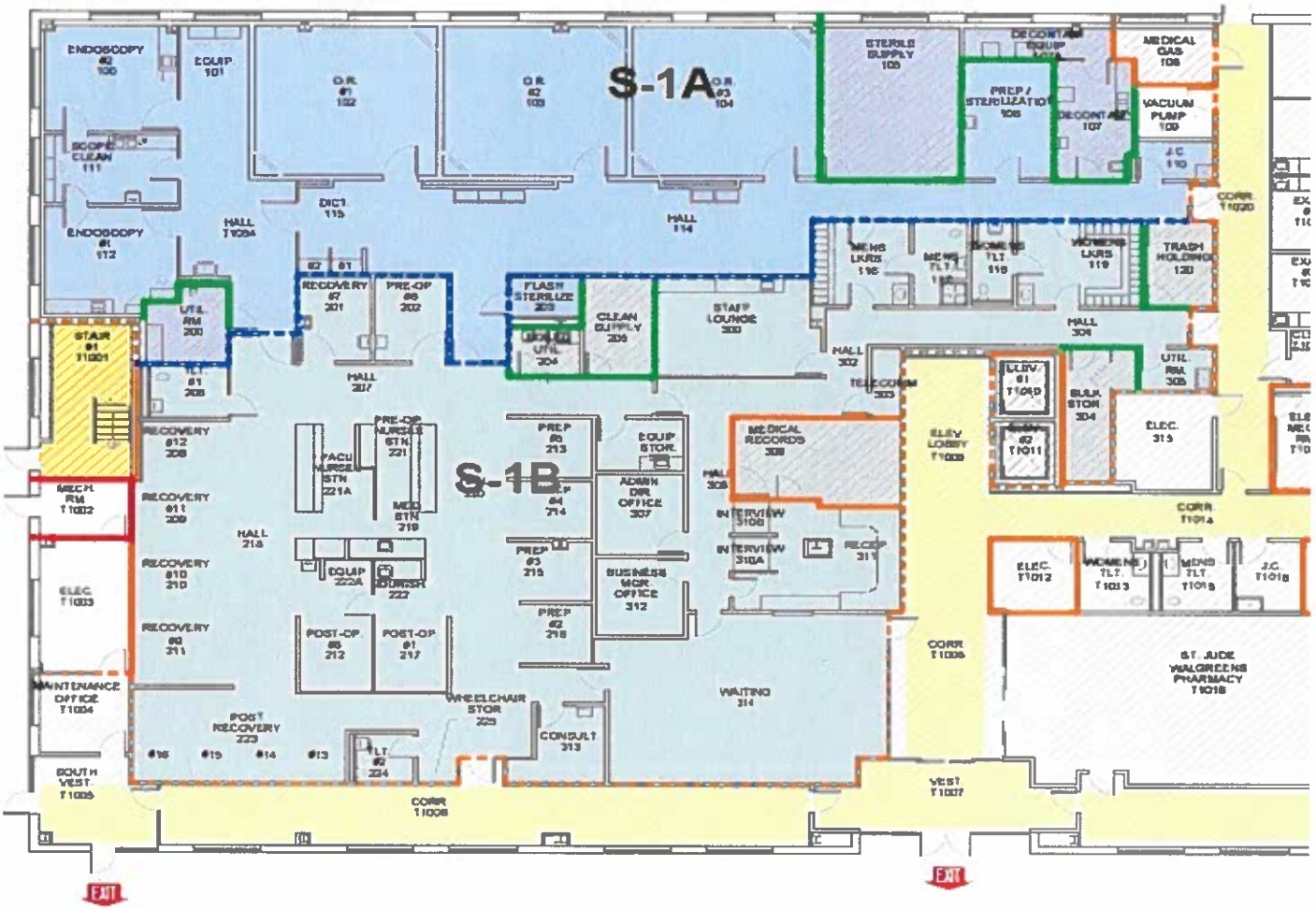
ATTACHMENT 7
Project Costs and Sources of Funds (cont'd)

Leasing Costs - The annual rent for year 1 will be $625,835 or $52,153 per month. The proposed lease is for a period of 5 years and has 3% escalator each year. Below is a breakdown of the leasing costs for the facility.

Year	Annual Rent	Monthly Rent
Year 1	$625,835	$52,153
Year 2	$644,610	$53,718
Year 3	$663,948	$55,329
Year 4	$683,867	$56,989
Year 5	$704,383	$58,699
Total	**$3,322,643**	

ATTACHMENT 8
Project Status and Completion Schedules

The proposed project plans are still at a schematic stage. The proposed project completion date is July 1, 2026. Financial Commitment for the project will occur following permit issuance and in accordance with HFSRB regulations.



ATTACHMENT 9
Cost Space Requirement

The proposed project involves the establishment of an ASTC with 3 operating rooms and 2 procedure rooms in a total of 10,972 GSF.

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
ASC	$4,040,088		8,370	8,370			
Total Clinical	$4,040,088		8,370	8,370			
NON-REVIEWABLE							
Administrative	1,428,155		2,602	2,602			
Total Non-clinical	1,428,155		2,602	2,602			
TOTAL	**$5,468,243**		**10,972**	**10,972**			

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

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 ASTC will provide a proper standard of health care services for the community.

Prime Healthcare ASC – Joliet, LLC

Prime Healthcare ASC – Joliet, LLC ("Prime ASC") is a newly formed entity established to develop and operate a state-licensed ambulatory surgical treatment center (ASTC) in Joliet, Illinois. Strategically located within an existing outpatient building adjacent to Saint Joseph Medical Center, Prime ASC has been created as part of a broader initiative to optimize the use of existing healthcare infrastructure while meeting the growing demand for outpatient surgical care in Will County and surrounding communities.

The formation of Prime ASC reflects a collaborative effort between experienced physician partners and the affiliated hospital organization. Together, these partners bring clinical expertise, operational excellence, and a shared commitment to high-quality, patient-centered care. By concentrating routine and lower-acuity procedures in a dedicated outpatient setting, Prime ASC is designed to enhance efficiency, reduce unnecessary hospital utilization, and deliver measurable cost savings for both patients and payers.

Prime Healthcare ASC – Joliet, LLC has been purposefully established to support the community's evolving surgical needs by expanding access to affordable, high-quality outpatient care. Through strategic alignment with Saint Joseph Medical Center, robust clinical leadership, and the use of existing adjacent infrastructure, Prime ASC is well-positioned to serve as a vital extension of the local healthcare delivery system and a key driver of improved outcomes and system-wide value.

Saint Joseph Medical Center – Joliet, LLC

Saint Joseph Medical Center (SJMC) in Joliet, Illinois has been a cornerstone of healthcare in Will County for more than 130 years. Founded in 1882 by the Franciscan Sisters of the Sacred Heart, the hospital has grown into a full-service, Joint Commission-accredited regional medical center with nearly 500 licensed beds. As the largest hospital in Joliet and one of the most significant employers in the area, SJMC provides a comprehensive range of acute care services, including 24/7 emergency services, a Level II Trauma Center, advanced surgical specialties, oncology, cardiology, orthopedics, stroke care, and maternal-child health services. It has long served a growing and demographically diverse region that bridges suburban and exurban populations in the southwest corridor of the Chicago metropolitan area.

On March 1, 2025, Saint Joseph Medical Center officially became part of the Prime Healthcare system, following its acquisition from Ascension. This transition marked a new chapter for SJMC. Unlike prior transactions, however, Prime brought with it not only a commitment to preserving the hospital's Catholic identity and charitable mission but also a robust plan for reinvestment and clinical revitalization. The Illinois Health Facilities and Services Review Board approved the acquisition unanimously, and the transaction was endorsed by the Archdiocese of Chicago and the Vatican. Prime retained nearly all of the hospital's existing staff approximately 3,000 employees—and has since made strategic investments aimed at stabilizing operations, strengthening quality, and expanding needed services.

Prime is upgrading clinical infrastructure across the state, including at Saint Joseph Medical Center. Key initiatives include the systemwide implementation of the EPIC electronic medical record platform to improve care coordination and patient experience, as well as targeted investments in surgical technology, diagnostic imaging, and specialty care. At SJMC specifically, Prime has invested in advanced neurosurgical and spine care services, including the acquisition of state-of-the-art C-arm and neurosurgical mapping technology to support the growth of its minimally invasive and complex spine programs.

ATTACHMENT 11
Background of the Applicant

More broadly, Prime is expanding high-demand services at SJMC, such as behavioral health, with plans to establish a new geriatric psychiatric unit. This initiative is part of Prime's statewide investment in addressing the mental health crisis, particularly among seniors—a growing demographic in the region. In doing so, Prime is not only preserving access to care but actively working to meet unmet needs in the community.

Prime Healthcare Services, Inc.

Prime Healthcare and the Prime Healthcare Foundation (collectively, "Prime") are nationally recognized healthcare organizations with a shared mission: to save hospitals, save jobs, and save lives. Founded in 2001 by Dr. Prem Reddy, a practicing cardiologist and entrepreneur, Prime is a physician-founded and physician-led health system that has grown into one of the largest and most successful privately held health systems in the United States. With headquarters in Ontario, California, Prime operates 51 hospitals across 14 states, including both for-profit and not-for-profit facilities, and serves tens of thousands of patients daily through its network of acute care hospitals, outpatient centers, physician groups, and affiliated services.

Prime's unique model of physician leadership and evidence-based operations has allowed the organization to transform more than 45 financially distressed hospitals into clinically advanced, sustainable institutions that continue to serve their communities. The Prime Healthcare Foundation, a 501(c)(3) public charity established in 2006, owns and operates not-for-profit hospitals within the system and is committed to reinvesting all surplus revenues into improving patient care, medical education, and public health initiatives.

Together, Prime and the Foundation have contributed more than $13.7 billion in charity care and community benefits since 2010, with an emphasis on serving high-need, underserved, and safety-net populations. In total, Prime has invested over $2.78 billion since 2020 alone in capital improvements and operational enhancements at facilities that were previously at risk of closure.

Prime Healthcare's performance and commitment to quality are validated by a consistent record of independent accolades and awards. Among the most notable:

- Named a "Top 10 Health System" and "Top 15 Health System" three times by Truven Health Analytics, now part of IBM Watson Health.
- 51 Prime hospitals have earned the "100 Top Hospitals" designation from Premier Inc. a combined total of 72 times. In 2025, only one hospital in Illinois earned this recognition, and it is a Prime hospital.
- 31 Prime hospitals received "A" grades from The Leapfrog Group for hospital safety in 2025.
- Prime was awarded the 2021 John M. Eisenberg Patient Safety and Quality Award for its innovations in patient safety and addressing social determinants of health.
- Healthgrades awarded 16 Prime hospitals the 2025 Patient Safety Excellence Award, placing them among the top-performing hospitals in the nation.
- The Lown Institute recognized Prime for top rankings in social responsibility, health equity, inclusivity, and patient outcomes.

These accolades reflect Prime's consistent ability to outperform national benchmarks in quality, safety, and patient experience—particularly in hospitals that were previously failing or under-resourced. According to Healthgrades' 2025 analysis, if all hospitals in the U.S. performed at the level of Prime's five-star hospitals, more than 220,000 lives could have been saved and 140,000 complications avoided during the study period from 2021–2023.

ATTACHMENT 11
Background of the Applicant

The Prime Healthcare Foundation also supports medical education as part of its long-term investment in health system sustainability. It donated $80 million to establish the California University of Science and Medicine (CUSM), one of the newest accredited medical schools in the nation. CUSM's mission is to advance medicine and health equity while inspiring service to underserved communities. Since its first graduating class in 2022, CUSM has produced four cohorts of medical doctors, with a near 100% match rate in competitive specialties nationwide.

Prime Healthcare's Investments in Illinois: Strengthening Care and Preserving Access

In March 2025, Prime Healthcare and the Prime Healthcare Foundation acquired eight hospitals, two ambulatory surgical treatment centers, and two skilled nursing facilities from Ascension, including some of the most historically significant community hospitals in Illinois. At the time of acquisition, these facilities and affiliated medical groups were losing a combined $200 million annually, with Saint Joseph Medical Center in Joliet alone accounting for losses of approximately $90 million.

Rather than retreat from these challenges, Prime has committed to investing more than $250 million in Illinois to revitalize infrastructure, expand needed services, and improve patient outcomes. These investments are already being realized in multiple ways:

1. Technology and Electronic Medical Records

Prime is undertaking a multi-million-dollar market wide implementation of EPIC, a best-in-class electronic medical records system, across all its Illinois facilities. This major investment will improve care coordination, clinical outcomes, operational efficiency, and the overall experience for patients, physicians, and staff. Implementation of EPIC is foundational to Prime's broader quality transformation strategy and supports seamless integration across care settings.

2. Clinical Infrastructure and Equipment

Capital investments include significant upgrades to diagnostic and surgical capabilities. At Saint Joseph Medical Center in Joliet, Prime has invested over $1 million in neurosurgical mapping and C-arm imaging technology, expanding the hospital's neurosurgery and spine care programs. Similar investments are being made across other facilities to enhance cardiology, orthopedics, emergency care, and outpatient services.

3. Workforce Retention and Growth

Prime preserved nearly all 13,000 jobs following the acquisition of Ascension's Illinois operations and created over 1,000 new jobs by in-sourcing key support services like lab work and environmental support. Prime also created a new nonprofit medical group under the Foundation to allow hundreds of physicians to remain employed while qualifying for federal loan forgiveness programs. Hospitalist services, previously outsourced to a for-profit private equity firm, have been transitioned to the Foundation's nonprofit model—strengthening accountability and continuity of care.

4. Commitment to Service Line Realignment Based on Clinical Best Practices

Prime is aligning services with evidence-based quality thresholds, ensuring that all service lines meet minimum volume standards necessary for high-reliability care. Prime has worked in collaboration with EMS, the Illinois Department of Public Health (IDPH), and the Illinois Health Facilities and Services Review Board (HFSRB) to ensure transparency, compliance, and open communication during each transition. Additionally, Prime has formally notified regulatory bodies of all major service realignments and remains committed to continued engagement with local and state stakeholders.

ATTACHMENT 11
Background of the Applicant

Facilities owned by Prime Healthcare Services, Inc.

Facility Name	IDPH Facility Number
Resurrection Medical Center (Chicago, IL)	0006031
Saint Mary of Nazareth Hospital (Chicago, IL)	0006015
Holy Family Medical Center (Des Plaines, IL)	0006023
Saint Joseph Hospital – Elgin (Elgin, IL)	0004887
Mercy Medical Center (Aurora, IL)	0004903
Prime Healthcare GI - Lakeshore, LLC	7003215
Prime Healthcare ASC - Belmont Harlem, LLC	7003131

Saint Joseph Medical Center

July 1, 2025

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

Re: Certification and Authorization Letter -Prime Healthcare ASC – Joliet, LLC

Dear Mr. Kniery,

As a representative of Prime Healthcare ASC – Joliet, LLC ("Prime ASC") Prime Healthcare Services, Inc. and Saint Joseph Medical Center, Joliet, LLC, I, Colleen Pawlik, MSN, BSN, 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 Prime ASC and Saint Joseph Medical Center, Joliet, LLC has no ownership interest in other healthcare facilities. This ambulatory surgical treatment center has had no adverse actions to report for the past three (3) years. Prime Healthcare Services has an ownership interest in several healthcare facilities including:

- Resurrection Medical Center (Chicago, IL)
- Saint Mary of Nazareth Hospital (Chicago, IL)
- Saint Francis Hospital (Evanston, IL)
- Holy Family Medical Center (Des Plaines, IL)
- Saint Joseph Hospital – Elgin (Elgin, IL)
- Mercy Medical Center (Aurora, IL)
- St. Mary's Hospital – Kankakee (Kankakee, IL)

I further verify that the healthcare facilities owned by Prime Healthcare Services have had no adverse actions to report for the past three (3) years.

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,

Colleen Pawlik, MSN

Colleen Pawlik, MSN, BSN
Interim Chief Executive Officer
Saint Joseph Medical Center – Joliet

27205239 v5

ATTACHMENT 12
Purpose of the Project

Prime Healthcare ASC – Joliet, LLC ("Prime ASC") is submitting this application for a Certificate of Need to the Illinois Health Facilities and Services Review Board for the purpose of establishing a multi-specialty ambulatory surgical treatment center ("ASTC") in an existing office building located at 301 Madison Street, Suite 100, Joliet, Illinois 60435. Prime ASC will offer a range of surgical and procedural services, including colon and rectal surgery, general surgery, gastroenterology, neurological surgery, obstetrics/gynecology, ophthalmology, orthopedic surgery, otolaryngology, pain management, podiatric surgery, thoracic surgery, and urology.

The planning area for this project is Will County, which includes Joliet and surrounding communities. Saint Joseph Medical Center in Joliet—adjacent to the proposed ASTC—serves as the region's principal acute care provider and surgical referral center. The ASTC's primary service area will include patients already receiving care at or through the hospital and affiliated physician groups, with additional access offered to area residents seeking outpatient surgical services outside of hospital settings. In particular, this facility seeks to provide the patients of Saint Jospeh Medical Center with increased access to high quality outpatient surgical care.

This project aligns with the key goals of the Certificate of Need program: better utilization of existing facilities, cost containment, and improved access to quality care. The proposed ASTC will support these objectives by establishing a cost-effective, high-quality alternative to inpatient surgical care, while also reducing the financial burden on payers and patients alike. By delivering services in a non-hospital setting, Prime ASC can offer safe, efficient care at a lower cost—without compromising quality or outcomes.

This project responds to several clear needs in the market:

- **Insufficient outpatient surgical capacity** in the community, especially as surgical volumes grow and more procedures are shifted to ambulatory settings.
- **High-cost hospital-based care** for procedures that can safely be performed in more affordable, efficient outpatient environments.
- **Increased pressure from public and private payers** to shift procedures away from inpatient and hospital outpatient settings in favor of ASCs.
- **Lack of dedicated, locally governed surgical infrastructure** that allows for alignment between physicians and healthcare systems to provide community-based, patient-centered care.

The ASTC will be located within the existing outpatient surgical department, eliminating the need for new construction and enabling expedited implementation. The center is designed with three operating rooms and 2 procedure rooms, an intentional sizing strategy to meet community demand while minimizing any adverse impact on existing providers. Although the space could support additional surgical capacity, Prime ASC is pursuing a right-sized approach to ensure balance between access, efficiency, and system impact.

A key strength of this project is its direct connection to Saint Joseph Medical Center, a full-service community hospital located adjacent to the proposed ASTC site. The hospital has long served as a hub for specialty and surgical care in the region. Establishing the ASTC in such close proximity will allow for seamless care coordination, continuity of services, and increased access for existing patients already receiving care through hospital and its affiliated physician network.

This ASTC will serve as an extension of the hospital's specialty services by offering a high-quality, efficient outpatient alternative for procedures that do not require hospital-based care. It will directly benefit the hospital's large base of surgical patients and support its referring specialists by providing timely, accessible surgical services in a setting designed for convenience, cost-effectiveness, and clinical excellence.

ATTACHMENT 12
Purpose of the Project

The project team is committed to bringing this facility online quickly after approval, and its location within an existing building means the community will benefit from improved access to outpatient surgical care without delay. This project is a model for how health systems and physician leaders can collaborate to deliver patient-centered care that is both clinically excellent and financially responsible.

This project is grounded in collaboration. Prime ASC brings together healthcare professionals with deep experience in surgical specialties and outpatient care, supported by the operational and compliance infrastructure necessary for successful ASTC operations. The model is responsive to the increasing demand for outpatient surgical services, particularly as public and private payers continue to shift procedures from inpatient settings to ambulatory environments in the interest of value-based care.

Orthopedic, pain management, and gastrointestinal procedures represent some of the fastest-growing segments of outpatient care, driven by both clinical advances and patient preference.

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. While other systems and practitioners have resisted this evolution which can have an impact on profit, this is not expected to be a short-lived trend; it is expected to be the new normal and requires a fresh approach and collaboration between physicians and facilities to ensure accessible, cost effective, quality care in our communities. It is that collaborative mindset that drives this project. This collaborative mindset is necessary in the marketplace to meet the evolving healthcare needs of our communities.

Studies consistently show that ambulatory surgical centers provide equivalent or superior outcomes compared to hospitals in terms of complication rates, infection control, and patient satisfaction—while also delivering significant cost savings. For example, in a study of outpatient surgical procedure times, researchers found that patients treated in ASCs spent 31.8 fewer minutes undergoing procedures than patients treated in hospitals—a 25 percent reduction. ASCs can perform more procedures per day than hospitals with equivalent numbers of staff, operating rooms, and recovery bays.[1] Orthopedic procedures performed in ASCs are also up to 26% less expensive than those in hospital outpatient departments, with better outcomes for readmission and infection rates.[2] These cost savings persist even with increasing surgical complexity: the total cost of care for knee and hip replacements is 12-15% lower when performed at an ASC compared to a hospital.[3]

Once operational, the ASTC will also alleviate some of the procedural burden on hospital operating rooms, allowing Saint Joseph Medical Center to focus its resources on inpatient and higher-acuity surgical cases. This integrated, collaborative approach promotes system-wide efficiency while meeting evolving community healthcare needs.

This project demonstrates the value of collaboration. It shows the importance of pursuing thoughtful balanced projects that are right sized for the needs of the community but also right sized to minimize adverse impact on the existing healthcare ecosystem.

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[1] E. Munnich, S.T. Parente, *Procedures Take Less Time at Ambulatory Surgery Centers, Keeping Costs Down and Ability to Meet Demand Up*, Health Affairs, Vol. 33. No. 5 (2014).
[2] K.Y. Wang, V. Puvanesarajah, *Ambulatory Surgery Centers Versus Hospital Outpatient Departments for Orthopaedic Surgeries*, Journal of the Maerican Academy of Orthopaedic Surgeons, Vol. 30, Issue 5 (2022).
[3] K. Carey, J.R. Morgan, *Patient Outcomes Following Total Joint Replacement Surgery: A Comparison of Hospitals and Ambulatory Surgery Centers*, The Journal of Arthroplasty, Vol. 35, Issue 1 (2020), pp. 10.

ATTACHMENT 12
Purpose of the Project

Prime ASC is a purpose-built solution to meet the rising demand for surgical services in a lower-cost, high-quality outpatient setting. By repurposing an existing outpatient surgical department adjacent to the hospital, the project will:

- Offer more timely access to surgical care, reducing delays for patients and decompressing hospital ORs for higher-acuity cases.
- Lower costs for patients and payers, with ASC procedures routinely costing 12–26% less than those performed in hospitals, even as case complexity increases.
- Support better clinical outcomes, as ASCs demonstrate superior performance in complication, infection, and readmission rates for many procedures.
- Foster collaborative, physician-led care, enhancing care continuity for patients referred from affiliated or independent providers.
- Expand services in key growth areas, such as orthopedics, GI, and pain management, which represent the fastest-growing segments of outpatient surgical care.

In addition to relieving pressure on hospital resources, the ASTC will allow Saint Joseph Medical Center to focus its inpatient capacity and resources on more complex and emergent cases. This ensures more efficient use of limited healthcare infrastructure and supports a system-wide improvement in operational sustainability.

Sources of Documentation

- U.S. Department of Health and Human Services, Office of the Inspector General. *("Ambulatory Surgical Centers: Medicare and Medicaid Cost Comparisons")*
- Health Affairs: *Ambulatory Surgery Centers—A Key to Lowering Costs* (2015)
- JAMA Surgery, "Comparing Surgical Outcomes and Efficiency Between ASCs and HOPDs"
- Becker's ASC Review, CMS Data (2021–2023)
- Illinois Health Facilities and Services Review Board reports and local demographic projections
- Internal data from Saint Joseph Medical Center and affiliated physician networks

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RESEARCH ARTICLE

Ambulatory Surgery Centers and Their Intended Effects on Outpatient Surgery

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Objectives. To assess the impact of ambulatory surgery centers (ASCs) on rates of hospital-based outpatient procedures and adverse events.

Data Sources. Twenty percent national sample of Medicare beneficiaries.

Study Design. A retrospective study of beneficiaries undergoing outpatient surgery between 2001 and 2010. Health care markets were sorted into three groups—those with ASCs, those without ASCs, and those where one opened for the first time. Generalized linear mixed models were used to assess the impact of ASC opening on rates of hospital-based outpatient surgery, perioperative mortality, and hospital admission.

Principal Findings. Adjusted hospital-based outpatient surgery rates declined by 7 percent, or from 2,333 to 2,163 procedures per 10,000 beneficiaries, in markets where an ASC opened for the first time ($p < .001$ for test between slopes). Within these markets, procedure use at ASCs outpaced the decline observed in the hospital setting. Perioperative mortality and admission rates remained flat after ASC opening (both $p > .4$ for test between slopes).

Conclusions. The opening of an ASC in a Hospital Service Area resulted in a decline in hospital-based outpatient surgery without increasing mortality or admission. In markets where facilities opened, procedure growth at ASCs was greater than the decline in outpatient surgery use at their respective hospitals.

Key Words. Ambulatory surgery, ambulatory surgery center, utilization

Pressures for improved efficiency and enhancements in perioperative care have prompted considerable growth in outpatient surgery in the United States. Of the 100 million procedures performed in 2006, approximately two-thirds were performed in the outpatient setting (Cullen, Hall, and Golosinskiy 2009). Concurrent with this evolution, there has been a proliferation of free-standing ambulatory surgery centers (ASCs) that are designed to offload volume from the more expensive hospital-based outpatient department (MedPAC 2013a,b).

Because ASCs provide outpatient surgery at a lower cost per episode (Centers for Medicare and Medicaid Services 2008; MedPAC 2013b), they

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have the potential to improve the efficiency of the delivery system insofar as they are able to reduce rates of hospital-based surgery without negatively impacting quality. Previous work in this area demonstrated modest declines in hospital-based surgery after ASC entry (Lynk and Longley 2002; Bian and Morrisey 2007; Courtemanche and Plotzke 2010), although these studies predated the proliferation of facilities that occurred in the last decade. Further, some worry that ASCs lack oversight and accountability, raising concerns about the quality of care delivered in these facilities (Office of Inspector General 2002). For instance, lapses in infection control (Schaefer et al. 2010) have further amplified these concerns and are partly responsible for the recent implementation of a value-based purchasing program for ASC payments by the Centers for Medicare and Medicaid Services (2010). The recent increase in surgeon-owned freestanding facilities (Ambulatory Surgery Center Association 2009), and their associated financial incentives, has the potential to exacerbate gaps in quality by encouraging the redistribution of less suitable patients (i.e., those with multiple medical problems) to ASCs.

For these reasons, we used national Medicare data to assess the extent to which freestanding ASCs have had their intended effects on the delivery system. In particular, we were interested in the impact of ASCs on rates of hospital-based outpatient surgery and quality, as measured by perioperative mortality and hospital admission.

METHODS

Study Subjects

We performed a retrospective cohort study of fee-for-service Medicare beneficiaries undergoing outpatient surgical procedures between 2001 and 2010. We used a 20 percent national sample of claims in the Carrier, Outpatient, Medicare Provider Analysis and Review, and Denominator files. We included only those patients aged 65–99 years who underwent a procedure at either a

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hospital-based facility or freestanding ASC and who were eligible for Medicare Part B. Information on age, race, and gender of patients was obtained from the Denominator file. Comorbidity was assessed using *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnoses codes submitted in the year preceding the index outpatient procedure and categorized into groups using established methods (Klabunde et al. 2000). Additional detail on the local health care and regulatory milieu was specified using data from the Area Resource File (Health Resources and Services Administration 2013) and the American Health Planning Association's National Directory (American Health Planning Association 2012). Specifically, we included measures of socioeconomic class, education, capacity for surgery (i.e., surgeons per capita and hospital discharges per capita), presence of certificate of need regulations, and population density.

Surgical procedures were enumerated using Healthcare Common Procedure Coding Systems codes. The type of procedure (inpatient vs. outpatient) and setting (hospital outpatient department vs. ASC) were determined using explicit codes in the Medicare files. We used Hospital Service Areas (HSAs), as described by the Dartmouth Atlas (Wennberg 1999), to reflect distinct health care markets. We chose HSAs, as opposed to another unit of geography, because outpatient surgery is elective, discretionary, and low risk. Thus, patients are likely to undergo such procedures where they commonly receive most of their primary health care (i.e., locally) as opposed to where they would be referred to for tertiary care.

Freestanding ASCs were identified in each HSA using the Provider of Services Extract reported by the Centers for Medicare and Medicaid Services (CMS). These files, released annually, provide detailed information on all Medicare-certified ASCs in the United States, including the facility location. HSAs were sorted into one of three mutually exclusive categories: (1) those with at least one ASC present as of January 1, 2001; (2) those initially without an ASC but in which at least one opened between 2001 and 2010; and (3) those without an ASC throughout the study. A small number of HSAs (n = 190, or 5.5 percent) had ASCs open and close during the study and were excluded from the analysis.

Outcomes

The primary objective was to assess the extent to which the opening of an ASC in a health care market had its intended effects of offloading surgery from the hospital without compromising quality. Our first outcome was population

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rates of hospital-based outpatient surgery, which includes all surgical procedures (i.e., Healthcare Common Procedure Coding System codes between 10,000 and 69,999) that were performed in either the hospital or ASC over the study period. Ideally, the opening of an ASC would facilitate the migration of outpatient surgery from the more expensive hospital to these facilities. For this measure, the numerator consisted of annual counts of hospital-based outpatient procedures within an HSA, and the denominator was comprised of Medicare beneficiaries eligible for Medicare part B residing in each HSA. Because of the stark differences in population size of the two ASC-containing HSA types (e.g., in 2010, a mean of 21,266 beneficiaries in HSAs where ASCs were always present and 9,020 beneficiaries in HSAs where ASCs were added for the first time), we secondarily examined changes in ASC surgery rates within these markets. One concern is that patient migration across HSA boundaries might explain some of the observed changes in procedure use at the hospital. That is, boundary crossing for surgery by a few beneficiaries in the relatively small HSAs where ASCs opened for the first time (e.g., to nearby larger markets with greater ASC capacity) could have a large impact on rates of hospital procedure use. To address this issue, we examined the direct effect of facility opening on procedures performed in the ASC and contrasted them with the observed change in hospital use within each HSA.

In addition to measuring procedure use, we also assessed the impact of ASC opening on quality, as measured by rates of hospital admission and mortality following outpatient surgery. Preferably, the opening of a new facility within a health care market would have no effect on rates of these events. That is, redistribution from the hospital to the ASC should occur without added patient risk. For these aspects of perioperative quality, we examined the impact of ASC opening on the entire population undergoing outpatient surgery (i.e., procedures performed in both the hospital and ASC). One outcome was hospital admission within 30 days after the index surgery. For this measure, the numerator consisted of counts of admissions. The denominator was the amount of time "at risk," expressed in person years, among eligible beneficiaries undergoing outpatient surgery annually. A similar measure was developed for perioperative mortality, in which the numerator consisted of all patients dying within 30 days of an outpatient procedure. Due to concerns that procedure selection might artificially lead to more favorable findings for ASCs (i.e., ASCs would preferentially select procedures with the lowest likelihood of adverse events), we also contrasted rates of mortality between hospitals and ASCs for the 10 most common procedures performed in both settings.

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Statistical Analysis

The three groups of HSAs (ASC always present, ASC never present, ASC opens for the first time) were contrasted according to beneficiary and regional characteristics using nonparametric statistics. To address differences between HSAs, we used multiple propensity score methods (Spreeuwenberg et al. 2010). To this end, we fit a multinomial logistic regression model in which the dependent variable was the HSA group and the independent variables were the aforementioned beneficiary and regional characteristics. The Hausman test was used to verify that the multinomial model met the Irrelevant Alternatives Assumption, and overlapping of the distributions was visually confirmed. For this model, the Wald χ^2 was 789.2 with 24 degrees of freedom ($p < .0001$) and the pseudo R^2 was 0.38. This approach enabled us to effectively calculate the predicted probability of each HSA of being assigned to one of the three market types. These probabilities were then included in subsequent models assessing relationships between HSA group and outcomes.

Longitudinal rates of hospital-based outpatient surgery were estimated after adjustment for their multiple propensity scores, aggregated patient, and regional characteristics using generalized linear mixed models. The unit of analysis was the HSA. We incorporated a random effect for each HSA to account for the correlation between repeated measures within a market. For HSAs where an ASC opened for the first time, "baseline" was classified as the year prior to the first facility opening within its boundaries. For the other two categories of HSAs, "baseline" was randomly assigned and proportionally matched to the "opened for the first time" category so that the distribution of baseline years matched the distribution of baseline years in the "opened for the first time" category. We accounted for temporal trends by introducing the calendar year as a fixed effect and contrasted changes in rates over time both within and between HSA groups. These models were fit using splines with a knot at baseline, which allowed for different linear trends to be assessed in the pre- and post-ASC introduction phases. Splines, interactions, and all adjustment variables were included as fixed effects. In addition to looking at overall rates of hospital-based outpatient surgery, we also sorted patients into groups of procedures (i.e., ophthalmologic, gastrointestinal, and musculoskeletal) commonly performed in ASCs (see Appendix for listing of codes) (MedPAC 2013b).

A similar modeling strategy was used to assess the impact of ASC opening on quality (i.e., hospital admission and mortality) among those undergoing

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an outpatient procedure. However, for these models, the patient was the unit of analysis.

All analyses were performed using *SAS v9.2* (Cary, NC, USA). The probability of a type I error was set at .05 and all testing was two-sided. The institutional review board at the University of Michigan approved this study.

RESULTS

An ASC was introduced into a previously naïve market in 255 HSAs. As shown in Table 1, aggregate beneficiary and regional characteristics varied across the three HSA types. While statistically significant differences were evident across market type for most characteristics, many of these were relatively small in magnitude. Of note, HSAs without ASCs had significantly fewer surgeons per capita and lower population densities (i.e., much more likely to be in a rural setting). All differences between markets abated after multiple propensity score adjustment.

As shown in Figure 1, adjusted rates of hospital-based outpatient surgery remained stable in all HSA types in the 2 years preceding baseline ($p = .22$ for test between the three slopes). However, in HSAs where an ASC opened for the first time, hospital-based outpatient surgery rates declined by 7.4 percent, or from 2,333 to 2,163 procedures per 10,000 beneficiaries ($p < .0001$ for test between the three slopes) during the 4-year period after opening. In contrast, rates of hospital-based outpatient surgery in HSAs where ASCs were always or never present increased by 7.8 percent and 6.6 percent, respectively. The declines in these two market types occurred at a similar pace with one another ($p = .11$ for test between the two slopes).

In terms of outpatient surgery use at ASCs themselves, rates in markets where they were always present remained relatively stable over time, increasing by 52 procedures per 10,000 between baseline and 4 years after baseline ($p = .60$ for trend). In contrast, rates of outpatient surgery in ASCs in HSAs where they opened for the first time increased by 624 procedures per 10,000 during the 4-year period after opening ($p < .001$ for trend). This increase was more than twofold greater than the decline in hospital-based outpatient surgery observed over the same period in these HSAs (i.e., a decrease of 299 procedures per 10,000 between baseline and 4 years after baseline).

The effect of ASC opening to lower rates of hospital-based outpatient surgery held true for each of the common procedures groups (Figure 2). Notably, the strongest relative impact was observed for ophthalmologic sur-

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Table 1: Characteristics of the Population Undergoing Outpatient Surgery Based on National Medicare Data

	Hospital Service Area Type			*p-value*	
	ASC Always Present	*ASC Never Present*	*ASC Added for the First Time*	*Before Multiple PS Correction*	*After Multiple PS Correction*
No. HSAs	837	2,154	255	–	–
No. patients in 2010	17,793,686	6,295,820	2,308,790	–	–
Age, mean	70.6	70.5	70.5	.55	.97
Gender, % female	55.0	53.8	54.9	<.001	.97
Race, % non-white	14.8	10.3	11.3	<.001	.41
Charlson score, % 2 or higher	25.8	23.1	25.0	<.001	.81
Living below poverty, %	14.0	16.0	13.6	<.001	.60
College education or more among those 25 years and older, %	23.5	16.2	23.1	<.001	.42
Log of hospital discharges per 10,000 population	8.8	8.4	8.8	<.001	.94
Log of surgeons per 10,000 population	4.4	2.9	4.4	<.001	.45
Certificate of need, %	64.8	67.7	62.1	.09	.88
Urban, %	79.6	28.0	65.8	<.001	.30

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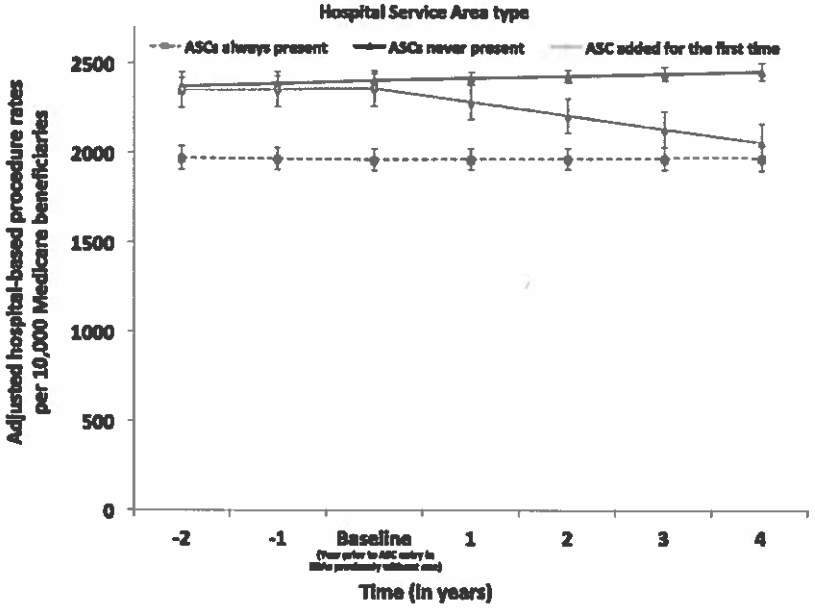
Figure 1: Adjusted Rates of Hospital-Based Outpatient Surgery in Markets Where ASCs Were Always Present, Never Present, and in Those Where an ASC Opened for the First Time. In the period prior to baseline, the rate of change in outpatient surgery across the three market groups was similar ($p = .22$). However, for the 4-year period following baseline, rates of outpatient surgery decreased more rapidly in markets where an ASC was added for the first time ($p < .001$ for change over time relative to HSAs always with and without ASCs)



gery (Figure 2a). Adjusted rates of hospital-based surgery declined by 53.9 percent by 4 years in HSAs where an ASC opened for the first time, or from 408.4 to 188.3 procedures per 10,000 beneficiaries ($p < .0001$ for test between the three slopes). Conversely, hospital-based rates of ophthalmologic surgery actually increased at a similar pace over the 4-year period after baseline in HSAs where ASCs were always and never present, or by 5.7 percent and 6.2 percent, respectively ($p = .11$ for test between the two slopes).

As shown in Figure 3, changes in mortality within 30 days for the 4-year period after baseline did not vary significantly across the three market types ($p = .43$ for test between the three slopes). For each of the 10 most common

procedures performed in both settings, rates of mortality were similar or significantly lower for those performed in the ASC compared to the hospital. We found no significant change in hospital admission within 30 days of the index procedure (Figure 4) across the three market types. Rates of admission in markets where an ASC opened for the first time were flat during the 4-year period after baseline (7.6 admissions per 1,000 person years at baseline and 7.6 admissions per 1,000 person years at 4 years after baseline; $p = .56$ for test between three slopes).

COMMENT

The opening of a freestanding ASC was associated with significant reductions in hospital-based surgery within a health care market. In contrast to markets without ASCs, in which hospital-based outpatient surgery rates increased by 7 percent, those where an ASC opened for the first time experienced a 7 percent reduction. This redistribution was even more evident in some surgical disciplines, particularly ophthalmology. Importantly, the shift of outpatient surgery from the hospital to the ASC was not associated with higher rates of hospital admission or mortality. Collectively, our findings suggest that freestanding ASCs can safely achieve their intended effects of outpatient procedure redistribution to a less expensive setting without sacrificing quality, as measured by hospital admission or mortality.

Since the 1980s, the volume of outpatient procedures has grown considerably. Concurrent with this growth, there has been a sea change in the setting for these procedures, with movement out of the hospital and into the ASC (Ambulatory Surgery Center Association 2012). These freestanding facilities were originally championed by the federal government and payers as a means to curtail rising health care expenditures (Davis 1987). While previous studies have demonstrated the ability of these facilities to achieve their desired effects on hospital utilization (Lynk and Longley 2002; Bian and Morrisey 2007; Courtemanche and Plotzke 2010) and outpatient surgery quality (Hollingsworth et al. 2012) in some contexts, they were generally limited in scope or predated the recent proliferation of ASCs. Indeed, the number of ASCs essentially doubled during the first part of the last decade, with nearly 5,500 facilities in 2011 (American Hospital Association 2012). Because these facilities tend to be owned by the physicians who staff them (Ambulatory Surgery Center Association 2009), some worry that inherent financial incentives might spur utilization (i.e., induced demand).

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Implicit in the possibility of induced demand by owners of ASCs is the notion that there is an asymmetry of information between the physician and the patient such that the latter cannot make a rationale choice as to the health "value" of the procedure (Wennberg, Barnes, and Zubkoff 1982). Rather, the physician serves in the agency role for the patient. While several factors (e.g., patient preference, medical liability pressures) may cause surgeons to lower their threshold for surgery, many believe that the financial incentives associated with increased productivity (Conrad et al. 2002) and ASC ownership may fuel the use of outpatient surgery. While our study does not address the question of induced demand directly, we did observe that ASCs did not simply offload procedures from the hospitals within markets where new facilities opened for the first time. Four years after opening in these markets, the increase in outpatient surgery at ASCs was more than double the decline in such procedures performed in the hospital setting.

While unmet clinical need might explain this differential, prior empirical work in this area has suggested the possibility of induced demand. First, rates of discretionary outpatient surgery (e.g., knee arthroscopy, cataract surgery) are strongly correlated with the penetration of ASCs (i.e., the proportion of outpatient surgery delivered by ASCs) within a market (Hollenbeck et al. 2010). Second, physician owners of ASCs uniformly perform higher volumes of outpatient procedures (Hollingsworth et al. 2009, 2010; Strope et al. 2009) and patients who see these physicians are much more likely to have surgery compared to those of nonowners (Mitchell 2010). Third, physician owners preferentially manage well-insured patients (Gabel et al. 2008) and perform well-reimbursed procedures (Plotzke and Courtemanche 2011) at ASCs. Finally, the opening of an ASC in a health care market has been associated with significantly higher rates of outpatient surgery relative to markets without them (Hollingsworth et al. 2011; Hollenbeck et al. 2014). Importantly, this growth appears to be driven by procedures with less stringent clinical indications for their use (Hollingsworth et al. 2011).

Figure 2: Adjusted Rates of Ophthalmologic (a), Gastrointestinal (b), and Musculoskeletal (c) Hospital-Based Outpatient Surgery in Markets Where ASCs Were Always Present, Never Present, and in Those Where an ASC Opened for the First Time. In the period after baseline, adjusted rates of hospital-based outpatient surgery declined more sharply in markets where an ASC opened for the first time compared to HSAs with and without ASCs ($p < .01$ for all three specialty groups)

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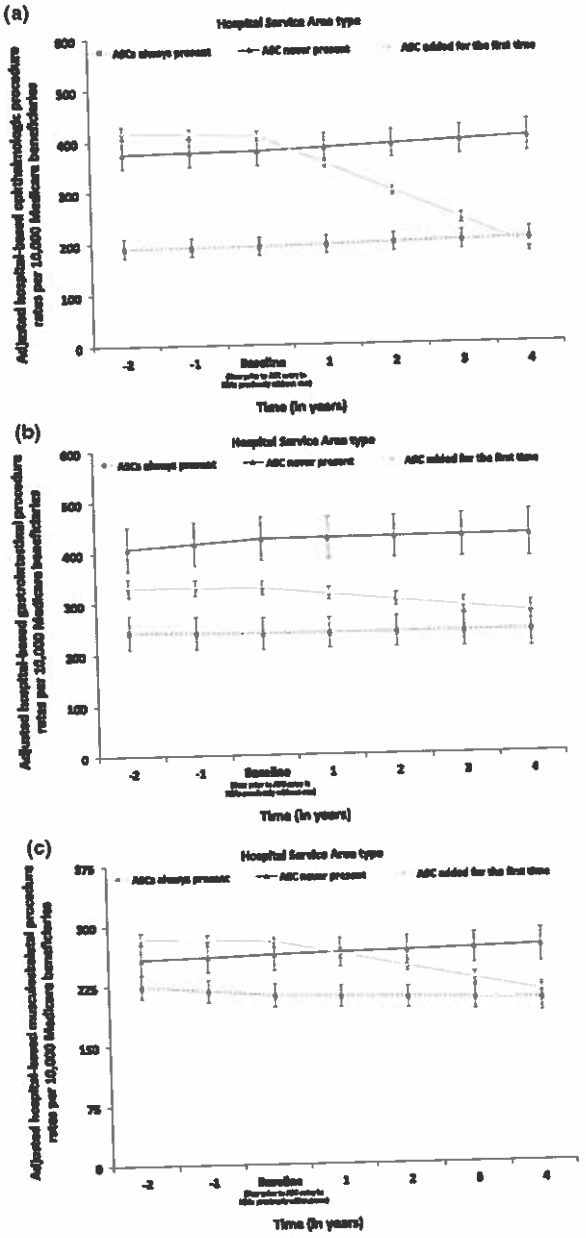

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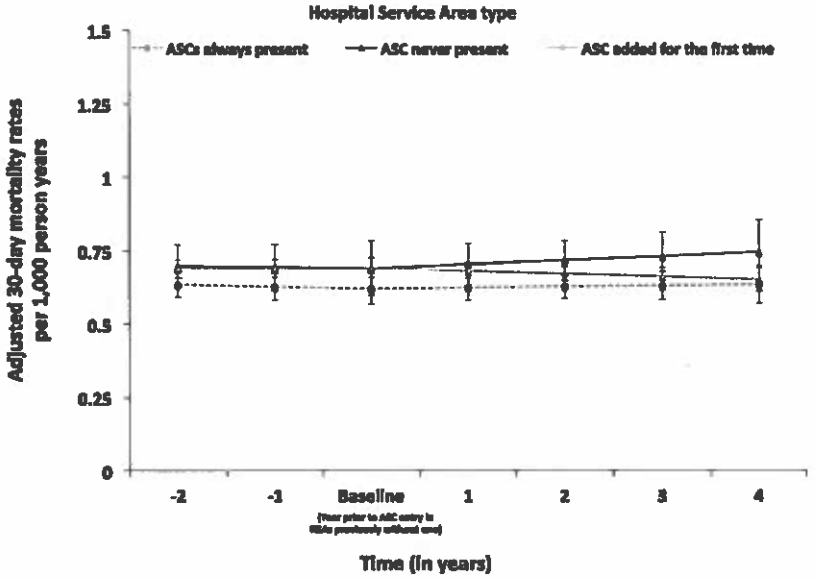
Figure 3: Adjusted Thirty-Day Mortality Rates among Patients Undergoing Outpatient Surgery in Markets with ASCs, Those without and Those Where ASCs Were Added for the First Time. Rates of mortality were similar across HSA groups before ($p = .84$ for test between three slopes) and after ($p = .43$ for test between three slopes) baseline



In addition to concerns surrounding induced demand, other implications of financially motivated procedure redistribution are untoward outcomes and poor quality. As per CMS Conditions for Coverage (Centers for Medicare and Medicaid Services 2011), ASCs are intended for procedures that do not require hospitalization. Unlike hospital outpatient departments, ASCs have limited access to specialty physicians and ancillary services that may be necessary to care for complicated surgical patients undergoing outpatient procedures. A potential consequence of procedure offloading to ASCs after their opening is that some patients may be inappropriately selected for treatment in these facilities, thereby inadvertently leading to higher rates of hospital admission and perioperative mortality.

This study is the first of its kind to comprehensively assess the impact of ASCs on their intended effects on broad indicators of ASC quality. As

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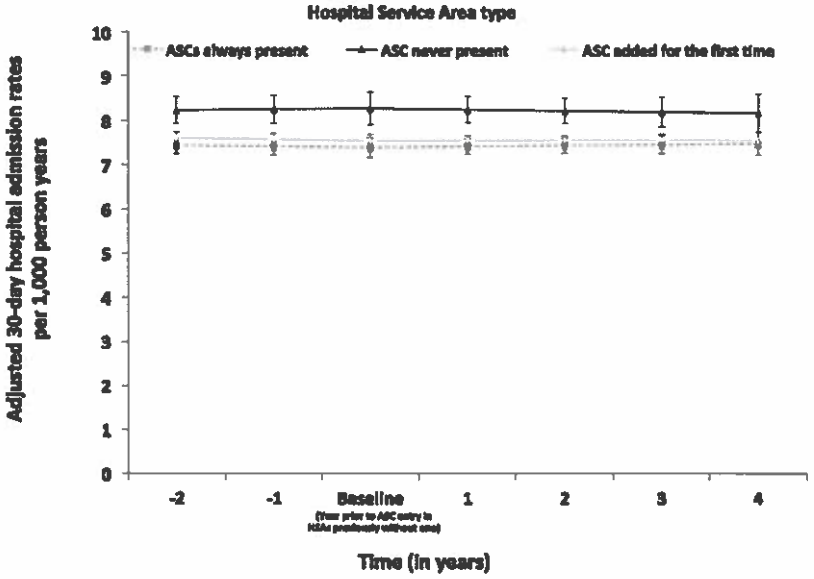
Figure 4: Adjusted Thirty-Day Hospital Admission Rates among Patients Undergoing Outpatient Surgery in Markets with ASCs, Those without ASCs, and Those Where ASCs Were Added for the First Time. Rates of hospital admission were similar across HSA groups before ($p = .43$ for test between three slopes) and after ($p = .56$ for test between three slopes) baseline



opposed to comparing quality between hospitals and ASCs, which would clearly bias against the hospital due to favorable patient selection, we instead focused on the effects of ASC opening on rates of adverse events for the entire population undergoing outpatient surgery. Importantly, procedure redistribution to the ASC was not associated with higher population-based rates of unexpected admission or mortality. Further, even within the most common procedures, we observed similar or lower rates of these adverse events at ASCs, implying that our population-level findings were not simply due to favorable procedure-mix selection by the ASCs. Collectively, our data suggest that the observed procedure redistribution from hospitals to ASCs had a negligible impact on these aspects of quality.

Our findings should be interpreted in the context of three limitations. First, because of our reliance on claims data, our measures of ambulatory surgical quality, though well accepted, are limited in scope. While we observed

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no ill effects of procedure redistribution on unanticipated hospital admission and mortality, there may have been improvements (or decrements) in quality that are underappreciated. For instance, due to their laser-sharp focus on specific procedure lines, ASCs may enhance quality by achieving better clinical outcomes. Second, because we are using Medicare claims, our findings do not reflect the effects of non-Medicare-certified ASCs on procedure redistribution and quality. However, as approximately 80 percent of all ASCs are Medicare-certified, our findings include facilities where the vast majority of outpatient surgery is performed. Third, although ASC opening was able to successfully offload procedures from the hospital, the subsequent utilization by these facilities outpaced the declines at hospitals within their respective markets. Thus, the broader effects of ASCs on utilization and overall health care spending remain unclear and are the focus of our ongoing research efforts. For instance, some worry that the cost savings garnered by ASC efficiency may be offset by financial incentives to increase procedure utilization.

These limitations notwithstanding, our findings have important implications with respect to ambulatory surgery. First and foremost, the rapid proliferation of ASCs in the 2000s was associated with significant reductions in hospital-based outpatient surgery. Because ASCs can provide similar care at a lower cost (Centers for Medicare and Medicaid Services 2008), such procedure redistribution could yield substantial cost savings to the Medicare program, at least on a per episode basis. These savings have the potential to be further amplified by the recent implementation of provisions in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 that greatly expanded the types of procedures eligible for payment in ASCs. Second, the observed redistribution did not come at the expense of quality as measured by population-based rates of mortality and hospital admission, suggesting that patient selection did not negatively impact these outcomes. However, procedure volumes at new ASCs were substantially greater than the declines in volumes at local hospitals.

The dissemination of freestanding ASCs results in a decline in outpatient surgery in the hospital. Insofar as thresholds for intervention remain constant, additional redistribution to these facilities may alleviate latent need and further reduce the use of the more costly hospital setting. Unfortunately, the within-market discrepancy between hospital volume declines and ASC volume increases raises the possibility of induced demand. Additional research surrounding the net effects of ASCs on outpatient surgery expenditures would be helpful for gauging their overall value to the health care system. Given the economics surrounding outpatient surgery and their importance to spending

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growth for Medicare, understanding the gains in health productivity relative to what is spent is of paramount importance to improving the efficiency of the delivery system.

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Disclosures: None.

Disclaimers: None.

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SUPPORTING INFORMATION

Additional supporting information may be found in the online version of this article:

Appendix SA1: Author Matrix.

Appendix SA2: Common Procedures Performed in Both the Hospital and ASC That Comprised the Three Specialty Group Analyses.

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Journal of Orthopaedic Business

Hand and Upper Extremity Procedures Are Significantly More Cost Effective When Performed in Ambulatory Surgery Centers Versus Hospital Outpatient Departments

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Objectives: Orthopaedic surgery has a high rate of utilization of outpatient settings, including ambulatory surgery centers (ASC) and hospital outpatient departments (HOPD). We seek to compare costs at these outpatient facilities, ASC versus HOPD, for hand and upper extremity procedures.

Design: Database review was performed with publicly available data from the Center for Medicare and Medicaid Services (CMS) via the Medicare Procedure Price Lookup Tool.

Main Outcome Measurements: Current Procedural Terminology (CPT) codes for hand and upper extremity procedures. Total costs, facility fees, Medicare payments, and patient payments were obtained for each procedure code.

Results: Thirty-seven CPT codes were divided into arthroscopy, fracture, arthroplasty/arthrodesis, and other. Arthroscopy demonstrated cost savings in the total cost of the procedure, facility fees, Medicare payments, and patient payments in ASCs compared to HOPD. Fracture procedures had lower total costs, Medicare payments, facility fees, and patient payments in ASCs. When CPT codes were grouped together, there were 35% savings in total cost, 41% savings for facility fees, 36% savings in Medicare payments, and 28% in patient payments for procedures performed at ASCs.

Conclusions: ASCs demonstrate cost-savings across multiple procedures for the hand and upper extremity in various areas, including total costs, facility fees, Medicare payments, and patient payments when compared to HOPDs.

Level of Evidence: Level 4; Retrospective cost-analysis

Key Words: ambulatory surgery center, cost, hand, hospital outpatient departments, upper extremity

INTRODUCTION

Healthcare expenditure in the United States remains an ongoing topic of discussion for policymakers, state departments, and hospital officials. The United States remains at the top of the list for countries with the highest healthcare costs and the greatest portion of gross domestic product attributed to healthcare expenses.[1-2] Given the continual rise of costs, it is prudent to determine areas of savings while maximizing patient outcomes and decreasing overall disease burden. When evaluating the breakdown of U.S. healthcare spending, the most is consumed by inpatient hospital services.[3] Therefore, targeting inpatient resource utilization may be a promising area to mitigate the overall rise of U.S. healthcare costs. This has been recognized, as there has been a trend of transitioning from inpatient to outpatient settings for cost reduction while maintaining the same high level of care, especially in specialties such as orthopaedic surgery.[4-5] Moreover, the COVID pandemic pushed hospital capacity limits across the country unlike ever before, emphasizing the necessity to transition elective orthopaedic procedures from the inpatient to outpatient setting.[6-9]

Electively-based orthopaedic subspecialties, such as hand and elbow, sports, and foot and ankle, have dominated the outpatient space, with more recent literature demonstrating the safety of performing outpatient procedures in adult reconstruction and spine.[9-11] Different healthcare settings are utilized as treatment centers for elective hand and upper extremity procedures, including

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inpatient hospital operating rooms, hospital outpatient departments (HOPDs), ambulatory surgery centers (ASCs), and in-office procedures. Each facility's benefits are considered when deciding where patients would be most appropriately cared for based on the complexity of the procedure, patient comorbidities, and equipment necessities. The benefits of ambulatory surgery centers and hospital outpatient departments are well established, with significant cost-savings, increased efficiency, and high levels of patient satisfaction.[12-13]

Hand and upper extremity procedures performed in stand-alone ASCs result in low rates of postoperative utilization of urgent care and emergency department visits and infrequent hospital readmissions.[14] Furthermore, ASC surgical visits are 25% to 39% shorter than hospital outpatient department visits.[15] Carey reported that ASCs can effectively operate at lower costs than HOPDs across multiple surgical specialties.[16] However, there is limited literature evaluating the difference in costs associated with specific hand and upper extremity procedures in ambulatory surgery centers versus hospital outpatient departments. We seek to report on differences between these two healthcare settings, highlighting potential cost-savings in one over the other for hand and upper extremity procedures.

METHODS

Data Collection

Medicare is a federal health insurance program administered to United States citizens over 65 and those who meet certain eligibility requirements, including younger people with disabilities and patients with end-stage renal disease.[17] Due to previous legislation, Medicare has attempted to increase price and volume transparency via the publication of various online databases. The use of these databases to track volume and reimbursement data has been well-established within the orthopaedic literature. [18-23]

Ambulatory surgery centers and hospital outpatient departments allow for various outpatient procedures without the significant costs associated with hospital stays. The limitations on patient length of stay vary according to state and local regulations. The difference between the facilities relates to regulations specific to each center, with an ASC typically a freestanding facility with a distinct financial and administrative contract with Medicare and/or private insurance.[24,25] Conversely, an independent surgery center can still be considered an HOPD if it is close to a hospital and negotiates with the same financial and administrative contracts as the hospital governing body.

To evaluate differences in cost between ASCs and HOPDs, the Medicare Procedure Price Lookup Tool was queried for individual Current Procedural Terminology (CPT) codes approved for outpatient surgery by the Center for Medicare and Medicaid Services (CMS). The included CPT codes are included in Table 1. Procedures were grouped into arthroscopy, fracture, arthroplasty/arthrodesis, other procedure cohorts, and an overall cohort. Data regarding total costs, facility fees, surgeon fees,

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Table 1. CPT codes and description of procedure.

CPT Code	Procedure
Arthroscopy	
29840	Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)
29843	Arthroscopy, wrist, surgical; for infection, lavage and drainage
29845	Arthroscopy, wrist, surgical; synovectomy, complete
29846	Arthroscopy, wrist, surgical; excision and/or repair of triangular fibrocartilage and/or joint debridement
Fracture	
25525	Open treatment of radial shaft fracture, includes internal fixation, when performed, and closed treatment of distal radioulnar joint dislocation (galeazzi fracture/ dislocation), includes percutaneous skeletal fixation, when performed
25526	Open treatment of radial shaft fracture, includes internal fixation, when performed, and open treatment of distal radioulnar joint dislocation (galeazzi fracture/ dislocation), includes internal fixation, when performed, includes repair of triangular fibrocartilage complex
25574	Open treatment of radial and ulnar shaft fractures, with internal fixation, when performed; of radius or ulna
25575	Open treatment of radial and ulnar shaft fractures, with internal fixation, when performed; of radius and ulna
25606	Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation
25607	Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation
25608	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments
25609	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments
25628	Open treatment of carpal scaphoid (navicular) fracture, includes internal fixation, when performed
25651	Percutaneous skeletal fixation of ulnar styloid fracture
26727	Percutaneous skeletal fixation of unstable phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with manipulation, each
26756	Percutaneous skeletal fixation of distal phalangeal fracture, finger or thumb, each
Arthroplasty/Arthrodesis	
24363	Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)
25446	Arthroplasty with prosthetic replacement; distal radius and partial or entire carpus (total wrist)
25447	Arthroplasty, interposition, intercarpal or carpometacarpal joints
25800	Arthrodesis, wrist; complete, without bone graft (includes radiocarpal and/or intercarpal and/or carpometacarpal joints)
25820	Arthrodesis, wrist; limited, without bone graft (eg, intercarpal or radiocarpal)
Other	
24359	Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open with tendon repair or reattachment
25000	Incision, extensor tendon sheath, wrist (eg, de quervains disease)
25111	Excision of ganglion, wrist (dorsal or volar); primary
25210	Carpectomy; 1 bone
25215	Carpectomy; all bones of proximal row
25240	Excision distal ulna partial or complete (eg, darrach type or matched resection)
25260	Repair, tendon or muscle, flexor, forearm and/or wrist, primary, single, each tendon or muscle
26045	Fasciotomy, palmar (eg, dupuytren's contracture); open, partial
26055	Tendon sheath incision (eg, for trigger finger)
26350	Repair or advancement, flexor tendon, not in zone 2 digital flexor tendon sheath (eg, no man's land); primary or secondary without free graft, each tendon
26352	Repair or advancement, flexor tendon, not in zone 2 digital flexor tendon sheath (eg, no man's land); secondary with free graft (includes obtaining graft), each tendon
26356	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon
26540	Repair of collateral ligament, metacarpophalangeal or interphalangeal joint
29848	Endoscopy, wrist, surgical, with release of transverse carpal ligament
64718	Neuroplasty and/or transposition; ulnar nerve at elbow
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel

CPT = Current Procedural Terminology

Medicare payments, and patient payments were extracted for each procedure.

Statistical Analysis

Descriptive statistics were used to express each variable's mean and standard deviation. Given the non-parametric distribution of the data, Mann-Whitney *U* tests were utilized to assess differences in total costs, facility fees, surgeon fees, Medicare payments, and patient payments between ASC and HOPD for arthroscopy procedures, fracture procedures, arthrodesis/arthroplasty procedures, other procedures, as well as all a combined cohort including all available CPT codes. All tests were 2-sided, with significance set at a probability value of $p<0.05$.

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RESULTS

Arthroscopy Codes

When comparing four different CPT codes (**Table 1**), significant cost savings in the total cost of the procedure (1,886.00±58.72 vs. 3,418.00±58.78; p=0.009), facility fees (1,360.00±0 vs. 2,892.00±0; p=0.021), Medicare payments (1,509.00±47.27 vs. 2,734.00±47.27 p=0.021), and patient payments (376.75±11.87 vs. 682.75±11.87; p=0.021) in ASCs as compared to HOPD were identified (**Table 2**). This resulted in an approximately 45% savings for total costs, Medicare payments, and patient payments, as well as approximately 53% cost savings for facility fees if procedures are performed at an ASC compared to a HOPD. Surgeon fees were the same regardless of the surgery setting.

Fracture Codes

Twelve Medicare-approved outpatient CPT codes were identified (**Table 1**). Fracture procedures had significantly lower total costs (3,886.58±1,527.61 vs 5,975.92±1,890.96; p=0.021), Medicare payments (3,109.17±1,221.21 vs 4,780.75±1,511.90; p=0.021), facility fees (3,055.17±1,503.23 vs 5,228.67±1,725.74; p=0.018), and patient payments (776.92±305.46 vs 1,194.75±377.97; p=0.021) in ASCs (**Table 2**). This resulted in an approximately 35% savings for total costs, Medicare payments, and patient payments, as well as approximately 42% cost savings for facility fees if procedures were performed at an ASC as compared to a HOPD. Surgeon fees were the same regardless of the surgery setting.

Arthroplasty/Arthrodesis Codes

When comparing five different CPT codes (Table 1), overall costs at ASCs were lower for total costs of procedure (8,105.80±5,714.19 vs 10,734.40±6,643.11; p=0.347), facility fees (7,113.80±5,997.65 vs 9,742.40±6,344.16; p=0.343), and Medicare payments (6,484.20±4,365.60 vs 9.285.60.00±6,254.08; p=0.347). For these five procedures, the average amount of the procedure required to be covered by the patient was higher at the ASC than the HOPD (1,620.40±1,159.13 vs 1,447.60±440.43; p=0.917). However, none of these differences reached statistical significance. Surgeon fees were the same regardless of the surgery setting.

Other Codes

When comparing 16 different CPT codes (Table 1), significant cost savings in the total cost of procedure (1,815.81±686.56 vs 3,181.38±1,343.83; p=0.003), facility fees (1,240.63±551.50 vs 2,606.19±1,212.08; p<0.001), Medicare payments (1,452.63±549.27 vs 2,554.75±1,074.92; p=0.003), and patient payments (362.44±137.22 vs 635.31.17±268.69; p=0.003) in ASCs as compared to HOPD were identified (Table 2). This resulted in an approximately 43% savings for total costs, Medicare payments, and patient payments, as well as approximately 52% cost saving for facility fees, if procedures are performed at an ASC as compared

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to a HOPD. Surgeon fees were the same regardless of surgery setting.

Overall

When grouping all 37 procedural codes into a single cohort, significant cost savings in an ASC setting were demonstrated across all variables outside of surgeon fees. Total cost (3,345.00±3,026.81 vs. 5,133.98±3,655.54; p=0.002), facility fees (2,635.70±2,839.88 vs. 4,451.97±3,444.87; p<0.001), Medicare payments (2,675.92±2,421.41 vs. 4,201.32±3,269.11; p=0.002), and patient payments (668.41±605.40 vs. 931.65±448.42; p=0.002) were all significantly lower if performed at an ASC (**Table 2**). This resulted in an approximately 35% savings in total cost, 41% savings for facility fees, 36% savings in Medicare payments, and 28% in patient payments for procedures performed at ASCs. Surgeon reimbursements were the same regardless of the surgery setting.

Table 2. Mean and standard deviation of costs associated with ambulatory surgical centers and hospital outpatient departments for common hand and upper extremity procedures.

	ASC (Mean ± SD)	HOPD (Mean ± SD)	*p-value
Arthroplasty			
Total Cost	1,886.00±58.78	3,418±58.78	**0.009**
Doctor Fee	526.00±58.78	526.00±58.78	1.000
Facility Fee	1,360.00±0.00	2,892.00±0.00	**0.021**
Medicare Payment	1,509±47.27	2,734±47.27	**0.021**
Patient Payment	376.75±11.87	682.75±11.87	**0.021**
Fracture			
Total Cost	3,886.58±1,527.61	5,975.92±1,890.96	**0.021**
Doctor Fee	748.08±200.02	748.08±200.02	1.000
Facility Fee	3,055.17±1,503.03	5,228.67±1,725.74	**0.018**
Medicare Payment	3,109.17±1,222.21	4,780.75±1,511.90	**0.021**
Patient Payment	776.92±305.46	1,194.75±377.97	**0.021**
Arthroplasty/Arthrodesis			
Total Cost	8,105.80±5,794.19	10,734.40±6,643.11	0.347
Doctor Fee	992.00±339.47	992.00±339.47	1.000
Facility Fee	7,113.80±5,497.65	9,742.40±6,344.16	0.343
Medicare Payment	6,484.20±4,635.60	9,285.60±6,344.16	0.347
Patient Payment	1,620.40±1,159.13	1,447.60±440.42	0.917
Other			
Total Cost	1,815.81±686.56	3,181.38±1,343.83	**0.003**
Doctor Fee	575.19±177.11	575.19±177.11	1.000
Facility Fee	1,240.63±551.50	2,606.19±1,212.08	**<0.001**
Medicare Payment	1,452.63±549.27	2,544.75±1,074.92	**0.003**
Patient Payment	362.44±137.22	635.31±268.69	**0.003**
Overall			
Total Cost	3,345.00±3,026.81	5,133.97±3,655.54	**0.002**
Doctor Fee	682.27±246.91	682.27±246.91	1.000
Facility Fee	2,635.70±2,839.89	4,451.97±3,444.87	**<0.001**
Medicare Payment	2,675.92±2,421.41	4,201.32±3,269.12	**0.002**
Patient Payment	668.41±605.40	931.65±448.62	**0.003**

ASC = ambulatory surgical center; HOPD = hospital outpatient department; SD = standard deviation
*p-value calculated using Mann-Whitney *U* tests. **Bolding** indicates significance (p<0.05).

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DISCUSSION

Over the last few decades, there has been a shift and growth to free-standing ambulatory surgery centers, with a 77% increase in orthopaedic procedures performed in them between 2000 to 2007.[26] More recently, The Centers for Medicare and Medicaid Services (CMS) removed over 250 musculoskeletal procedures from the "inpatient only" list, allowing a wider breadth of outpatient and ASC utilization.[27] In orthopaedics, prior studies have demonstrated the safety of outpatient procedures that were once believed to require inpatient hospitalization, including total joint arthroplasty, and minimally-invasive spine procedures. [9-10]

Regarding hand and upper extremity surgery, procedures are smaller, less invasive, and shorter, and therefore, intrinsically more suitable to be carried out in the outpatient setting. One circumstance that would offset the benefits of outpatient settings, such as HOPDs and ASCs, is postoperative emergency department visits or hospital readmissions. Goyal et al. reviewed over 28,000 cases over 11 years of upper extremity procedures performed in ambulatory surgery centers, reporting 0.2% of adverse events, including only 18 postoperative transfers to the hospital and 21 admissions after discharge.[28] Furthermore, Sandrowski et al. substantiated the extremely low rate of ER visits and hospital readmissions, as only 1.6% of patients required further care at these facilities following over 500 hand and upper extremity procedures at a free-standing ASC.[14]

While the benefits of HOPDs and ASCs are well known regarding cost-savings, efficiency, and patient satisfaction, many have attempted to further delineate the differences in cost-savings and efficiency between the two healthcare facilities.[5,31] Carey reported rising costs had affected HOPDs to greater degrees than ASCs in numerous specialties, including gastroenterology, ophthalmology, and orthopaedics.[16] Among common orthopaedic procedures, it has been shown there are 26% lower total costs and 33% lower technical fees at ASCs than HOPDs.[32] Hair et al. demonstrated a 39% decrease in operative times in free-standing ambulatory care centers compared to hospital-based outpatient departments in numerous specialties with notable efficiency across all phases of care, including surgical time, time spent in the operating room, and postoperative care time.[33]

While previous reports portray the benefits of ASCs over HOPDs, there is a lack of literature focusing on cost-saving, specifically in hand and upper extremity procedures. Ngyugen et al. emphasized the cost savings ASCs can provide over HOPDs, up to 30%, following carpal tunnel release.[12] While they evaluated only one procedure, our study expands upon their finding by demonstrating large discrepancies between ASCs and HOPDs in total costs, facility fees, Medicare payments, and patient payments in over 20 common procedures.

We evaluated major categories of hand and elbow procedures, including arthroscopy, fracture fixation, arthroplasty/arthrodesis, and others involving nerve decompressions, flexor tendon

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repairs, and additional bony procedures. Areas of comparison related to cost saving include total costs, facility fees, Medicare payments, and patient payments. We demonstrated significant differences between ACSs and HOPDs, with cost-savings coming from ACSs in the majority of individual and grouped CPT codes across all variables, with the exception of surgeon's fees. In areas of arthroscopy and other CPT code categories, there was approximately 43-45% cost savings in total procedure costs, Medicare payments, and patient payments in ASCs over HOPD, with facility fees almost half at ACS than they are at HOPDs. Moreover, fracture fixation demonstrated 1/3rd less in total procedure costs, Medicare payments, and patient payments in ACSs when compared to HOPD, with 42% less for facility fees. These findings cannot be ignored, as they demonstrate an enormous healthcare expenditure that can be mitigated by performing most of these procedures at ASCs if both facilities are available to the surgeon and patient.

Although there was a trend towards cost-savings for ASCs in total procedure costs, Medicare payments, and facility fees for arthroplasty/arthrodesis codes, we did not demonstrate statistically significant differences. Patient payments were comparable at both facilities for arthroplasty/arthrodesis.

In the last three years, theoretical situations that would push the limits of healthcare worldwide have become an unfortunate reality. The COVID-19 pandemic had a notable physical and psychological impact on patients, healthcare workers, and hospitals; further, the financial impact was significant. There was an increased demand for medical supplies, hospital beds, and intensive care unit level of care, with disruption of supply chains leading to substantial financial challenges. The American Hospital Association estimated a loss of 202.6 billion for American healthcare systems, with large academic systems experiencing disproportionate financial stress as they maintain relatively small operating margins.[8, 29-30] Our study demonstrates the potential for significant cost savings as we move towards a system focused on evidence-backed, value-based care.

Limitations to this study are inherent to database studies, including appropriate coding and general data organization. This study's data was compiled from Medicare patients and does not reflect cost savings associated with private sector, Medicaid, or self-pay. Furthermore, while we sought to report on differences in costs, we did not evaluate the clinical outcomes or complication data between the two healthcare settings.

CONCLUSION

Outpatient settings, including hospital outpatient departments and ambulatory surgery centers, are primary healthcare facilities for patients undergoing hand and upper extremity procedures. As healthcare expenditure increases, it's prudent to determine possible areas of savings. While the benefits of ASCs over HOPDs have been established in the literature, specific subspecialty data regarding cost-saving is limited. We demonstrate the enormous cost savings in

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arthroscopy, fracture fixation, and many common procedures performed in the upper extremity in ASCs over HOPDs. Further prospective studies are warranted to unveil the potential benefits of ASCs over HOPDs, including clinical outcomes and efficiency measures.

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Ambulatory surgery centers and outpatient urologic surgery among Medicare beneficiaries

Anne M. Suskind, Rodney L. Dunn, Yun Zhang, John M. Hollingsworth, and Brent K. Hollenbeck

Abstract

Objectives—To determine the effect of an ambulatory surgery center (ASC) opening in a healthcare market on utilization and quality of outpatient urologic surgery.

Methods—Retrospective cohort study of Medicare beneficiaries undergoing outpatient urologic surgery from 2001 to 2010. Markets were classified into three groups based on ASC status (i.e., those with ASCs, those without ASCs, and those where ASCs were introduced). Multiple propensity score methods adjusted for differences between markets and general linear mixed models determined the effect of ASC opening on utilization and quality, defined by mortality and hospital admission within 30 days of the index procedure.

Results—During the study period, 195 ASCs opened in markets previously without one. Rates of hospital based urologic surgery in markets where ASCs were introduced declined from 221 to 214 procedures per 10,000 beneficiaries in the 4 years after baseline. In contrast, rates in the other two market types increased over the same period ($p < 0.001$). Rates of outpatient urologic surgery overall (i.e., in the hospital and ASC) demonstrated similar growth across market types during same period ($p = 0.56$). The introduction of an ASC into a market was not associated with increases in hospital admission or mortality ($p's > 0.5$).

Conclusions—The introduction of an ASC into a healthcare market lowered rates of outpatient urologic surgery performed in the more expensive hospital setting. This redistribution was not associated with declines in quality or with greater growth in overall outpatient surgery use.

Keywords

population; propensity score; administrative claims; healthcare market; hospital service area; mortality; hospital admission

Introduction

The volume of outpatient surgery has increased dramatically over the last three decades, largely due to advances in medical technology and payment incentives.[1] Paralleling this growth, freestanding ambulatory surgery centers (ASCs) have proliferated widely,[2] serving as an alternative to the traditional hospital outpatient department. Procedure rates at ASCs have risen by 300% and currently these facilities deliver half of all outpatient surgery.[1]

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Relative to the hospital setting, ASCs can provide the same care at a lower cost per episode,[2–4] in part because facility payments are made at only a fraction of those for the same procedure performed in the hospital. In this context, redistribution of procedures to ASCs has the potential to improve the efficiency of the delivery system.

However, some worry that the recent proliferation of ASCs may in fact spur utilization and result in greater overall spending. Almost all freestanding ASCs are owned, at least in part, by the surgeons who staff them.[5] Because owners share in the profits of the facility in addition to collecting the professional fee for service, the Medicare Payment Advisory Commission (MedPAC) and others[2,6–9] are concerned that perverse financial incentives might result in volume creep, whereby indications for outpatient surgery, almost all of which is discretionary, are lowered. Such incentives also have the potential to encourage the redistribution of more marginal patients, or those less suitable due to health status, leading to possible declines in quality.

For these reasons, we used national Medicare data to determine the impact of the dissemination of ASCs on the delivery of outpatient urologic surgery. In particular, we interested in the effect of ASC on opening on both urologic procedure use and quality, as defined by perioperative mortality and hospital admission. Findings from this study directly inform policies surrounding physician ownership, financial incentives and utilization.

Material and Methods

Study subjects

This study represents a retrospective cohort study of Medicare beneficiaries undergoing outpatient urologic procedures between 2001 and 2010. We used a 20% sample of national claims form the Physician Carrier, Outpatient, Medicare Provider Analysis and Review (MEDPAR) and Denominator files. Patients between 65 to 99 years of age undergoing a urologic procedure, defined by a Healthcare Common Procedure Coding System code ranging from 50000 to 59999, at either a hospital outpatient department or freestanding ASC were included. The surgical setting was determined using explicit codes in the Medicare files.

The Provider of Service Extract, reported annually by the Centers for Medicare and Medicaid Services, was used to categorize each market according to the presence or absence of a Medicare certified freestanding ASC during each year of the study. For the purposes of this study, we chose the Hospital Service Area (HSA), as defined by the Dartmouth Atlas,[10] to reflect distinct healthcare markets. Each HSA, of which there 3,436 in the US, represents a collection of ZIP codes wherein residing Medicare beneficiaries receive the majority of their healthcare. We chose HSAs, as opposed to Hospital Referral Regions, because outpatient surgery is elective, discretionary and low risk. Thus, patients are likely to undergo such procedures locally as opposed to traveling large distances.

We then sorted each HSA into three mutually exclusive groups based on their ASC status: (1) those with an ASC present throughout the study period, (2) those without an ASC throughout the study period, and (3) those where at least one ASC opened for the first time

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after 2001. A small number of HSAs (n=287, or 8.4%) that had an ASC open and close during the study period were excluded from the analysis.

Outcomes and study variables

The objective of the study was to assess the effects of an ASC opening in a healthcare market on utilization and quality. Our utilization outcomes were population-based rates of outpatient urologic surgery, both in the hospital and overall. In order to calculate the first, the numerator consisted of annual counts of hospital-based outpatient procedures in a HSA, and the denominator was comprised of eligible Medicare beneficiaries with Part B coverage residing in that HSA. The second utilization outcome differed only in that the numerator consisted of annual counts of outpatient urologic surgery (i.e., those in either the hospital or an ASC) in each HSA.

We operationalized quality for outpatient urologic surgery using mortality and hospital admission occurring within 30 days of the index procedure. The numerator for this measure consisted of counts of admission (or mortality). In contrast to our utilization outcomes, the denominator was the amount of time "at risk", expressed in person years, among eligible beneficiaries undergoing urologic outpatient surgery annually.

Demographic information on age, race, and gender of patients was obtained from the Denominator file. Comorbidity was assessed using *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis codes submitted in the year preceding the index outpatient procedure and categorized into groups using the Charlson method.[11] To minimize confounding among healthcare markets, additional information pertaining to the local characteristics of the individual markets was abstracted from several data sources including the Area Resource File[12] and the American Health Planning Association's National Directory.[13]

Statistical analysis

The three categories of HSAs were contrasted according to beneficiary and contextual characteristics using nonparametric statistics. In order to address significant differences across healthcare markets, we used multiple propensity score-adjusted methods.[14] For this purpose, we fit a multinomial logistic regression model where the dependent variable was the HSA group and the independent variables were the clinical and contextual features previously described. The Hausman test was used to verify that the multinomial model met the Irrelevant Alternatives Assumption and overlapping of the distributions was visually performed. For this model, the Wald chi square was 492.4 with 24 degrees of freedom ($p < 0.0001$) and the pseudo R^2 was 0.3025. This approach enabled us to effectively calculate the predicted probability of each HSA to be assigned to one of the three market categories. These probabilities were then included as adjustment variables in subsequent models assessing relationships between HSA type and the outcomes.

We next assessed temporal relationships between HSA type and the utilization outcomes. In both cases, the HSA was the unit of analysis. Because ASCs open for the first time in HSAs in different years, it was necessary to use a multiple time series approach. For HSAs where

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ASCs opened for the first time, "baseline" was defined as the year prior to the first facility opening within its boundaries. For the other two categories of HSAs, there are no changes during the study period, so there is not a natural "baseline". However, to allow for comparisons to be made with the ASC opened category, a "baseline" year was randomly assigned for these other two HSA categories. Since the baseline year is not distributed uniformly across the study period in the ASC opened category, to prevent a time bias that may occur using the standard technique where "baseline" years would be randomly chosen and evenly distributed (e.g., resulting in more "baseline" years in the earlier part of the study period for the ASC always present group as compared to the ASC opened group), the random "baseline" selections were proportionally matched to the "opened for the first time" category so that the distribution of baseline years in the always and never present categories matched the distribution of baseline years in the "opened for the first time" category. Generalized linear mixed models were fitted to assess for differences in utilization across HSA types. Models were adjusted for differences in population and healthcare markets, the multiple propensity score and calendar year by incorporating these variables as fixed effects. The HSA was included in the model as a random effect to account for repeated measures of utilization within each HSA. Similar methods were used to calculate adjusted rates of mortality and hospital admissions. However, for these outcomes, the unit of analysis was the patient.

All analyses were performed using SAS v9.2 (Cary, NC). The probability of a type I error was set at 0.05 and all testing was two-sided. The institutional review board at the University of Michigan approved this study. The requirement for informed consent was waived.

Results

Aggregate beneficiary and regional characteristics according to market type are shown in Table 1. While significant differences were evident for many factors, most of these were small and likely of limited clinical significance, with one exception. Markets without ASCs were considerably more likely to be located in more rural areas. After adjusting for multiple propensity scores, all significant differences across markets disappeared.

Adjusted rates for hospital based outpatient urologic surgery are shown in Figure 1 according to HSA group. Rates of urologic surgery performed in markets where ASCs were added for the first time declined 3.2% from 220.9 per 10,000 Medicare beneficiaries at baseline to 213.8 per 10,000 Medicare beneficiaries 4 years after baseline. There were no differences in the rate of change in use between market groups prior to baseline ($p=0.77$). However, the rate of change of hospital based urologic procedures did vary significantly across HSA grouping after baseline ($p<0.001$ for test between 3 slopes). This difference was attributable to the decline in utilization in markets where ASCs were added for the first time. In contrast, rates of hospital based outpatient surgery continued to increase in markets where ASCs were always or never present.

Adjusted rates of urologic procedures performed in both hospital based outpatient departments and in ASCs are shown in Figure 2 according to market type. Adjusted rates of

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urologic procedures performed in markets where at least 1 ASC was introduced during the study period increased by 15.8%, or from 268.8 per 10,000 Medicare beneficiaries at baseline to 311.3 per 10,000 Medicare beneficiaries 4 years after baseline. However, this overall rate of increase did not significantly differ from the rates of increase of outpatient urologic procedures performed in the other 2 market types, indicated by similar slopes for rates of change over time (p=0.56).

Adjusted rates of perioperative mortality and hospital admissions are shown in Figure 3A and B, respectively. Rates of mortality within 30 days of a urologic procedure remained flat in markets where ASCs were introduced for the first time, ranging from 0.65 deaths per 1,000 person-years for the 2-year period prior baseline to 0.66 deaths per 1,000 person years for the 4-year period after baseline. There were no differences in the rate of change of mortality across HSA grouping after ASC introduction (p=0.99 for test between 3 slopes). Similarly, rates of hospital admission remained stable, ranging from 9.8 admissions per 1,000 person-years for the 2-year period prior baseline to 10.6 admissions per 1,000 person years for the 4-year period after baseline. The introduction of an ASC into a healthcare market had no effect on hospital admission within 30 days of the index procedure (p=.50 for test between 3 slopes).

Comment

The introduction of an ASC into a healthcare market resulted in declines in hospital-based surgery. Further, the opening of an ASC performing urologic surgery did not lead to growth in overall rates of outpatient surgery. This redistribution from the hospital setting occurred without any negative implications for quality, as measured by perioperative mortality and hospital admission. Collectively, our data suggest that these facilities are achieving their desired effect for the delivery system, at least as they are measurable in claims data pertaining to urologic surgery.

Over the last several decades, there has been a shift from inpatient to outpatient surgery. Concurrent with this trend, there has been a sea change in the setting for these procedures with movement out of the hospital and into the ASC, such that approximately half of all outpatient surgery is performed in these facilities.[1] Compared to hospitals, ASCs have several advantages, most of which are derived from their efficiency. For payers, ASCs provide similar care at a lower cost per episode.[2,3] For patients, ASCs afford a patient-centered experience in a comfortable, and often plush, environment with lower co-payments.[15] Finally, physicians enjoy greater administrative control and higher productivity.[5,16]

Despite these advantages, however, many worry inherent conflicts of interest associated with ASCs may spur overall utilization and drive healthcare spending.[2] Freestanding ASCs, by and large, are owned by the surgeons who staff them.[5] In this arrangement, surgeons share in the facility profits, which can significantly eclipse revenue generated by the professional fee for service. For this reason, some believe that financial incentives may lead to lower thresholds for intervention, resulting in induced demand. Our findings allay these concerns as they pertain to urologic outpatient surgery.

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This study should be interpreted with two limitations in mind. First, these analyses were performed using Medicare claims and directly pertain to Medicare certified ASCs. Other insurers and non-Medicare certified ASCs may behave differently; however, it is common practice that Medicare policy mandates generally precede and guide those of third parties. Second, our measurement of surgical quality, as defined by perioperative mortality and hospital admission, are broad measures of quality. Understanding the impact of ASCs on other relevant measures, including patient reported quality-of-life and satisfaction, would help to better clarify their value to the delivery system.

Conclusions

The introduction of an ASC into a healthcare market served to effectively offload outpatient urology surgery from the hospital without spurring its overall utilization. This redistribution of urologic surgery occurred without negatively impacting quality, as measured by perioperative mortality and hospital admissions. In terms of outpatient urologic surgery, ASCs have the potential to improve the efficiency of the delivery system among Medicare beneficiaries undergoing these procedures.

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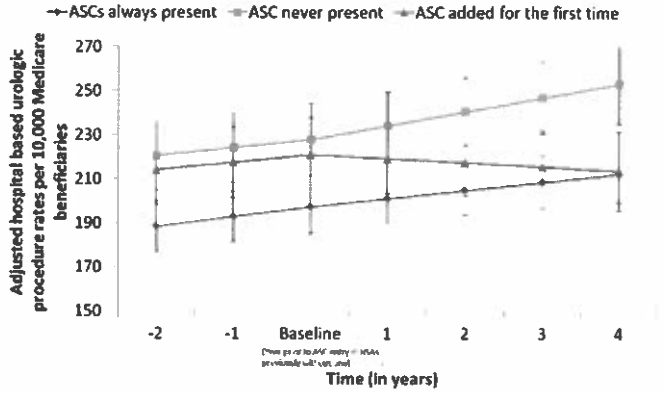

Figure 1.

Adjusted rates for hospital based outpatient urologic surgery based on type of healthcare market.

P=0.77 for all 3 healthcare markets from years −2 to 0

*P<0.001 for all 3 healthcare markets from years 0 to 4

P=0.081 for markets where ASCs were always present compared to markets where ASCs were never present from years 0 to 4

*P<0.001 for markets where ASCs were added compared to markets where ASCs were never present from years 0 to 4

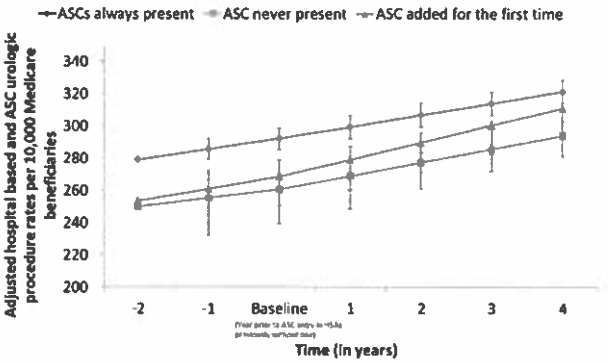

Figure 2.

Adjusted rates of outpatient urologic surgery performed in hospital based outpatient departments and ASCs based on type of healthcare market.

P=0.43 for all 3 healthcare markets from years −2 to 0

P=0.56 for all 3 healthcare markets from years 0 to 4

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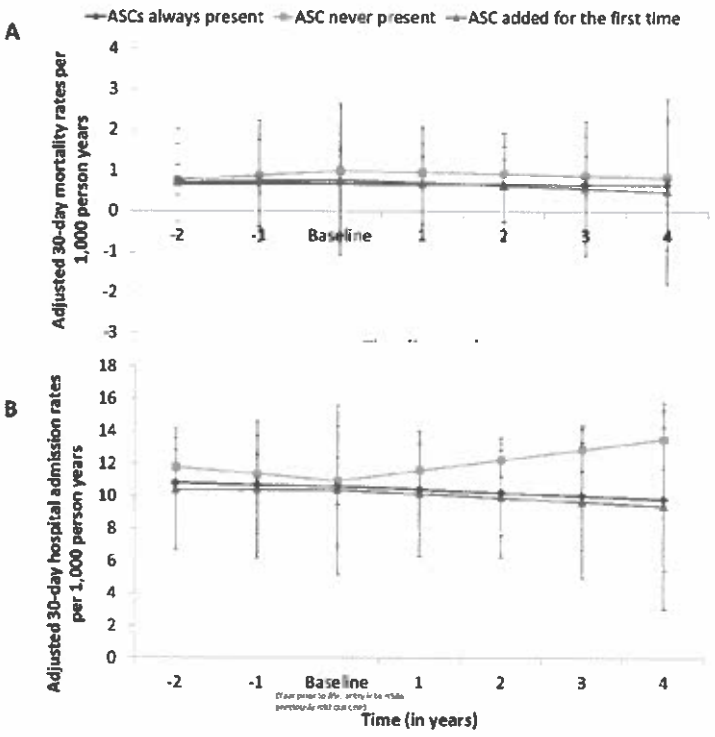

Figure 3.

Adjusted rates for (A) 30-day mortality and (B) 30-day hospital admission per 1,000 person years of follow-up based on hospital market.

[(A): P =0.85 for all 3 healthcare markets from years −2 to 0, P=0.99 for all 3 healthcare markets from years 0 to 4; (B) P=0.81 for all 3 healthcare markets from years −2 to 0, P=0.50 for all 3 healthcare markets from years 0 to 4]

Table 1

Characteristics of the population undergoing outpatient urologic surgery and the associated healthcare markets

	Hospital Service Area type			p-value	
	ASC always present	ASC never present	ASC added	Before multiple PS correction	After multiple PS correction
No. HSAs	414	2540	195	--	--
No. patients in 2010	11,499,643	9,951,317	2,522,493	--	--
Age, mean	70.7	70.5	70.5	0.093	0.82
Gender, % female	55.1	54.0	54.9	<0.001	0.90
Race, % non-white	13.4	10.6	12.5	<0.001	0.75
Charlson score 2+, %	26.0	23.5	25.6	<0.001	0.74
Living below poverty, %	13.7	15.7	13.8	<0.001	0.77
College education or more among those 25 years and older, %	24.8	17.1	22.8	<0.001	0.79
Log of hospital discharges per 10,000	8.7	8.4	8.8	0.0023	0.91
Log of urologists per 10,000	2.0	1.1	2.0	<0.001	0.31
Certificate of need, %	65.9	67.1	64.2	0.54	0.97
Urban, %	85.8	33.3	72.9	<0.001	0.44

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JAMA Ophthalmology | Original Investigation

Trends in Use of Ambulatory Surgery Centers for Cataract Surgery in the United States, 2001-2014

Brian C. Stagg, MD; Nidhi Talwar, MA; Cynthia Mattox, MD; Paul P. Lee, MD, JD; Joshua D. Stein, MD, MS

IMPORTANCE Cataract surgery is commonly performed at ambulatory surgery centers (ASCs) and hospital outpatient departments (HOPDs). These venues differ in many ways, including surgical efficiency, patient throughput, patient safety, and costs per surgery.

OBJECTIVE To determine trends in use of ASCs and HOPDs for cataract surgery from 2001 to 2014 and factors affecting the site of surgery.

DESIGN, SETTING, AND PARTICIPANTS This retrospective longitudinal cohort analysis involved individuals 40 years and older who underwent cataract surgery between January 2001 and December 2014 from a nationwide US managed care network. Data were analyzed from February 2016 to February 2017.

MAIN OUTCOMES AND MEASURES We identified all enrollees who underwent cataract surgery and determined whether the surgery was performed at an ASC or HOPD. We calculated the proportion of surgeries performed at each site each year from 2001 to 2014. Multivariable logistic regression identified characteristics of enrollees who had cataract surgery at an ASC vs a HOPD. We also assessed geographic variation in the proportion of cataract surgeries performed at ASCs in 306 communities throughout the United States.

RESULTS Of the 369 320 enrollees included in this study, 208 319 (56.4%) were female, and the mean (SD) age was 66.3 (10.4) years. All enrollees underwent cataract surgery (531 325 surgeries) from 2001 to 2014. Of these, 237 046 (64.2%) underwent cataract surgery at an ASC. The proportion of cataract surgeries performed at ASCs increased from 43.6% in 2001 to 73.0% in 2014. Compared with enrollees with incomes less than $40 000, those with incomes greater than $100 000 were 20% more likely to undergo cataract surgery at an ASC (odds ratio, 1.20; 95% CI, 1.12-1.29). Enrollees with better overall health were no more likely to undergo cataract surgery at an ASC (odds ratio, 1.00; 95% CI, 0.99-1.00) than at an HOPD. Enrollees who lived in communities without certificate of need laws were more than twice as likely to have surgery at an ASC (odds ratio, 2.49; 95% CI, 2.35-2.63). The proportion of cataract surgeries performed at ASCs from 2012 to 2014 varied considerably, from 1.6% in La Crosse, Wisconsin, to 98.8% in Pueblo, Colorado.

CONCLUSIONS AND RELEVANCE We observed a large shift in the site of cataract surgery from HOPDs to ASCs from 2001 to 2014. Future research is needed to assess the effect of this transition in site of surgical care on patient access to surgery, surgical outcomes, patient safety, and societal costs.

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Supplemental content

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Approximately 53 million outpatient surgeries are performed in the United States annually.[1] Years ago, nearly all of these surgeries required inpatient hospitalization. Over time, most of these surgeries moved to hospital outpatient departments (HOPDs), and now many are performed at ambulatory surgery centers (ASCs). By 2006, across all areas of medicine, nearly half of all outpatient surgeries were performed at ASCs.[1,2]

Reasons for the increasing popularity of ASCs relative to HOPDs include enhanced surgeon productivity, improved convenience for patients and surgeons, decreased out-of-pocket patient costs, and decreased per-case costs for insurers.[3-5] An advantage of performing surgeries at HOPDs rather than ASCs is that when HOPDs are attached to hospitals, they are often better equipped to deal with medical emergencies.[6] To curtail rising surgical care costs, some insurers have considered incentivizing patients to undergo surgery at ASCs rather than HOPDs.[7] These policies could profoundly affect ophthalmologic surgical care delivery, as more than 95% of ocular surgeries are performed in outpatient settings.[8]

The proportion of ocular surgeries performed at ASCs increased considerably from 1998 to 2011 in Florida, but to the best of our knowledge, nationwide trends are unknown.[8,9] In this study, we evaluate trends in the performance of cataract surgeries at ASCs and HOPDs from 2001 to 2014 among enrollees in a nationwide managed care network and the extent of geographic variation in ASC use over time. We also identify sociodemographic and other patient characteristics associated with the likelihood of receiving cataract surgery at an ASC vs an HOPD. Finally, we compare trends in ASC use for cataract surgery with several ophthalmic subspecialty surgeries. Understanding these shifts in facility choice has important implications for societal health care costs, access to care, and surgical efficiency, safety, and outcomes.

Key Points

Question What proportion of cataract surgeries in the United States are performed at ambulatory surgery centers (ASCs), how has this changed over time, and what factors affect the location where cataract surgery takes place?

Findings In this cohort study including 369 320 individuals in a large managed care network who underwent 531 325 surgeries, the proportion of cataract surgeries performed at ASCs increased from 43.6% in 2001 to 73.0% in 2014, with dramatic geographic variation in ASC use, from 1.6% in La Crosse, Wisconsin, to 98.8% in Pueblo, Colorado.

Meaning The large shift of cataract surgery from hospital outpatient departments to ASCs has important implications for patient access to surgery, outcomes, safety, and societal costs.

Methods

Data Source

We used the Clinformatics DataMart database (OptumInsight), which contains claims data for all beneficiaries in a nationwide US managed care network from 2001 to 2014. The data set includes information for all individuals in the network with 1 or more *International Classification of Diseases, Ninth Revision, Clinical Modification*[10] codes for eye-related diagnoses (360-379.9), 1 or more *Current Procedural Terminology*[11] codes for any eye-related visits and diagnostic or therapeutic procedures (65091-68899 and 92002-92499), or any other claim submitted by an ophthalmologist or optometrist from January 1, 2001, through December 31, 2014. We had access to all enrollees' claims for ocular and nonocular conditions and all procedures performed. Information about enrollees' age, sex, race/ethnicity, education level, and annual income were available. The database includes individuals with commercial health insurance along with those in Medicare Advantage plans and various plan types (eg, HMO and PPO). The database contains information on enrollees in states throughout the United States, although certain regions, such as the upper Midwest, are more heavily represented relative to others. We have used this resource previously to study ocular diseases.[12-14] The University of Michigan Institutional Review Board approved this study. Informed consent was waived because data were deidentified.

Sample Selection

We identified individuals 40 years and older undergoing cataract surgery from 2001 to 2014. eTable 1 in the Supplement lists the billing codes used to identify cataract surgeries. The database captures the location of every surgery. Our analyses focus on enrollees who underwent cataract surgery at an HOPD or an ASC. We excluded those with surgery performed elsewhere, such as during an inpatient hospitalization, and those for whom the surgery site was unclear. Some enrollees had surgery on one eye at an ASC and the contralateral eye at an HOPD. Because of this, the sum of enrollees receiving surgery at each venue is greater than the total number of enrollees undergoing cataract surgery.

Analyses

We performed statistical analyses using SAS version 9.4 (SAS Institute). Enrollee characteristics were summarized using means and standard deviations for continuous variables and frequencies and percentages for categorical variables. Univariate differences were assessed with χ^2 tests. For all analyses, we report 2-tailed P values, and $P < .05$ was considered statistically significant. To assess trends in cataract surgery over time, the proportions of cataract surgeries performed at ASCs and HOPDs were calculated annually. We used t tests as part of a linear regression to compare trends in other ocular surgeries and that of cataract surgery. The study was designed and completed from February 2016 to February 2017.

Geographic Variation in ASC vs HOPD Use for Cataract Surgery

To assess the extent of geographic variation in the use of ASCs and HOPDs for cataract surgery, we divided the United States into 306 hospital referral regions (HRRs).[15,16] Hospital referral regions are geographic units based on referral patterns for tertiary medical care services. Enrollees were assigned to an

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Table 1. Sociodemographic Characteristics of Eligible Enrollees Undergoing Cataract Surgery

Characteristic	No. (%)		
	Enrollees Undergoing Cataract Surgery at an ASC	Enrollees Undergoing Cataract Surgery at an HOPD	All Enrollees Undergoing Cataract Surgery
No. of enrollees	237 046	136 261	369 320
No. of surgeries[a]	339 142	192 183	531 325
Age, mean (SD), y	66.0 (10.3)	66.7 (10.6)	66.3 (10.4)
Sex			
Male	103 717 (43.8)	58 977 (43.3)	161 001 (43.6)
Female	133 329 (56.3)	77 284 (56.7)	208 319 (56.4)
Race/ethnicity[b]			
White	176 501 (81.5)	97 268 (81.5)	270 824 (81.5)
Black	21 667 (10.0)	13 900 (11.6)	35 116 (10.6)
Latino	13 536 (6.2)	5550 (4.6)	18 917 (5.7)
Asian American	4959 (2.3)	2692 (2.3)	7565 (2.3)
Education level[c]			
<High school	1380 (0.6)	657 (0.5)	2020 (0.6)
High school diploma	68 464 (30.5)	42 118 (34.0)	109 390 (31.7)
Some college	122 770 (54.7)	63 177 (51.0)	183 894 (53.4)
College diploma or more	31 900 (14.2)	17 940 (14.5)	49 319 (14.3)
Annual income, $[d]			
<40 000	56 989 (31.6)	32 142 (35.4)	88 047 (32.8)
40 000-59 999	33 119 (18.4)	17 240 (19.0)	49 774 (18.6)
60 000-99 999	44 280 (24.5)	21 453 (23.6)	65 034 (24.2)
≥100 000	46 010 (25.5)	20 042 (22.1)	65 405 (24.4)
Insurance plan			
Medicare advantage	85 027 (35.9)	45 938 (33.7)	129 263 (35.0)
Commercial	152 019 (64.1)	90 323 (66.3)	240 057 (65.0)
Plan type			
HMO	82 577 (34.8)	52 448 (38.5)	133 354 (36.1)
PPO	24 910 (10.5)	15 659 (11.5)	40 164 (10.9)
EPO	16 170 (6.8)	7782 (5.7)	23 731 (6.4)
POS	78 493 (33.1)	39 182 (28.8)	116 613 (31.6)
IND	23 167 (9.8)	14 151 (10.4)	36 881 (10.0)
Other	11 729 (5.0)	7039 (5.2)	18 577 (5.0)
Year of first cataract surgery			
2001-2003	24 767 (10.5)	28 994 (21.3)	53 429 (14.5)
2004-2006	42 846 (18.1)	30 253 (22.2)	72 390 (19.6)
2007-2009	63 087 (26.6)	33 057 (24.3)	95 018 (25.7)
2010-2012	67 030 (28.3)	29 308 (21.5)	95 211 (25.8)
2013-2014	39 316 (16.6)	14 649 (10.8)	53 272 (14.4)

Abbreviations: ASC, ambulatory surgery center; EPO, exclusive provider organization; HMO, health maintenance organization; HOPD, hospital outpatient department; IND, indemnity; POS, point of service; PPO, preferred provider organization.

[a] Some enrollees had surgery on one eye at one of these surgical sites and the contralateral eye at a different site (n = 3987). Because of this, the sum of enrollees who had surgery at each venue is greater than the total number of enrollees undergoing cataract surgery.

[b] Race/ethnicity information missing for 36 898 enrollees.

[c] Education level information missing for 24 697 enrollees.

[d] Annual income information missing for 101 060 enrollees.

HRR based on their residential zip code at plan enrollment. We assessed the proportion of patients undergoing cataract surgery at an ASC for each HRR during 2 periods: an earlier period (2004-2006) and a later period (2012-2014). Use of these years permitted a 3-year look-back period (2001-2003 and 2009-2011) for both groups. The change in proportion of cataract surgeries performed at ASCs during the 2004-2006 period to the 2012-2014 period was also calculated for each HRR. Some states have certificate of need (CON) laws, which regulate the number of ASCs that are permitted to operate in the state.[17] Each HRR was characterized as possessing CON laws or no such laws; HRRs that covered states with and without CON laws were categorized as "mixed CON."

Multivariable Regression Model

A multivariable logistic regression model identified characteristics of enrollees undergoing cataract surgery at an ASC vs an HOPD. For this particular analysis, enrollees were included in the model only if they had not had prior cataract surgery in a 3-year look-back period, as we were interested in assessing factors associated with the location of their initial cataract surgery. Enrollees were also required to have no record of aphakia or pseudophakia, indicative of prior cataract surgery during the look-back period. Model predictors included age at surgery, sex, race/ethnicity, education level, annual income, calendar year of surgery, whether the patient had exclusively commercial health insurance or Medicare Advantage, insurance plan type,

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and Charlson comorbidity index score (indicating patients' overall health).[18] Whether the enrollee lived in an HRR with CON, no CON, or mixed CON as well as the presence or absence of comorbid dementia, diabetes, hypertension, chronic kidney disease, congestive heart failure, chronic obstructive pulmonary disease, or myocardial infarction were also included in the model. Model results are presented as odds ratios (ORs) with 95% CIs.

Trends in Use of Cataract Surgery at ASCs and HOPDs Compared With Other Ophthalmic Surgeries

To compare with the trends in use of ASCs for cataract surgery, we evaluated the trends of use of other common ophthalmologic surgeries at ASCs vs HOPDs. Using *Current Procedural Terminology* codes, ophthalmologic surgeries were grouped into strabismus, cornea, glaucoma, or retina surgeries (eTable 1 in the Supplement). Because some of these other surgeries are frequently performed on children and adults, we did not restrict the sample to individuals 40 years and older for this subanalysis. The proportion of surgeries of each type performed at an ASC and HOPD was calculated annually from 2001 to 2014. Linear regression was used to calculate and compare the slope of change for each other surgery type with that of cataract surgery.

Results

Characteristics of Cataract Surgery Recipients at ASCs and HOPDs

There were 369 320 enrollees who underwent 1 or more cataract surgeries from 2001 to 2014, for a total of 531 325 cataract surgeries. The mean (SD) age at initial cataract surgery was 66.3 (10.4) years. During the 14-year period, 237 046 individuals (64.2%) underwent cataract surgery at an ASC, 136 261 (36.9%) at an HOPD, and 3987 (1.1%) at both settings. Among individuals who had surgery at an ASC, 133 329 (56.3%) were female, 176 501 (81.5%) were white, 21 667 (10.0%) were black, 13 536 (6.2%) were Latino, and 4959 (2.3%) were Asian American. Among those who had surgery at an HOPD, 77 284 (56.7%) were female, 97 268 (81.5%) were white, 13 900 (11.6%) were black, 5550 (4.6%) were Latino, and 2692 (2.3%) were Asian American (Table 1).

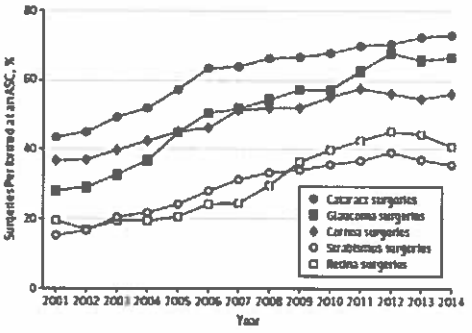
Trends in Use of ASCs, 2001-2014

In 2001, 9693 of 22 258 cataract surgeries (43.6%) were performed at ASCs. The proportion of cataract surgeries performed at ASCs increased steadily over time, reaching 73.0% (25 040 of 34 288) in 2014, representing a 67.4% increase compared with 2001 (Figure 1).

Geographic Variation in Use of ASCs vs HOPDs for Cataract Surgery

In the early period (2004-2006), the mean (SD) number of surgeries performed in each HRR was 325 (769), and the median was 101 surgeries. During the later period (2012-2014), the mean (SD) number of cataract surgeries in each HRR was 419 (819), and the median was 139 surgeries. There was considerable

Figure 1. Proportion of Different Types of Ocular Surgeries Performed at an Ambulatory Surgery Center (ASC) Each Year From 2001 to 2014



geographic variation in the proportion of cataract surgeries performed at ASCs rather than HOPDs. In the early period, the mountain states, desert southwest, and southwest Florida had large proportions of cataract surgeries performed at ASCs, while such proportions were much lower in the upper Midwest and Northeast (eFigure 1 in the Supplement). These same regions continued to have higher proportions of cataract surgeries performed at ASCs compared with other regions in the later period (eFigure 2 in the Supplement), although there was a widespread increase in the proportion of cataract surgeries performed in ASCs rather than HOPDs across much of the nation from 2004-2006 to 2012-2014 (Figure 2). Table 2 lists communities with the highest and lowest proportions of surgeries performed at ASCs rather than HOPDs in the early and late periods; eTable 2 in the Supplement lists communities with the largest change in proportions during these times.

Factors Associated With Undergoing Cataract Surgery at an ASC

Older age (adjusted OR, 0.99; 95% CI, 0.99-1.00) was associated with a decreased likelihood of receiving surgery at an ASC. Compared with white individuals, Latino individuals had an 18% increased odds of undergoing cataract surgery at an ASC (OR, 1.18; 95% CI, 1.06-1.31). Compared with those with a household income less than $40 000, persons with incomes of $60 000-$99 000 had a 14% increased odds of undergoing cataract surgery at an ASC rather than an HOPD (OR, 1.14; 95% CI, 1.07-1.20); those with incomes of $100 000 or greater had a 20% increased odds of undergoing the surgery at an ASC (OR, 1.20; 95% CI, 1.12-1.29). Better overall health (lower Charlson comorbidity index score) was not associated with increased likelihood of undergoing cataract surgery at an ASC rather than an HOPD (OR, 1.00; 95% CI, 0.99-1.00). The presence of most concomitant medical conditions studied did not affect the odds of receiving surgery at an ASC either. Persons living in HRRs without CON laws were considerably more likely to have surgery at ASCs than at HOPDs (OR, 2.49; 95% CI, 2.35-2.63). The odds of undergoing cataract surgery at an ASC increased by

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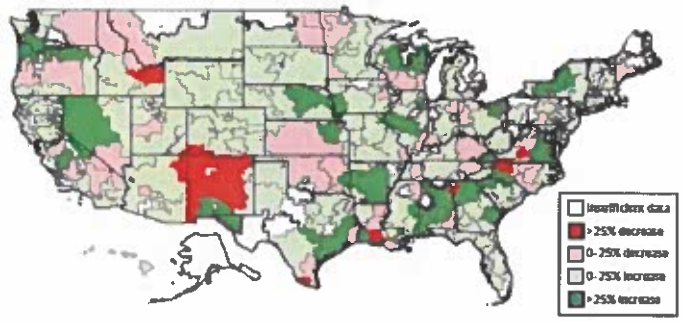
Figure 2. Geographic Variation in the Change in Site of Surgery From 2004-2006 to 2012-2014



Map showing the increase or decrease in proportion of cataract surgeries performed at ambulatory surgery centers from 2004-2006 to 2012-2014 by hospital referral region. Hospital referral regions with fewer than 20 patients undergoing cataract surgery in either 2004-2006 or 2012-2014 are reported as "insufficient data" (n = 42).

Table 2. Variation in Site of Cataract Surgery in Communities With at Least 100 Cataract Surgeries Performed

HRR	No. at ASCs	Total No. at ASCs + HOPDs	Cataract Surgeries Performed at ASCs, %
HRRs With the Lowest Proportion of Cataract Surgeries Performed at ASCs			
2004-2006			
Rochester, MN	5	182	2.7
Green Bay, WI	7	198	3.5
St. Paul, MN	157	1097	14.3
Hickory, NC	15	100	15.0
Appleton, WI	31	198	15.7
2012-2014			
La Crosse, WI	2	126	1.6
Rochester, MN	15	266	5.6
Binghamton, NY	7	116	6.0
Waterloo, IA	12	144	8.3
Dubuque, IA	42	416	10.1
HRRs With the Highest Proportion of Cataract Surgeries Performed at ASCs			
2004-2006			
Hudson, FL	672	680	98.8
Bradenton, FL	331	340	97.4
Sun City, AZ	366	377	97.1
St. Petersburg, FL	774	798	97.0
Salem, OR	186	193	96.4
2012-2014			
Pueblo, CO	255	258	98.8
St. Petersburg, FL	662	671	98.7
Bradenton, FL	227	232	97.8
Hattiesburg, MS	130	134	97.0
Sun City, AZ	212	219	96.8

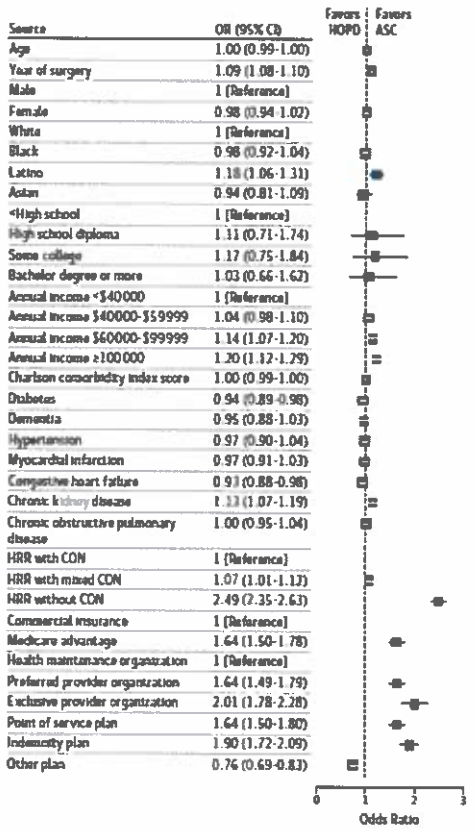
Abbreviations: ASC, ambulatory surgery center; HOPD, hospital outpatient department; HRR, hospital referral region.

9.4% for each later calendar year the surgery took place (OR, 1.09; 95% CI, 1.08-1.10; $P < .001$) (Figure 3).

Trends in ASC Use for Other Ocular Surgeries

Like cataract surgery, other types of ocular surgeries were increasingly performed at ASCs rather than HOPDs from 2001 to 2014 (Figure 1). For glaucoma surgery, the proportion of surgeries performed at ASCs increased from 28.3% (478 of 1687) in 2001 to 66.6% (1247 of 1873) in 2014. Use of ASCs for cornea surgery rose from 36.8% (439 of 1192) in 2001 to 56.1% (594 of 1059) in 2014. For strabismus surgery, the proportion of surgeries performed at ASCs rose from 15.3% (220 of 1436) in 2001 to 35.6% (548 of 1538) in 2014. The proportion of retina surgeries performed at ASCs increased from 19.6% (790 of 4026) in 2001 to 40.9% (2677 of 6546) in 2014. The rate of increase in ASC use for cataract surgery of 2.34% per year was similar to the rate of increase for strabismus surgery of 1.84% per year ($P = .08$) and for retina surgery of 2.44% per year ($P = .70$). The

Figure 3. Factors Associated With Undergoing Cataract Surgery at an Ambulatory Surgery Center



Multivariable logistic regression model identifying factors associated with undergoing cataract surgery at an ambulatory surgery center (ASC) rather than a hospital outpatient department (HOPD). The error bars indicate 95% CIs. CON indicates certificate of need law; HRR, hospital referral region; OR, odds ratio.

rate of increase for glaucoma surgery (3.26% per year) was faster than cataract surgery ($P = .002$). The rate of increase for cornea surgery (1.68% per year) was slower than cataract surgery ($P = .02$).

Discussion

Over the past 14 years, use of ASCs for cataract surgery rose dramatically. The largest increase in ASC use for cataract surgery occurred from 2001 to 2006, although further increases were noted from 2007 to 2014. This increase in use occurred in many US communities from the early to the later period, such that in some locales, nearly every cataract surgery in the database took place at an ASC. Patients were more likely to undergo cataract surgery at an ASC rather than an HOPD if they were younger age, had higher income, lived in states without CON laws, and had surgery during later calendar years. Similar trends in ASC use to those observed for cataract surgery were noted for all of the subspecialty ocular surgeries studied.

Surgery performed at ASCs is less expensive for insurers than surgery performed at HOPDs.[19,20] In 2014, the national average Medicare facility payment rate for cataract removal was $976 at an ASC and $1766 at an HOPD.[21] One analysis estimated that cataract surgeries performed at ASCs rather than HOPDs saved Medicare $829 million in 2011.[22] Ambulatory surgery centers also save money for beneficiaries through lower copayments; the average cataract surgery copayment in 2014 was approximately $190 at an ASC and $350 at an HOPD.[22] Although the facility fee and the patient copayment are less for surgeries performed at ASCs, the physician payment is the same at both facility types. However, because some surgeons have partial ownership of the ASC where they perform surgery, they receive a portion of the facility payment plus the physician fee.[23] This, coupled with improved surgeon efficiency, may explain some of the observed shift in surgical care from HOPDs to ASCs.

Although surgeries performed at ASCs are reimbursed at a lower rate than those performed at HOPDs, ASCs maintain their financial solvency through greater efficiency and patient throughput and lower turnover times, resulting in increased surgical volume.[1,23] This is particularly beneficial for relatively quick surgeries like cataract extraction; many surgeries can be performed on a given day at a single ASC. Ambulatory surgery centers are more convenient than HOPDs for many patients because they are often closer to patients' homes.[23,24] Additionally, across all types of surgeries, the average surgical experience is reduced by at least 30 minutes when performed in an ASC compared with an HOPD.[25]

When comparing and contrasting surgical care at ASCs and HOPDs, an important issue is patient safety. One advantage of HOPDs is that these facilities are often better equipped to deal with serious medical complications that may occur because they are typically attached to a hospital.[6] A few high-profile cases of severe medical complications and deaths that occurred during surgeries performed at ASCs highlight the importance of this issue.[26] Nevertheless, studies have demonstrated similar patient safety between the 2 facility types.[27-30] However, the studies' authors have recommended performing surgeries at ASCs only in selected patient populations with few medical comorbidities.

Whether ASCs are as safe as HOPDs for patients with multiple medical conditions is less clear. In one study,[31] only 1 in 1000 patients without major preexisting medical comorbidities required hospitalization in the first postoperative week after cataract surgery, compared with 8 in 1000 among patients with 4 or more medical comorbidities. In our analyses, the overall health of the patients (according to their Charlson comorbidity index score) appeared not to be driving use of surgical care at one facility type vs another. Given the increasing trend toward topical and monitored anesthesia care with intravenous sedation for most anterior segment surger-

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ies, including cataract extraction, coexisting medical comorbidities may be of lesser importance in the decision to perform surgery at an ASC vs an HOPD than in years past. Nevertheless, in our study, older enrollees were more likely to have surgery in an HOPD, suggesting that in selected patient groups, surgeons may feel more comfortable performing cataract surgery at an HOPD. Additional research is required to assess for differences in safety between the 2 facility types.

Of interest, wealthier enrollees were more likely to undergo cataract surgery at an ASC than at an HOPD. More affluent individuals may be more likely to live in communities with more ASCs or be more apt to seek care from surgeons who prefer to operate in these facilities. Because patient copayments tend to be higher for surgeries performed at HOPDs and a disproportionately greater number of lesser affluent patients undergo cataract surgery at these facilities, this may influence the ability for some lesser affluent patients to undergo cataract surgery, despite their possessing health insurance.

We also identified considerable geographic variation in the rate of cataract surgery performed at ASCs, ranging from less than 10% in some communities to nearly 100% in others. Unsurprisingly, during the later period (2012-2014), several communities with the lowest proportions of cataract surgeries performed at ASCs had large academic medical centers, such as in Rochester, Minnesota (5.6%), Iowa City, Iowa (15.9%), and Durham, North Carolina (16.4%). Most communities (74.6%) experienced an increase in ASC use for cataract surgery from 2004-2006 to 2012-2014, although approximately one-fourth of the communities studied experienced a decline. Certificate of need laws may be influencing some of the observed geographic variation, as they likely affect the number of ASCs present in a given community. Additionally, some health care systems have acquired ASCs and converted them to HOPDs to increase revenue; this may help explain the decline of ASC use for cataract surgery in some communities.[22,23] Moreover, some insurers may have contracts with hospitals requiring patients to receive surgery at specific HOPDs. Furthermore, if many ophthalmologists who are practicing in a given community are members of one large group practice and there is a change in the sites where they operate (eg, the sale of an ASC to a hospital system, which then converts it to an HOPD), then this could greatly affect some of the observed trends. This may help explain the large decline in ASC use in selected communities.

Strengths and Limitations

A strength of these analyses is the use of a database with millions of enrollees, more than 350 000 of whom underwent cataract surgery. This large sample size enabled sophisticated modeling to evaluate patient-level factors associated with use of ASCs vs HOPDs for cataract surgery and to study geographic variation. To our knowledge, this is the first study reporting rates of ASC use for various ophthalmologic subspecialty surgeries and changes in rates over time.

Our study has limitations. These results may be nongeneralizable to patients outside this particular managed care network who have other forms of health insurance. Future work repeating these analyses using other data sources, such as Medicare claims, will assess the generalizability of these findings. Our database lacks information on the types of facilities at which the patients' surgeons have privileges. Whether surgeons have privileges to perform surgeries at only ASCs or HOPDs or at both facility types would certainly affect the site of surgical care.

Conclusions

A major shift in ophthalmic surgical care in the United States from HOPDs to ASCs occurred over the past decade. Additional research is needed to assess whether this observed increase in the use of ASCs for cataract and other ocular surgeries affects overall access to surgery, surgical outcomes, patient safety, and societal costs.

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Study concept and design: Stagg, Mattox, Lee, Stein.
Acquisition, analysis, or interpretation of data: Stagg, Talwar, Mattox, Stein.
Drafting of the manuscript: Stagg, Stein.
Critical revision of the manuscript for important intellectual content: Stagg, Talwar, Mattox, Lee.
Statistical analysis: Talwar.
Obtained funding: Lee, Stein.
Administrative, technical, or material support: Lee, Stein.
Study supervision: Stagg.

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ATTACHMENT 12
Purpose of the Project

Endoscopic Ambulatory Surgery Centers

Kiran Kanji, M.D.[1]

ABSTRACT

Endoscopic ambulatory surgery centers are more efficient than hospital-based procedures, they are less costly to payers than hospital-based procedures, and they provide an additional source of revenue to healthcare providers. Physicians interested in establishing endoscopic ambulatory surgery centers must be aware of advantages and disadvantages of such units as well as optimal financing and equipment and personnel utilization.

KEYWORDS: Endoscopy, ambulatory surgery center, endo-center, management, office

Objectives: On completion of this article, the reader should be familiar with the advantages, disadvantages, and development of ambulatory surgery centers.

There are many reasons why endoscopic ambulatory surgery centers (EASCs) are thriving in the United States. We have an aging population and a shortage of physicians and healthcare costs are rising. As our population grows and grows older, there are increasing demands on physicians to become more efficient to keep up with the numbers. This is happening in a time when reimbursements are decreasing. Physicians are now at the point of having realized that they can increase efficiency only so far before they end up sacrificing good patient care and their own sense of well-being. EASCs fit well for everyone in this healthcare scenario. They are more efficient than hospital-based procedures, they are less costly to payers than hospital-based procedures, and they provide an additional source of revenue to healthcare providers.[1]

In comparison with hospital-based procedures, EASCs are advantageous to all parties involved. A low-risk patient is provided with a pleasant, convenient, and less intimidating atmosphere. The EASC is also more economical for the patient, which adds to his or her positive view of the experience. The insurance provider/payer is assured that the patient is receiving quality care in an accessible environment. In addition, the payer pays less for the EASC procedure than he or she would with a hospital-based procedure.

The physician also benefits from the EASC environment. When a group of physicians establishes an EASC, they are given control that they do not have in the hospital environment. This management aspect of the business allows the doctors to ensure that quality personnel are hired and trained to give both the patient and the physician the necessary services in a timely fashion. The physician is better able to control turnaround time and scheduling of procedures. Doctors are also able to incorporate their daily tasks, such as clinics and hospital rounds, with their time at the EASC because of their control over scheduling and the efficiency of the operation.

One major disadvantage of the EASC is the strain it often puts on the relationship between the physician and his/her affiliated hospital. A physician affiliated with an EASC who previously did all procedures in the hospital may now find it more difficult to schedule hospital-based procedures. This is probably due to a combination of factors: lack of resources, other

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physicians now using the hospital's allotted procedure times, and the hospital staff feeling lack of loyalty from the EASC-affiliated physician. Another issue that affects the hospital-physician relationship is the loss of revenue the hospital experiences when lucrative services such as endoscopy are moved from the hospital setting to an EASC.

Establishing an EASC means physicians must delve into the business aspect of medicine. The process means getting state licensure, becoming certified by payer groups, and accreditation by JACHO. Once these are approved, the decision-making process begins.

Many factors are involved in deciding how to run an EASC:

1. What services will be provided? The physicians have to decide which patients will be eligible to have a colonoscopy or endoscopy in this setting according to their risk factors.
2. Which physicians will be allowed to work in the EASC? Are only partners of a group or physicians who have a financial stake in the EASC be offered use of the facility, or will there be open access? The number of physicians and the size of the unit will affect these decisions. Gastroenterologists usually attend clinic or perform endoscopy while colorectal surgeons divide their time between the operating room, clinic, and the endoscopy unit. A facility that is not maximally utilized will be less efficient.
3. Which equipment will be used? There are many options to choose from when deciding on the type of equipment that will make the most physicians comfortable with their procedures. Of course, cost and which company is willing to provide the best deal to the EASC play a role as well. Will the equipment be leased or bought?
4. How will the facility be designed? The way in which an EASC is physically set up can be a great factor in how efficiently it is able to run and how the patient feels about the environment.
5. What criteria will be used to hire personnel? Hiring personnel means putting together an efficient and competent group of staff members. Issues to be considered include requirements for nursing degrees (what combination of RNs and LPNs one desires), medical assistants, front office/medical records staff, and billing staff. Along with hiring staff come decisions on appropriate salary compensation and benefits. Personnel will be the EASC's largest overhead expense.
6. How will quality of care be attained? All prior decisions impact the quality of care one will provide at the EASC. The services provided, the equipment used, the facility design will all factor into the quality of care provided. Personnel is the most costly aspect of the EASC, but it is also the most important and the most influential on quality of care provided.[2]

EASC DEVELOPMENT

Is It Necessary?

"If you build it, they will come." Does this adage really apply to EASCs? Every year there is an 8% increase in the number of EASCs. In 2003 there were 432. However, every year a small number of EASCs close or are bought up by hospitals or corporations. Limitations to success include the location of an EASC. Will the patient come to an area where real estate is more competitive, but is "on the other side of the track"? Is there a closer facility, specifically the hospital or another ambulatory surgery center (multiple versus single specialty)? Is transportation a limiting factor? All these questions should be considered from the patient's perspective.

Another barrier to setting up a viable EASC may be exclusive contracts that managed care companies have with hospitals. Most insurance companies will not contract with a facility until it is JACHO accredited.

In terms of viability, the revenue potential must be calculated. The number of cases multiplied by the base rate equals the potential gross revenue. An average of 1000 cases per physician per year at $450 base rate would generate a gross revenue of $900,000 for two physicians. One can expect the number of procedures to increase 5 to 10% per year and the revenue to grow 3.5% per year for all payers except Medicare. Medicare has frozen rates until 2009.[3]

The risk involved in setting up an EASC can limit physicians from undertaking this step. There are alternate setups, specifically corporate partners and hospital ventures. Is it worth it? It depends. Half of something is better than all of nothing. A corporate partner (hospital or third party) can help with planning and development, financing, negotiating contracts, staffing, marketing, and policy and procedures. In the end, physician-owners will have to share that revenue. Ultimately, it depends on the specific relationship between the physician and third party and if that relationship is necessary to get the ambulatory surgery center developed.[4]

Room Utilization

Before a decision is made to set up an EASC, it is crucial to determine the number of procedure rooms. That decision is based on the number of physicians participating in the EASC. If one calculates a capacity of 1000 procedures per room per year, it is possible to determine the number of endoscopy rooms that are necessary. The average EASC in the United States has between two to three procedure rooms. By calculating the average time a patient spends in an EASC from admission to

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Table 1 Room Utilization

							Preop Area	Postop Area
Time	Preop	Room 1	Postop	Preop	Room 2	Postop	# of Patients	
6:30–7:00	PT # 1			PT # A			2	
7:00–7:30	PT # 2	PT # 1		PT # B	PT # A		2	
7:30–8:00	PT # 3	PT # 2	PT # 1	PT # C	PT # B	PT # A	2	2
8:00–8:30	PT # 4	PT # 3	PT # 2	PT # D	PT # C	PT # B	2	2
8:30–9:00	PT # 5	PT #4	PT # 3	PT # E	PT # D	PT # C	2	2
9:00–9:30	PT # 6	PT # 5	PT # 4	PT # F	PT # E	PT # D	2	2
9:30–10:00	PT # 7	PT # 6	PT # 5	PT # G	PT # F	PT # E	2	2
10:00–10:30	PT # 8	PT # 7	PT # 6	PT # H	PT # G	PT # F	2	2
10:30–11:00	PT # 9	PT # 8	PT # 7	PT # I	PT # H	PT # G	2	2
11:00–11:30	PT # 10	PT # 9	PT # 8	PT # J	PT # I	PT # H	2	2
11:30–12:00		PT # 10	PT # 9		PT # J	PT # I		2
			PT # 10			PT # J		2

PT, patient.

discharge, one can determine the efficiency of the setup and the number of preop and recovery beds that would be needed. In general, allocating 20 minutes for preop, 30 minutes per procedure (including turn-around time), and 40 minutes for recovery is adequate. With this allocation, one to two preop beds and two to three recovery beds per procedure room seem to be necessary for adequate flow of patients.[5] A sample flow pattern is described in Table 1.

If the endoscopists' procedure time is equal to or less than the room turnover time (end of one procedure to start of next procedure), the best physician efficiency is obtained if each endoscopist has at least two procedure rooms assigned.[6] This allows the endoscopist to continue scoping in one room while "turnover" is occurring in the second room.

Physical Plant

Once you have determined that developing an EASC is a worthwhile undertaking and you are willing to invest the time and energy to set one up, you must determine the amount of space that will be necessary. Should you rent or build a free-standing EASC? The advantages to renting or leasing a space are decreased financial risk and location closer to a hospital. You can also offset tension with the hospital by leasing a space in the hospital office building. The advantages to building a free-standing EASC are freedom of design and little need for space or expansion reconstruction.

Marasco and Associates, Inc, a healthcare consulting firm, has developed a formula to help determine the square footage necessary for an EASC (Table 2).

Equipment

Deciding on the type of equipment and the number of endoscopes can be the most difficult part of the planning process. In general, five scopes (three lower and two upper) per room is a good rule. However, if you have an excess of scopes, you are wasting money on leasing or buying expensive equipment. On the other hand, if there are not enough scopes, you may be waiting around to do procedures, resulting in reduced physician efficiency.

One must also consider what type of equipment is necessary for keeping the EASC running efficiently: what type of software will you use? Do you want to use electronic medical records (EMR) to keep records? The different vendors (such as Olympus, Pentax, and Fuji) each have their unique advantages and disadvantages. One must consider scopes, software, long-term service, and cost before making a decision.

According to Gastrointestinal Associates, P.C., one can estimate equipment costs at $500,000 for the first procedure room and $150,000 for each additional procedure room.[6] The types of equipment required for an EASC are listed in Table 3.

If capital is available and the equipment will be efficiently used, purchase of the equipment is the best financial option. If startup capital is limited, most of the major equipment companies have lease options available. With leasing, the unit is charged a fixed amount for each procedure performed. The amount of the charge is contractual, based on the cost of the equipment and its utilization (number of procedures performed per month or year). A typical lease agreement may charge $35 to $50 per colonoscopy.

Anesthesia and Sedation

Sedation for procedures can vary from moderate sedation (pain and sedative medication such as fentanyl, meperidine, and/or midazolam) administered by RNs to deep sedation (propofol) which is administered by certified RN anesthetists or anesthesiologists. Unless

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Table 2 Endoscopic Ambulatory Surgery Center Space Requirements

A. ENTRY/WAITING MODULE			TOTAL SF
1 Vestibule/Wheelchair	80 SF		80
2 Waiting room	9 seats/procedure room @ 15 SF each	4 × 9 × 15	540
3 Nourishment/TV	35 SF		35
4 Toilet(s)	1/30 seats (round up) @ 50 SF each	2 × 50	100
5 Consultation room	80 SF (optional w/private prep/recovery room(s))		0
Subtotal			755
B. RECEPTION/BUSINESS MODULE			TOTAL SF
1 Reception	0.5/procedure room (round up) @ 50 SF each	2 × 50	100
2 Private interviews	0.5/procedure room (round up) @ 50 SF each	2 × 50	100
3 Billing/Collections	0.5/procedure room (round up) @ 35 SF each	2 × 35	70
4 Medical Records room	35 SF/first procedure room (round up) + 15 SF every additional procedure room	35 + 45	80
5 Administrator's office	100 SF (optional—usually with 4 or more procedure rooms)		100
6 Nurse Director	100 SF		100
7 Work/Storage	50 SF		50
8 Computer/Telephone	35 SF		35
9 Break room	80 SF/first procedure room + 40 SF/every additional procedure room	80 + 120	200
10 Vestibule	50 SF		50
Subtotal			885
C. PREP/RECOVERY MODULE			TOTAL SF
1 Control/Drug distribution station	100 SF/first procedure room + 50 SF every additional procedure room	100 + 150	250
2 Private prep/Recovery	3/procedure room @ 85 SF each	4 × 3 × 85	1020
3 Step-down recovery	1/procedure room @ 50 SF each	4 × 50	200
4 Patient toilet/dressing	1/procedure room @ 50 SF each	4 × 50	200
5 Soiled/Housekeeping workroom	35 SF		35
6 Exit vestibule	65 SF		65
Subtotal			1770
D. PROCEDURE/PROCESSING MODULE			TOTAL SF
1 Procedure room(s)	1/2880 procedures @ 250 SF each	4 × 250	1000
2 Cleaning room(s)	0.5/procedure room (round up) @ 120 SF each	2 × 120	240
3 Disinfecting room	0.5/procedure room (round up) @ 120 SF each	2 × 120	240
4 Dictations/Medical Records	0.5/procedure room (round up) @ 50 SF each	2 × 50	100
5 Housekeeping workroom	35 SF		35
6 Anesthesia workroom	35 SF/first procedure room + 15 SF/any additional procedure room(s)	35 + 15	50
7 Waste disposal room	35 SF/first procedure room + 15 SF/any additional procedure room(s)	35 + 15	50
8 Equipment storage	50 SF (optional—usually only for fluoroscopy or multispecialty)		50
Subtotal			1765
E. RECEIVING/STORAGE MODULE			TOTAL SF
1 Receiving	35 SF/first procedure room + 15 SF/any additional procedure room(s)	35 + 15	50
2 General storage	100 SF/first procedure room + 50 SF/any additional procedure room (s)	100 + 150	250
Total			300
F. STAFF CHANGING MODULE			TOTAL SF
1 Female locker room	65 SF/first procedure room + 25 SF/every additional procedure room	65 + 75	140
2 Female toilet/shower	55 SF		55
3 Male locker room	50 SF/first procedure room + 25 SF/every additional procedure room	50 + 75	125

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Table 2 *(continued)*

4 Male toilet/shower	55 SF		55
Subtotal			375
G. BUILDING SERVICES MODULE			TOTAL SF
1 Mechanical room	50 SF/first procedure room + 25 SF/every additional procedure room	50 + 75	125
2 Electrical room	50 SF/first procedure room + 25 SF/every additional procedure room	50 + 75	125
3 Medical gas room	35 SF/first procedure room + 15 SF/every additional procedure room	35 + 45	80
Subtotal			330
H. TOTAL BUILDING SIZE			TOTAL SF
1 Total net area	A + B + C + D + E + F + G		6180
2 Circulation	40% of the total net area	6,180 × 40%	2472
3 Total gross area	Total net area + circulation	6,180 + 2,472	8652

SF, square footage.

specific reimbursement is available to support the additional charge for anesthesia personnel, nurse-administered sedation is the most cost-effective and safe option. Physical control of the anesthesia medications must also be considered.

Staffing Cost

Once the physical plant and equipment are in place, the largest recurrent expense for the EASC will be staffing costs.[6] Again, a good balance must be achieved in which staff members are utilized to their maximum efficiency without being over- or underworked. Too few staff members or staff that is improperly matched to a job (e.g., an RN assigned to a tech job) can result in higher turnover and ultimately higher staffing costs. It is essential to establish a hardworking and motivated staff that is determined to make the EASC a success. Profit-sharing plans and/or financial bonus structures can give staff a sense of ownership and spark efficiency and the necessary work drive. The quality of service depends critically on the staff and affects not only the participating doctor, but also the patient and referring physicians. This will also be reflected by customer loyalty.

There are certain fundamentals to consider before making staffing decisions. One must consider the number of procedures, the number of rooms, the number of staff members who will be part- or full-time, and the qualifications of the staff (i.e., nurse versus tech for a particular position). Generally, one can use the formula below to decide on the appropriate number of staff members.

$$\text{Time per procedure} \times \text{number of procedures per day} = \frac{\text{hours required}}{8} = \text{FTE}$$

FTE = full-time employee (40 hours/week)

Gastrointestinal Associates, P.C., has provided estimates on numbers for staffing as well as salaries (Tables 4 and 5).

Maximizing efficiency without affecting the morale of staff members is one way to control staff cost. Efficiency is based on the time from admission to discharge. Patient flow management can help increase efficiency and decrease costs. Time studies can help identify where problems lie. Studies of issues listed in column A of Table 6 can help identify delay reasons listed in column B and can ultimately help increase efficiency.

Table 3 Equipment Necessary for an Endoscopic Ambulatory Surgery Center

1. Scope washer	6. Crash cart
2. Autoclave	7. Office equipment
3. Preparation and recovery beds	8. Office furnishings
4. Endoscopes	9. Telephones/Computers
5. Monitors	

CONCLUSION

EASCs are not only a profitable addition to a gastrointestinal or colorectal practice, but they are also a means of controlling efficiency and quality of the care provided. It is difficult to predict the future and how favorable or unfavorable the climate will be for EASCs. There are

Table 4 Staffing Needs for an Endoscopic Ambulatory Surgery Center

	1 Room	2 Rooms	3 Rooms	4 Rooms
Director	1	1	1	1
RN	2	3	4	5
LPN	2	3	4	5
Other	1	2	3	4
Total	6	9	12	15

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Table 5 2003 Salary Levels

Position	Hourly Salary	# of Positions	Total
Director	$31	1	$31
RN	$22	5	$110
LPN	$17	5	$85
Other	$13	4	$52
		15	$278
	Average salary per hour		$18.53

Table 6 Efficiency Issues

Column A	Column B
• Arrival to facility	• Late arrival of patient
• Chart to ambulatory surgery center	• Late arrival of physician
• Patient to ambulatory surgery center	• No staff available
• Admission complete	• Difficult IV placement
• Procedure begins	• No bed space
• Procedure complete	• Previous procedure still going
• Admit to recovery	• Equipment not available
• Ready for discharge	• Physician delay
• Discharge	• Medical reasons
	• Transportation not available

many factors that could hurt EASC development including lack of EASC set referral, expanded certificate of need review, and more rigorous licensure requirements.

If you can't have an EASC, office endoscopy is a good alternative. This type of service mainly exists in states with certificate of need requirements. The advantages are lower cost setup compared with an EASC, seemingly fewer hassles, and optional accreditation in many states. The disadvantage is lower profit margins. Medicare reimbursement does have a site of service differential (Table 7).[7]

EASCs provide control over the quality of care one provides, control over the efficiency with which one provides that care, and an alternate source of revenue.

Table 7 Medicare Reimbursement Model for Gastrointestinal Endoscopy

Procedure	Location	Professional Fee	Facility Fee	Total
EGD	Hospital	$135–159		$135–159
	Office	$286–324	None	$286–324
	EASC	$135–159	$340–455	$475–614
Colonoscopy	Hospital	$208–241		$208–241
	Office	$374–442	None	$374–442
	EASC	$208–241	$455	$663–696

EGD, esophagogastroduodenoscopy; EASC, endoscopic ambulatory surgery center.

The average EASC is small, independently owned, successful, and growing.

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ATTACHMENT 13
Alternatives

Status Quo **(No additional CON costs / Healthcare Delivery Costs)**

Maintaining the status quo was considered but ultimately not selected. Under the current structure, too many procedures that could be safely and more cost-effectively performed in an ambulatory surgical treatment center (ASTC) setting are instead being performed in a hospital-based outpatient department (HOPD). The status quo limits physician access to a facility specifically designed, staffed, and equipped for these types of procedures. Additionally, the hospital's existing HOPD remains underutilized, despite its potential to be better leveraged as an ASTC. This inefficiency perpetuates higher healthcare delivery costs for payers and patients alike. Because the current state is a central driver of the issues this project seeks to resolve, it was not selected as a viable alternative.

Alternate Partners **(Increased CON cost due to land/space acquisition)**

The option of pursuing alternative partners—either hospital or non-hospital—was also considered. However, introducing third-party entities without established relationships or shared priorities would likely shift the focus from patient-centered care to financial performance. In contrast, this proposal reflects a strategic investment by Prime Healthcare to improve Saint Joseph Medical Center, and demonstrate its commitment to enhancing access, quality, and affordability of care. Many systems resist relocating services from the hospital setting to lower-cost ambulatory environments; the willingness of Prime to support such a transition demonstrates alignment with national trends and payer preferences favoring outpatient surgical care. For these reasons, and because other potential partnerships lacked this strategic alignment, this alternative was not selected.

Stand Alone Facility **(Increased CON cost due to construction & land acquisition)**

The Applicants also evaluated the feasibility of constructing a new standalone ASTC. However, this option would significantly increase capital expenditures due to the need for land acquisition and new construction. Moreover, it would forgo the opportunity to repurpose existing, underutilized hospital-based space—thereby contradicting the goals of resource stewardship and infrastructure optimization. By maximizing use of the hospital's existing footprint, the proposed project represents a more cost-effective and sustainable model. Accordingly, the standalone facility alternative was not selected.

Project as Proposed

The proposed project reflects a balanced, patient-focused approach that aligns with HFSRB criteria for need, cost, and impact. It supports the collaborative development of an ASTC on the campus of Saint Joseph Medical Center, enabling better utilization of existing hospital resources while improving access to outpatient surgical care. The project is designed to be appropriately sized for the community's needs, avoids unnecessary duplication, and is consistent with broader healthcare trends promoting quality, safety, and cost-effectiveness in ambulatory care settings. By selecting this path, the Applicants demonstrate their commitment to aligning clinical excellence with financial responsibility, always with the patient's best interest at the center.

ATTACHMENT 14
Size of the Project

The square footage identified in this application for the proposed projects, includes three operating rooms and 2 procedure rooms which are consistent with the standards identified in Appendix B of 77 Illinois Admin. Code Section 1110, as documented below, reflects renovation and reuse of an existing clinical space in a manner that supports efficient workflow, meets applicable life safety and infection control requirements, and appropriately supports the volume and scope of services to be provided.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	**PROPOSED BGSF/DGSF**	**STATE STANDARD**	**DIFFERENCE**	**MET STANDARD?**
ASTC (3 Operating Rooms 2 Procedure Rooms)	8,370 GSF	13,750 GSF	5,020 GSF	YES

ATTACHMENT 15
Project Services Utilization

The expected annual utilization for an ambulatory surgical treatment center (ASTC) is 1,500 hours per surgical or procedure room. This proposal includes three operating rooms and two procedure rooms, setting the utilization benchmark at over 6,000 hours. Based on historical utilization patterns and projected patient volume, the facility is anticipated to meet or exceed the state's utilization standard within its first year of operation.

UTILIZATION					
	DEPT/ SERVICE	**HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.**	**PROJECTED UTILIZATION**	**STATE STANDARD**	**MEET STANDARD?**
YEAR 1	ASTC	17,588 Hours	7,543 Hours	6,000 Hours	YES
YEAR 2	ASTC	17,588 Hours	7,770 Hours	6,000 Hours	YES

Specialty Type	**Number of Historical Procedures**	**Number of Hours**	**Proposed Number of Procedures**	**Proposed Hours to ASC**
Gastroenterology	4,174	2087	3131	1565
Colon Rectal Surgery	252	377	101	151
General Surgery	1409	2113	563	845
Neurological	10	13	4	5
Obstetrics/Gynecology	36	40	14	16
Ophthalmology	1413	1178	565	471
Orthopedic	723	964	506	675
Otolaryngology	1957	2153	783	652
Pain Management	1180	983	472	236
Cardiovascular	1832	3664	366	733
Podiatric	371	519	148	208
Thoracic	280	280	112	56
Urology	2681	3217	1609	1930
Total	**16317**	**17588**	**8374**	**7543**

The projected 8,374 procedures are based on anticipated cases from multiple physicians affiliated with Saint Joseph Medical Center who currently perform procedures both at the hospital and at other licensed facilities. The historical total of 16,317 procedures reflects all cases performed by these referring physicians across various locations. The referral letters submitted by the undersigned physicians indicate their intent to direct cases to this proposed facility.

Below are the average procedure times by service category, which were used to calculate the estimated surgical hours for the new facility. These times — which include room preparation, procedure duration, and post-procedure clean-up — are sourced directly from the 2023 Annual Hospital Questionnaire submitted to the Illinois Health Facilities and Services Review Board (HFSRB).

ATTACHMENT 15
Project Services Utilization

Specialty Type	Average Procedure Time in Hours (including Prep Time, Procedure Time, and Clean-up)
Gastroenterology	0.50
Colon Rectal Surgery	1.50
General Surgery	1.50
Neurological	1.40
Obstetrics/Gynecology	1.10
Ophthalmology	0.90
Orthopedic	1.40
Otolaryngology	1.10
Pain Management	0.90
Cardiovascular	2.00
Podiatric	1.40
Thoracic	1.00
Urology	1.20

Based on the facility operating 250 days a year, for a 7.5 hours per day, the entire facility will be operating at the state's target utilization rates by year one of operation.

ATTACHMENT 15
Project Services Utilization

Utilization Calculation	
Operational Days	250
Average Hours of Operation	7.5
Available Surgical Time per Room (in hours)	1875
Procedure Hours per Operating Room – Year 1	7543
Number of Operating/Procedure Rooms	5
Total Available Procedure Hours	9375
State Target Utilization 80% (in hours)	1500
First Year Proposed Procedure Hours	7,543
First Year Utilization Operating Room 1	80%
Second Year Proposed Procedure Hours	7,770
Second Year Utilization Operating Room 1	83%

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 by Prime Healthcare ASC – Joliet, LLC ("Prime ASC") is necessary to meet the current and growing healthcare needs of residents within the planning area. The project involves the establishment of a multi-specialty ambulatory surgical treatment center ("ASTC") in an hospital outpatient surgical space located adjacent to Saint Joseph Medical Center, a key provider of inpatient and outpatient services in the region. This location ensures continuity of care for many patients already receiving services at the hospital and strengthens access to surgical care within the community.

The ASTC will contain three operating rooms and two procedure rooms, which will provide sufficient capacity to meet demand from both the existing patient population of Saint Joseph Medical Center and additional patients of the physician investors and affiliated practices. Notably, the project will enable the hospital to increase access to it's patients for convenient, safe, and lower cost outpatient procedures. This improved convenience for patients allows for greater continuity of care and the reduction of care fragmentation.

This facility will provide the hospital with an opportunity to attract additional physicians to perform procedures at the facility and although area hospitals may maintain some degree of surgical capacity, the recent national healthcare trends have increasingly emphasized the transition of appropriate surgical procedures from hospital outpatient departments (HOPDs) to ambulatory surgical centers (ASTCs), a shift strongly supported by evolving policies and reimbursement models from the Centers for Medicare & Medicaid Services (CMS). Recognizing the safety, efficiency, and cost-effectiveness of ASTCs, CMS has expanded coverage and adjusted reimbursement structures to encourage this migration. These changes reflect a broader federal strategy aimed at reducing overall healthcare expenditures while maintaining or improving patient care outcomes. By promoting ASCs for suitable cases, CMS seeks to leverage the streamlined operations and lower overhead costs of these facilities, ultimately passing savings along to both patients and the healthcare system at large.

Among the procedures most impacted by this shift are those in ophthalmology, orthopedics, podiatry, pain management, and other lower-extremity specialties. Advances in minimally invasive techniques, anesthesia, and postoperative care have made it increasingly feasible—and clinically appropriate—to perform a wide range of surgeries in outpatient settings. Cataract extractions, joint arthroscopies, podiatric corrective surgeries, pain management interventions, and various other procedures now routinely occur in ASCs. These specialties are particularly well-suited to the ambulatory setting because their procedures typically involve predictable operative times, low complication risks, and shorter recovery periods. Patients also benefit from more convenient scheduling, reduced costs, and lower exposure to hospital-associated infections.

This national trend is not only reshaping surgical practice patterns but is also driving significant growth in the ASC market. Health systems, private investors, and physician groups are responding by developing or expanding ASC facilities to capture this patient population and align with reimbursement incentives. In doing so, they are positioning themselves to meet both regulatory expectations and patient demand for accessible, high-quality care delivered outside the traditional hospital setting. The shift underscores the healthcare industry's broader move toward value-based care models that prioritize efficiency, affordability, and patient satisfaction. This is an approach that aligns with this project's goals and the mission of the Illinois Health Facilities and Services Review Board to promote cost-effective, accessible, and high-quality care.

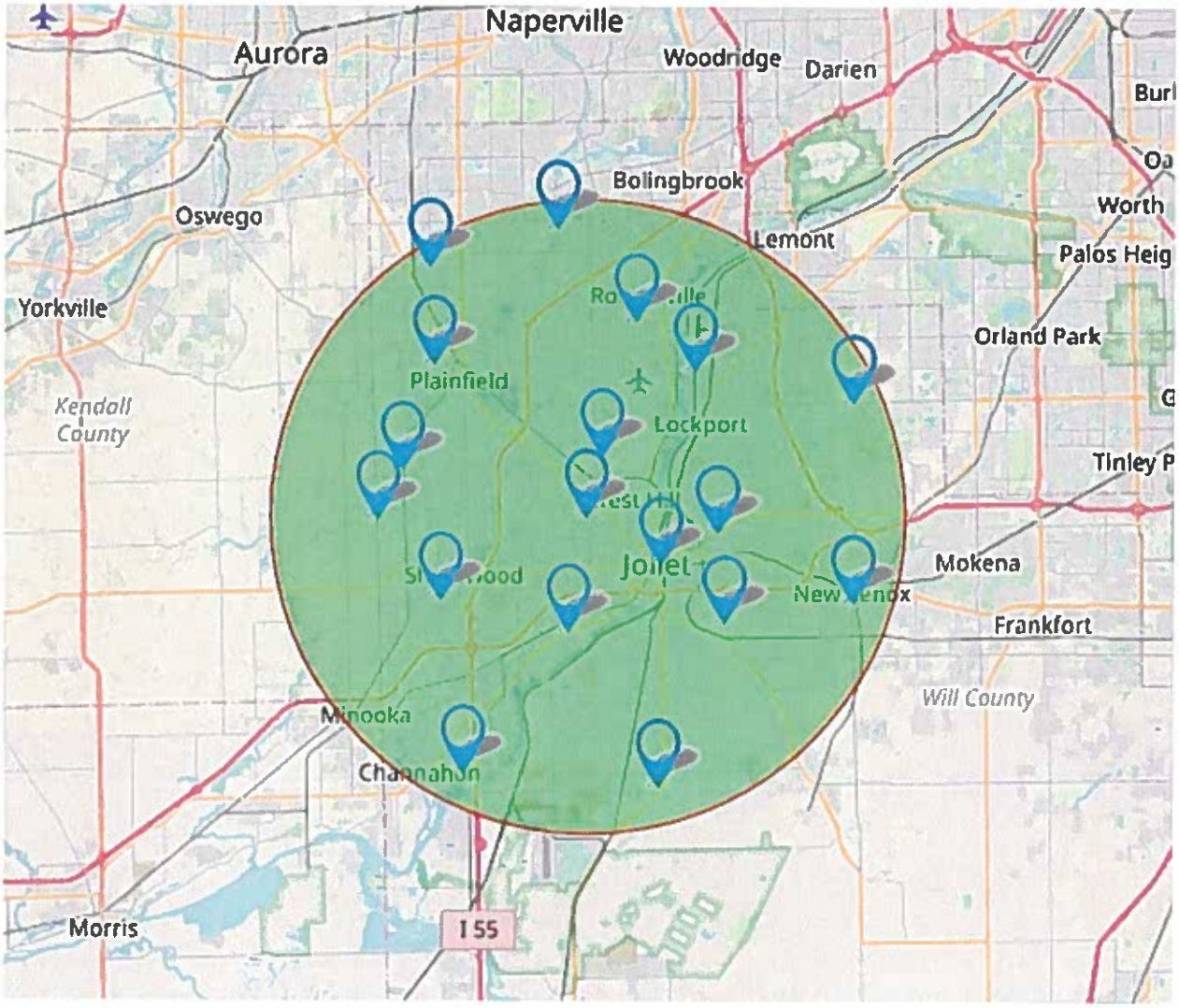
ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Service to GSA Residents - 1110.235(c)(2)(B)

Prime ASC will operate under an open staffing policy, enabling access to qualified area surgeons and expanding options for patients in need of outpatient surgical services. The ASTC's co-location with Saint Joseph Medical Center not only enables resource sharing but also supports the long-term viability of the hospital by offloading appropriate elective cases to a more cost-efficient environment.

The primary purpose of this project is to provide necessary health care to the 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 radiuses 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 301 Madison St. Suite 100 Joliet, IL 60435



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

Below is a list of zip codes with the population for each city within 10 miles of the proposed facility.

Zip Code	City	Population
60431	Joliet	26,789
60432	Joliet	20,098
60433	Joliet	15,293
60435	Joliet	48,521
60436	Joliet	19,446
60403	Crest Hill	17,226
60404	Shorewood	20,052
60441	Lockport	36,841
60586	Plainfield	48,006
60446	Romeoville	41,933
60544	Plainfield	27,937
60451	New Lenox	37,481
60421	Elwood	3,786
60410	Channahon	14,027
60491	Homer Glen	22,585
60490	Bolingbrook	21,739
60585	Plainfield	24,948
	Total	**446,708**

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

We are submitting a letter from the Saint Joseph Medical Center Chief Medical Officer with anticipated referrals from several physicians affiliated with the facility that include 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. The provided zip code information documents that the projects patient volume is from within the geographic service area defined in subsection (c)(2)(B).

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

The expected annual utilization for an ambulatory surgical treatment center (ASTC) is 1,500 hours per surgical or procedure room. This proposal includes three operating rooms and two procedure rooms, setting the utilization benchmark at over 6,000 hours. Based on historical utilization patterns and projected patient volume, the facility is anticipated to meet or exceed the state's utilization standard within its first year of operation.

UTILIZATION					
	DEPT/ SERVICE	**HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.**	**PROJECTED UTILIZATION**	**STATE STANDARD**	**MEET STANDARD?**
YEAR 1	ASTC	17,588 Hours	7,543 Hours	6,000 Hours	YES
YEAR 2	ASTC	17,588 Hours	7,770 Hours	6,000 Hours	YES

Specialty Type	**Number of Historical Procedures**	**Number of Hours**	**Proposed Number of Procedures**	**Proposed Hours to ASC**
Gastroenterology	4,174	2087	3131	1565
Colon Rectal Surgery	252	377	101	151
General Surgery	1409	2113	563	845
Neurological	10	13	4	5
Obstetrics/Gynecology	36	40	14	16
Ophthalmology	1413	1178	565	471
Orthopedic	723	964	506	675
Otolaryngology	1957	2153	783	652
Pain Management	1180	983	472	236
Cardiovascular	1832	3664	366	733
Podiatric	371	519	148	208
Thoracic	280	280	112	56
Urology	2681	3217	1609	1930
Total	**16317**	**17588**	**8374**	**7543**

The projected 8,374 procedures are based on anticipated cases from multiple physicians affiliated with Saint Joseph Medical Center who currently perform procedures both at the hospital and at other licensed facilities. The historical total of 16,317 procedures reflects all cases performed by these referring physicians across various locations. The referral letters submitted by the undersigned physicians indicate their intent to direct cases to this proposed facility.

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

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Colon Rectal Surgery	1.50
General Surgery	1.50
Neurological	1.40
Obstetrics/Gynecology	1.10
Ophthalmology	0.90
Orthopedic	1.40
Otolaryngology	1.10
Pain Management	0.90
Cardiovascular	2.00
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Thoracic	1.00
Urology	1.20

Based on the facility operating 250 days a year, for a 7.5 hours per day, the entire facility will be operating at the state's target utilization rates by year one of operation.

Utilization Calculation	
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Second Year Proposed Procedure Hours	7,770
Second Year Utilization Operating Room 1	83%

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

The establishment of Prime ASC in Joliet, Illinois, is essential to improving access to ambulatory surgical services for residents of the Geographic Service Area (GSA). The project satisfies multiple regulatory criteria confirming the necessity for the proposed services.

First, the existing outpatient surgical capacity in the GSA is either limited or operating at state utilization benchmarks. Prime ASC's market analysis confirms that several hospital outpatient departments (HOPDs) and licensed Ambulatory Surgical Treatment Centers (ASTCs) within a 10-mile radius are experiencing high demand, with many operating at or near capacity as defined by 77 Ill. Adm. Code 1100. This sustained utilization leaves limited availability for patients needing timely outpatient surgical procedures, particularly in high-demand specialties such as ophthalmology, podiatry, orthopedics, pain management, and gastroenterology. The establishment of Prime ASC directly addresses this access gap by expanding outpatient surgical capacity in a location already serving a substantial patient base but lacking adequate ASTC resources.

Second, the Prime ASC will serve a broad cross section of patients and will not have restrictive admission policies. Existing ASTCs in the GSA have little or no Medicaid patient volume. While certain procedures may be performed in hospital outpatient settings, the flexibility and efficiency offered by ASTCs—especially for lower-acuity, high-volume surgeries—are currently limited within the GSA. Existing facilities prioritize higher-acuity cases, leaving patients seeking lower-complexity procedures, like cataract surgery, GI endoscopy, or podiatric interventions, with longer wait times and limited scheduling options. By focusing on these outpatient procedures, Prime ASC will fill a critical service gap and offer more accessible, cost-effective care options for the community.

Finally, Prime ASC is a cooperative venture with Saint Joseph Medical Center (SJMC), a longstanding healthcare provider in the Joliet community. The facility is designed to support and increase access specifically for SJMC patients. As part of this cooperative venture, SJMC has agreed not to increase its outpatient surgical capacity until Prime ASC's rooms have been operational and met the state's utilization benchmarks for at least 12 consecutive months. This partnership ensures coordinated capacity management and maximizes efficient resource utilization within the community. Furthermore, procedures performed at Prime ASC will be offered at lower charges compared to the hospital outpatient setting, improving both affordability and accessibility for patients.

Through this proposal, Prime ASC demonstrates a comprehensive commitment to meeting community need, enhancing access, and collaborating with existing healthcare providers to ensure responsible, patient-centered service expansion within the Joliet region.

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

Healthcare Facilities within a 10 Mile Radius of Proposed Facility

Facility Name	Facility Address	Specialties	Distance from Prime ASC	% of Medicaid Recipients Served
Silver Cross Ambulatory Surgery Center	1003 Pawlak Parkway New Lenox, IL 60451	-General Surgery -OB/Gynecology -Ophthalmology -Orthopedic -Otolaryngology -Pain Management -Plastic Surgery -Podiatry -Urology	9.6 miles	0.1%
AmSurg Surgery Center	998 129th Infantry Dr. Joliet, IL 60435	-Gastroenterology -General Surgery -Neurological -OB/Gynecology -Ophthalmology -Oral/Maxillofacial -Orthopedic -Otolaryngology -Pain Management -Plastic Surgery -Podiatry -Gastro-Intestinal -Laser Eye	1.9 miles	0.0%

The establishment of Prime ASC in Joliet, Illinois, will not result in an unnecessary duplication of services within the General Service Area (GSA). The total population within the identified GSA zip codes—including Joliet, Crest Hill, Plainfield, Shorewood, Lockport, Romeoville, Channahon, and surrounding communities—is approximately 446,708, based on the most recent U.S. Census estimates. This substantial population base supports the need for expanded access to outpatient surgical services.

Currently, two existing ambulatory surgical treatment centers (ASTCs) are operating within the GSA:

Silver Cross Ambulatory Surgery Center which serves as direct support for the patients of Silver Cross Hospital and AmSurg Surgery Center.

While these facilities offer a variety of services, their combined capacity is insufficient to meet the procedural demand generated by the region's large and growing population. Furthermore, neither facility meaningfully serves Medicaid patients, with one reporting 0.0% Medicaid utilization and the other 0.1%. Prime ASC intends to fill this accessibility gap by welcoming a broader patient demographic, including those covered by Medicaid.

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

Healthcare Facilities within a 10 Mile Radius of Proposed Facility

Regarding maldistribution, the ratio of surgical/treatment rooms to population within the GSA does not exceed the state threshold of one and one-half times the state average. On the contrary, existing facilities are highly utilized and, in some cases, operating at or near capacity, particularly in high-demand specialties such as ophthalmology, gastroenterology, podiatry, and pain management.

Additionally, Prime ASC has conducted a thorough market analysis and utilization forecast. Based on historical case volumes and referral patterns from Saint Joseph Medical Center and affiliated physicians, Prime ASC anticipates achieving the state's utilization benchmarks within its first full year of operation. The facility's addition will enhance access without detrimentally impacting the volume or viability of existing providers. To further safeguard against market disruption, Prime ASC will monitor regional utilization trends and collaborate with community providers to ensure responsible growth.

In conclusion, Prime ASC addresses an existing and growing demand for ambulatory surgical services in the Joliet area without contributing to unnecessary duplication or maldistribution. It will improve accessibility, particularly for underserved patient populations, and complement the existing healthcare infrastructure while adhering to state planning standards.

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

The facility will appoint a surgeon affiliated with Saint Joseph Medical Center as Medical Director for the facility. The applicant has not traditionally had any difficulties in staffing their existing offices nor do they anticipate difficulty in staffing the proposed ASTC. As needed additional staff will be identified and employed utilizing existing job search sites and professional placement services.

Saint Joseph Medical Center

July 1, 2025

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

Re: Charge Commitment – Prime Healthcare ASC – Joliet, LLC

Dear Mr. Kniery,

As a representative of Prime Healthcare ASC – Joliet, LLC ("Prime ASC"), I, Colleen Pawlik, MSN, BSN, 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 organization for the ASTC services, and if outcomes do not meet or exceed those standards, that a quality improvement plan will be initiated.

Furthermore, I attest that in order to meet the objectives of the 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 systems 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 Title 77 Ill. Admin. Code Section 1130.310(a).

Sincerely,

Colleen Pawlik, MSN

Colleen Pawlik, MSN, BSN
Interim Chief Executive Officer
Saint Joseph Medical Center – Joliet

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 (excluding changes in the Medicare Fee Schedule) for a minimum of 24 months.

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

HCPCS Code	Short Descriptor	Cost Per Procedure
0101T	Esw muscskel sys nos	$135.38
0102T	Esw phy anes lat hmrl epcndl	$1,658.12
0200T	Perq sacral augmt unilat inj	$4,819.31
0201T	Perq sacral augmt bilat inj	$3,686.38
0213T	Njx paravert w/us cer/thor	$501.84
0216T	Njx paravert w/us lumb/sac	$501.84
0238T	Trluml perip athrc iliac art	$12,108.85
0253T	Insert aqueous drain device	$3,099.52
0263T	Im b1 mrw cel ther cmpl	$2,641.05
0264T	Im b1 mrw cel ther xcl hrvst	$2,641.05
0265T	Im b1 mrw cel ther hrvst onl	$2,641.05
0266T	Implt/rpl crtd sns dev total	$44,317.92
0268T	Implt/rpl crtd sns dev gen	$27,842.73
0269T	Rev/remvl crtd sns dev total	$3,244.10
0270T	Rev/remvl crtd sns dev lead	$2,041.55
0271T	Rev/remvl crtd sns dev gen	$2,041.55
0274T	Perq lamot/lam crv/thrc	$3,686.38
0275T	Perq lamot/lam lumbar	$5,547.02
0308T	Insj ocular telescope prosth	$11,938.56
0335T	Insj sinus tarsi implant	$5,822.15
0338T	Trnscth renal symp denrv unl	$2,761.10
0339T	Trnscth renal symp denrv bil	$3,927.46
0342T	Thxp apheresis w/hdl delip	$2,641.05
0402T	Colgn crs-link crn&pachymtry	$1,077.30
0408T	Insj/rplc cardiac modulj sys	$27,285.04
0409T	Insj/rplc car modulj pls gn	$22,132.46
0410T	Insj/rplc car modulj atr elt	$7,347.24
0411T	Insj/rplc car modulj vnt elt	$4,584.90
0412T	Rmvl cardiac modulj pls gen	$2,051.52
0413T	Rmvl car modulj tranvns elt	$2,051.52
0414T	Rmvl & rpl car modulj pls gn	$19,754.53
0415T	Repos car modulj tranvns elt	$348.93
0416T	Reloc skin pocket pls gen	$1,030.14
0419T	Dstrj neurofibroma xtnsv	$344.70
0420T	Dstrj neurofibroma xtnsv	$344.70
0421T	Waterjet prostate abltj cmpl	$7,094.10
0440T	Abltj perc uxtr/perph nrv	$1,578.76
0441T	Abltj perc lxtr/perph nrv	$1,513.65
0442T	Abltj perc plex/trncl nrv	$4,857.99
0446T	Insj impltbl glucose sensor	$1,832.21
0447T	Rmvl impltbl glucose sensor	$52.30
0448T	Remvl insj impltbl gluc sens	$1,832.21

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

0449T	Insj aqueous drain dev 1st	$4,092.93
0479T	Fxjl abl lsr 1st 100 sq cm	$344.70
0510T	Rmvl sinus tarsi implant	$1,658.12
0511T	Rmvl&rinsj sinus tarsi implt	$5,245.19
0512T	Esw integ wnd hlg 1st wnd	$112.11
0524T	Ev cath dir chem abltj w/img	$2,231.45
0525T	Insj/rplcmt compl iims	$15,010.79
0526T	Insj/rplcmt iims eltrd only	$7,347.24
0527T	Insj/rplcmt iims implt mntr	$6,991.22
0530T	Removal complete iims	$2,051.52
0531T	Removal iims electrode only	$2,051.52
0532T	Removal iims implt mntr only	$2,051.52
0581T	Abltj mal brst tum perq crtx	$2,320.98
0583T	Tmpst auto tube dlvr sys	$874.87
0587T	Perq impltj/rplcmt isdns ptn	$6,253.46
0588T	Revision/removal isdns ptn	$2,041.55
0594T	Osteot hum xtrnl lngth dev	$4,672.36
0596T	Temp fml iu vlv-pmp 1st insj	$331.73
0597T	Temp fml iu valve-pmp rplcmt	$331.73
0600T	Ire abltj 1+tum organ perq	$7,478.72
0601T	Ire abltj 1+tumors open	$7,669.00
0614T	Rmvl&rplcmt ss impl dfb pg	$19,816.77
0619T	Cysto w/prst8 commissurotomy	$6,749.42
0620T	Evasc ven artlz tibl/prnl vn	$33,300.20
0621T	Trabeculostomy interno laser	$2,787.21
0627T	Perq njx algc fluor lmbr 1st	$11,851.08
0629T	Perq njx algc ct lmbr 1st	$12,405.73
0632T	Perq tcat us abltj nrv p-art	$12,919.45
0644T	Tcat rmvl/dblk icar mas perq	$4,134.96
0647T	Insj gtube perq mag gastrpxy	$907.36
0651T	Mag ctrld capsule endoscopy	$733.36
0652T	Egd flx transnasal dx br/wa	$907.36
0653T	Egd flx transnasal bx 1/mlt	$907.36
0654T	Egd flx transnasal tube/cath	$1,969.60
0655T	Tprnl focal abltj mal prst8	$2,647.68
0660T	Implt ant sgm io nbio rx sys	$2,199.05
0661T	Rmvl&rimpltj ant sgm implt	$2,199.05
0671T	Insj ant sgm aq drg dev 1+	$4,312.23
0673T	Abltj b9 thyr ndul perq lasr	$743.69
0674T	Laps insj nw/rpcmt prm isdss	$27,528.15
0675T	Laps insj nw/rpcmt isdss 1ld	$8,905.46
0677T	Laps repos lead isdss 1st ld	$6,515.79
0679T	Laps rmvl lead isdss	$5,140.80

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

0680T	Insj/rplcmt pg only isdss	$20,831.34
0681T	Rlcj pulse gen only isdss	$2,041.55
0682T	Removal pulse gen only isdss	$2,041.55
0686T	Histotripsy mal hepatcel tis	$9,864.50
0699T	Njx pst chmbr eye medication	$1,275.03
0707T	Njx b1 sub mtrl sbchdrl dfct	$2,400.76
0714T	Tpla b9 prst8 hyprplsa<50ml	$2,647.68
0717T	Adrc ther prtl rc tear	$2,055.20
0718T	Adrc ther prtl rc tear njx	$2,055.20
0737T	Xenograft impltj artclr surf	$9,806.12
0784T	Ins/rplmt eltrd ra spi nstim	$8,905.46
0785T	Revj/rmvl nea spi w/nstim	$2,041.55
0787T	Revj/rmvl nea sac w/nstim	$2,041.55
0793T	Prq tcat thrm ablt nrv p-art	$12,919.45
0797T	Tcat ins 2chmbr ldls pm rv	$14,081.81
0800T	Tcat rmvl 2chmbr ldls pm rv	$2,114.30
0803T	Tcat rmv&rpl2chmb ldls pm rv	$14,081.81
0810T	Subrta njx rx agt w/vtrc	$2,395.88
0813T	Egd vol adjmt bariatric balo	$528.56
0816T	Opn insj/rplcmt ins ptn subq	$20,831.34
0817T	Opn insj/rplcmt ins ptn subf	$20,831.34
0818T	Revj/rmvl ins ptn subq	$2,041.55
0819T	Revj/rmvl ins ptn subf	$2,041.55
0864T	Low ntsty eswt corpus cvrnsm	$137.24
0867T	Tpla b9 prst8 hyprplsa>=50ml	$2,647.68
0869T	Njx b1 sub mtrl hw fixj aug	$2,101.62
0884T	Esphgsc flx 1st tndsc dilat	$3,598.94
0885T	Colsc flx 1st tndsc dilat	$3,598.94
0886T	Sgmdsc flx 1st tndsc dilat	$3,598.94
0888T	Histotripsy mal renal tissue	$9,864.50
0913T	Prq tcat ther rx ntrac balo1	$3,499.61
0915T	Insj perm ccm-d sys pg&eltrd	$26,381.17
0916T	Insj perm ccm-d sys pg only	$19,754.53
0917T	Insj perm ccm-d sys 1 lead	$7,347.24
0918T	Insj perm ccm-d sys dual ld	$7,347.24
0919T	Rmvl perm ccm-d sys pg only	$2,051.52
0920T	Rmvl perm ccm-d sys 1 pac ld	$2,051.52
0921T	Rmvl perm ccm-d sys 1 dfb ld	$2,051.52
0922T	Rmvl perm ccm-d sys dual ld	$2,051.52
0923T	Rmvl&rplcmt perm ccm-d pg	$19,754.53
0924T	Rpos prv ccm-d trnsvns eltrd	$348.93
0925T	Rlcj skin pocket ccm-d pg	$1,030.14
0933T	Tcat impl wrls l atr prs snr	$2,203.49

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10005	Fna bx w/us gdn 1st les	$396.48
10007	Fna bx w/fluor gdn 1st les	$239.44
10009	Fna bx w/ct gdn 1st les	$396.48
10011	Fna bx w/mr gdn 1st les	$396.48
10021	Fna bx w/o img gdn 1st les	$62.50
10030	Img gid flu coll drg sft tis	$396.48
10060	I&d abscess simple/single	$84.57
10061	I&d abscess comp/multiple	$125.33
10080	I&d pilonidal cyst simple	$202.08
10081	I&d pilonidal cyst comp	$243.18
10120	Inc&rmvl fb subq tiss smpl	$108.00
10121	Inc&rmvl fb subq tiss comp	$743.69
10140	I&d hmtma seroma/fluid collj	$112.08
10160	Pnxr aspir absc hmtma bulla	$84.91
10180	I&d complex po wound infctj	$1,262.00
11000	Dbrdmt ecz/infected skin<10%	$38.04
11010	Debride skin at fx site	$396.48
11011	Debride skin musc at fx site	$396.48
11012	Deb skin bone at fx site	$1,262.00
11042	Dbrdmt subq tis 1st 20sqcm/<	$225.11
11043	Dbrdmt musc&/fsca 1st 20/<	$344.70
11044	Dbrdmt bone 1st 20 sq cm/<	$743.69
11057	Parng/cutg b9 hyprkr les >4	$66.91
11102	Tangntl bx skin single les	$76.08
11104	Punch bx skin single lesion	$93.74
11106	Incal bx skn single les	$117.18
11307	Shave skin lesion 1.1-2.0 cm	$93.74
11310	Shave skin lesion 0.5 cm/<	$85.93
11311	Shave skin lesion 0.6-1.0 cm	$96.45
11312	Shave skin lesion 1.1-2.0 cm	$108.00
11313	Shave skin lesion >2.0 cm	$119.89
11400	Exc tr-ext b9+marg 0.5 cm<	$95.43
11401	Exc tr-ext b9+marg 0.6-1 cm	$109.70
11402	Exc tr-ext b9+marg 1.1-2 cm	$119.89
11403	Exc tr-ext b9+marg 2.1-3cm	$130.76
11404	Exc tr-ext b9+marg 3.1-4 cm	$743.69
11406	Exc tr-ext b9+marg >4.0 cm	$743.69
11420	Exc h-f-nk-sp b9+marg 0.5/<	$90.01
11421	Exc h-f-nk-sp b9+marg 0.6-1	$106.98
11422	Exc h-f-nk-sp b9+marg 1.1-2	$118.87
11423	Exc h-f-nk-sp b9+marg 2.1-3	$131.44
11424	Exc h-f-nk-sp b9+marg 3.1-4	$743.69
11426	Exc h-f-nk-sp b9+marg >4 cm	$1,262.00

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11440	Exc face-mm b9+marg 0.5 cm/<	$105.28
11441	Exc face-mm b9+marg 0.6-1 cm	$118.53
11442	Exc face-mm b9+marg 1.1-2 cm	$129.40
11443	Exc face-mm b9+marg 2.1-3 cm	$142.99
11444	Exc face-mm b9+marg 3.1-4 cm	$743.69
11446	Exc face-mm b9+marg >4 cm	$1,262.00
11450	Exc skn hdrdnt ax smpl/ntrm	$1,262.00
11451	Exc skn hdrdnt ax complex	$1,262.00
11462	Exc skn hdrdnt ing smpl/ntrm	$1,262.00
11463	Exc skn hdrdnt ing complex	$1,262.00
11470	Exc skn h/p/p/u smpl/ntrm	$1,262.00
11471	Exc skn h/p/p/u complex	$1,262.00
11600	Exc tr-ext mal+marg 0.5 cm/<	$138.23
11601	Exc tr-ext mal+marg 0.6-1 cm	$153.86
11602	Exc tr-ext mal+marg 1.1-2 cm	$164.04
11603	Exc tr-ext mal+marg 2.1-3 cm	$177.29
11604	Exc tr-ext mal+marg 3.1-4 cm	$396.48
11606	Exc tr-ext mal+marg >4 cm	$743.69
11620	Exc h-f-nk-sp mal+marg 0.5/<	$138.23
11621	Exc s/n/h/f/g mal+mrg 0.6-1	$154.19
11622	Exc s/n/h/f/g mal+mrg 1.1-2	$166.43
11623	Exc s/n/h/f/g mal+mrg 2.1-3	$182.72
11624	Exc s/n/h/f/g mal+mrg 3.1-4	$743.69
11626	Exc s/n/h/f/g mal+mrg >4 cm	$1,262.00
11640	Exc f/e/e/n/l mal+mrg 0.5cm<	$142.99
11641	Exc f/e/e/n/l mal+mrg 0.6-1	$158.27
11642	Exc f/e/e/n/l mal+mrg 1.1-2	$173.22
11643	Exc f/e/e/n/l mal+mrg 2.1-3	$189.86
11644	Exc f/e/e/n/l mal+mrg 3.1-4	$743.69
11646	Exc f/e/e/n/l mal+mrg >4 cm	$1,262.00
11750	Removal of nail bed	$104.95
11755	Biopsy nail unit	$77.77
11760	Repair of nail bed	$126.35
11762	Reconstruction of nail bed	$183.40
11765	Excision of nail fold toe	$0.00
11770	Remove pilonidal cyst simple	$1,262.00
11771	Remove pilonidal cyst exten	$1,262.00
11772	Remove pilonidal cyst compl	$1,262.00
11920	Correct skin color 6.0 cm/<	$139.59
11921	Correct skn color 6.1-20.0cm	$146.73
11950	Tx contour defects 1 cc/<	$50.61
11951	Tx contour defects 1.1-5.0cc	$64.53
11952	Tx contour defects 5.1-10cc	$82.19

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11954	Tx contour defects >10.0 cc	$91.02
11960	Insert tissue expander(s)	$2,055.20
11970	Rplcmt tiss xpndr perm implt	$3,686.38
11971	Rmvl tis xpndr wo insj implt	$1,262.00
11976	Remove contraceptive capsule	$76.76
12005	Rpr s/n/a/gen/trk12.6-20.0cm	$225.11
12006	Rpr s/n/a/gen/trk20.1-30.0cm	$225.11
12007	Rpr s/n/ax/gen/trnk >30.0 cm	$112.11
12015	Rpr f/e/e/n/l/m 7.6-12.5 cm	$112.11
12016	Rpr fe/e/en/l/m 12.6-20.0 cm	$225.11
12017	Rpr fe/e/en/l/m 20.1-30.0 cm	$225.11
12018	Rpr f/e/e/n/l/m >30.0 cm	$112.11
12020	Tx supfc wnd dehsn smpl clsr	$344.70
12021	Tx supfc wnd dehsn w/packing	$225.11
12031	Intmd rpr s/a/t/ext 2.5 cm/<	$189.51
12032	Intmd rpr s/a/t/ext 2.6-7.5	$213.30
12034	Intmd rpr s/tr/ext 7.6-12.5	$225.11
12035	Intmd rpr s/a/t/ext 12.6-20	$225.11
12036	Intmd rpr s/a/t/ext 20.1-30	$344.70
12037	Intmd rpr s/tr/ext >30.0 cm	$1,030.14
12041	Intmd rpr n-hf/genit 2.5cm/<	$186.46
12042	Intmd rpr n-hf/genit2.6-7.5	$208.54
12044	Intmd rpr n-hf/genit7.6-12.5	$344.70
12045	Intmd rpr n-hf/genit12.6-20	$344.70
12046	Intmd rpr n-hf/genit20.1-30	$344.70
12047	Intmd rpr n-hf/genit >30.0cm	$1,030.14
12051	Intmd rpr face/mm 2.5 cm/<	$197.33
12052	Intmd rpr face/mm 2.6-5.0 cm	$210.58
12053	Intmd rpr face/mm 5.1-7.5 cm	$225.11
12054	Intmd rpr face/mm 7.6-12.5cm	$225.11
12055	Intmd rpr face/mm 12.6-20 cm	$225.11
12056	Intmd rpr face/mm 20.1-30.0	$225.11
12057	Intmd rpr face/mm >30.0 cm	$225.11
13100	Cmplx rpr trunk 1.1-2.5 cm	$344.70
13101	Cmplx rpr trunk 2.6-7.5 cm	$344.70
13120	Cmplx rpr s/a/l 1.1-2.5 cm	$344.70
13121	Cmplx rpr s/a/l 2.6-7.5 cm	$344.70
13131	Cmplx rpr f/c/c/m/n/ax/g/h/f	$225.11
13132	Cmplx rpr f/c/c/m/n/ax/g/h/f	$344.70
13151	Cmplx rpr e/n/e/l 1.1-2.5 cm	$344.70
13152	Cmplx rpr e/n/e/l 2.6-7.5 cm	$344.70
13160	Sec clsr surg wnd/dehsn xtn	$1,030.14
14000	Tis trnfr trunk 10 sq cm/<	$1,030.14

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14001	Tis trnfr trunk 10.1-30sqcm	$1,030.14
14020	Tis trnfr s/a/l 10 sq cm/<	$1,030.14
14021	Tis trnfr s/a/l 10.1-30 sqcm	$1,030.14
14040	Tis trnfr f/c/c/m/n/a/g/h/f	$1,030.14
14041	Tis trnfr f/c/c/m/n/a/g/h/f	$1,030.14
14060	Tis trnfr e/n/e/l 10 sq cm/<	$1,030.14
14061	Tis trnfr e/n/e/l10.1-30sqcm	$1,030.14
14301	Tis trnfr any 30.1-60 sq cm	$2,055.20
14350	Filleted finger/toe flap	$1,030.14
15002	Wound prep trk/arm/leg	$1,030.14
15004	Wound prep f/n/hf/g	$344.70
15011	Hrv skn cll ssp agrft 1st 25	$1,030.14
15013	Prepj skn cll ssp agrft 1st	$4,086.89
15015	App skn cl ssp agrft t/a/l 1	$1,030.14
15017	App skn cll ssp f/n/g/hf 1st	$1,030.14
15040	Harvest cultured skin graft	$1,030.14
15050	Pinch graft up to 2 cm diam	$344.70
15100	Splt agrft t/a/l 1st 100sqcm	$1,030.14
15110	Epidrm agrft t/a/l 1st 100	$1,030.14
15115	Epdrm agrft f/s/n/h/f/g/m 1	$1,030.14
15120	Splt agrft f/s/n/h/f/g/m 1st	$2,055.20
15130	Drm agrft t/a/l 1st 100 sqcm	$1,030.14
15135	Drm agrft f/s/n/h/f/g/m 1st	$2,055.20
15150	Tis cltr skn agrft t/a/l 1st	$1,030.14
15155	Tis cltr agrft f/s/n/h/f/g 1	$2,055.20
15200	Fth/gft fr trnk 20 sq cm/<	$1,030.14
15220	Fth/gft fr s/a/l 20 sq cm/<	$1,030.14
15240	Fth/gft f/c/c/m/n/ax/g/h/f20	$1,030.14
15260	Fth/gft fr n/e/e/l 20 sqcm/<	$1,030.14
15271	Skin sub graft trnk/arm/leg	$1,030.14
15273	Skin sub grft t/arm/lg child	$2,055.20
15275	Skin sub graft face/nk/hf/g	$93.40
15277	Skn sub grft f/n/hf/g child	$1,030.14
15570	Skin pedicle flap trunk	$1,030.14
15572	Skin pedicle flap arms/legs	$2,055.20
15574	Pedcle fh/ch/ch/m/n/ax/g/h/f	$1,030.14
15576	Pedicle e/n/e/l/ntroral	$1,030.14
15600	Delay flap trunk	$2,055.20
15610	Delay flap arms/legs	$1,030.14
15620	Delay flap f/c/c/n/ax/g/h/f	$1,030.14
15630	Delay flap eye/nos/ear/lip	$1,030.14
15650	Transfer skin pedicle flap	$1,030.14
15730	Mdfc flap w/prsrv vasc pedcl	$2,055.20

ATTACHMENT 24
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15731	Forehead flap w/vasc pedicle	$2,055.20
15733	Musc myoq/fscq flp h&n pedcl	$2,055.20
15734	Muscle-skin graft trunk	$2,055.20
15736	Muscle-skin graft arm	$1,030.14
15738	Muscle-skin graft leg	$2,055.20
15740	Island pedicle flap graft	$1,030.14
15750	Neurovascular pedicle flap	$2,055.20
15760	Composite skin graft	$1,030.14
15769	Grfg autol soft tiss dir exc	$2,055.20
15770	Derma-fat-fascia graft	$2,055.20
15771	Grfg autol fat lipo 50 cc/<	$2,055.20
15773	Grfg autol fat lipo 25 cc/<	$1,030.14
15775	Hair trnspl 1-15 punch grfts	$225.11
15776	Hair trnspl >15 punch grafts	$225.11
15780	Dermabrasion total face	$538.32
15781	Dermabrasion segmental face	$343.37
15782	Dermabrasion other than face	$330.47
15783	Dermabrasion suprfl any site	$225.11
15789	Chemical peel facial dermal	$344.70
15820	Blepharoplasty lower eyelid	$1,030.14
15821	Blepharp lwr eyelid fat pad	$1,030.14
15822	Blepharoplasty upper eyelid	$1,030.14
15823	Blepharp upr eyelid xcsv skn	$1,030.14
15824	Rhytidectomy forehead	$1,030.14
15825	Rhytdct nck pltysml tghtg	$2,055.20
15826	Rhytidectomy glblr frn lines	$2,055.20
15828	Rhytidectomy cheek chn & nck	$2,055.20
15829	Rhytidectomy smas flap	$2,055.20
15830	Exc excessive skin abdomen	$2,816.52
15832	Exc excessive skin thigh	$1,262.00
15833	Exc excessive skin leg	$1,262.00
15834	Exc excessive skin hip	$1,262.00
15835	Exc excessive skin buttock	$1,262.00
15836	Exc excessive skin arm	$1,262.00
15837	Exc excsv skin forearm/hand	$1,262.00
15838	Exc excsv submental fat pad	$1,262.00
15839	Exc excessive skn other area	$1,262.00
15840	Nerve palsy fascial graft	$2,055.20
15841	Nerve palsy muscle graft	$2,055.20
15842	Nerve palsy microsurg graft	$1,030.14
15845	Skin and muscle repair face	$2,055.20
15851	Removal sutr/staple req anes	$16.31
15876	Suction lipectomy head&neck	$2,055.20

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15877	Suction lipectomy trunk	$2,055.20
15878	Suction lipectomy upr extrem	$1,030.14
15879	Suction lipectomy lwr extrem	$2,055.20
15920	Exc coccygl pr ulc prim sutr	$1,262.00
15922	Exc coccygl pr ulc flap clsr	$2,055.20
15931	Exc sacral pr ulc prim sutr	$1,262.00
15933	Exc sac pr ulc prim str ostc	$1,262.00
15934	Exc sacral pr ulc skn flap	$2,055.20
15935	Exc sac pr ulc skn flp ostc	$2,055.20
15936	Exc sac pr ulc prep mus flap	$1,030.14
15937	Exc sac pr ulc prep mus ostc	$1,030.14
15940	Exc ischial pr ulc prim sutr	$1,262.00
15941	Exc isch pr ulc prm sut ostc	$1,262.00
15944	Exc isch pr ulc skn flp clsr	$2,055.20
15945	Exc isch pr ulc skn flp ostc	$1,030.14
15946	Exc isch pr ulc prep mus flp	$1,030.14
15950	Exc trchntr pr ulc prim sutr	$743.69
15951	Exc trchntr pr ulc ostc	$1,262.00
15952	Exc trchntr pr ulc flp clsr	$1,030.14
15953	Exc trchntr pr ulc flp ostc	$2,055.20
15956	Exc trchntr pr ulc prep flap	$1,030.14
15958	Exc trchntr pr ulc prep ostc	$2,055.20
16025	Dress/debrid p-thick burn m	$112.11
16030	Dress/debrid p-thick burn l	$225.11
16035	Incision of burn scab initi	$225.11
17004	Destroy premal lesions 15/>	$117.85
17106	Destruction of skin lesions	$214.32
17107	Destruction of skin lesions	$280.20
17108	Destruction of skin lesions	$365.45
17264	Dstrj mal les t/a/l 3.1-4.0	$136.88
17266	Dstrj mal les t/a/l >4.0 cm	$150.80
17270	Dstr mal les s/n/h/f/g .5 /<	$101.56
17271	Dstr mal les s/n/h/f/g 0.6-1	$112.11
17273	Dstr mal les s/n/h/f/g 2.1-3	$135.18
17274	Dstr mal les s/n/h/f/g 3.1-4	$151.14
17276	Dstr mal les s/n/h/f/g >4.0	$167.44
17281	Dstr mal ls f/e/e/n/l/m .6-1	$112.11
17282	Dstr mal ls f/e/e/n/l/m1.1-2	$112.11
17283	Dstr mal ls f/e/e/n/l/m2.1-3	$147.75
17284	Dstr mal ls f/e/e/n/l/m3.1-4	$162.35
17286	Dstr mal ls f/e/e/n/l/m>4.0	$195.97
17311	Mohs 1 stage h/n/hf/g	$344.70
17313	Mohs 1 stage t/a/l	$344.70

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17380	Electrolysis epilation ea 30	$344.70
19000	Puncture aspir cyst breast	$66.23
19020	Mastotomy expl drg absc dp	$743.69
19081	Bx breast 1st lesion strtctc	$743.69
19083	Bx breast 1st lesion us imag	$743.69
19085	Bx breast 1st lesion mr imag	$743.69
19100	Bx breast percut w/o image	$743.69
19101	Biopsy of breast open	$1,614.95
19105	Cryosurg ablate fa each	$2,548.38
19110	Nipple exploration	$1,614.95
19112	Excise breast duct fistula	$1,614.95
19120	Removal of breast lesion	$1,614.95
19125	Excision breast lesion	$1,614.95
19296	Place po breast cath for rad	$4,698.83
19298	Place breast rad tube/caths	$4,526.07
19300	Mastectomy for gynecomastia	$1,614.95
19301	Partial mastectomy	$1,614.95
19302	P-mastectomy w/ln removal	$2,816.52
19303	Mast simple complete	$2,816.52
19307	Mast mod rad	$2,816.52
19316	Mastopexy	$2,816.52
19318	Breast reduction	$2,816.52
19325	Breast augmentation w/implt	$3,333.12
19328	Rmvl intact breast implant	$1,614.95
19330	Rmvl ruptured breast implant	$1,614.95
19340	Insj breast implt sm d mast	$2,816.52
19342	Insj/rplcmt brst implt sep d	$3,333.12
19350	Nipple/areola reconstruction	$1,614.95
19355	Correct inverted nipple(s)	$1,614.95
19357	Tiss xpndr plmt brst rcnstj	$5,583.21
19370	Revj peri-implt capsule brst	$1,614.95
19371	Peri-implt capslc brst compl	$1,614.95
19380	Revj reconstructed breast	$2,816.52
19396	Design custom breast implant	$1,614.95
20103	Expl pentrg wound extremity	$743.69
20150	Excision epiphyseal bar	$1,658.12
20200	Muscle biopsy superficial	$743.69
20205	Deep muscle biopsy	$1,262.00
20206	Biopsy muscle perq needle	$743.69
20220	Bone biopsy trocar/ndl supfc	$743.69
20225	Bone biopsy trocar/ndl deep	$743.69
20240	Bone biopsy open superficial	$1,262.00
20245	Bone biopsy open deep	$1,262.00

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20250	Biopsy vrt bdy open thoracic	$1,658.12
20251	Biopsy vrt bdy open lmbr/crv	$3,686.38
20500	Injection of sinus tract	$79.81
20520	Removal of foreign body	$148.42
20525	Removal of foreign body	$1,262.00
20526	Ther injection carp tunnel	$47.55
20527	Inj dupuytren cord w/enzyme	$50.26
20550	Inj tendon sheath/ligament	$30.57
20551	Inj tendon origin/insertion	$30.57
20552	Inj trigger point 1/2 muscl	$28.53
20553	Inject trigger points 3/>	$33.29
20555	Place ndl musc/tis for rt	$1,658.12
20600	Drain/inj joint/bursa w/o us	$29.88
20604	Drain/inj joint/bursa w/us	$50.61
20605	Drain/inj joint/bursa w/o us	$30.23
20606	Drain/inj joint/bursa w/us	$53.32
20610	Drain/inj joint/bursa w/o us	$35.32
20611	Drain/inj joint/bursa w/us	$58.42
20612	Aspirate/inj ganglion cyst	$39.74
20615	Treatment of bone cyst	$164.39
20650	Insert and remove bone pin	$1,658.12
20662	Application halo pelvic	$880.20
20663	Application halo femoral	$1,658.12
20665	Rmvl tongs/halo anthr indiv	$222.31
20670	Removal implant superficial	$743.69
20680	Removal of implant deep	$1,262.00
20690	Appl unipln uni ext fixj sys	$5,171.08
20692	Appl mltpln uni ext fixj sys	$8,841.02
20693	Adjmt/revj ext fixj sys anes	$3,686.38
20694	Rmvl ext fixj sys under anes	$880.20
20696	App mltpln uni xtrnl fix 1st	$15,597.61
20697	App mltpln uni xtrnl fix xch	$880.20
20822	Replantation digit complete	$880.20
20900	Removal of bone for graft	$5,067.38
20902	Removal of bone for graft	$3,686.38
20910	Remove cartilage for graft	$344.70
20912	Remove cartilage for graft	$2,055.20
20920	Removal of fascia for graft	$1,030.14
20922	Removal of fascia for graft	$1,030.14
20924	Removal of tendon for graft	$3,686.38
20950	Fluid pressure muscle	$396.48
20972	Bone/skin graft metatarsal	$3,686.38
20973	Bone/skin graft great toe	$3,686.38

ATTACHMENT 24
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20982	Ablate bone tumor(s) perq	$6,964.92
20983	Ablate bone tumor(s) perq	$5,156.77
21010	Incision of jaw joint	$1,464.17
21011	Exc face les sc <2 cm	$264.24
21012	Exc face les sbq 2 cm/>	$743.69
21013	Exc face tum deep < 2 cm	$329.78
21014	Exc face tum deep 2 cm/>	$1,262.00
21015	Resect face/scalp tum < 2 cm	$1,262.00
21016	Resect face/scalp tum 2 cm/>	$1,262.00
21025	Excision of bone lower jaw	$3,063.22
21026	Excision of facial bone(s)	$3,063.22
21029	Contour of face bone lesion	$1,464.17
21030	Excise max/zygoma b9 tumor	$288.02
21031	Remove exostosis mandible	$266.28
21032	Remove exostosis maxilla	$257.79
21034	Excise max/zygoma mal tumor	$3,063.22
21040	Excise mandible lesion	$1,464.17
21044	Removal of jaw bone lesion	$3,063.22
21046	Remove mandible cyst complex	$3,063.22
21047	Excise lwr jaw cyst w/repair	$3,063.22
21048	Remove maxilla cyst complex	$3,063.22
21050	Removal of jaw joint	$3,063.22
21060	Remove jaw joint cartilage	$3,063.22
21070	Remove coronoid process	$3,063.22
21073	Mnpj of tmj w/anesth	$287.33
21076	Impres&prep surg obt prosth	$406.89
21077	Impres&prep orbital prosth	$946.91
21079	Impres&prep intrm obt prosth	$687.77
21080	Impres&prep def obt prosth	$793.39
21081	Impres&prep mndbl res prosth	$738.72
21082	Impres&prep paltl aug prosth	$720.71
21083	Impres&prep paltl lft prosth	$700.68
21084	Impres&prep sp aid prosth	$780.49
21085	Impres&prep oral surg splint	$130.34
21086	Impres&prep auricular prosth	$707.12
21087	Impres&prep nasal prosth	$707.12
21088	Impres&prep facial prosth	$1,464.17
21100	Maxillofacial fixation	$3,063.22
21110	Interdental fixation	$643.27
21120	Genioplasty augmentation	$3,063.22
21121	Geniop sldg osteot 1	$2,252.83
21122	Geniop sldg osteot 2/>	$3,882.52
21123	Geniop sldg augmentation	$1,464.17

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21125	Augmentation mndblr prostc	$3,882.52
21127	Augmentation mndblr b1 grf	$3,063.22
21137	Rdctj forehead cntrg only	$1,464.17
21138	Rdctj forehead cntrg&prostc	$3,063.22
21139	Rdctj forehead cntrg&setback	$3,063.22
21150	Lefort ii anterior intrusion	$3,882.52
21181	Contour cranial bone lesion	$3,063.22
21194	Reconst lwr jaw w/graft	$3,063.22
21195	Reconst lwr jaw w/o fixation	$4,105.05
21198	Reconstr lwr jaw segment	$3,063.22
21199	Reconstr lwr jaw w/advance	$3,063.22
21206	Reconstruct upper jaw bone	$3,063.22
21208	Augmentation of facial bones	$3,927.18
21209	Reduction of facial bones	$3,063.22
21210	Face bone graft	$4,179.05
21215	Lower jaw bone graft	$4,048.50
21230	Rib cartilage graft	$3,063.22
21235	Ear cartilage graft	$3,063.22
21240	Reconstruction of jaw joint	$3,063.22
21242	Reconstruction of jaw joint	$3,063.22
21243	Reconstruction of jaw joint	$14,615.46
21244	Reconstruction of lower jaw	$4,338.95
21245	Reconstruction of jaw	$4,434.10
21246	Reconstruction of jaw	$3,063.22
21248	Reconstruction of jaw	$3,063.22
21249	Reconstruction of jaw	$3,063.22
21260	Revise eye sockets	$3,063.22
21267	Revise eye sockets	$5,149.00
21270	Augmentation cheek bone	$4,175.88
21275	Revision orbitofacial bones	$3,892.82
21280	Medial canthopexy	$1,464.17
21282	Lateral canthopexy	$1,464.17
21295	Revision of jaw muscle/bone	$690.25
21296	Revision of jaw muscle/bone	$1,464.17
21315	Clsd tx nsl fx mnpj wo stblj	$690.25
21320	Clsd tx nsl fx w/mnpj&stablj	$1,464.17
21325	Open tx nose fx uncomplicatd	$1,464.17
21330	Open tx nose fx w/skele fixj	$3,063.22
21335	Open tx nose & septal fx	$1,464.17
21336	Open tx septal fx w/wo stabj	$1,658.12
21337	Closed tx septal&nose fx	$1,464.17
21338	Open nasoethmoid fx w/o fixj	$3,063.22
21339	Open nasoethmoid fx w/ fixj	$3,063.22

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21340	Perq tx nasoethmoid fx	$1,464.17
21345	Closed tx nose/jaw fx	$690.25
21355	Perq tx malar fracture	$1,464.17
21356	Opn tx dprsd zygomatic arch	$3,063.22
21360	Opn tx dprsd malar fracture	$3,063.22
21365	Opn tx complx malar fx	$3,063.22
21390	Opn tx orbit periorbtl implt	$3,063.22
21400	Closed tx orbit w/o manipulj	$286.69
21401	Closed tx orbit w/manipulj	$690.25
21406	Opn tx orbit fx w/o implant	$3,063.22
21407	Opn tx orbit fx w/implant	$3,063.22
21421	Cltx palatal/max fx wire fix	$1,464.17
21440	Cltx mndblr/max alv ridge fx	$632.75
21445	Optx mndblr/max alv ridge fx	$3,063.22
21450	Cltx mndblr fx w/o mnpj	$286.69
21451	Cltx mndblr fx w/mnpj	$690.25
21452	Perq tx mndblr fx xtrnl fixj	$3,922.68
21453	Cltx mndblr fx ntrdntl fixj	$3,063.22
21454	Optx mndblr fx xtrnl fixj	$3,940.92
21461	Optx mndblr fx wo ntrdntl	$4,062.50
21462	Optx mndblr fx w/ntrdntl	$3,889.39
21465	Optx mndblr cndylr fx	$3,910.80
21480	Cltx tmprmand dislc 1st/sbsq	$135.38
21485	Cltx tmprmand dislc comp	$690.25
21490	Optx tmprmand dislocation	$1,464.17
21497	Interdental wirg oth/thn fx	$690.25
21501	I&d dp absc/hmtma sft ts nck	$1,262.00
21502	I&d dp abs/hmtm nck rib ostc	$1,658.12
21550	Biopsy of neck/chest	$743.69
21552	Exc neck les sc 3 cm/>	$1,262.00
21554	Exc neck tum deep 5 cm/>	$1,262.00
21555	Exc neck les sc < 3 cm	$743.69
21556	Exc neck tum deep < 5 cm	$1,262.00
21557	Resect neck thorax tumor<5cm	$1,262.00
21558	Resect neck tumor 5 cm/>	$1,262.00
21600	Partial removal of rib	$3,686.38
21610	Partial removal of rib	$1,658.12
21685	Hyoid myotomy & suspension	$3,913.71
21700	Revision of neck muscle	$3,686.38
21720	Revision of neck muscle	$1,658.12
21725	Revision of neck muscle	$396.48
21820	Treat sternum fracture	$135.38
21920	Biopsy soft tissue of back	$176.27

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21925	Biopsy soft tissue of back	$743.69
21930	Exc back les sc < 3 cm	$743.69
21931	Exc back les sc 3 cm/>	$743.69
21932	Exc back tum deep < 5 cm	$1,262.00
21933	Exc back tum deep 5 cm/>	$1,262.00
21935	Resect back tum < 5 cm	$1,262.00
21936	Resect back tum 5 cm/>	$1,262.00
22102	Remove part lumbar vertebra	$3,686.38
22310	Closed tx vert fx w/o manj	$135.38
22315	Closed tx vert fx w/manj	$1,658.12
22505	Manipulation of spine	$880.20
22510	Perq cervicothoracic inject	$1,658.12
22511	Perq lumbosacral injection	$1,658.12
22513	Perq vertebral augmentation	$3,686.38
22514	Perq vertebral augmentation	$3,686.38
22551	Arthrd ant ntrbdy cervical	$9,522.47
22554	Arthrd ant ntrbd min dsc crv	$9,425.13
22612	Arthrd pst tq 1ntrspc lumbar	$14,738.45
22856	Tot disc arthrp 1ntrspc crv	$14,705.54
22867	Insj stabij dev w/dcmprn	$14,795.61
22869	Insj stabij dev w/o dcmprn	$11,421.41
22900	Exc abdl tum deep < 5 cm	$1,262.00
22901	Exc abdl tum deep 5 cm/>	$1,262.00
22902	Exc abd les sc < 3 cm	$743.69
22903	Exc abd les sc 3 cm/>	$1,262.00
22904	Radical resect abd tumor<5cm	$1,262.00
22905	Rad resect abd tumor 5 cm/>	$1,262.00
23000	Removal of calcium deposits	$1,262.00
23020	Release shoulder joint	$1,658.12
23030	Drain shoulder lesion	$1,262.00
23031	Drain shoulder bursa	$1,262.00
23035	Drain shoulder bone lesion	$880.20
23040	Exploratory shoulder surgery	$1,658.12
23044	Exploratory shoulder surgery	$1,658.12
23065	Biopsy shoulder tissues	$139.93
23066	Biopsy shoulder tissues	$1,262.00
23071	Exc shoulder les sc 3 cm/>	$743.69
23073	Exc shoulder tum deep 5 cm/>	$1,262.00
23075	Exc shoulder les sc < 3 cm	$743.69
23076	Exc shoulder tum deep < 5 cm	$1,262.00
23077	Resect shoulder tumor < 5 cm	$1,262.00
23078	Resect shoulder tumor 5 cm/>	$1,262.00
23100	Biopsy of shoulder joint	$1,658.12

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23101	Shoulder joint surgery	$1,658.12
23105	Remove shoulder joint lining	$3,686.38
23106	Incision of collarbone joint	$1,658.12
23107	Explore treat shoulder joint	$3,686.38
23120	Claviculectomy partial	$1,658.12
23125	Claviculectomy total	$1,658.12
23130	Acromp/acromionectomy prtl	$1,658.12
23140	Removal of bone lesion	$1,658.12
23145	Removal of bone lesion	$1,658.12
23146	Removal of bone lesion	$3,686.38
23150	Removal of humerus lesion	$1,658.12
23155	Removal of humerus lesion	$3,686.38
23156	Removal of humerus lesion	$3,686.38
23170	Remove collar bone lesion	$2,138.81
23172	Remove shoulder blade lesion	$1,658.12
23174	Remove humerus lesion	$3,686.38
23180	Remove collar bone lesion	$3,686.38
23182	Remove shoulder blade lesion	$3,686.38
23184	Remove humerus lesion	$3,686.38
23190	Partial removal of scapula	$1,658.12
23195	Removal of head of humerus	$3,686.38
23330	Remove shoulder foreign body	$743.69
23333	Remove shoulder fb deep	$1,262.00
23334	Shoulder prosthesis removal	$1,262.00
23395	Muscle transfer shoulder/arm	$4,726.11
23397	Muscle transfers	$3,686.38
23400	Fixation of shoulder blade	$3,686.38
23405	Incision of tendon & muscle	$3,686.38
23406	Incise tendon(s) & muscle(s)	$3,686.38
23410	Repair rotator cuff acute	$3,686.38
23412	Repair rotator cuff chronic	$3,686.38
23415	Release of shoulder ligament	$3,686.38
23420	Repair of shoulder	$3,686.38
23430	Repair biceps tendon	$4,833.62
23440	Remove/transplant tendon	$3,686.38
23450	Repair shoulder capsule	$3,686.38
23455	Repair shoulder capsule	$4,716.25
23460	Repair shoulder capsule	$4,672.05
23462	Repair shoulder capsule	$3,686.38
23465	Repair shoulder capsule	$3,686.38
23466	Repair shoulder capsule	$3,686.38
23470	Reconstruct shoulder joint	$10,136.63
23472	Reconstruct shoulder joint	$15,245.98

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23480	Revision of collar bone	$3,686.38
23485	Revision of collar bone	$9,124.06
23490	Reinforce clavicle	$3,686.38
23491	Reinforce shoulder bones	$8,827.80
23500	Cltx clavicular fx w/o mnpj	$135.38
23505	Cltx clavicular fx w/mnpj	$880.20
23515	Optx clavicular fx w/int fix	$4,840.93
23520	Cltx strnclav dislc w/o mnpj	$880.20
23525	Cltx strnclav dislc w/mnpj	$135.38
23530	Optx strnclav dislc aqt/chrn	$3,686.38
23532	Optx strclv dslc aq/chrn grf	$3,686.38
23540	Cltx acromclav dislc wo mnpj	$135.38
23545	Cltx acromclav dislc w/mnpj	$135.38
23550	Optx acromclv dislc aqt/chrn	$4,795.77
23552	Optx acrclv dslc aq/chrn grf	$4,862.56
23570	Cltx scapular fx w/o mnpj	$135.38
23575	Cltx scap fx w/mnpj +-tractj	$880.20
23585	Optx scapular fx w/int fixj	$4,966.25
23600	Cltx prox humrl fx w/o mnpj	$135.38
23605	Cltx prx hmrl fx mnpj+-tract	$880.20
23615	Optx prox humrl fx w/int fix	$9,474.40
23616	Optx prx hmrl fx fix rpr rpl	$14,905.61
23620	Cltx gr hmrl tbrs fx wo mnpj	$135.38
23625	Cltx gr hmrl tbrs fx w/mnpj	$880.20
23630	Optx gr hmrl tbrs fx int fix	$4,778.91
23650	Cltx sho dslc w/mnpj wo anes	$135.38
23655	Cltx sho dslc w/mnpj w/anes	$880.20
23660	Optx acute shoulder dislc	$3,686.38
23665	Cltx sho dslc fx gr hmrl tbr	$880.20
23670	Optx sho dislc fx	$4,773.18
23675	Cltx sho dislc neck fx mnpj	$880.20
23680	Optx sho dislc neck fx fixj	$8,874.67
23700	Mnpj anes sho jt fixj aprats	$880.20
23800	Arthrodesis glenohumeral jt	$3,686.38
23802	Arthrd glenohumeral jt w/grf	$6,964.92
23921	Disarticulation sho sec clsr	$1,030.14
23930	I&d upr a/e dp absc/hmtma	$1,262.00
23931	I&d upr a/e bursa	$743.69
23935	Inc dp opn b1 crtx hum/elbw	$1,658.12
24000	Arthrt elbw expl drg/rmvl fb	$1,658.12
24006	Arthrt elbw capsl exc rls	$1,658.12
24065	Biopsy arm/elbow soft tissue	$181.03
24066	Biopsy arm/elbow soft tissue	$1,262.00

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24071	Exc arm/elbow les sc 3 cm/>	$1,262.00
24073	Ex arm/elbow tum deep 5 cm/>	$1,262.00
24075	Exc arm/elbow les sc < 3 cm	$743.69
24076	Ex arm/elbow tum deep < 5 cm	$1,262.00
24077	Rad rescj tum tiss a/e <5cm	$1,262.00
24079	Rad rescj tum tiss a/e 5 cm+	$1,262.00
24100	Arthrt elbw synovial bx only	$1,658.12
24101	Arthrt elbw jt expl bx rmvl	$1,658.12
24102	Arthrt elbow w/synovectomy	$1,658.12
24105	Excision olecranon bursa	$1,658.12
24110	Exc/curtg b1 cst/b9 tum hum	$1,658.12
24115	Exc/crtg b1 cst/tum hum agrf	$3,686.38
24116	Exc/crtg b1 cst/tum hum algr	$4,672.36
24120	Exc/crtg b1 cst/b9 tum rds	$1,658.12
24125	Exc/crtg b1 cst/tum rds agrf	$1,658.12
24126	Exc/crtg b1 cst/tum rds algr	$4,795.13
24130	Excision radial head	$1,658.12
24134	Sequestrectomy shft/dstl hum	$3,686.38
24136	Sequestrectomy radial h/n	$1,658.12
24138	Sequestrectomy olecrn proces	$3,686.38
24140	Partial exc bone humerus	$1,658.12
24145	Prtl exc bone radial h/n	$3,686.38
24147	Prtl exc bone olecrn process	$1,658.12
24149	Radical resection of elbow	$3,686.38
24152	Rad resection tum radial h/n	$4,937.94
24155	Resection of elbow joint	$1,658.12
24160	Rmvl prosthhumrl&ulnar cmpnt	$1,658.12
24164	Removal prosth radial head	$1,658.12
24200	Rmvl fb upper arm/elbw subq	$155.56
24201	Rmvl fb upper arm/elbw deep	$1,262.00
24300	Mnpj elbow under anes	$880.20
24301	Musc/tdn transfer upr a/e 1	$3,686.38
24305	Tendon lngth upr a/e ea tdn	$1,658.12
24310	Tnot opn elbw to sho ea tdn	$1,658.12
24320	Tenoplasty elbow to sho 1	$3,686.38
24330	Flexor-plasty elbow	$3,686.38
24331	Flexor-plasty elbw w/advmnt	$3,686.38
24332	Tenolysis triceps	$1,658.12
24340	Tenodesis biceps tdn at elbw	$3,686.38
24341	Rpr tdn/musc upr a/e each	$3,686.38
24342	Repair of ruptured tendon	$3,686.38
24343	Repr elbow lat ligmnt w/tiss	$1,658.12
24344	Reconstruct elbow lat ligmnt	$4,833.94

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24345	Repr elbw med ligmnt w/tissu	$3,686.38
24346	Reconstruct elbow med ligmnt	$6,964.92
24357	Repair elbow perc	$1,658.12
24358	Repair elbow w/deb open	$1,658.12
24359	Repair elbow deb/attch open	$1,658.12
24360	Reconstruct elbow joint	$5,266.18
24361	Reconstruct elbow joint	$14,738.45
24362	Reconstruct elbow joint	$10,250.21
24363	Replace elbow joint	$15,011.27
24365	Reconstruct head of radius	$9,788.69
24366	Reconstruct head of radius	$10,078.34
24370	Revise reconst elbow joint	$9,453.37
24371	Revise reconst elbow joint	$14,340.05
24400	Revision of humerus	$3,686.38
24410	Revision of humerus	$6,964.92
24420	Revision of humerus	$3,686.38
24430	Repair of humerus	$9,459.98
24435	Repair humerus with graft	$9,451.56
24470	Revision of elbow joint	$1,658.12
24495	Decompression of forearm	$3,686.38
24498	Reinforce humerus	$9,719.58
24500	Treat humerus fracture	$135.38
24505	Treat humerus fracture	$880.20
24515	Treat humerus fracture	$9,096.41
24516	Treat humerus fracture	$9,220.21
24530	Treat humerus fracture	$135.38
24535	Treat humerus fracture	$880.20
24538	Treat humerus fracture	$3,686.38
24545	Treat humerus fracture	$9,416.72
24546	Treat humerus fracture	$9,786.28
24560	Treat humerus fracture	$135.38
24565	Treat humerus fracture	$880.20
24566	Treat humerus fracture	$880.20
24575	Treat humerus fracture	$8,915.54
24576	Treat humerus fracture	$135.38
24577	Treat humerus fracture	$880.20
24579	Treat humerus fracture	$8,910.73
24582	Treat humerus fracture	$3,686.38
24586	Treat elbow fracture	$9,430.53
24587	Treat elbow fracture	$9,427.53
24600	Treat elbow dislocation	$135.38
24605	Treat elbow dislocation	$880.20
24615	Treat elbow dislocation	$4,805.31

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24620	Treat elbow fracture	$880.20
24635	Treat elbow fracture	$5,041.63
24640	Treat elbow dislocation	$61.13
24650	Treat radius fracture	$135.38
24655	Treat radius fracture	$880.20
24665	Treat radius fracture	$3,686.38
24666	Treat radius fracture	$10,417.26
24670	Treat ulnar fracture	$135.38
24675	Treat ulnar fracture	$880.20
24685	Treat ulnar fracture	$4,737.88
24800	Fusion of elbow joint	$3,686.38
24802	Fusion/graft of elbow joint	$6,964.92
24925	Amputation follow-up surgery	$1,658.12
25000	Incision of tendon sheath	$880.20
25001	Incise flexor carpi radialis	$1,658.12
25020	Decompress forearm 1 space	$880.20
25023	Decompress forearm 1 space	$1,658.12
25024	Decompress forearm 2 spaces	$1,658.12
25025	Decompress forearm 2 spaces	$880.20
25028	Drainage of forearm lesion	$1,658.12
25031	Drainage of forearm bursa	$880.20
25035	Treat forearm bone lesion	$3,686.38
25040	Explore/treat wrist joint	$1,658.12
25065	Biopsy forearm soft tissues	$180.35
25066	Biopsy forearm soft tissues	$1,262.00
25071	Exc forearm les sc 3 cm/>	$743.69
25073	Exc forearm tum deep 3 cm/>	$1,262.00
25075	Exc forearm les sc < 3 cm	$743.69
25076	Exc forearm tum deep < 3 cm	$743.69
25077	Resect forearm/wrist tum<3cm	$1,262.00
25078	Resect forarm/wrist tum 3cm>	$1,262.00
25085	Incision of wrist capsule	$1,658.12
25100	Biopsy of wrist joint	$1,658.12
25101	Explore/treat wrist joint	$1,658.12
25105	Remove wrist joint lining	$1,658.12
25107	Remove wrist joint cartilage	$1,658.12
25109	Excise tendon forearm/wrist	$1,658.12
25110	Remove wrist tendon lesion	$880.20
25111	Remove wrist tendon lesion	$880.20
25112	Reremove wrist tendon lesion	$880.20
25115	Remove wrist/forearm lesion	$880.20
25116	Remove wrist/forearm lesion	$1,658.12
25118	Excise wrist tendon sheath	$880.20

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25119	Partial removal of ulna	$1,658.12
25120	Removal of forearm lesion	$1,658.12
25125	Remove/graft forearm lesion	$880.20
25126	Remove/graft forearm lesion	$1,658.12
25130	Removal of wrist lesion	$1,658.12
25135	Remove & graft wrist lesion	$3,686.38
25136	Remove & graft wrist lesion	$3,686.38
25145	Remove forearm bone lesion	$1,658.12
25150	Partial removal of ulna	$1,658.12
25151	Partial removal of radius	$1,658.12
25210	Removal of wrist bone	$1,658.12
25215	Removal of wrist bones	$1,658.12
25230	Partial removal of radius	$1,658.12
25240	Partial removal of ulna	$1,658.12
25248	Remove forearm foreign body	$880.20
25250	Removal of wrist prosthesis	$880.20
25251	Removal of wrist prosthesis	$1,658.12
25259	Manipulate wrist w/anesthes	$880.20
25260	Repair forearm tendon/muscle	$1,658.12
25263	Repair forearm tendon/muscle	$3,686.38
25265	Repair forearm tendon/muscle	$1,658.12
25270	Repair forearm tendon/muscle	$1,658.12
25272	Repair forearm tendon/muscle	$1,658.12
25274	Repair forearm tendon/muscle	$1,658.12
25275	Repair forearm tendon sheath	$1,658.12
25280	Revise wrist/forearm tendon	$1,658.12
25290	Incise wrist/forearm tendon	$1,658.12
25295	Release wrist/forearm tendon	$1,658.12
25300	Fusion of tendons at wrist	$1,658.12
25301	Fusion of tendons at wrist	$1,658.12
25310	Transplant forearm tendon	$1,658.12
25312	Transplant forearm tendon	$1,658.12
25315	Revise palsy hand tendon(s)	$3,686.38
25316	Revise palsy hand tendon(s)	$3,686.38
25320	Repair/revise wrist joint	$3,686.38
25332	Revise wrist joint	$2,101.62
25335	Centralization wrist on ulna	$1,658.12
25337	Reconstruct ulna/radioulnar	$4,855.24
25350	Revision of radius	$5,097.60
25355	Revision of radius	$1,658.12
25360	Revision of ulna	$3,686.38
25365	Revise radius & ulna	$6,964.92
25370	Revise radius or ulna	$1,658.12

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25375	Revise radius & ulna	$1,658.12
25390	Shorten radius or ulna	$5,106.83
25391	Lengthen radius or ulna	$9,938.31
25392	Shorten radius & ulna	$3,686.38
25393	Lengthen radius & ulna	$4,717.21
25394	Repair carpal bone shorten	$1,658.12
25400	Repair radius or ulna	$4,955.12
25405	Repair/graft radius or ulna	$4,805.94
25415	Repair radius & ulna	$4,672.36
25420	Repair/graft radius & ulna	$4,672.36
25425	Repair/graft radius or ulna	$5,849.50
25426	Repair/graft radius & ulna	$2,187.60
25430	Vasc graft into carpal bone	$1,658.12
25431	Repair nonunion carpal bone	$5,380.04
25440	Repair nonu scphd carpl b1	$3,686.38
25441	Arthrp w/prostc dstl rds	$10,545.26
25442	Arthrp w/prostc dstl ulna	$15,514.46
25443	Arthrp prostc dstl scph crpl	$5,302.44
25444	Arthrp w/prostc lunate	$11,304.83
25445	Arthrp w/prostc trapezium	$5,070.89
25446	Arthrp w/prostc dst rds&crps	$15,358.57
25447	Arthrp ntrcrp/crp/mtcr ntrps	$1,658.12
25448	Arthrp ntrcrpl/crp/mtcrp ssp	$1,658.12
25449	Revj arthrp wrist joint	$3,686.38
25450	Epiphysl arrst dstl rds/ulna	$1,658.12
25455	Epiphysl arrst dstl rds&ulna	$1,658.12
25490	Prophylactic tx radius	$3,686.38
25491	Prophylactic tx ulna	$8,827.80
25492	Prophylactic tx radius&ulna	$1,658.12
25500	Cltx rdl shft fx w/o mnpj	$135.38
25505	Cltx rdl shft fx w/mnpj	$880.20
25515	Optx radial shaft fracture	$4,691.13
25520	Cltx rdl shft fx&dislc	$880.20
25525	Optx rdl shft fx&cltx rad/ul	$4,887.69
25526	Optx rdl shft fx&dstl rad/ul	$5,021.28
25530	Cltx ulnar shft fx w/o mnpj	$135.38
25535	Cltx ulnar shft fx w/mnpj	$135.38
25545	Optx ulnar shft fx int fixj	$4,649.15
25560	Cltx rdl&uln shft fx wo mnpj	$135.38
25565	Cltx rdl&uln shft fx w/mnpj	$880.20
25574	Optx rdl&uln shft fx rds/uln	$4,974.20
25575	Optx rdl&uln shft fx rds&uln	$4,941.44
25600	Cltx dst rdl fx/ephys sep wo	$135.38

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25605	Cltx dst rdl fx/ephys sep w/	$880.20
25606	Perq skel fixj dstl rdl fx	$1,658.12
25607	Optx dst rd xartc fx/epi sep	$4,997.42
25608	Optx dst rd xart fx/epi sep2	$5,002.50
25609	Optx dst rd xart fx/ep sep3+	$5,029.23
25622	Cltx carpl scphd fx w/o mnpj	$135.38
25624	Cltx carpl scphd fx w/mnpj	$880.20
25628	Optx carpl scphd fx int fixj	$3,686.38
25630	Cltx carpl fx w/o mnpj ea b1	$135.38
25635	Cltx carpl fx w/mnpj ea b1	$880.20
25645	Optx crpl fx oth/thn scph ea	$1,658.12
25650	Cltx ulnar styloid fracture	$135.38
25651	Perq skel fix ulnar styld fx	$1,658.12
25652	Optx ulnar styloid fracture	$5,110.96
25660	Cltx rdcrpl/ntrcrpl dislc 1+	$135.38
25670	Optx rdcrpl/ntrcrpl dislc 1+	$3,686.38
25671	Perq skel fix rad/uln dislc	$1,658.12
25675	Cltx dstl rad/uln dislc mnpj	$135.38
25676	Optx rad/uln dislc aqt/chrnc	$3,686.38
25680	Cltx trns-scphprlnr fx mnpj	$135.38
25685	Optx trns-scphprlnr fx dislc	$3,686.38
25690	Cltx lunate dislc w/mnpj	$880.20
25695	Optx lunate dislocation	$3,686.38
25800	Arthrd wrist complete wo grf	$5,038.13
25805	Arthrd wrist w/sliding graft	$5,234.69
25810	Arthrd wrst iliac/oth agrft	$9,065.76
25820	Arthrd wrist lmtd w/o b1 grf	$4,913.77
25825	Arthrd wrist with autograft	$4,691.44
25830	Arthrd dst rad/ul jt sgm rsc	$3,686.38
25907	Amputation follow-up surgery	$1,658.12
25922	Amputate hand at wrist	$880.20
25929	Amputation follow-up surgery	$1,030.14
25931	Amputation follow-up surgery	$1,658.12
26010	Drainage of finger abscess	$112.11
26011	Drainage of finger abscess	$743.69
26020	Drain hand tendon sheath	$1,658.12
26025	Drainage of palm bursa	$1,658.12
26030	Drainage of palm bursas	$1,658.12
26034	Treat hand bone lesion	$880.20
26035	Decompress fingers/hand	$1,658.12
26037	Decompress fingers/hand	$1,658.12
26040	Release palm contracture	$880.20
26045	Release palm contracture	$1,658.12

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26055	Incise finger tendon sheath	$880.20
26060	Incision of finger tendon	$880.20
26070	Explore/treat hand joint	$880.20
26075	Explore/treat finger joint	$1,658.12
26080	Explore/treat finger joint	$880.20
26100	Biopsy hand joint lining	$1,658.12
26105	Biopsy finger joint lining	$1,658.12
26110	Biopsy finger joint lining	$880.20
26111	Exc hand les sc 1.5 cm/>	$743.69
26113	Exc hand tum deep 1.5 cm/>	$743.69
26115	Exc hand les sc < 1.5 cm	$743.69
26116	Exc hand tum deep < 1.5 cm	$743.69
26117	Rad resect hand tumor < 3 cm	$1,262.00
26118	Rad resect hand tumor 3 cm/>	$1,262.00
26121	Release palm contracture	$1,658.12
26123	Release palm contracture	$1,658.12
26130	Remove wrist joint lining	$1,658.12
26135	Revise finger joint each	$1,658.12
26140	Revise finger joint each	$880.20
26145	Tendon excision palm/finger	$880.20
26160	Remove tendon sheath lesion	$880.20
26170	Removal of palm tendon each	$880.20
26180	Removal of finger tendon	$880.20
26185	Remove finger bone	$880.20
26200	Remove hand bone lesion	$880.20
26205	Remove/graft bone lesion	$3,686.38
26210	Removal of finger lesion	$880.20
26215	Remove/graft finger lesion	$1,658.12
26230	Partial removal of hand bone	$1,658.12
26235	Partial removal finger bone	$880.20
26236	Partial removal finger bone	$880.20
26250	Extensive hand surgery	$1,658.12
26260	Resect prox finger tumor	$1,658.12
26262	Resect distal finger tumor	$880.20
26320	Removal of implant from hand	$743.69
26340	Manipulate finger w/anesth	$880.20
26341	Manipulat palm cord post inj	$84.57
26350	Repair finger/hand tendon	$1,658.12
26352	Repair/graft hand tendon	$3,686.38
26356	Repair finger/hand tendon	$1,658.12
26357	Repair finger/hand tendon	$1,658.12
26358	Repair/graft hand tendon	$3,686.38
26370	Repair finger/hand tendon	$1,658.12

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26372	Repair/graft hand tendon	$4,693.67
26373	Repair finger/hand tendon	$1,658.12
26390	Revise hand/finger tendon	$4,665.36
26392	Repair/graft hand tendon	$3,686.38
26410	Repair hand tendon	$880.20
26412	Repair/graft hand tendon	$1,658.12
26415	Excision hand/finger tendon	$1,658.12
26416	Graft hand or finger tendon	$1,658.12
26418	Repair finger tendon	$880.20
26420	Repair/graft finger tendon	$1,658.12
26426	Repair finger/hand tendon	$1,658.12
26428	Repair/graft finger tendon	$1,658.12
26432	Repair finger tendon	$880.20
26433	Repair finger tendon	$1,658.12
26434	Repair/graft finger tendon	$1,658.12
26437	Realignment of tendons	$1,658.12
26440	Release palm/finger tendon	$880.20
26442	Release palm & finger tendon	$1,658.12
26445	Release hand/finger tendon	$1,658.12
26449	Release forearm/hand tendon	$1,658.12
26450	Incision of palm tendon	$1,658.12
26455	Incision of finger tendon	$880.20
26460	Incise hand/finger tendon	$880.20
26471	Fusion of finger tendons	$1,658.12
26474	Fusion of finger tendons	$880.20
26476	Tendon lengthening	$1,658.12
26477	Tendon shortening	$1,658.12
26478	Lengthening of hand tendon	$1,658.12
26479	Shortening of hand tendon	$1,658.12
26480	Transplant hand tendon	$1,658.12
26483	Transplant/graft hand tendon	$1,658.12
26485	Transplant palm tendon	$1,658.12
26489	Transplant/graft palm tendon	$1,658.12
26490	Revise thumb tendon	$1,658.12
26492	Tendon transfer with graft	$1,658.12
26494	Hand tendon/muscle transfer	$1,658.12
26496	Revise thumb tendon	$1,658.12
26497	Finger tendon transfer	$1,658.12
26498	Finger tendon transfer	$1,658.12
26499	Revision of finger	$1,658.12
26500	Hand tendon reconstruction	$3,686.38
26502	Hand tendon reconstruction	$1,658.12
26508	Release thumb contracture	$1,658.12

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26510	Thumb tendon transfer	$1,658.12
26516	Fusion of knuckle joint	$1,658.12
26517	Fusion of knuckle joints	$1,658.12
26518	Fusion of knuckle joints	$3,686.38
26520	Release knuckle contracture	$1,658.12
26525	Release finger contracture	$880.20
26530	Revise knuckle joint	$4,922.99
26531	Revise knuckle with implant	$5,094.11
26535	Revise finger joint	$1,658.12
26536	Revise/implant finger joint	$4,849.52
26540	Repair hand joint	$1,658.12
26541	Repair hand joint with graft	$2,142.97
26542	Repair hand joint with graft	$2,150.68
26545	Reconstruct finger joint	$2,156.27
26546	Repair nonunion hand	$3,686.38
26548	Reconstruct finger joint	$1,658.12
26550	Pollicization digit	$1,658.12
26555	Positional change of finger	$3,686.38
26560	Repair of web finger	$880.20
26561	Repair of web finger	$1,658.12
26562	Repair of web finger	$1,658.12
26565	Correct metacarpal flaw	$1,658.12
26567	Correct finger deformity	$1,658.12
26568	Lengthen metacarpal/finger	$5,005.06
26580	Repair cleft hand	$1,658.12
26587	Reconstruct extra finger	$1,658.12
26590	Repair finger deformity	$880.20
26591	Repair muscles of hand	$1,658.12
26593	Release muscles of hand	$1,658.12
26596	Excision constricting tissue	$1,658.12
26600	Treat metacarpal fracture	$135.38
26605	Treat metacarpal fracture	$135.38
26607	Treat metacarpal fracture	$1,658.12
26608	Treat metacarpal fracture	$1,658.12
26615	Treat metacarpal fracture	$1,658.12
26641	Treat thumb dislocation	$135.38
26645	Treat thumb fracture	$880.20
26650	Treat thumb fracture	$1,658.12
26665	Treat thumb fracture	$1,658.12
26670	Treat hand dislocation	$135.38
26675	Treat hand dislocation	$880.20
26676	Pin hand dislocation	$1,658.12
26685	Treat hand dislocation	$1,658.12

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26686	Treat hand dislocation	$2,101.62
26700	Treat knuckle dislocation	$135.38
26705	Treat knuckle dislocation	$880.20
26706	Pin knuckle dislocation	$1,658.12
26715	Treat knuckle dislocation	$1,658.12
26720	Treat finger fracture each	$135.38
26725	Treat finger fracture each	$135.38
26727	Treat finger fracture each	$1,658.12
26735	Treat finger fracture each	$1,658.12
26740	Treat finger fracture each	$135.38
26742	Treat finger fracture each	$880.20
26746	Treat finger fracture each	$1,658.12
26750	Treat finger fracture each	$131.44
26755	Treat finger fracture each	$135.38
26756	Pin finger fracture each	$1,658.12
26765	Treat finger fracture each	$1,658.12
26770	Treat finger dislocation	$135.38
26775	Treat finger dislocation	$149.66
26776	Pin finger dislocation	$1,658.12
26785	Treat finger dislocation	$1,658.12
26820	Thumb fusion with graft	$3,686.38
26841	Fusion of thumb	$3,686.38
26842	Thumb fusion with graft	$4,672.36
26843	Fusion of hand joint	$4,672.36
26844	Fusion/graft of hand joint	$5,093.79
26850	Fusion of knuckle	$3,686.38
26852	Fusion of knuckle with graft	$3,686.38
26860	Fusion of finger joint	$1,658.12
26862	Fusion/graft of finger joint	$1,658.12
26910	Amputate metacarpal bone	$1,658.12
26951	Amputation of finger/thumb	$1,658.12
26952	Amputation of finger/thumb	$1,658.12
26990	Drainage of pelvis lesion	$1,658.12
26991	Drainage of pelvis bursa	$880.20
27000	Incision of hip tendon	$880.20
27001	Incision of hip tendon	$1,658.12
27003	Incision of hip tendon	$3,686.38
27006	Incision of hip tendons	$1,658.12
27033	Exploration of hip joint	$3,686.38
27035	Denervation of hip joint	$1,658.12
27040	Biopsy of soft tissues	$743.69
27041	Biopsy of soft tissues	$743.69
27043	Exc hip pelvis les sc 3 cm/>	$1,262.00

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27045	Exc hip/pelv tum deep 5 cm/>	$1,262.00
27047	Exc hip/pelvis les sc < 3 cm	$1,262.00
27048	Exc hip/pelv tum deep < 5 cm	$1,262.00
27049	Resect hip/pelv tum < 5 cm	$1,262.00
27050	Biopsy of sacroiliac joint	$880.20
27052	Biopsy of hip joint	$880.20
27059	Resect hip/pelv tum 5 cm/>	$1,262.00
27060	Removal of ischial bursa	$3,686.38
27062	Remove femur lesion/bursa	$1,658.12
27065	Remove hip bone les super	$3,686.38
27066	Remove hip bone les deep	$1,658.12
27067	Remove/graft hip bone lesion	$5,234.37
27080	Removal of tail bone	$1,658.12
27086	Remove hip foreign body	$1,262.00
27087	Remove hip foreign body	$1,658.12
27097	Revision of hip tendon	$1,658.12
27098	Transfer tendon to pelvis	$2,154.40
27100	Transfer of abdominal muscle	$3,686.38
27105	Transfer of spinal muscle	$1,658.12
27110	Transfer of iliopsoas muscle	$4,958.61
27111	Transfer of iliopsoas muscle	$1,658.12
27130	Total hip arthroplasty	$9,921.49
27197	Clsd tx pelvic ring fx	$135.38
27198	Clsd tx pelvic ring fx	$135.38
27200	Treat tail bone fracture	$124.65
27202	Treat tail bone fracture	$1,658.12
27220	Treat hip socket fracture	$135.38
27230	Treat thigh fracture	$135.38
27238	Treat thigh fracture	$880.20
27246	Treat thigh fracture	$135.38
27250	Treat hip dislocation	$135.38
27252	Treat hip dislocation	$880.20
27256	Treat hip dislocation	$135.38
27257	Treat hip dislocation	$880.20
27265	Treat hip dislocation	$135.38
27266	Treat hip dislocation	$880.20
27267	Cltx thigh fx	$1,658.12
27275	Manipulation of hip joint	$880.20
27278	Arthrd si jt prq wo tfxj dev	$16,454.17
27279	Arthrd si jt perq/min nvas	$15,935.39
27301	Drain thigh/knee lesion	$1,262.00
27305	Incise thigh tendon & fascia	$1,658.12
27306	Incision of thigh tendon	$1,658.12

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27307	Incision of thigh tendons	$1,658.12
27310	Exploration of knee joint	$1,658.12
27323	Biopsy thigh soft tissues	$743.69
27324	Biopsy thigh soft tissues	$1,262.00
27325	Neurectomy hamstring	$971.18
27326	Neurectomy popliteal	$971.18
27327	Exc thigh/knee les sc < 3 cm	$743.69
27328	Exc thigh/knee tum deep <5cm	$1,262.00
27329	Resect thigh/knee tum < 5 cm	$1,262.00
27330	Biopsy knee joint lining	$1,658.12
27331	Explore/treat knee joint	$1,658.12
27332	Removal of knee cartilage	$1,658.12
27333	Removal of knee cartilage	$1,658.12
27334	Remove knee joint lining	$1,658.12
27335	Remove knee joint lining	$3,686.38
27337	Exc thigh/knee les sc 3 cm/>	$1,262.00
27339	Exc thigh/knee tum dep 5cm/>	$1,262.00
27340	Removal of kneecap bursa	$1,658.12
27345	Removal of knee cyst	$1,658.12
27347	Remove knee cyst	$1,658.12
27350	Removal of kneecap	$3,686.38
27355	Remove femur lesion	$1,658.12
27356	Remove femur lesion/graft	$8,827.80
27357	Remove femur lesion/graft	$4,672.36
27360	Partial removal leg bone(s)	$1,658.12
27364	Resect thigh/knee tum 5 cm/>	$1,262.00
27372	Removal of foreign body	$1,262.00
27380	Repair of kneecap tendon	$3,686.38
27381	Repair/graft kneecap tendon	$4,681.27
27385	Repair of thigh muscle	$3,686.38
27386	Repair/graft of thigh muscle	$3,686.38
27390	Incision of thigh tendon	$1,658.12
27391	Incision of thigh tendons	$1,658.12
27392	Incision of thigh tendons	$1,658.12
27393	Lengthening of thigh tendon	$3,686.38
27394	Lengthening of thigh tendons	$3,686.38
27395	Lengthening of thigh tendons	$1,658.12
27396	Transplant of thigh tendon	$3,686.38
27397	Transplants of thigh tendons	$5,448.74
27400	Revise thigh muscles/tendons	$4,649.15
27403	Repair of knee cartilage	$4,766.19
27405	Repair of knee ligament	$3,686.38
27407	Repair of knee ligament	$5,246.46

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27409	Repair of knee ligaments	$3,686.38
27412	Autochondrocyte implant knee	$3,686.38
27415	Osteochondral knee allograft	$11,551.81
27416	Osteochondral knee autograft	$3,686.38
27418	Repair degenerated kneecap	$3,686.38
27420	Revision of unstable kneecap	$3,686.38
27422	Revision of unstable kneecap	$3,686.38
27424	Revision/removal of kneecap	$3,686.38
27425	Lat retinacular release open	$1,658.12
27427	Reconstruction knee	$5,015.55
27428	Reconstruction knee	$6,964.92
27429	Reconstruction knee	$9,882.43
27430	Revision of thigh muscles	$3,686.38
27435	Incision of knee joint	$1,658.12
27437	Revise kneecap	$3,686.38
27438	Revise kneecap with implant	$8,899.31
27440	Revision of knee joint	$9,447.35
27441	Revision of knee joint	$6,964.92
27442	Revision of knee joint	$9,232.23
27443	Revision of knee joint	$10,068.72
27446	Revision of knee joint	$9,536.30
27447	Total knee arthroplasty	$9,718.38
27475	Surgery to stop leg growth	$3,686.38
27479	Surgery to stop leg growth	$3,686.38
27496	Decompression of thigh/knee	$1,658.12
27497	Decompression of thigh/knee	$1,658.12
27498	Decompression of thigh/knee	$880.20
27499	Decompression of thigh/knee	$3,686.38
27500	Treatment of thigh fracture	$135.38
27501	Treatment of thigh fracture	$135.38
27502	Treatment of thigh fracture	$880.20
27503	Treatment of thigh fracture	$880.20
27508	Treatment of thigh fracture	$135.38
27509	Treatment of thigh fracture	$4,802.76
27510	Treatment of thigh fracture	$880.20
27516	Treat thigh fx growth plate	$135.38
27517	Treat thigh fx growth plate	$880.20
27520	Treat kneecap fracture	$135.38
27524	Treat kneecap fracture	$3,686.38
27530	Treat knee fracture	$135.38
27532	Treat knee fracture	$1,658.12
27538	Treat knee fracture(s)	$135.38
27550	Treat knee dislocation	$135.38

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27552	Treat knee dislocation	$880.20
27560	Treat kneecap dislocation	$135.38
27562	Treat kneecap dislocation	$135.38
27566	Treat kneecap dislocation	$3,686.38
27570	Fixation of knee joint	$880.20
27594	Amputation follow-up surgery	$1,658.12
27600	Decompression of lower leg	$1,658.12
27601	Decompression of lower leg	$1,658.12
27602	Decompression of lower leg	$1,658.12
27603	Drain lower leg lesion	$1,262.00
27604	Drain lower leg bursa	$1,658.12
27605	Incision of achilles tendon	$880.20
27606	Incision of achilles tendon	$1,658.12
27607	Treat lower leg bone lesion	$1,658.12
27610	Explore/treat ankle joint	$1,658.12
27612	Exploration of ankle joint	$1,658.12
27613	Biopsy lower leg soft tissue	$171.18
27614	Biopsy lower leg soft tissue	$1,262.00
27615	Resect leg/ankle tum < 5 cm	$1,262.00
27616	Resect leg/ankle tum 5 cm/>	$1,262.00
27618	Exc leg/ankle tum < 3 cm	$743.69
27619	Exc leg/ankle tum deep <5 cm	$1,262.00
27620	Explore/treat ankle joint	$1,658.12
27625	Remove ankle joint lining	$1,658.12
27626	Remove ankle joint lining	$1,658.12
27630	Removal of tendon lesion	$1,658.12
27632	Exc leg/ankle les sc 3 cm/>	$1,262.00
27634	Exc leg/ankle tum dep 5 cm/>	$1,262.00
27635	Remove lower leg bone lesion	$1,658.12
27637	Remove/graft leg bone lesion	$4,966.89
27638	Remove/graft leg bone lesion	$3,686.38
27640	Partial removal of tibia	$1,658.12
27641	Partial removal of fibula	$1,658.12
27647	Resect talus/calcaneus tum	$1,658.12
27650	Repair achilles tendon	$3,686.38
27652	Repair/graft achilles tendon	$4,859.69
27654	Repair of achilles tendon	$4,662.82
27656	Repair leg fascia defect	$1,658.12
27658	Repair of leg tendon each	$1,658.12
27659	Repair of leg tendon each	$3,686.38
27664	Repair of leg tendon each	$3,686.38
27665	Repair of leg tendon each	$4,660.59
27675	Repair lower leg tendons	$1,658.12

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27676	Repair lower leg tendons	$3,686.38
27680	Release of lower leg tendon	$1,658.12
27681	Release of lower leg tendons	$1,658.12
27685	Revision of lower leg tendon	$1,658.12
27686	Revise lower leg tendons	$1,658.12
27687	Revision of calf tendon	$1,658.12
27690	Revise lower leg tendon	$3,686.38
27691	Revise lower leg tendon	$3,686.38
27695	Repair of ankle ligament	$4,910.59
27696	Repair of ankle ligaments	$4,736.61
27698	Repair of ankle ligament	$4,809.13
27700	Revision of ankle joint	$5,582.34
27702	Reconstruct ankle joint	$15,619.26
27704	Removal of ankle implant	$1,658.12
27705	Osteotomy tibia	$4,650.09
27707	Osteotomy fibula	$1,658.12
27709	Osteotomy tibia & fibula	$9,056.16
27720	Repair of tibia	$4,877.19
27726	Repair fibula nonunion	$4,977.38
27730	Repair of tibia epiphysis	$2,101.62
27732	Repair of fibula epiphysis	$1,658.12
27734	Repair lower leg epiphyses	$1,658.12
27740	Repair of leg epiphyses	$1,658.12
27742	Repair of leg epiphyses	$1,658.12
27745	Reinforce tibia	$5,003.15
27750	Treatment of tibia fracture	$135.38
27752	Treatment of tibia fracture	$880.20
27756	Treatment of tibia fracture	$5,101.74
27758	Treatment of tibia fracture	$9,345.80
27759	Treatment of tibia fracture	$9,258.07
27760	Cltx medial ankle fx	$135.38
27762	Cltx med ankle fx w/mnpj	$880.20
27766	Optx medial ankle fx	$3,686.38
27767	Cltx post ankle fx	$135.38
27768	Cltx post ankle fx w/mnpj	$880.20
27769	Optx post ankle fx	$4,957.03
27780	Treatment of fibula fracture	$135.38
27781	Treatment of fibula fracture	$880.20
27784	Treatment of fibula fracture	$3,686.38
27786	Treatment of ankle fracture	$135.38
27788	Treatment of ankle fracture	$135.38
27792	Treatment of ankle fracture	$4,825.99
27808	Treatment of ankle fracture	$135.38

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27810	Treatment of ankle fracture	$880.20
27814	Treatment of ankle fracture	$4,795.77
27816	Treatment of ankle fracture	$135.38
27818	Treatment of ankle fracture	$880.20
27822	Treatment of ankle fracture	$4,838.70
27823	Treatment of ankle fracture	$4,748.38
27824	Treat lower leg fracture	$135.38
27825	Treat lower leg fracture	$880.20
27826	Treat lower leg fracture	$4,858.74
27827	Treat lower leg fracture	$9,196.77
27828	Treat lower leg fracture	$9,435.94
27829	Treat lower leg joint	$5,020.95
27830	Treat lower leg dislocation	$135.38
27831	Treat lower leg dislocation	$1,658.12
27832	Treat lower leg dislocation	$4,936.98
27840	Treat ankle dislocation	$135.38
27842	Treat ankle dislocation	$880.20
27846	Treat ankle dislocation	$3,686.38
27848	Treat ankle dislocation	$5,323.43
27860	Fixation of ankle joint	$1,658.12
27870	Fusion of ankle joint open	$10,068.72
27871	Fusion of tibiofibular joint	$9,979.78
27884	Amputation follow-up surgery	$1,658.12
27889	Ankle disarticulation	$3,686.38
27892	Decompression of leg	$1,658.12
27893	Decompression of leg	$3,686.38
27894	Decompression of leg	$1,658.12
28001	Drainage of bursa of foot	$99.52
28002	Treatment of foot infection	$880.20
28003	Treatment of foot infection	$1,658.12
28005	Treat foot bone lesion	$1,658.12
28008	Incision of foot fascia	$1,658.12
28010	Incision of toe tendon	$133.14
28011	Incision of toe tendons	$880.20
28020	Exploration of foot joint	$1,658.12
28022	Exploration of foot joint	$1,658.12
28024	Exploration of toe joint	$880.20
28035	Decompression of tibia nerve	$971.18
28039	Exc foot/toe tum sc 1.5 cm/>	$1,262.00
28041	Exc foot/toe tum dep 1.5cm/>	$1,262.00
28043	Exc foot/toe tum sc < 1.5 cm	$743.69
28045	Exc foot/toe tum deep <1.5cm	$1,262.00
28046	Resect foot/toe tumor < 3 cm	$1,262.00

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28047	Resect foot/toe tumor 3 cm/>	$1,262.00
28050	Biopsy of foot joint lining	$1,658.12
28052	Biopsy of foot joint lining	$1,658.12
28054	Biopsy of toe joint lining	$1,658.12
28055	Neurectomy foot	$971.18
28060	Partial removal foot fascia	$1,658.12
28062	Removal of foot fascia	$1,658.12
28070	Removal of foot joint lining	$3,686.38
28072	Removal of foot joint lining	$1,658.12
28080	Removal of foot lesion	$880.20
28086	Excise foot tendon sheath	$1,658.12
28088	Excise foot tendon sheath	$1,658.12
28090	Removal of foot lesion	$880.20
28092	Removal of toe lesions	$880.20
28100	Removal of ankle/heel lesion	$1,658.12
28102	Remove/graft foot lesion	$5,286.86
28103	Remove/graft foot lesion	$5,512.35
28104	Removal of foot lesion	$1,658.12
28106	Remove/graft foot lesion	$5,950.96
28107	Remove/graft foot lesion	$3,686.38
28108	Removal of toe lesions	$880.20
28110	Part removal of metatarsal	$1,658.12
28111	Part removal of metatarsal	$1,658.12
28112	Part removal of metatarsal	$1,658.12
28113	Part removal of metatarsal	$1,658.12
28114	Removal of metatarsal heads	$1,658.12
28116	Revision of foot	$1,658.12
28118	Removal of heel bone	$1,658.12
28119	Removal of heel spur	$1,658.12
28120	Part removal of ankle/heel	$1,658.12
28122	Partial removal of foot bone	$1,658.12
28124	Partial removal of toe	$300.24
28126	Partial removal of toe	$1,658.12
28130	Removal of ankle bone	$4,672.36
28140	Removal of metatarsal	$1,658.12
28150	Removal of toe	$1,658.12
28153	Partial removal of toe	$1,658.12
28160	Partial removal of toe	$1,658.12
28171	Resect tarsal tumor	$1,658.12
28173	Resect metatarsal tumor	$1,658.12
28175	Resect phalanx of toe tumor	$880.20
28190	Removal of foot foreign body	$166.43
28192	Removal of foot foreign body	$743.69

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28193	Removal of foot foreign body	$743.69
28200	Repair of foot tendon	$1,658.12
28202	Repair/graft of foot tendon	$4,968.16
28208	Repair of foot tendon	$1,658.12
28210	Repair/graft of foot tendon	$5,080.44
28220	Release of foot tendon	$280.54
28222	Release of foot tendons	$1,658.12
28225	Release of foot tendon	$1,658.12
28226	Release of foot tendons	$1,658.12
28230	Incision of foot tendon(s)	$276.80
28232	Incision of toe tendon	$251.67
28234	Incision of foot tendon	$880.20
28238	Revision of foot tendon	$3,686.38
28240	Release of big toe	$1,658.12
28250	Revision of foot fascia	$1,658.12
28260	Release of midfoot joint	$1,658.12
28261	Revision of foot tendon	$880.20
28262	Revision of foot and ankle	$4,672.36
28264	Release of midfoot joint	$880.20
28270	Release of foot contracture	$1,658.12
28272	Release of toe joint each	$243.52
28280	Fusion of toes	$1,658.12
28285	Repair of hammertoe	$1,658.12
28286	Repair of hammertoe	$1,658.12
28288	Partial removal of foot bone	$1,658.12
28289	Corrj halux rigdus w/o implt	$1,658.12
28291	Corrj halux rigdus w/implt	$5,096.97
28292	Cor hlx vlgs rsc prx phlx bs	$1,658.12
28295	Cor hlx vlgs prx mtar osteot	$1,658.12
28296	Cor hlx vlgs dstl mtar osteo	$1,658.12
28297	Cor hlx vlgs jt arthrd	$10,310.90
28298	Cor hlx vlgs prx phlx osteot	$4,653.92
28299	Cor hlx vlgs double osteot	$4,700.67
28300	Incision of heel bone	$4,784.33
28302	Incision of ankle bone	$4,683.49
28304	Incision of midfoot bones	$3,686.38
28305	Incise/graft midfoot bones	$5,116.05
28306	Incision of metatarsal	$3,686.38
28307	Incision of metatarsal	$3,686.38
28308	Incision of metatarsal	$1,658.12
28309	Incision of metatarsals	$3,686.38
28310	Revision of big toe	$3,686.38
28312	Revision of toe	$1,658.12

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28313	Repair deformity of toe	$1,658.12
28315	Removal of sesamoid bone	$1,658.12
28320	Repair of foot bones	$8,938.98
28322	Repair of metatarsals	$5,021.28
28340	Resect enlarged toe tissue	$1,658.12
28341	Resect enlarged toe	$1,658.12
28344	Repair extra toe(s)	$1,658.12
28345	Repair webbed toe(s)	$880.20
28400	Treatment of heel fracture	$135.38
28405	Treatment of heel fracture	$135.38
28406	Treatment of heel fracture	$3,686.38
28415	Treat heel fracture	$4,862.88
28420	Treat/graft heel fracture	$9,813.32
28430	Treatment of ankle fracture	$135.38
28435	Treatment of ankle fracture	$880.20
28436	Treatment of ankle fracture	$6,387.65
28445	Treat ankle fracture	$3,686.38
28446	Osteochondral talus autogrft	$4,672.36
28450	Treat midfoot fracture each	$135.38
28455	Treat midfoot fracture each	$149.78
28456	Treat midfoot fracture	$3,686.38
28465	Treat midfoot fracture each	$4,735.33
28470	Treat metatarsal fracture	$135.38
28475	Treat metatarsal fracture	$135.38
28476	Treat metatarsal fracture	$1,658.12
28485	Treat metatarsal fracture	$4,754.42
28490	Treat big toe fracture	$106.30
28495	Treat big toe fracture	$128.38
28496	Treat big toe fracture	$1,658.12
28505	Treat big toe fracture	$1,658.12
28510	Treatment of toe fracture	$84.23
28515	Treatment of toe fracture	$115.48
28525	Treat toe fracture	$1,658.12
28530	Treat sesamoid bone fracture	$83.55
28531	Treat sesamoid bone fracture	$3,686.38
28540	Treat foot dislocation	$127.03
28545	Treat foot dislocation	$1,658.12
28546	Treat foot dislocation	$1,183.97
28555	Repair foot dislocation	$5,287.17
28570	Treat foot dislocation	$135.38
28575	Treat foot dislocation	$1,658.12
28576	Treat foot dislocation	$3,686.38
28585	Repair foot dislocation	$5,287.17

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28600	Treat foot dislocation	$135.38
28605	Treat foot dislocation	$135.38
28606	Treat foot dislocation	$1,658.12
28615	Repair foot dislocation	$4,709.89
28630	Treat toe dislocation	$92.38
28635	Treat toe dislocation	$880.20
28636	Treat toe dislocation	$1,658.12
28645	Repair toe dislocation	$1,658.12
28660	Treat toe dislocation	$80.83
28665	Treat toe dislocation	$149.66
28666	Treat toe dislocation	$1,658.12
28675	Repair of toe dislocation	$1,658.12
28705	Arthrodesis pantalar	$14,799.08
28715	Arthrodesis triple	$10,182.90
28725	Arthrodesis subtalar	$9,919.69
28730	Fusion of foot bones	$10,348.15
28735	Fusion of foot bones	$10,436.49
28737	Revision of foot bones	$10,638.40
28740	Fusion of foot bones	$5,298.62
28750	Fusion of big toe joint	$5,200.98
28755	Fusion of big toe joint	$3,686.38
28760	Fusion of big toe joint	$3,686.38
28810	Amputation toe & metatarsal	$1,658.12
28820	Amputation of toe	$1,658.12
28825	Partial amputation of toe	$1,658.12
28890	Hi enrgy eswt plantar fascia	$189.51
29000	Application of body cast	$149.66
29010	Application of body cast	$149.66
29015	Application of body cast	$149.66
29035	Application of body cast	$149.66
29040	Application of body cast	$149.66
29044	Application of body cast	$88.95
29046	Application of body cast	$149.66
29049	Application of figure eight	$69.96
29055	Application of shoulder cast	$149.66
29058	Application of shoulder cast	$77.44
29065	Application of long arm cast	$67.59
29075	Application of forearm cast	$61.81
29085	Apply hand/wrist cast	$67.25
29086	Apply finger cast	$59.09
29105	Apply long arm splint	$54.68
29200	Strapping thorax	$18.34
29305	Application of hip cast	$149.66

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29325	Application of hip casts	$149.66
29345	Application of long leg cast	$85.93
29355	Application of long leg cast	$87.29
29358	Apply long leg cast brace	$113.44
29365	Application of long leg cast	$83.21
29405	Apply short leg cast	$53.32
29425	Apply short leg cast	$48.91
29435	Apply short leg cast	$82.88
29440	Addition of walker to cast	$24.12
29445	Apply rigid leg cast	$65.55
29450	Application of leg cast	$72.00
29505	Application long leg splint	$68.27
29515	Application lower leg splint	$47.89
29540	Strapping of ankle and/or ft	$14.61
29580	Strapping unna boot	$43.47
29581	Apply multlay comprs lwr leg	$67.92
29584	Appl multlay comprs arm/hand	$67.25
29700	Removal/revision of cast	$45.51
29705	Removal/revision of cast	$36.68
29710	Removal/revision of cast	$74.72
29720	Repair of body cast	$63.85
29730	Windowing of cast	$37.36
29740	Wedging of cast	$58.42
29750	Wedging of clubfoot cast	$60.80
29800	Jaw arthroscopy/surgery	$1,658.12
29804	Jaw arthroscopy/surgery	$1,658.12
29805	Sho arthrs dx +- synovial bx	$1,658.12
29806	Sho arthrs srg capsulorraphy	$3,686.38
29807	Sho arthrs srg rpr slap les	$3,686.38
29819	Sho arthrs srg rmvl loose/fb	$1,658.12
29820	Sho arthrs srg prtl synvct	$3,686.38
29821	Sho arthrs srg compl synvct	$1,658.12
29822	Sho arthrs srg lmtd dbrdmt	$1,658.12
29823	Sho arthrs srg xtnsv dbrdmt	$1,658.12
29824	Sho arthrs srg dstl claviclc	$1,658.12
29825	Sho arthrs srg lss&rescj ads	$1,658.12
29827	Sho arthrs srg rt8tr cuf rpr	$3,686.38
29828	Sho arthrs srg bicp tenodsis	$3,686.38
29830	Elbow arthroscopy	$1,658.12
29834	Elbow arthroscopy/surgery	$1,658.12
29835	Elbow arthroscopy/surgery	$1,658.12
29836	Elbow arthroscopy/surgery	$3,686.38
29837	Elbow arthroscopy/surgery	$1,658.12

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29838	Elbow arthroscopy/surgery	$1,658.12
29840	Wrist arthroscopy	$1,658.12
29843	Wrist arthroscopy/surgery	$1,658.12
29844	Wrist arthroscopy/surgery	$1,658.12
29845	Wrist arthroscopy/surgery	$1,658.12
29846	Wrist arthroscopy/surgery	$1,658.12
29847	Wrist arthroscopy/surgery	$3,686.38
29848	Wrist endoscopy/surgery	$880.20
29850	Knee arthroscopy/surgery	$880.20
29851	Knee arthroscopy/surgery	$880.20
29855	Tibial arthroscopy/surgery	$4,981.52
29856	Tibial arthroscopy/surgery	$11,381.75
29860	Hip arthroscopy dx	$3,686.38
29861	Hip arthro w/fb removal	$3,686.38
29862	Hip arthr0 w/debridement	$3,686.38
29863	Hip arthr0 w/synovectomy	$1,658.12
29866	Autgrft implnt knee w/scope	$3,686.38
29867	Allgrft implnt knee w/scope	$10,513.41
29868	Meniscal trnspl knee w/scpe	$3,686.38
29870	Knee arthroscopy dx	$1,658.12
29871	Knee arthroscopy/drainage	$1,658.12
29873	Knee arthroscopy/surgery	$1,658.12
29874	Knee arthroscopy/surgery	$1,658.12
29875	Knee arthroscopy/surgery	$1,658.12
29876	Knee arthroscopy/surgery	$1,658.12
29877	Knee arthroscopy/surgery	$1,658.12
29879	Knee arthroscopy/surgery	$1,658.12
29880	Knee arthroscopy/surgery	$1,658.12
29881	Knee arthroscopy/surgery	$1,658.12
29882	Knee arthroscopy/surgery	$1,658.12
29883	Knee arthroscopy/surgery	$1,658.12
29884	Knee arthroscopy/surgery	$1,658.12
29885	Knee arthroscopy/surgery	$4,980.24
29886	Knee arthroscopy/surgery	$1,658.12
29887	Knee arthroscopy/surgery	$5,288.44
29888	Knee arthroscopy/surgery	$4,859.69
29889	Knee arthroscopy/surgery	$8,902.32
29891	Ankle arthroscopy/surgery	$1,658.12
29892	Ankle arthroscopy/surgery	$3,686.38
29893	Scope plantar fasciotomy	$1,658.12
29894	Ankle arthroscopy/surgery	$1,658.12
29895	Ankle arthroscopy/surgery	$1,658.12
29897	Ankle arthroscopy/surgery	$1,658.12

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29898	Ankle arthroscopy/surgery	$1,658.12
29899	Ankle arthroscopy/surgery	$4,672.36
29900	Mcp joint arthroscopy dx	$1,658.12
29901	Mcp joint arthroscopy surg	$1,658.12
29902	Mcp joint arthroscopy surg	$880.20
29904	Subtalar arthro w/fb rmvl	$1,658.12
29905	Subtalar arthro w/exc	$3,686.38
29906	Subtalar arthro w/deb	$1,658.12
29907	Subtalar arthro w/fusion	$9,280.30
29914	Hip arthro w/femoroplasty	$3,686.38
29915	Hip arthro acetabuloplasty	$3,686.38
29916	Hip arthro w/labral repair	$3,686.38
30000	Drainage of nose lesion	$130.34
30020	Drainage of nose lesion	$211.60
30100	Intranasal biopsy	$104.95
30110	Removal of nose polyp(s)	$186.12
30115	Removal of nose polyp(s)	$1,464.17
30117	Removal of intranasal lesion	$1,464.17
30118	Removal of intranasal lesion	$1,464.17
30120	Revision of nose	$1,464.17
30124	Removal of nose lesion	$690.25
30125	Removal of nose lesion	$3,063.22
30130	Excise inferior turbinate	$1,464.17
30140	Resect inferior turbinate	$1,464.17
30150	Rhinectomy partial	$3,063.22
30160	Rhinectomy total	$3,063.22
30200	Injection treatment of nose	$80.83
30210	Nasal sinus therapy	$110.39
30220	Insert nasal septal button	$690.25
30310	Remove nasal foreign body	$1,464.17
30320	Remove nasal foreign body	$690.25
30400	Reconstruction of nose	$3,063.22
30410	Reconstruction of nose	$3,063.22
30420	Reconstruction of nose	$3,063.22
30430	Revision of nose	$3,063.22
30435	Revision of nose	$3,063.22
30450	Revision of nose	$3,063.22
30460	Revision of nose	$3,063.22
30462	Revision of nose	$3,063.22
30465	Repair nasal stenosis	$3,063.22
30468	Rpr nsl vlv collapse w/implt	$4,414.80
30469	Rpr nsl vlv collapse w/rmdlg	$4,012.82
30520	Repair of nasal septum	$1,464.17

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30540	Rpr choanal atresia ntranasl	$3,063.22
30545	Rpr choanal atresia trsnpltn	$3,063.22
30560	Lysis intranasal synechia	$286.69
30580	Repair upper jaw fistula	$3,063.22
30600	Repair mouth/nose fistula	$3,063.22
30620	Intranasal reconstruction	$3,063.22
30630	Repair nasal septum defect	$1,464.17
30801	Ablate inf turbinate superf	$690.25
30802	Ablate inf turbinate submuc	$690.25
30903	Control of nosebleed	$73.26
30905	Control of nosebleed	$73.26
30906	Repeat control of nosebleed	$130.34
30915	Ligation nasal sinus artery	$1,668.12
30920	Ligation upper jaw artery	$1,668.12
30930	Ther fx nasal inf turbinate	$1,464.17
31000	Irrigation maxillary sinus	$130.34
31002	Irrigation sphenoid sinus	$690.25
31020	Exploration maxillary sinus	$1,464.17
31030	Exploration maxillary sinus	$3,063.22
31032	Explore sinus remove polyps	$3,063.22
31040	Exploration behind upper jaw	$3,063.22
31050	Exploration sphenoid sinus	$3,063.22
31051	Sphenoid sinus surgery	$3,063.22
31070	Exploration of frontal sinus	$3,063.22
31075	Exploration of frontal sinus	$3,063.22
31080	Removal of frontal sinus	$3,063.22
31081	Removal of frontal sinus	$3,063.22
31084	Removal of frontal sinus	$3,882.52
31085	Removal of frontal sinus	$3,989.02
31086	Removal of frontal sinus	$3,063.22
31087	Removal of frontal sinus	$4,349.78
31090	Exploration of sinuses	$3,063.22
31200	Removal of ethmoid sinus	$3,063.22
31201	Removal of ethmoid sinus	$690.25
31205	Removal of ethmoid sinus	$1,464.17
31231	Nasal endoscopy dx	$109.66
31233	Nsl/sins ndsc dx max sinusc	$219.15
31235	Nsl/sins ndsc dx sphn sinusc	$831.75
31237	Nsl/sins ndsc surg bx polypc	$831.75
31238	Nsl/sins ndsc srg nsl hemrrg	$831.75
31239	Nsl/sinus endoscopy surg dcr	$1,690.83
31240	Nsl/sns ndsc cnch bull rescj	$831.75
31242	Nsl/sinus ndsc rf abltj pnn	$3,882.52

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31243	Nsl/sinus ndsc cryoabltj pnn	$4,297.19
31253	Nsl/sins ndsc total	$2,547.13
31254	Nsl/sins ndsc w/prtl ethmdct	$2,547.13
31255	Nsl/sins ndsc w/tot ethmdct	$2,547.13
31256	Exploration maxillary sinus	$1,690.83
31257	Nsl/sins ndsc tot w/sphendt	$2,547.13
31259	Nsl/sins ndsc sphn tiss rmvl	$2,547.13
31267	Endoscopy maxillary sinus	$2,547.13
31276	Nsl/sins ndsc frnt tiss rmvl	$2,547.13
31287	Nasal/sinus endoscopy surg	$2,547.13
31288	Nasal/sinus endoscopy surg	$2,547.13
31295	Nsl/sins ndsc surg max sins	$3,228.40
31296	Nsl/sins ndsc surg frnt sins	$1,503.58
31297	Nsl/sins ndsc surg sphn sins	$1,488.29
31298	Nsl/sins ndsc surg frnt&sphn	$3,265.10
31300	Removal of larynx lesion	$1,464.17
31400	Revision of larynx	$3,063.22
31420	Epiglottidectomy	$3,063.22
31500	Insert emergency airway	$130.34
31502	Change of windpipe airway	$130.34
31505	Diagnostic laryngoscopy	$66.57
31510	Laryngoscopy with biopsy	$1,690.83
31511	Remove foreign body larynx	$109.66
31512	Removal of larynx lesion	$1,690.83
31513	Injection into vocal cord	$219.15
31515	Laryngoscopy for aspiration	$219.15
31520	Dx laryngoscopy newborn	$219.15
31525	Dx laryngoscopy excl nb	$831.75
31526	Dx laryngoscopy w/oper scope	$831.75
31527	Laryngoscopy for treatment	$1,690.83
31528	Laryngoscopy and dilation	$1,690.83
31529	Laryngoscopy and dilation	$1,690.83
31530	Laryngoscopy w/fb removal	$831.75
31531	Laryngoscopy w/fb & op scope	$1,690.83
31535	Laryngoscopy w/biopsy	$1,690.83
31536	Laryngoscopy w/bx & op scope	$1,690.83
31540	Laryngoscopy w/exc of tumor	$1,690.83
31541	Larynscop w/tumr exc + scope	$1,690.83
31545	Remove vc lesion w/scope	$1,690.83
31546	Remove vc lesion scope/graft	$2,547.13
31551	Laryngoplasty laryngeal sten	$3,063.22
31552	Laryngoplasty laryngeal sten	$3,063.22
31553	Laryngoplasty laryngeal sten	$3,063.22

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31554	Laryngoplasty laryngeal sten	$3,063.22
31560	Laryngoscop w/arytenoidectom	$2,547.13
31561	Larynscop remve cart + scop	$2,547.13
31570	Laryngoscope w/vc inj	$1,690.83
31571	Laryngoscop w/vc inj + scope	$1,690.83
31572	Largsc w/laser dstrj les	$1,690.83
31573	Largsc w/ther injection	$196.31
31574	Largsc w/njx augmentation	$817.85
31575	Diagnostic laryngoscopy	$93.06
31576	Laryngoscopy with biopsy	$831.75
31577	Largsc w/rmvl foreign bdy(s)	$219.15
31578	Largsc w/removal lesion	$1,690.83
31579	Laryngoscopy telescopic	$127.70
31580	Laryngoplasty laryngeal web	$3,063.22
31590	Reinnervate larynx	$3,063.22
31591	Laryngoplasty medialization	$3,063.22
31592	Cricotracheal resection	$3,063.22
31603	Emer tracheostomy ttrach	$690.25
31605	Emer tracheostomy cthyr mem	$130.34
31611	Constj trachesophgl fstl	$1,464.17
31612	Perq trchl pnxr ttrach aspir	$1,464.17
31613	Tracheostoma revj simple	$1,464.17
31614	Tracheostoma revj complex	$3,063.22
31615	Trcheobrnchsc est trachs inc	$286.69
31622	Dx bronchoscope/wash	$831.75
31623	Dx bronchoscope/brush	$831.75
31624	Dx bronchoscope/lavage	$831.75
31625	Bronchoscopy w/biopsy(s)	$831.75
31626	Bronchoscopy w/markers	$2,547.13
31628	Bronchoscopy/lung bx each	$1,690.83
31629	Bronchoscopy/needle bx each	$1,690.83
31630	Bronchoscopy dilate/fx repr	$1,690.83
31631	Bronchoscopy dilate w/stent	$2,547.13
31634	Bronch w/balloon occlusion	$2,547.13
31635	Bronchoscopy w/fb removal	$831.75
31636	Bronchoscopy bronch stents	$3,614.96
31638	Bronchoscopy revise stent	$2,547.13
31640	Bronchoscopy w/tumor excise	$1,690.83
31641	Bronchoscopy treat blockage	$1,690.83
31643	Diag bronchoscope/catheter	$831.75
31645	Brnchsc w/ther aspir 1st	$831.75
31646	Brnchsc w/ther aspir sbsq	$219.15
31647	Bronchial valve init insert	$3,510.80

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31648	Bronchial valve remov init	$1,690.83
31649	Bronchial valve remov addl	$831.75
31652	Bronch ebus sampling 1/2 node	$1,690.83
31653	Bronch ebus sampling 3/> node	$1,690.83
31717	Bronchial brush biopsy	$219.15
31730	Intro windpipe wire/tube	$831.75
31750	Tracheoplasty cervical	$3,063.22
31755	Trachplsty trchphryngl fstlj	$3,063.22
31820	Closure of windpipe lesion	$1,464.17
31825	Repair of windpipe defect	$1,464.17
31830	Revise windpipe scar	$1,464.17
32400	Needle biopsy chest lining	$743.69
32408	Core ndl bx lng/med perq	$743.69
32550	Insert pleural cath	$2,317.64
32552	Remove lung catheter	$348.93
32553	Ins mark thor for rt perq	$1,027.20
32554	Aspirate pleura w/o imaging	$348.93
32555	Aspirate pleura w/ imaging	$348.93
32556	Insert cath pleura w/o image	$907.36
32557	Insert cath pleura w/ image	$664.02
32960	Therapeutic pneumothorax	$348.93
32994	Ablate pulm tumor perq crybl	$7,391.79
32998	Ablate pulm tumor perq rf	$3,003.34
33016	Pericardiocentesis w/imaging	$664.02
33206	Insert heart pm atrial	$7,778.52
33207	Insert heart pm ventricular	$7,968.72
33208	Insrt heart pm atrial & vent	$8,074.20
33210	Insert electrd/pm cath sngl	$4,584.90
33211	Insert card electrodes dual	$7,789.11
33212	Insert pulse gen sngl lead	$6,845.24
33213	Insert pulse gen dual leads	$7,923.13
33214	Upgrade of pacemaker system	$7,975.17
33215	Reposition pacing-defib lead	$1,668.12
33216	Insert 1 electrode pm-defib	$6,197.68
33217	Insert 2 electrode pm-defib	$6,487.65
33218	Repair lead pace-defib one	$2,051.52
33220	Repair lead pace-defib dual	$2,051.52
33221	Insert pulse gen mult leads	$14,161.11
33222	Relocation pocket pacemaker	$1,030.14
33223	Relocate pocket for defib	$1,030.14
33224	Insert pacing lead & connect	$8,018.47
33226	Reposition l ventric lead	$2,278.23
33227	Remove&replace pm gen singl	$6,744.77

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33228	Remv&replc pm gen dual lead	$7,908.39
33229	Remv&replc pm gen mult leads	$13,883.57
33230	Insrt pulse gen w/dual leads	$20,211.65
33231	Insrt pulse gen w/mult leads	$26,049.93
33233	Removal of pm generator	$5,781.53
33234	Removal of pacemaker system	$2,051.52
33235	Removal pacemaker electrode	$2,051.52
33240	Insrt pulse gen w/singl lead	$19,522.74
33241	Remove pulse generator	$2,051.52
33249	Insj/rplcmt defib w/lead(s)	$26,170.63
33262	Rmvl& replc pulse gen 1 lead	$19,659.02
33263	Rmvl & rplcmt dfb gen 2 lead	$19,798.52
33264	Rmvl & rplcmt dfb gen mlt ld	$26,412.05
33270	Ins/rep subq defibrillator	$26,720.82
33271	Insj subq impltbl dfb elctrd	$7,876.53
33273	Repos prev impltbl subq dfb	$2,051.52
33274	Tcat insj/rpl perm ldls pm	$14,297.15
33275	Tcat rmvl perm ldls pm w/img	$2,575.29
33276	Insj phrnc nrv stim sys	$38,982.33
33278	Rmvl phrnc nrv stim sys	$2,041.55
33279	Rmvl phrnc nrv stim transvns	$2,587.59
33280	Rmvl phrnc nrv stim pg only	$2,041.55
33281	Reposg phrnc nrv stim trnsvn	$2,041.55
33285	Insj subq car rhythm mntr	$7,379.28
33286	Rmvl subq car rhythm mntr	$396.48
33287	Rmv&rplcmt phrnc nrv stim pg	$26,533.33
33288	Rmv&rplcmt phrnc nrv stim ld	$11,446.71
33289	Tcat impl wrls p-art prs snr	$26,472.42
33900	Perq p-art revsc 1 nm nt uni	$6,776.90
33901	Perq p-art revsc 1 nm nt bi	$7,360.47
33902	Perq p-art revsc 1 abnor uni	$12,137.80
33903	Perq p-art revsc 1 abnor bi	$8,460.26
34490	Removal of vein clot	$2,114.30
35188	Rpr acq av fistula head&neck	$3,160.03
35207	Rpr bld vsl dir hand finger	$1,668.12
35875	Removal of clot in graft	$3,160.03
35876	Removal of clot in graft	$3,160.03
36002	Pseudoaneurysm injection trt	$348.93
36260	Insertion of infusion pump	$3,160.03
36261	Revision of infusion pump	$2,051.52
36262	Removal of infusion pump	$2,051.52
36430	Transfusion bld/bld compnt	$42.80
36440	Bld push tfuj 2 yr/<	$248.82

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36450	Bld exchange truj newborn	$248.82
36455	Bld exchange truj oth thn nb	$248.82
36465	Njx noncmpnd sclrsnt 1 vein	$1,030.14
36466	Njx noncmpnd sclrsnt mlt vn	$1,030.14
36470	Njx sclrsnt 1 incmptnt vein	$86.60
36471	Njx sclrsnt mlt incmptnt vn	$140.61
36473	Endovenous mchnchem 1st vein	$1,008.39
36475	Endovenous rf 1st vein	$1,668.12
36478	Endovenous laser 1st vein	$1,668.12
36482	Endoven ther chem adhes 1st	$1,464.52
36511	Apheresis wbc	$923.60
36512	Apheresis rbc	$923.60
36513	Apheresis platelets	$248.82
36514	Apheresis plasma	$923.60
36516	Apheresis immunoads slctv	$2,110.85
36522	Photopheresis	$2,641.05
36555	Insert non-tunnel cv cath	$1,668.12
36556	Insert non-tunnel cv cath	$1,668.12
36557	Insert tunneled cv cath	$3,160.03
36558	Insert tunneled cv cath	$1,668.12
36560	Insert tunneled cv cath	$1,668.12
36561	Insert tunneled cv cath	$1,668.12
36563	Insert tunneled cv cath	$3,160.03
36565	Insert tunneled cv cath	$1,668.12
36566	Insert tunneled cv cath	$3,160.03
36568	Insj picc <5 yr w/o imaging	$664.02
36569	Insj picc 5 yr+ w/o imaging	$664.02
36570	Insert picvad cath	$1,668.12
36571	Insert picvad cath	$1,668.12
36572	Insj picc rs&i <5 yr	$348.93
36573	Insj picc rs&i 5 yr+	$664.02
36575	Repair tunneled cv cath	$348.93
36576	Repair tunneled cv cath	$664.02
36578	Replace tunneled cv cath	$2,107.97
36580	Replace cvad cath	$664.02
36581	Replace tunneled cv cath	$2,120.49
36582	Replace tunneled cv cath	$1,668.12
36583	Replace tunneled cv cath	$5,546.76
36584	Compl rplcmt picc rs&i	$664.02
36585	Replace picvad cath	$1,668.12
36589	Removal tunneled cv cath	$348.93
36590	Removal tunneled cv cath	$664.02
36593	Declot vascular device	$34.64

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36595	Mech remov tunneled cv cath	$442.21
36596	Mech remov tunneled cv cath	$664.02
36597	Reposition venous catheter	$664.02
36598	Inj w/fluor eval cv device	$91.02
36640	Insertion catheter artery	$1,668.12
36800	Insertion of cannula	$3,160.03
36810	Insertion of cannula	$2,123.79
36815	Insertion of cannula	$3,160.03
36818	Av fuse uppr arm cephalic	$3,160.03
36819	Av fuse uppr arm basilic	$3,160.03
36820	Av fusion/forearm vein	$3,160.03
36821	Av fusion direct any site	$1,668.12
36825	Artery-vein autograft	$3,160.03
36830	Artery-vein nonautograft	$3,160.03
36831	Open thrombect av fistula	$3,160.03
36832	Av fistula revision open	$3,160.03
36833	Av fistula revision	$3,160.03
36835	Insertion thomas shunt	$2,389.77
36836	Prq av fstl crtj uxtr 1 acs	$12,149.68
36837	Prq av fstl crt uxtr sep acs	$11,894.33
36860	External cannula declotting	$664.02
36861	Cannula declotting	$4,596.60
36901	Intro cath dialysis circuit	$554.63
36902	Intro cath dialysis circuit	$2,761.10
36903	Intro cath dialysis circuit	$7,718.92
36904	Thrmbc/nfs dialysis circuit	$3,691.61
36905	Thrmbc/nfs dialysis circuit	$6,815.66
36906	Thrmbc/nfs dialysis circuit	$12,372.37
37184	Prim art m-thrmbc 1st vsl	$12,540.13
37187	Venous mech thrombectomy	$8,190.39
37188	Ven mechnl thrmbc repeat tx	$2,798.95
37192	Redo endovas vena cava filtr	$2,272.47
37193	Rem endovas vena cava filter	$1,668.12
37197	Remove intrvas foreign body	$1,668.12
37200	Transcatheter biopsy	$3,160.03
37211	Thrombolytic art therapy	$4,186.54
37212	Thrombolytic venous therapy	$1,668.12
37220	Iliac revasc	$3,596.81
37221	Iliac revasc w/stent	$7,534.85
37224	Fem/popl revas w/tla	$3,821.69
37225	Fem/popl revas w/ather	$13,067.18
37226	Fem/popl revasc w/stent	$7,957.88
37227	Fem/popl revasc stnt & ather	$13,166.65

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37228	Tib/per revasc w/tla	$6,933.29
37229	Tib/per revasc w/ather	$12,448.09
37230	Tib/per revasc w/stent	$12,010.87
37231	Tib/per revasc stent & ather	$12,874.18
37236	Open/perq place stent 1st	$7,375.69
37238	Open/perq place stent same	$7,457.35
37241	Vasc embolize/occlude venous	$6,776.90
37242	Vasc embolize/occlude artery	$12,454.03
37243	Vasc embolize/occlude organ	$6,856.71
37246	Trluml balo angiop 1st art	$3,593.47
37248	Trluml balo angiop 1st vein	$3,486.98
37500	Endoscopy ligate perf veins	$3,160.03
37607	Lig/banding angioacs av fstl	$1,668.12
37609	Ligation/bx temporal artery	$743.69
37650	Ligation of femoral vein	$1,668.12
37700	Ligation&div long saph vein	$1,668.12
37718	Lig div&strpg short saph vn	$1,668.12
37722	Lig div&strpg long saph vein	$1,668.12
37735	Lig&div&compl strpg saph vn	$1,668.12
37760	Lig prfratr vn radical 1 leg	$1,668.12
37761	Ligate leg veins open	$1,668.12
37765	Stab phleb veins xtr 10-20	$218.04
37766	Phleb veins - extrem 20+	$244.88
37780	Revision of leg vein	$1,668.12
37785	Ligate/divide/excise vein	$1,668.12
37790	Penile venous occlusion	$1,738.08
38206	Harvest auto stem cells	$923.60
38220	Dx bone marrow aspirations	$116.16
38221	Dx bone marrow biopsies	$116.83
38222	Dx bone marrow bx & aspir	$1,262.00
38230	Bone marrow harvest allogen	$923.60
38232	Bone marrow harvest autolog	$2,641.05
38241	Transplt autol hct/donor	$923.60
38242	Transplt allo lymphocytes	$923.60
38243	Transplj hematopoietic boost	$923.60
38300	Drainage lymph node lesion	$1,262.00
38305	Drainage lymph node lesion	$1,262.00
38308	Incision of lymph channels	$1,614.95
38500	Biopsy/removal lymph nodes	$1,614.95
38505	Needle biopsy lymph nodes	$743.69
38510	Biopsy/removal lymph nodes	$1,614.95
38520	Biopsy/removal lymph nodes	$1,614.95
38525	Biopsy/removal lymph nodes	$1,614.95

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38530	Biopsy/removal lymph nodes	$1,614.95
38531	Open bx/exc inguinofem nodes	$1,614.95
38542	Explore deep node(s) neck	$3,003.34
38550	Removal neck/armpit lesion	$1,614.95
38555	Removal neck/armpit lesion	$2,816.52
38570	Laparoscopy lymph node biop	$3,003.34
38571	Laparoscopy lymphadenectomy	$5,140.80
38572	Laparoscopy lymphadenectomy	$5,140.80
38573	Laps pelvic lymphadec	$5,140.80
38700	Removal of lymph nodes neck	$2,816.52
38740	Remove armpit lymph nodes	$3,003.34
38745	Remove armpit lymph nodes	$3,003.34
38760	Remove groin lymph nodes	$2,816.52
40490	Biopsy of lip	$78.46
40500	Partial excision of lip	$1,464.17
40510	Partial excision of lip	$1,464.17
40520	Partial excision of lip	$1,464.17
40525	Reconstruct lip with flap	$1,464.17
40527	Reconstruct lip with flap	$3,063.22
40530	Partial removal of lip	$1,464.17
40650	Rpr lip fth vermilion only	$286.69
40652	Rpr lip fth<half ver height	$286.69
40654	Rpr lip fth>1half ver ht/cpx	$690.25
40700	Repair cleft lip/nasal	$3,063.22
40701	Repair cleft lip/nasal	$3,063.22
40702	Repair cleft lip/nasal	$3,063.22
40720	Repair cleft lip/nasal	$1,464.17
40761	Repair cleft lip/nasal	$3,063.22
40800	Drainage of mouth lesion	$161.67
40801	Drainage of mouth lesion	$286.69
40805	Removal foreign body mouth	$189.86
40806	Incision of lip fold	$90.34
40808	Biopsy of mouth lesion	$131.44
40810	Excision of mouth lesion	$167.10
40812	Excise/repair mouth lesion	$192.23
40814	Excise/repair mouth lesion	$1,464.17
40816	Excision of mouth lesion	$1,464.17
40818	Excise oral mucosa for graft	$286.69
40819	Excise lip or cheek fold	$690.25
40820	Treatment of mouth lesion	$208.54
40830	Repair mouth laceration	$130.34
40831	Repair mouth laceration	$286.69
40840	Reconstruction of mouth	$3,063.22

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40842	Reconstruction of mouth	$3,063.22
40843	Reconstruction of mouth	$3,063.22
40844	Reconstruction of mouth	$3,063.22
40845	Reconstruction of mouth	$3,063.22
41000	Drainage of mouth lesion	$99.86
41005	Drainage of mouth lesion	$130.34
41006	Drainage of mouth lesion	$690.25
41007	Drainage of mouth lesion	$690.25
41008	Drainage of mouth lesion	$1,464.17
41009	Drainage of mouth lesion	$286.69
41010	Incision of tongue fold	$690.25
41015	Drainage of mouth lesion	$286.69
41016	Drainage of mouth lesion	$3,063.22
41017	Drainage of mouth lesion	$1,464.17
41018	Drainage of mouth lesion	$690.25
41019	Place needles h&n for rt	$3,063.22
41100	Biopsy of tongue	$135.51
41105	Biopsy of tongue	$134.49
41108	Biopsy of floor of mouth	$128.38
41110	Excision of tongue lesion	$171.18
41112	Excision of tongue lesion	$1,464.17
41113	Excision of tongue lesion	$1,464.17
41114	Excision of tongue lesion	$1,464.17
41115	Excision of tongue fold	$192.92
41116	Excision of mouth lesion	$1,464.17
41120	Partial removal of tongue	$3,063.22
41251	Repair tongue laceration	$130.34
41252	Repair tongue laceration	$130.34
41510	Tongue to lip surgery	$1,464.17
41512	Tongue suspension	$3,882.52
41520	Reconstruction tongue fold	$1,464.17
41530	Tongue base vol reduction	$768.94
41805	Removal foreign body gum	$257.45
41806	Removal foreign body jawbone	$306.36
41820	Excision gum each quadrant	$1,464.17
41821	Excision of gum flap	$690.25
41822	Excision of gum lesion	$264.92
41823	Excision of gum lesion	$390.24
41825	Excision of gum lesion	$169.14
41826	Excision of gum lesion	$214.99
41827	Excision of gum lesion	$3,063.22
41828	Excision of gum lesion	$235.37
41830	Removal of gum tissue	$339.30

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57421	Exam/biopsy of vag w/scope	$93.74
57425	Laparoscopy surg colpopexy	$5,140.80
57426	Revise prosth vag graft lap	$3,277.44
57452	Exam of cervix w/scope	$69.96
57454	Bx/curett of cervix w/scope	$79.81
57455	Biopsy of cervix w/scope	$85.93
57456	Endocerv curettage w/scope	$81.86
57460	Bx of cervix w/scope leep	$201.06
57461	Conz of cervix w/scope leep	$214.99
57500	Biopsy of cervix	$105.97
57505	Endocervical curettage	$108.69
57510	Cauterization of cervix	$93.74
57511	Cryocautery of cervix	$124.31
57513	Laser surgery of cervix	$1,757.97
57520	Conization of cervix	$1,757.97
57522	Conization of cervix	$1,757.97
57530	Removal of cervix	$2,336.86
57550	Removal of residual cervix	$2,336.86
57556	Remove cervix repair bowel	$2,336.86
57558	D&c of cervical stump	$1,757.97
57700	Revision of cervix	$1,757.97
57720	Revision of cervix	$1,757.97
57800	Dilation of cervical canal	$48.23
58100	Biopsy of uterus lining	$54.34
58120	Dilation and curettage	$1,757.97
58145	Myomectomy vag method	$1,757.97
58260	Vaginal hysterectomy	$2,336.86
58262	Vag hyst including t/o	$2,336.86
58301	Remove intrauterine device	$61.13
58321	Artificial insemination	$47.55
58322	Artificial insemination	$49.59
58323	Sperm washing	$5.78
58345	Reopen fallopian tube	$1,757.97
58346	Insert heyman uteri capsule	$2,336.86
58350	Reopen fallopian tube	$2,336.86
58353	Endometr ablate thermal	$2,336.86
58356	Endometrial cryoablation	$1,365.68
58541	Lsh uterus 250 g or less	$5,140.80
58542	Lsh w/t/o ut 250 g or less	$5,140.80
58543	Lsh uterus above 250 g	$5,140.80
58544	Lsh w/t/o uterus above 250 g	$5,140.80
58545	Laparoscopic myomectomy	$3,003.34
58546	Laparo-myomectomy complex	$5,140.80

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56810	Perineoplasty rpr per nonob	$1,757.97
56820	Colposcopy vulva	$68.94
56821	Colposcopy vulva w/biopsy	$89.66
57000	Colpotomy w/exploration	$1,757.97
57010	Colpotomy drg pel abscess	$1,757.97
57020	Colpocentesis sep px	$2,336.86
57022	I&d vaginal hematoma ob/pp	$1,262.00
57023	I&d vaginal hematoma non-ob	$1,262.00
57061	Destruction vag lesions smpl	$118.20
57065	Destruction vag lesion xtnsv	$1,757.97
57100	Biopsy vaginal mucosa simple	$57.74
57105	Biopsy vaginal mucosa xtnsv	$1,757.97
57120	Colpocleisis le fort type	$2,336.86
57130	Excision vaginal septum	$1,757.97
57135	Excision vaginal cyst/tumor	$1,757.97
57155	Insert uteri tandem/ovoids	$2,336.86
57156	Ins vag brachytx device	$171.23
57160	Insert pessary/other device	$40.41
57170	Fitting of diaphragm/cap	$42.45
57180	Treat vaginal bleeding	$114.21
57200	Repair of vagina	$1,757.97
57210	Repair vagina/perineum	$1,757.97
57220	Revision of urethra	$2,336.86
57230	Repair of urethral lesion	$1,757.97
57240	Anterior colporrhaphy	$2,336.86
57250	Repair rectum & vagina	$2,336.86
57260	Cmbn ant pst colprhy	$2,336.86
57265	Cmbn ap colprhy w/ntrcl rpr	$2,336.86
57268	Repair of bowel bulge	$2,336.86
57282	Colpopexy extraperitoneal	$3,277.44
57283	Colpopexy intraperitoneal	$3,277.44
57287	Revise/remove sling repair	$1,757.97
57288	Repair bladder defect	$3,031.05
57289	Repair bladder & vagina	$3,277.44
57291	Construction of vagina	$2,336.86
57295	Revise vag graft via vagina	$1,757.97
57300	Repair rectum-vagina fistula	$1,757.97
57310	Repair urethrovaginal lesion	$3,277.44
57320	Repair bladder-vagina lesion	$2,336.86
57400	Dilation of vagina	$1,757.97
57410	Pelvic examination	$1,757.97
57415	Remove vaginal foreign body	$1,757.97
57420	Exam of vagina w/scope	$72.68

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

55120	Removal of scrotum lesion	$1,007.87
55150	Removal of scrotum	$1,738.08
55175	Revision of scrotum	$1,738.08
55180	Revision of scrotum	$2,647.68
55200	Incision of sperm duct	$1,738.08
55250	Removal of sperm duct(s)	$1,007.87
55400	Repair of sperm duct	$1,738.08
55500	Removal of hydrocele	$1,738.08
55520	Removal of sperm cord lesion	$1,738.08
55530	Revise spermatic cord veins	$1,738.08
55535	Revise spermatic cord veins	$3,329.71
55540	Revise hernia & sperm veins	$1,769.43
55550	Laparo ligate spermatic vein	$3,003.34
55600	Vesiculotomy	$1,007.87
55680	Remove sperm pouch lesion	$1,738.08
55700	Biopsy of prostate	$1,007.87
55705	Biopsy of prostate	$1,738.08
55706	Prostate saturation sampling	$1,738.08
55720	Drainage of prostate abscess	$1,738.08
55725	Drainage of prostate abscess	$1,738.08
55860	Surgical exposure prostate	$2,647.68
55870	Electroejaculation	$85.59
55873	Cryoablate prostate	$7,266.87
55874	Tprnl plmt biodegrdabl matrl	$4,098.96
55875	Transperi needle place pros	$2,647.68
55876	Place rt device/marker pros	$1,010.19
55880	Abltj mal prst8 tiss hifu	$5,018.69
55882	Ablt trurl prst8 tis trnsdcr	$11,263.93
55920	Place needles pelvic for rt	$2,336.86
56405	I & d of vulva/perineum	$88.99
56420	Drainage of gland abscess	$114.21
56440	Mrsplzatn brthlns glnd cst	$1,757.97
56441	Lysis of labial adhesions	$1,757.97
56442	Hymenotomy	$1,757.97
56501	Destroy vulva lesions sim	$132.79
56515	Destroy vulva lesion/s compl	$1,030.14
56605	Biopsy of vulva/perineum	$54.34
56620	Vulvectomy simple partial	$1,757.97
56625	Vulvectomy simple complete	$1,757.97
56700	Prtl hymnctmy/revj hymnl rng	$1,757.97
56740	Exc bartholins gland/cyst	$1,757.97
56800	Plastic repair introitus	$1,757.97
56805	Clitoroplasty intersex state	$1,757.97

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

54405	Insert multi-comp penis pros	$18,140.42
54406	Remove muti-comp penis pros	$1,738.08
54408	Repair multi-comp penis pros	$2,647.68
54410	Remove/replace penis prosth	$17,804.60
54415	Remove self-contd penis pros	$1,738.08
54416	Remv/repl penis contain pros	$17,632.81
54420	Revision of penis	$1,738.08
54435	Revision of penis	$1,738.08
54437	Repair corporeal tear	$1,738.08
54440	Repair of penis	$1,738.08
54450	Preputial stretching	$137.24
54500	Biopsy of testis	$1,262.00
54505	Biopsy of testis	$1,738.08
54512	Excise lesion testis	$1,738.08
54520	Removal of testis	$1,738.08
54522	Orchiectomy partial	$1,738.08
54530	Removal of testis	$1,769.43
54550	Exploration for testis	$1,769.43
54560	Exploration for testis	$1,007.87
54600	Reduce testis torsion	$1,738.08
54620	Suspension of testis	$1,738.08
54640	Orchiopexy ingun/scrot appr	$1,769.43
54650	Orchiopexy (fowler-stephens)	$1,769.43
54660	Revision of testis	$3,581.08
54670	Repair testis injury	$1,738.08
54680	Relocation of testis(es)	$1,738.08
54690	Laparoscopy orchiectomy	$3,003.34
54692	Laparoscopy orchiopexy	$3,003.34
54700	Drainage of scrotum	$1,007.87
54800	Biopsy of epididymis	$743.69
54830	Remove epididymis lesion	$1,738.08
54840	Remove epididymis lesion	$1,007.87
54860	Removal of epididymis	$1,738.08
54861	Removal of epididymis	$1,738.08
54865	Explore epididymis	$1,738.08
54900	Fusion of spermatic ducts	$1,007.87
54901	Fusion of spermatic ducts	$1,738.08
55000	Drainage of hydrocele	$67.92
55040	Removal of hydrocele	$1,769.43
55041	Removal of hydroceles	$1,769.43
55060	Repair of hydrocele	$1,738.08
55100	Drainage of scrotum abscess	$743.69
55110	Explore scrotum	$1,738.08

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

54055	Destruction penis lesion(s)	$95.43
54057	Laser surg penis lesion(s)	$1,030.14
54060	Excision of penis lesion(s)	$1,030.14
54065	Destruction penis lesion(s)	$1,030.14
54100	Biopsy of penis	$743.69
54105	Biopsy of penis	$1,262.00
54110	Treatment of penis lesion	$1,738.08
54111	Treat penis lesion graft	$2,647.68
54112	Treat penis lesion graft	$5,018.69
54115	Treatment of penis lesion	$1,262.00
54120	Partial removal of penis	$1,738.08
54150	Circumcision w/regionl block	$1,007.87
54160	Circumcision neonate	$331.73
54161	Circum 28 days or older	$1,007.87
54162	Lysis penil circumic lesion	$1,007.87
54163	Repair of circumcision	$1,007.87
54164	Frenulotomy of penis	$1,007.87
54200	Injection px peyronie ds	$77.77
54205	Njx px peyronie ds exps plaq	$2,647.68
54220	Irrg crpra cavrnosa priapism	$137.24
54231	Dynamic cavernosometry	$70.64
54235	Njx corpora cavernosa rx agt	$48.23
54240	Penile plethysmography	$44.84
54250	Nctrnl pen tmscn&/rgdity tst	$14.61
54300	Revision of penis	$1,738.08
54304	Revision of penis	$1,738.08
54308	Reconstruction of urethra	$2,647.68
54312	Reconstruction of urethra	$1,738.08
54316	Reconstruction of urethra	$5,018.69
54318	Reconstruction of urethra	$1,738.08
54322	Reconstruction of urethra	$1,738.08
54324	Reconstruction of urethra	$1,738.08
54326	Reconstruction of urethra	$1,738.08
54328	Revise penis/urethra	$1,738.08
54340	Rpr hypspad comp simple	$1,738.08
54344	Rrp hypspad comp moblj&urtp	$5,018.69
54348	Rpr hypspad comp dsj & urtp	$2,647.68
54352	Revj prior hypspad repair	$2,647.68
54360	Penis plastic surgery	$1,738.08
54380	Repair penis	$1,007.87
54385	Repair penis	$1,007.87
54400	Insert semi-rigid prosthesis	$11,456.79
54401	Insert self-contd prosthesis	$18,056.94

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

53270	Removal of urethra gland	$1,738.08
53275	Repair of urethra defect	$1,738.08
53400	Revise urethra stage 1	$2,647.68
53405	Revise urethra stage 2	$2,647.68
53410	Reconstruction of urethra	$2,647.68
53420	Reconstruct urethra stage 1	$2,647.68
53425	Reconstruct urethra stage 2	$2,647.68
53430	Reconstruction of urethra	$2,647.68
53431	Reconstruct urethra/bladder	$2,647.68
53440	Male sling procedure	$11,209.98
53442	Remove/revise male sling	$3,387.36
53444	Insert tandem cuff	$17,710.44
53445	Insert uro/ves nck sphincter	$18,154.01
53446	Remove uro sphincter	$2,647.68
53447	Remove/replace ur sphincter	$17,824.98
53449	Repair uro sphincter	$5,018.69
53450	Revision of urethra	$1,738.08
53451	Tprnl balo cntnc dev bi	$11,467.95
53452	Tprnl balo cntnc dev uni	$7,561.31
53453	Tprnl balo cntnc dev rmvl ea	$1,738.08
53454	Tprnl balo cntnc dev adjmt	$137.24
53460	Revision of urethra	$1,738.08
53502	Repair of urethra injury	$1,738.08
53505	Repair of urethra injury	$2,647.68
53510	Repair of urethra injury	$2,647.68
53515	Repair of urethra injury	$2,647.68
53520	Repair of urethra defect	$2,647.68
53600	Dilate urethra stricture	$44.15
53605	Dilate urethra stricture	$1,738.08
53620	Dilate urethra stricture	$108.35
53621	Dilate urethra stricture	$111.74
53660	Dilation of urethra	$50.26
53665	Dilation of urethra	$1,007.87
53850	Prostatic microwave thermotx	$1,178.54
53852	Prostatic rf thermotx	$1,127.94
53854	Trurl dstrj prst8 tiss rf wv	$1,403.04
53855	Insert prost urethral stent	$1,529.54
53860	Transurethral rf treatment	$1,007.87
53865	Cysto insj dev ischmc rmdlg	$7,774.36
53866	Cathj rmvl dev ischmc rmdlg	$87.29
54000	Slitting of prepuce	$1,738.08
54001	Slitting of prepuce	$1,007.87
54015	Drain penis lesion	$743.69

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
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52332	Cystoscopy and treatment	$1,738.08
52334	Create passage to kidney	$1,738.08
52341	Cysto w/ureter stricture tx	$1,738.08
52342	Cysto w/up stricture tx	$1,738.08
52343	Cysto w/renal stricture tx	$1,738.08
52344	Cysto/uretero stricture tx	$1,738.08
52345	Cysto/uretero w/up stricture	$2,212.56
52346	Cystouretero w/renal strict	$2,647.68
52351	Cystouretero & or pyeloscope	$1,738.08
52352	Cystouretero w/stone remove	$1,738.08
52353	Cystouretero w/lithotripsy	$2,647.68
52354	Cystouretero w/biopsy	$2,647.68
52355	Cystouretero w/excise tumor	$2,647.68
52356	Cysto/uretero w/lithotripsy	$2,647.68
52400	Cystouretero w/congen repr	$1,738.08
52402	Cystourethro cut ejacul duct	$1,738.08
52450	Incision of prostate	$1,738.08
52500	Revision of bladder neck	$1,738.08
52601	Prostatectomy (turp)	$2,647.68
52630	Remove prostate regrowth	$2,647.68
52640	Relieve bladder contracture	$1,738.08
52647	Laser surgery of prostate	$2,647.68
52648	Laser surgery of prostate	$2,647.68
52649	Prostate laser enucleation	$2,647.68
52700	Drainage of prostate abscess	$1,738.08
53000	Incision of urethra	$1,007.87
53010	Incision of urethra	$2,647.68
53020	Incision of urethra	$1,007.87
53025	Incision of urethra	$1,007.87
53040	Drainage of urethra abscess	$1,738.08
53060	Drainage of urethra abscess	$87.62
53080	Drainage of urinary leakage	$331.73
53085	Drainage of urinary leakage	$1,007.87
53200	Biopsy of urethra	$1,007.87
53210	Removal of urethra	$1,738.08
53215	Removal of urethra	$2,647.68
53220	Treatment of urethra lesion	$1,738.08
53230	Removal of urethra lesion	$2,647.68
53235	Removal of urethra lesion	$2,647.68
53240	Surgery for urethra pouch	$1,738.08
53250	Removal of urethra gland	$1,738.08
53260	Treatment of urethra lesion	$1,738.08
53265	Treatment of urethra lesion	$1,007.87

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

51727	Cystometrogram w/up	$239.79
51728	Cystometrogram w/vp	$240.46
51729	Cystometrogram w/vp&up	$237.75
51784	Anal/urinary muscle study	$27.85
51785	Anal/urinary muscle study	$137.24
51880	Repair of bladder opening	$1,738.08
51992	Laparo sling operation	$4,115.51
52000	Cystourethroscopy	$331.73
52001	Cysto w/irrg&evac mlt clots	$1,738.08
52005	Cysto w/urtrl cathj	$1,007.87
52007	Cysto urtrl cathj brush bx	$1,738.08
52010	Cystoscopy & duct catheter	$331.73
52204	Cystoscopy w/biopsy(s)	$1,007.87
52214	Cystoscopy and treatment	$1,738.08
52224	Cystoscopy and treatment	$1,738.08
52234	Cystoscopy and treatment	$1,738.08
52235	Cystoscopy and treatment	$1,738.08
52240	Cystoscopy and treatment	$2,647.68
52250	Cystoscopy and radiotracer	$1,738.08
52260	Cystoscopy and treatment	$1,007.87
52265	Cystoscopy and treatment	$241.83
52270	Cystoscopy & revise urethra	$1,007.87
52275	Cystoscopy & revise urethra	$1,007.87
52276	Cystoscopy and treatment	$1,007.87
52277	Cystoscopy and treatment	$1,738.08
52281	Cystoscopy and treatment	$1,007.87
52282	Cystoscopy implant stent	$1,738.08
52283	Cystoscopy and treatment	$1,007.87
52284	Cysto rx balo cath urtl strx	$3,481.49
52285	Cystoscopy and treatment	$331.73
52287	Cystoscopy chemodenervation	$1,007.87
52290	Cystoscopy and treatment	$1,007.87
52300	Cystoscopy and treatment	$1,738.08
52301	Cystoscopy and treatment	$1,738.08
52305	Cystoscopy and treatment	$2,647.68
52310	Cystoscopy and treatment	$1,007.87
52315	Cystoscopy and treatment	$1,007.87
52317	Remove bladder stone	$1,738.08
52318	Remove bladder stone	$1,738.08
52320	Cystoscopy and treatment	$1,738.08
52325	Cystoscopy stone removal	$2,647.68
52327	Cystoscopy inject material	$3,742.59
52330	Cystoscopy and treatment	$1,738.08

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

50576	Kidney endoscopy & treatment	$5,018.69
50580	Kidney endoscopy & treatment	$2,647.68
50590	Fragmenting of kidney stone	$1,738.08
50592	Perc rf ablate renal tumor	$3,003.34
50593	Perc cryo ablate renal tum	$7,346.10
50686	Measure ureter pressure	$87.97
50688	Change of ureter tube/stent	$1,007.87
50693	Plmt ureteral stent prq	$1,738.08
50694	Plmt ureteral stent prq	$1,738.08
50695	Plmt ureteral stent prq	$1,738.08
50727	Revise ureter	$1,738.08
50947	Laparo new ureter/bladder	$5,140.80
50948	Laparo new ureter/bladder	$5,140.80
50951	Endoscopy of ureter	$1,738.08
50953	Endoscopy of ureter	$1,738.08
50955	Ureter endoscopy & biopsy	$2,647.68
50957	Ureter endoscopy & treatment	$2,647.68
50961	Ureter endoscopy & treatment	$2,647.68
50970	Ureter endoscopy	$1,738.08
50972	Ureter endoscopy & catheter	$1,738.08
50974	Ureter endoscopy & biopsy	$2,647.68
50976	Ureter endoscopy & treatment	$2,647.68
50980	Ureter endoscopy & treatment	$2,647.68
51020	Cystotomy/cystostomy w/fulg	$1,738.08
51040	Incise & drain bladder	$1,007.87
51045	Incise bladder/drain ureter	$1,007.87
51050	Removal of bladder stone	$2,647.68
51065	Remove ureter calculus	$1,738.08
51080	Drainage of bladder abscess	$1,262.00
51100	Drain bladder by needle	$44.84
51101	Drain bladder by trocar/cath	$114.11
51102	Drain bl w/cath insertion	$1,007.87
51500	Removal of bladder cyst	$3,003.34
51520	Removal of bladder lesion	$1,738.08
51535	Repair of ureter lesion	$1,738.08
51700	Irrigation of bladder	$54.34
51703	Insert bladder cath complex	$89.46
51705	Change of bladder tube	$64.87
51710	Change of bladder tube	$331.73
51715	Endoscopic injection/implant	$2,412.75
51720	Treatment of bladder lesion	$57.06
51725	Simple cystometrogram	$134.16
51726	Complex cystometrogram	$137.24

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
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49550	Rpr rem hernia init reduce	$1,769.43
49553	Rpr fem hernia init blocked	$1,769.43
49555	Rerepair fem hernia reduce	$1,769.43
49557	Rerepair fem hernia blocked	$1,769.43
49591	Rpr aa hrn 1st < 3 cm rdc	$1,769.43
49592	Rpr aa hrn 1st < 3 ncr/strn	$3,003.34
49593	Rpr aa hrn 1st 3-10 rdc	$3,329.71
49594	Rpr aa hrn 1st 3-10 ncr/strn	$3,003.34
49595	Rpr aa hrn 1st > 10 rdc	$3,329.71
49600	Repair umbilical lesion	$1,769.43
49613	Rpr aa hrn rcr < 3 rdc	$1,769.43
49614	Rpr aa hrn rcr < 3 ncr/strn	$3,003.34
49615	Rpr aa hrn rcr 3-10 rdc	$3,329.71
49650	Lap ing hernia repair init	$3,003.34
49651	Lap ing hernia repair recur	$3,003.34
50080	Perq nl/pl lithotrp smpl<2cm	$5,018.69
50081	Perq nl/pl lithotrp cplx>2cm	$5,018.69
50200	Renal biopsy perq	$743.69
50382	Change ureter stent percut	$1,007.87
50384	Remove ureter stent percut	$1,007.87
50385	Change stent via transureth	$1,007.87
50386	Remove stent via transureth	$619.84
50387	Change nephroureteral cath	$1,007.87
50389	Remove renal tube w/fluoro	$331.73
50390	Drainage of kidney lesion	$396.48
50391	Instll rx agnt into rnal tub	$52.65
50396	Measure kidney pressure	$331.73
50432	Plmt nephrostomy catheter	$1,007.87
50433	Plmt nephroureteral catheter	$1,738.08
50434	Convert nephrostomy catheter	$1,007.87
50435	Exchange nephrostomy cath	$1,007.87
50436	Dilat xst trc ndurlgc px	$1,738.08
50437	Dilat xst trc new access rcs	$1,738.08
50551	Kidney endoscopy	$2,647.68
50553	Kidney endoscopy	$2,647.68
50555	Kidney endoscopy & biopsy	$5,018.69
50557	Kidney endoscopy & treatment	$5,018.69
50561	Kidney endoscopy & treatment	$2,647.68
50562	Renal scope w/tumor resect	$5,018.69
50570	Kidney endoscopy	$1,738.08
50572	Kidney endoscopy	$331.73
50574	Kidney endoscopy & biopsy	$1,738.08
50575	Kidney endoscopy	$2,647.68

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

47564	Laparo cholecystectomy/explr	$5,140.80
48102	Needle biopsy pancreas	$743.69
49082	Abd paracentesis	$528.56
49083	Abd paracentesis w/imaging	$528.56
49084	Peritoneal lavage	$528.56
49180	Biopsy abdominal mass	$743.69
49250	Excision of umbilicus	$1,769.43
49320	Diag laparo separate proc	$3,003.34
49321	Laparoscopy biopsy	$3,003.34
49322	Laparoscopy aspiration	$3,003.34
49324	Lap insert tunnel ip cath	$3,003.34
49325	Lap revision perm ip cath	$3,003.34
49402	Remove foreign body adbomen	$1,769.43
49406	Image cath fluid peri/retro	$743.69
49407	Image cath fluid trns/vgnl	$743.69
49411	Ins mark abd/pel for rt perq	$349.49
49418	Insert tun ip cath perc	$1,769.43
49419	Insert tun ip cath w/port	$3,160.03
49421	Ins tun ip cath for dial opn	$1,769.43
49422	Remove tunneled ip cath	$1,668.12
49423	Exchange drainage catheter	$907.36
49426	Revise abdomen-venous shunt	$1,769.43
49429	Removal of shunt	$1,668.12
49436	Embedded ip cath exit-site	$907.36
49440	Place gastrostomy tube perc	$907.36
49441	Place duod/jej tube perc	$907.36
49442	Place cecostomy tube perc	$664.61
49446	Change g-tube to g-j perc	$907.36
49450	Replace g/c tube perc	$528.56
49451	Replace duod/jej tube perc	$528.56
49452	Replace g-j tube perc	$528.56
49460	Fix g/colon tube w/device	$528.56
49465	Fluoro exam of g/colon tube	$136.79
49495	Rpr ing hernia baby reduc	$1,769.43
49496	Rpr ing hernia baby blocked	$1,769.43
49500	Rpr ing hernia init reduce	$3,329.71
49501	Rpr ing hernia init blocked	$1,769.43
49505	Prp i/hern init reduc >5 yr	$1,769.43
49507	Prp i/hern init block >5 yr	$1,769.43
49520	Rerepair ing hernia reduce	$1,769.43
49521	Rerepair ing hernia blocked	$3,329.71
49525	Repair ing hernia sliding	$1,769.43
49540	Repair lumbar hernia	$3,003.34

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

46612	Anoscopy remove lesions	$1,467.87
46614	Anoscopy control bleeding	$128.72
46615	Anoscopy	$1,467.87
46700	Repair of anal stricture	$1,467.87
46706	Repr of anal fistula w/glue	$1,467.87
46707	Repair anorectal fist w/plug	$1,467.87
46750	Repair of anal sphincter	$1,467.87
46753	Reconstruction of anus	$1,467.87
46754	Removal of suture from anus	$1,467.87
46760	Repair of anal sphincter	$1,467.87
46761	Repair of anal sphincter	$1,467.87
46900	Destruction anal lesion(s)	$173.89
46910	Destruction anal lesion(s)	$195.64
46916	Cryosurgery anal lesion(s)	$112.11
46917	Laser surgery anal lesions	$1,467.87
46922	Excision of anal lesion(s)	$1,467.87
46924	Destruction anal lesion(s)	$1,467.87
46930	Destroy internal hemorrhoids	$163.37
46940	Treatment of anal fissure	$178.65
46942	Treatment of anal fissure	$175.93
46945	Int hrhc lig 1 hroid w/o img	$1,467.87
46946	Int hrhc lig 2+hroid w/o img	$1,467.87
46947	Hemorrhoidopexy by stapling	$1,467.87
46948	Int hrhc tranal dartlzj 2+	$1,467.87
47000	Needle biopsy of liver perq	$743.69
47382	Percut ablate liver rf	$3,003.34
47383	Perq abltj lvr cryoablation	$7,513.32
47533	Plmt biliary drainage cath	$1,769.43
47534	Plmt biliary drainage cath	$1,769.43
47535	Conversion ext bil drg cath	$1,769.43
47536	Exchange biliary drg cath	$1,769.43
47537	Removal biliary drg cath	$528.56
47538	Perq plmt bile duct stent	$4,266.57
47539	Perq plmt bile duct stent	$4,325.65
47540	Perq plmt bile duct stent	$3,978.43
47541	Plmt access bil tree sm bwl	$4,220.31
47552	Biliary endo perq dx w/speci	$3,329.71
47553	Biliary endoscopy thru skin	$3,329.71
47554	Biliary endoscopy thru skin	$5,140.80
47555	Biliary endoscopy thru skin	$2,243.15
47556	Biliary endoscopy thru skin	$6,892.36
47562	Laparoscopic cholecystectomy	$3,003.34
47563	Laparo cholecystectomy/graph	$3,003.34

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

45500	Repair of rectum	$1,467.87
45505	Repair of rectum	$1,467.87
45541	Correct rectal prolapse	$1,467.87
45560	Repair of rectocele	$1,467.87
45900	Reduction of rectal prolapse	$513.94
45905	Dilation of anal sphincter	$664.61
45910	Dilation of rectal narrowing	$664.61
45915	Remove rectal obstruction	$664.61
45990	Surg dx exam anorectal	$1,467.87
46020	Placement of seton	$1,467.87
46030	Removal anal seton oth mrk	$664.61
46040	Incision of rectal abscess	$664.61
46045	Incision of rectal abscess	$1,467.87
46050	Incision of anal abscess	$513.94
46060	Incision of rectal abscess	$1,467.87
46070	Incision anal septum infant	$1,467.87
46080	Incision of anal sphincter	$1,467.87
46083	Incise external hemorrhoid	$137.24
46200	Removal of anal fissure	$1,467.87
46220	Excise anal ext tag/papilla	$664.61
46221	Ligation of hemorrhoid(s)	$200.38
46230	Removal of anal tags	$1,467.87
46250	Remove ext hem groups 2+	$1,467.87
46255	Remove int/ext hem 1 group	$1,467.87
46257	Remove in/ex hem grp & fiss	$1,467.87
46258	Remove in/ex hem grp w/fistu	$1,467.87
46260	Remove in/ex hem groups 2+	$1,467.87
46261	Remove in/ex hem grps & fiss	$1,467.87
46262	Remove in/ex hem grps w/fist	$1,467.87
46270	Remove anal fist subq	$1,467.87
46275	Remove anal fist inter	$1,467.87
46280	Remove anal fist complex	$1,467.87
46285	Remove anal fist 2 stage	$1,467.87
46288	Repair anal fistula	$1,467.87
46320	Removal of hemorrhoid clot	$150.80
46500	Injection into hemorrhoid(s)	$250.66
46505	Chemodenervation anal musc	$664.61
46604	Anoscopy and dilation	$581.46
46606	Anoscopy and biopsy	$228.92
46607	Diagnostic anoscopy & biopsy	$664.61
46608	Anoscopy remove for body	$513.94
46610	Anoscopy remove lesion	$1,467.87
46611	Anoscopy	$513.94

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

45172	Exc rect tum transanal full	$1,467.87
45190	Destruction rectal tumor	$1,467.87
45300	Proctosigmoidoscopy dx	$100.19
45303	Proctosigmoidoscopy dilate	$664.61
45305	Proctosigmoidoscopy w/bx	$664.61
45307	Proctosigmoidoscopy fb	$1,467.87
45308	Proctosigmoidoscopy removal	$1,467.87
45309	Proctosigmoidoscopy removal	$664.61
45315	Proctosigmoidoscopy removal	$664.61
45317	Proctosigmoidoscopy bleed	$664.61
45320	Proctosigmoidoscopy ablate	$1,467.87
45321	Proctosigmoidoscopy volvul	$1,467.87
45327	Proctosigmoidoscopy w/stent	$4,455.17
45330	Diagnostic sigmoidoscopy	$156.23
45331	Sigmoidoscopy and biopsy	$513.94
45332	Sigmoidoscopy w/fb removal	$664.61
45333	Sigmoidoscopy & polypectomy	$513.94
45334	Sigmoidoscopy for bleeding	$664.61
45335	Sigmoidoscopy w/submuc inj	$513.94
45337	Sigmoidoscopy & decompress	$513.94
45338	Sigmoidoscopy w/tumr remove	$664.61
45340	Sig w/tndsc balloon dilation	$664.61
45341	Sigmoidoscopy w/ultrasound	$513.94
45342	Sigmoidoscopy w/us guide bx	$664.61
45346	Sigmoidoscopy w/ablation	$664.61
45347	Sigmoidoscopy w/plcmt stent	$4,462.28
45349	Sigmoidoscopy w/resection	$1,467.87
45350	Sgmdsc w/band ligation	$664.61
45378	Diagnostic colonoscopy	$513.94
45379	Colonoscopy w/fb removal	$664.61
45380	Colonoscopy and biopsy	$664.61
45381	Colonoscopy submucous njx	$664.61
45382	Colonoscopy w/control bleed	$664.61
45384	Colonoscopy w/lesion removal	$664.61
45385	Colonoscopy w/lesion removal	$664.61
45386	Colonoscopy w/balloon dilat	$664.61
45388	Colonoscopy w/ablation	$664.61
45389	Colonoscopy w/stent plcmt	$4,411.82
45390	Colonoscopy w/resection	$1,467.87
45391	Colonoscopy w/endoscope us	$664.61
45392	Colonoscopy w/endoscopic fnb	$664.61
45393	Colonoscopy w/decompression	$664.61
45398	Colonoscopy w/band ligation	$664.61

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

44360	Small bowel endoscopy	$907.36
44361	Small bowel endoscopy/biopsy	$907.36
44363	Small bowel endoscopy	$907.36
44364	Small bowel endoscopy	$907.36
44365	Small bowel endoscopy	$907.36
44366	Small bowel endoscopy	$907.36
44369	Small bowel endoscopy	$907.36
44370	Small bowel endoscopy/stent	$4,630.10
44372	Small bowel endoscopy	$907.36
44373	Small bowel endoscopy	$907.36
44376	Small bowel endoscopy	$907.36
44377	Small bowel endoscopy/biopsy	$907.36
44378	Small bowel endoscopy	$907.36
44379	S bowel endoscope w/stent	$2,839.47
44380	Small bowel endoscopy br/wa	$528.56
44381	Small bowel endoscopy br/wa	$907.36
44382	Small bowel endoscopy	$528.56
44384	Small bowel endoscopy	$1,179.08
44385	Endoscopy of bowel pouch	$513.94
44386	Endoscopy bowel pouch/biop	$513.94
44388	Colonoscopy thru stoma spx	$513.94
44389	Colonoscopy with biopsy	$664.61
44390	Colonoscopy for foreign body	$513.94
44391	Colonoscopy for bleeding	$664.61
44392	Colonoscopy & polypectomy	$664.61
44394	Colonoscopy w/snare	$664.61
44401	Colonoscopy with ablation	$664.61
44402	Colonoscopy w/stent plcmt	$2,839.47
44403	Colonoscopy w/resection	$664.61
44404	Colonoscopy w/injection	$664.61
44405	Colonoscopy w/dilation	$888.81
44406	Colonoscopy w/ultrasound	$664.61
44407	Colonoscopy w/ndl aspir/bx	$664.61
44408	Colonoscopy w/decompression	$513.94
44500	Intro gastrointestinal tube	$528.56
45000	Drainage of pelvic abscess	$664.61
45005	Drainage of rectal abscess	$664.61
45020	Drainage of rectal abscess	$1,467.87
45100	Biopsy of rectum	$1,467.87
45108	Anorectal myomectomy	$1,467.87
45150	Excision of rectal stricture	$664.61
45160	Excision of rectal lesion	$1,467.87
45171	Exc rect tum transanal part	$1,467.87

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

43250	Egd cautery tumor polyp	$907.36
43251	Egd remove lesion snare	$907.36
43252	Egd optical endomicroscopy	$907.36
43253	Egd us transmural injxn/mark	$907.36
43254	Egd endo mucosal resection	$907.36
43255	Egd control bleeding any	$907.36
43257	Egd w/thrml txmnt gerd	$2,500.14
43259	Egd us exam duodenum/jejunum	$907.36
43260	Ercp w/specimen collection	$1,969.60
43261	Endo cholangiopancreatograph	$1,969.60
43262	Endo cholangiopancreatograph	$1,969.60
43263	Ercp sphincter pressure meas	$907.36
43264	Ercp remove duct calculi	$1,969.60
43265	Ercp lithotripsy calculi	$2,839.47
43266	Egd endoscopic stent place	$4,422.60
43270	Egd lesion ablation	$1,204.60
43274	Ercp duct stent placement	$3,732.71
43275	Ercp remove forgn body duct	$907.36
43276	Ercp stent exchange w/dilate	$3,717.77
43277	Ercp ea duct/ampulla dilate	$1,969.60
43278	Ercp lesion ablate w/dilate	$1,969.60
43284	Laps esophgl sphnctr agmntj	$7,368.72
43285	Rmvl esophgl sphnctr dev	$3,003.34
43290	Egd flx trnsorl dplmnt balo	$1,335.25
43291	Egd flx trnsorl rmvl balo	$528.56
43450	Dilate esophagus 1/mult pass	$528.56
43453	Dilate esophagus	$907.36
43653	Laparoscopy gastrostomy	$3,003.34
43752	Nasal/orogastric w/tube plmt	$222.31
43755	Dx gastr intub w/asp specs	$89.46
43756	Dx duod intub w/asp spec	$528.56
43757	Dx duod intub w/asp specs	$528.56
43761	Reposition gastrostomy tube	$137.24
43762	Rplc gtube no revj trc	$137.24
43763	Rplc gtube revj gstrst trc	$137.24
43774	Lap rmvl gastr adj all parts	$1,969.60
43870	Repair stomach opening	$1,969.60
43886	Revise gastric port open	$2,055.20
43887	Remove gastric port open	$1,030.14
43888	Change gastric port open	$2,055.20
44100	Biopsy of bowel	$528.56
44312	Revision of ileostomy	$2,055.20
44340	Revision of colostomy	$2,055.20

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

43192	Esophagoscp rig trnso inject	$907.36
43193	Esophagoscp rig trnso biopsy	$907.36
43194	Esophagoscp rig trnso rem fb	$907.36
43195	Esophagoscopy rigid balloon	$1,969.60
43196	Esophagoscp guide wire dilat	$907.36
43197	Esophagoscopy flex dx brush	$136.53
43198	Esophagosc flex trnsn biopsy	$147.06
43200	Esophagoscopy flexible brush	$528.56
43201	Esoph scope w/submucous inj	$907.36
43202	Esophagoscopy flex biopsy	$907.36
43204	Esoph scope w/sclerosis inj	$907.36
43205	Esophagus endoscopy/ligation	$907.36
43206	Esoph optical endomicroscopy	$907.36
43210	Egd esophagogastrc fndoplsty	$7,481.83
43211	Esophagoscop mucosal resect	$907.36
43212	Esophagoscop stent placement	$4,221.46
43213	Esophagoscopy retro balloon	$907.36
43214	Esophagosc dilate balloon 30	$907.36
43215	Esophagoscopy flex remove fb	$907.36
43216	Esophagoscopy lesion removal	$907.36
43217	Esophagoscopy snare les remv	$907.36
43220	Esophagoscopy balloon <30mm	$907.36
43226	Esoph endoscopy dilation	$907.36
43227	Esophagoscopy control bleed	$907.36
43229	Esophagoscopy lesion ablate	$2,898.99
43231	Esophagoscop ultrasound exam	$907.36
43232	Esophagoscopy w/us needle bx	$907.36
43233	Egd balloon dil esoph30 mm/>	$907.36
43235	Egd diagnostic brush wash	$528.56
43236	Uppr gi scope w/submuc inj	$528.56
43237	Endoscopic us exam esoph	$907.36
43238	Egd us fine needle bx/aspir	$907.36
43239	Egd biopsy single/multiple	$528.56
43240	Egd w/transmural drain cyst	$4,512.99
43241	Egd tube/cath insertion	$907.36
43242	Egd us fine needle bx/aspir	$907.36
43243	Egd injection varices	$907.36
43244	Egd varices ligation	$907.36
43245	Egd dilate stricture	$907.36
43246	Egd place gastrostomy tube	$907.36
43247	Egd remove foreign body	$528.56
43248	Egd guide wire insertion	$528.56
43249	Esoph egd dilation <30 mm	$907.36

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

42450	Excise sublingual gland	$3,063.22
42500	Repair salivary duct	$3,063.22
42505	Repair salivary duct	$3,063.22
42507	Parotid duct diversion	$3,063.22
42509	Parotid duct diversion	$3,063.22
42510	Parotid duct diversion	$1,464.17
42600	Closure of salivary fistula	$1,464.17
42650	Dilation of salivary duct	$46.19
42660	Dilation of salivary duct	$57.74
42665	Ligation of salivary duct	$1,464.17
42700	Drainage of tonsil abscess	$130.34
42720	Drainage of throat abscess	$1,464.17
42725	Drainage of throat abscess	$3,063.22
42800	Biopsy of throat	$105.28
42804	Biopsy of upper nose/throat	$1,464.17
42806	Biopsy of upper nose/throat	$1,464.17
42808	Excise pharynx lesion	$1,464.17
42810	Excision of neck cyst	$1,464.17
42815	Excision of neck cyst	$3,063.22
42820	Remove tonsils and adenoids	$3,063.22
42821	Remove tonsils and adenoids	$1,464.17
42825	Removal of tonsils	$3,063.22
42826	Removal of tonsils	$1,464.17
42830	Removal of adenoids	$1,464.17
42831	Removal of adenoids	$1,464.17
42835	Removal of adenoids	$1,464.17
42836	Removal of adenoids	$1,464.17
42860	Excision of tonsil tags	$1,464.17
42870	Excision of lingual tonsil	$3,063.22
42890	Limited pharyngectomy	$3,063.22
42892	Revision of pharyngeal walls	$3,063.22
42900	Repair throat wound	$1,163.72
42950	Reconstruction of throat	$3,063.22
42955	Surgical opening of throat	$690.25
42960	Control throat bleeding	$286.69
42962	Control throat bleeding	$1,464.17
42970	Control nose/throat bleeding	$130.34
42972	Control nose/throat bleeding	$1,464.17
42975	Dise eval slp do brth flx dx	$831.75
43030	Cricopharyngeal myotomy	$3,063.22
43130	Removal of esophagus pouch	$3,063.22
43180	Esophagoscopy rigid trnso	$3,063.22
43191	Esophagoscopy rigid trnso dx	$907.36

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

41850	Treatment of gum lesion	$690.25
41870	Periodontal mucosal grafting	$690.25
41872	Gingivoplasty each quadrant	$361.71
41874	Alveoloplasty each quadrant	$279.52
42000	Drainage mouth roof lesion	$130.34
42100	Biopsy roof of mouth	$96.80
42104	Excision lesion mouth roof	$155.89
42106	Excision lesion mouth roof	$175.93
42107	Excision lesion mouth roof	$3,063.22
42120	Remove palate/lesion	$3,063.22
42140	Excision of uvula	$1,464.17
42145	Repair palate pharynx/uvula	$3,063.22
42160	Treatment mouth roof lesion	$157.59
42180	Repair lac palate<2 cm	$286.69
42182	Repair palate	$3,063.22
42200	Reconstruct cleft palate	$3,063.22
42205	Reconstruct cleft palate	$1,464.17
42210	Reconstruct cleft palate	$3,063.22
42215	Reconstruct cleft palate	$3,063.22
42220	Reconstruct cleft palate	$3,063.22
42225	Reconstruct cleft palate	$3,063.22
42226	Lengthening of palate	$3,063.22
42227	Lengthening of palate	$3,063.22
42235	Repair palate	$3,063.22
42260	Repair nose to lip fistula	$3,063.22
42280	Preparation palate mold	$119.89
42281	Insertion palate prosthesis	$3,063.22
42300	Drainage of salivary gland	$690.25
42305	Drainage of salivary gland	$1,464.17
42310	Drainage of salivary gland	$286.69
42320	Drainage of salivary gland	$286.69
42330	Removal of salivary stone	$151.82
42335	Removal of salivary stone	$305.68
42340	Removal of salivary stone	$1,464.17
42400	Biopsy of salivary gland	$66.91
42405	Biopsy of salivary gland	$690.25
42408	Excision of salivary cyst	$1,464.17
42409	Drainage of salivary cyst	$1,464.17
42410	Excise parotid gland/lesion	$3,063.22
42415	Excise parotid gland/lesion	$3,063.22
42420	Excise parotid gland/lesion	$3,063.22
42425	Excise parotid gland/lesion	$3,063.22
42440	Excise submaxillary gland	$3,063.22

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

58550	Laparo-asst vag hysterectomy	$3,003.34
58552	Laparo-vag hyst incl t/o	$5,140.80
58553	Laparo-vag hyst complex	$5,140.80
58554	Laparo-vag hyst w/t/o compl	$5,140.80
58555	Hysteroscopy dx sep proc	$1,757.97
58558	Hysteroscopy biopsy	$1,757.97
58559	Hysteroscopy lysis	$2,336.86
58560	Hysteroscopy resect septum	$2,336.86
58561	Hysteroscopy remove myoma	$2,336.86
58562	Hysteroscopy remove fb	$1,757.97
58563	Hysteroscopy ablation	$2,336.86
58565	Hysteroscopy sterilization	$2,961.88
58570	Tlh uterus 250 g or less	$5,140.80
58571	Tlh w/t/o 250 g or less	$5,140.80
58572	Tlh uterus over 250 g	$5,140.80
58573	Tlh w/t/o uterus over 250 g	$5,140.80
58580	Transcrv abltj utrn fibrd rf	$4,154.04
58600	Division of fallopian tube	$1,757.97
58615	Occlude fallopian tube(s)	$1,757.97
58660	Laparoscopy lysis	$3,003.34
58661	Laparoscopy remove adnexa	$3,003.34
58662	Laparoscopy excise lesions	$3,003.34
58670	Laparoscopy tubal cautery	$3,003.34
58671	Laparoscopy tubal block	$3,003.34
58672	Laparoscopy fimbrioplasty	$3,003.34
58673	Laparoscopy salpingostomy	$5,140.80
58674	Laps abltj uterine fibroids	$5,140.80
58800	Drainage of ovarian cyst(s)	$1,757.97
58805	Drainage of ovarian cyst(s)	$1,757.97
58820	Drain ovary abscess open	$1,757.97
58900	Biopsy of ovary(s)	$1,757.97
58970	Retrieval of oocyte	$490.53
58974	Embryo transfer intrauterine	$490.53
58976	Transfer of embryo	$171.23
59000	Amniocentesis diagnostic	$63.17
59001	Amniocentesis therapeutic	$171.23
59012	Fetal cord puncture prenatal	$171.23
59015	Chorion biopsy	$64.87
59020	Fetal contract stress test	$34.99
59025	Fetal non-stress test	$20.38
59070	Transabdom amnioinfus w/us	$171.23
59072	Umbilical cord occlud w/us	$231.28
59074	Fetal fluid drainage w/us	$171.23

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

D7210	Rem imp tooth w mucoper flp	$690.25
D7220	Impact tooth remov soft tiss	$937.24
D7230	Impact tooth remov part bony	$937.24
D7240	Impact tooth remov comp bony	$937.24
D7241	Impact tooth rem bony w/comp	$937.24
D7250	Tooth root removal	$937.24
D7251	Coronectomy	$690.25
D7270	Tooth reimplantation	$937.24
D7280	Exposure of unerupted tooth	$937.24
D7310	Alveoplasty w/ extraction	$690.25
D7311	Alveoloplasty w/extract 1-3	$690.25
D7320	Alveoplasty w/o extraction	$690.25
D7321	Alveoloplasty not w/extracts	$690.25
D7410	Rad exc lesion up to 1.25 cm	$690.25
D7411	Excision benign lesion>1.25c	$690.25
D7412	Excision benign lesion compl	$690.25
D7413	Excision malig lesion<=1.25c	$690.25
D7414	Excision malig lesion>1.25cm	$690.25
D7415	Excision malig les complicat	$690.25
D7450	Rem odontogen cyst to 1.25cm	$1,464.17
D7451	Rem odontogen cyst > 1.25 cm	$1,464.17
D7460	Rem nonodonto cyst to 1.25cm	$937.24
D7461	Rem nonodonto cyst > 1.25 cm	$937.24
D7471	Rem exostosis any site	$1,464.17
D7472	Removal of torus palatinus	$937.24
D7473	Remove torus mandibularis	$937.24
D7485	Surg reduct osseoustuberosit	$3,063.22
D7510	I&d absc intraoral soft tiss	$396.48
D7511	Incision/drain abscess intra	$396.48
D7520	I&d abscess extraoral	$396.48
D7521	Incision/drain abscess extra	$396.48
D7530	Removal fb skin/areolar tiss	$937.24
D7540	Removal of fb reaction	$937.24
D7550	Removal of sloughed off bone	$937.24
D7950	Mandible graft	$3,063.22
G0104	Ca screen;flexi sigmoidscope	$156.23
G0105	Colorectal scrn; hi risk ind	$513.94
G0121	Colon ca scrn not hi rsk ind	$513.94
G0186	Dstry eye lesn,fdr vssl tech	$309.25
G0260	Inj for sacroiliac jt anesth	$390.34
G0276	Pild/placebo control clin tr	$3,686.38
G0330	Facility svs dental rehab	$1,464.17
G0429	Dermal filler injection(s)	$57.06

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

C7551	Exc neuroma w/ implnt nv end	$3,244.10
C7554	Cystureth blu li cyst fl img	$1,007.87
C7555	Rmvl thyrd w/autotran parath	$5,140.80
C7556	Bronch lavage w/ebus	$1,690.83
C7560	Ercp remove forgn body&endo	$1,969.60
C7562	R&I hrt angio w/ffr & 3d map	$2,761.10
C7563	Trluml ballo angiop all art	$6,179.18
C7564	Vein mech throm w/intrvas us	$11,447.21
C7565	Rpr aa hrn < 3 rdc w/ rmvl	$2,839.47
C8002	Prep skin cell susp, automtd	$4,086.89
C8003	Imp extar knee shck absrb	$15,264.17
C8004	Sim ang w/prs cath rad emb	$7,360.47
C9600	Perc drug-el cor stent sing	$7,415.37
C9725	Place endorectal app	$513.94
C9727	Insert palate implants	$690.25
C9728	Place device/marker, non pro	$769.87
C9739	Cystoscopy prostatic imp 1-3	$4,104.67
C9740	Cysto impl 4 or more	$8,210.83
C9757	Spine device implant surgery	$10,003.82
C9761	Cysto, litho, vacuum kidney	$5,018.69
C9764	Revasc intravasc lithotripsy	$8,141.03
C9765	Revasc intra lithotrip-stent	$13,122.11
C9766	Revasc intra lithotrip-ather	$13,386.38
C9767	Revasc lithotrip-stent-ather	$13,301.01
C9772	Revasc lithotrip tibi/perone	$7,952.81
C9773	Revasc lithotr-stent tib/per	$12,217.97
C9774	Revasc lithotr-ather tib/per	$12,476.30
C9775	Revasc lith-sten-ath tib/per	$13,769.42
C9777	Esophag muc integ w/eso egd	$2,753.01
C9778	Colpopexy, min/inv, ex-perit	$2,961.88
C9781	Arthro/shoul surg; w/spacer	$10,685.87
C9789	Instill pharm renal pelvis	$1,268.54
C9796	Rpr intst excl anrect fist	$1,860.47
C9797	Vasc emb/occ w/prs cath	$12,919.45
D4210	Gingivectomy/plasty 4 or mor	$1,464.17
D4211	Gingivectomy/plasty 1 to 3	$1,464.17
D4212	Gingivectomy/plasty rest	$1,464.17
D4260	Osseous surgery 4 or more	$3,063.22
D4263	Bone replce graft first site	$937.24
D4270	Pedicle soft tissue graft pr	$690.25
D4273	Auto tissue graft 1st tooth	$690.25
D7111	Extraction coronal remnants	$937.24
D7140	Extraction erupted tooth/exr	$937.24

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

C5271	Low cost skin substitute app	$344.70
C5273	Low cost skin substitute app	$1,030.14
C5275	Low cost skin substitute app	$344.70
C5277	Low cost skin substitute app	$344.70
C7500	Deb bone 20 cm2 w/drug dev	$1,262.00
C7501	Perc bx breast lesions stero	$1,262.00
C7502	Perc bx breast lesions mr	$1,262.00
C7503	Open exc cerv node(s) w/ id	$2,816.52
C7504	Perq cvt&ls inj vert bodies	$3,686.38
C7505	Perq ls&cvt inj vert bodies	$3,686.38
C7506	Fusion of finger joints	$3,686.38
C7507	Perq thor&lumb vert aug	$6,964.92
C7509	Dx bronch w/ navigation	$1,690.83
C7510	Bronch/lavag w/ navigation	$1,690.83
C7512	Bronch/bpsy(s) w/ ebus	$1,690.83
C7513	Cath/angio dialcir w/aplasty	$1,668.12
C7514	Cath/angio dial cir w/stents	$1,668.12
C7515	Cath/angio dial cir w/embol	$1,668.12
C7516	Cor angio w/ ivus or oct	$2,761.10
C7517	Cor angio w/ilic/fem angio	$2,761.10
C7518	Cor/gft angio w/ ivus or oct	$2,761.10
C7519	Cor/gft angio w/ flow resrv	$2,761.10
C7521	R hrt angio w/ ivus or oct	$2,761.10
C7522	R hrt angio w/flow resrv	$2,761.10
C7523	L hrt angio w/ ivus or oct	$2,761.10
C7524	L hrt angio w/flow resrv	$2,761.10
C7525	L hrt gft ang w/ ivus or oct	$2,761.10
C7526	L hrt gft ang w/flow resrv	$2,761.10
C7527	R&l hrt angio w/ ivus or oct	$2,761.10
C7528	R&l hrt angio w/flow resrv	$2,761.10
C7529	R&l hrt gft ang w/flow resrv	$2,761.10
C7531	Angio fem/pop w/ us	$6,407.39
C7532	Angio w/ us non-coronary	$6,179.18
C7535	Fem/pop revasc w/stent & us	$11,214.70
C7537	Insrt atril pm w/l vent lead	$11,450.64
C7538	Insrt vent pm w/l vent lead	$11,640.85
C7539	Insrt a & v pm w/l vent lead	$11,746.32
C7540	Rmv&rplc pm dul w/l vnt lead	$11,580.51
C7545	Exch bil cath w/ rmv calculi	$2,839.47
C7546	Rep nph/urt cath w/dil stric	$1,738.08
C7548	Exch neph cath w/ dil stric	$1,738.08
C7549	Chge urtr stent w/ dil stric	$1,738.08
C7550	Cysto w/ bx(s) w/ blue light	$1,738.08

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

69662	Revise middle ear bone	$3,063.22
69666	Repair middle ear structures	$1,464.17
69667	Repair middle ear structures	$1,464.17
69670	Remove mastoid air cells	$3,063.22
69676	Remove middle ear nerve	$1,464.17
69700	Close mastoid fistula	$690.25
69705	Nps surg dilat eust tube uni	$4,448.89
69706	Nps surg dilat eust tube bi	$4,435.15
69711	Remove/repair hearing aid	$1,464.17
69714	Impl oi implt skull perq esp	$10,691.28
69716	Impl oi implt sk tc esp<100	$10,678.66
69717	Rplcmt oi implt skl prq esp	$5,606.50
69719	Rplcm oi implt sk tc esp<100	$11,098.71
69720	Release facial nerve	$3,063.22
69726	Rmv ntr oi implt skl prq esp	$1,658.12
69727	Rmv ntr oi imp sk tc esp<100	$1,658.12
69728	Rmv ntr oi imp sk tc>=100	$1,658.12
69729	Impl oi implt sk tc esp>=100	$10,770.01
69730	Rplc oi implt sk tc esp>=100	$9,806.12
69740	Repair facial nerve	$3,063.22
69745	Repair facial nerve	$3,063.22
69801	Incise inner ear	$150.45
69805	Explore inner ear	$3,063.22
69806	Explore inner ear	$3,063.22
69905	Remove inner ear	$3,063.22
69910	Remove inner ear & mastoid	$3,063.22
69915	Incise inner ear nerve	$1,464.17
69930	Implant cochlear device	$29,011.95
92920	Prq cardiac angioplast 1 art	$3,809.54
92928	Prq card stent w/angio 1 vsl	$7,343.87
93451	Right heart cath	$1,738.50
93452	Left hrt cath w/ventrclgrphy	$1,738.50
93453	R&l hrt cath w/ventriclgrphy	$1,738.50
93454	Coronary artery angio s&i	$1,738.50
93455	Coronary art/grft angio s&i	$1,738.50
93456	R hrt coronary artery angio	$1,738.50
93457	R hrt art/grft angio	$1,738.50
93458	L hrt artery/ventricle angio	$1,738.50
93459	L hrt art/grft angio	$1,738.50
93460	R&l hrt art/ventricle angio	$1,738.50
93461	R&l hrt art/ventricle angio	$1,738.50
93985	Dup-scan hemo compl bi std	$136.79
93986	Dup-scan hemo compl uni std	$59.55

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

69145	Remove ear canal lesion(s)	$1,262.00
69150	Extensive ear canal surgery	$3,063.22
69205	Clear outer ear canal	$743.69
69222	Clean out mastoid cavity	$162.00
69300	Revise external ear	$1,464.17
69310	Rebuild outer ear canal	$3,063.22
69320	Rebuild outer ear canal	$3,063.22
69420	Incision of eardrum	$130.34
69421	Incision of eardrum	$1,464.17
69424	Remove ventilating tube	$96.80
69433	Create eardrum opening	$144.34
69436	Create eardrum opening	$690.25
69440	Exploration of middle ear	$1,464.17
69450	Eardrum revision	$1,464.17
69501	Mastoidectomy	$3,063.22
69502	Mastoidectomy	$3,063.22
69505	Remove mastoid structures	$3,063.22
69511	Extensive mastoid surgery	$3,063.22
69530	Extensive mastoid surgery	$3,063.22
69540	Excision aural polyp	$163.37
69550	Exc aurl glomus tum trnscanl	$3,063.22
69552	Exc aurl glomus tum trnsmstd	$3,063.22
69601	Revj mstdc rsltg compl mstdc	$3,063.22
69602	Rev mstdc rslt mod rad mstdc	$3,063.22
69603	Revj mstdc rsltg rad mstdc	$3,063.22
69604	Revj mstdc rsltg tympanplsty	$3,063.22
69610	Tympanic membrane repair	$216.69
69620	Myringoplasty	$1,464.17
69631	Repair eardrum structures	$3,063.22
69632	Rebuild eardrum structures	$3,063.22
69633	Rebuild eardrum structures	$3,063.22
69635	Repair eardrum structures	$3,063.22
69636	Rebuild eardrum structures	$3,063.22
69637	Rebuild eardrum structures	$3,063.22
69641	Revise middle ear & mastoid	$3,063.22
69642	Revise middle ear & mastoid	$3,063.22
69643	Revise middle ear & mastoid	$3,063.22
69644	Revise middle ear & mastoid	$3,063.22
69645	Revise middle ear & mastoid	$3,063.22
69646	Revise middle ear & mastoid	$3,063.22
69650	Stapes mobilization	$1,464.17
69660	Revise middle ear bone	$3,063.22
69661	Revise middle ear bone	$3,063.22

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

68135	Destruction les conjunctiva	$91.02
68320	Revise/graft eyelid lining	$1,077.30
68325	Revise/graft eyelid lining	$1,666.39
68326	Revise/graft eyelid lining	$1,666.39
68328	Revise/graft eyelid lining	$1,077.30
68330	Revise eyelid lining	$1,275.03
68335	Revise/graft eyelid lining	$1,666.39
68340	Separate eyelid adhesions	$1,077.30
68360	Revise eyelid lining	$1,666.39
68362	Revise eyelid lining	$1,077.30
68371	Harvest eye tissue alograft	$1,077.30
68400	I&d lacrimal gland	$230.61
68420	I&d lacrimal sac	$243.52
68440	Snip inc lacrimal punctum	$69.96
68500	Removal of tear gland	$1,666.39
68505	Partial removal tear gland	$1,666.39
68510	Biopsy of tear gland	$1,077.30
68520	Removal of tear sac	$1,666.39
68525	Biopsy of tear sac	$1,077.30
68530	Clearance of tear duct	$168.12
68540	Remove tear gland lesion	$1,077.30
68550	Remove tear gland lesion	$1,666.39
68700	Repair tear ducts	$1,077.30
68705	Revise tear duct opening	$168.12
68720	Create tear sac drain	$1,666.39
68745	Create tear duct drain	$1,666.39
68750	Create tear duct drain	$1,666.39
68760	Close tear duct opening	$153.52
68761	Close tear duct opening	$95.43
68770	Close tear system fistula	$1,077.30
68810	Probe nasolacrimal duct	$168.12
68811	Probe nasolacrimal duct	$1,077.30
68815	Probe nasolacrimal duct	$1,077.30
68816	Probe nl duct w/balloon	$1,077.30
68840	Explore/irrigate tear ducts	$87.29
69000	Drg xtrnl ear absc/hem smpl	$129.40
69005	Drg xtrnl ear absc/hem comp	$138.57
69020	Drg xtrnl aud canal abscess	$174.24
69100	Biopsy of external ear	$65.89
69105	Biopsy of external ear canal	$111.41
69110	Remove external ear partial	$1,262.00
69120	Removal of external ear	$3,063.22
69140	Remove ear canal lesion(s)	$3,063.22

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

67810	Incal bx eyelid skn lid mrgn	$139.59
67825	Revise eyelashes	$83.55
67830	Revise eyelashes	$520.77
67835	Revise eyelashes	$1,077.30
67840	Remove eyelid lesion	$201.40
67850	Dstrj lesion lid margin <1cm	$153.17
67875	Closure of eyelid by suture	$520.77
67880	Revision of eyelid	$1,077.30
67882	Revision of eyelid	$1,077.30
67900	Repair brow defect	$1,077.30
67901	Repair eyelid defect	$1,077.30
67902	Repair eyelid defect	$1,666.39
67903	Repair eyelid defect	$1,077.30
67904	Repair eyelid defect	$1,077.30
67906	Repair eyelid defect	$1,666.39
67908	Repair eyelid defect	$1,077.30
67909	Revise eyelid defect	$1,077.30
67911	Revise eyelid defect	$1,077.30
67912	Correction eyelid w/implant	$1,077.30
67914	Repair eyelid defect	$1,077.30
67915	Repair eyelid defect	$237.75
67916	Repair eyelid defect	$1,077.30
67917	Repair eyelid defect	$1,077.30
67921	Repair eyelid defect	$1,077.30
67922	Repair eyelid defect	$232.65
67923	Repair eyelid defect	$1,077.30
67924	Repair eyelid defect	$1,077.30
67930	Repair eyelid wound	$237.41
67935	Repair eyelid wound	$1,077.30
67938	Remove eyelid foreign body	$168.12
67950	Revision of eyelid	$1,077.30
67961	Revision of eyelid	$1,077.30
67966	Revision of eyelid	$1,077.30
67971	Reconstruction of eyelid	$1,077.30
67973	Reconstruction of eyelid	$1,077.30
67974	Reconstruction of eyelid	$1,666.39
67975	Reconstruction of eyelid	$1,077.30
68020	Incise/drain eyelid lining	$71.33
68040	Treatment of eyelid lesions	$33.29
68100	Biopsy conjunctiva	$129.07
68110	Exc les conjunctiva <1 cm	$169.82
68115	Exc les conjunctiva >1 cm	$1,077.30
68130	Exc les conjunctiva adj scl	$1,077.30

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

67208	Treatment of retinal lesion	$168.12
67210	Treatment of retinal lesion	$285.63
67218	Treatment of retinal lesion	$1,666.39
67220	Treatment of choroid lesion	$300.58
67221	Ocular photodynamic ther	$158.27
67227	Dstrj extensive retinopathy	$169.48
67228	Treatment x10sv retinopathy	$181.03
67229	Tr retinal les preterm inf	$309.25
67250	Reinforce eye wall	$1,077.30
67255	Reinforce/graft eye wall	$2,199.05
67311	Revise eye muscle	$1,077.30
67312	Revise two eye muscles	$1,666.39
67314	Revise eye muscle	$1,077.30
67316	Revise two eye muscles	$1,077.30
67318	Revise eye muscle(s)	$1,077.30
67343	Release eye tissue	$1,077.30
67345	Destroy nerve of eye muscle	$130.08
67346	Biopsy eye muscle	$1,666.39
67400	Explore/biopsy eye socket	$1,666.39
67405	Explore/drain eye socket	$1,077.30
67412	Explore/treat eye socket	$1,077.30
67413	Explore/treat eye socket	$1,077.30
67414	Explr/decompress eye socket	$1,666.39
67415	Aspiration orbital contents	$1,077.30
67420	Explore/treat eye socket	$1,666.39
67430	Explore/treat eye socket	$1,666.39
67440	Explore/drain eye socket	$2,112.10
67445	Explr/decompress eye socket	$1,666.39
67450	Explore/biopsy eye socket	$1,666.39
67500	Inject/treat eye socket	$34.64
67505	Inject/treat eye socket	$43.13
67515	Inject/treat eye socket	$24.45
67516	Sprchoroidal spc njx rx agt	$65.22
67550	Insert eye socket implant	$1,666.39
67560	Revise eye socket implant	$1,666.39
67570	Decompress optic nerve	$1,666.39
67700	Blepharotomy drg absc eyelid	$168.12
67710	Severing tarsorrhaphy	$199.36
67715	Canthotomy	$1,077.30
67800	Remove eyelid lesion	$79.47
67801	Remove eyelid lesions	$95.43
67805	Remove eyelid lesions	$123.63
67808	Remove eyelid lesion(s)	$1,077.30

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

66821	After cataract laser surgery	$309.25
66825	Reposition intraocular lens	$1,275.03
66830	Removal of lens lesion	$1,275.03
66840	Removal of lens material	$1,275.03
66850	Removal of lens material	$1,275.03
66852	Removal of lens material	$2,199.05
66920	Extraction of lens	$1,275.03
66930	Extraction of lens	$2,199.05
66940	Extraction of lens	$1,275.03
66982	Xcapsl ctrc rmvl cplx wo ecp	$1,275.03
66983	Cataract surg w/iol 1 stage	$1,275.03
66984	Xcapsl ctrc rmvl w/o ecp	$1,275.03
66985	Insert lens prosthesis	$1,275.03
66986	Exchange lens prosthesis	$1,275.03
66987	Xcapsl ctrc rmvl cplx w/ecp	$2,199.05
66988	Xcapsl ctrc rmvl w/ecp	$2,199.05
66989	Xcpsl ctrc rmvl cplx insj 1+	$3,951.02
66991	Xcapsl ctrc rmvl insj 1+	$3,947.69
67005	Partial removal of eye fluid	$1,275.03
67010	Partial removal of eye fluid	$1,275.03
67015	Release of eye fluid	$1,275.03
67025	Replace eye fluid	$1,275.03
67027	Implant eye drug system	$1,976.10
67028	Injection eye drug	$61.48
67030	Incise inner eye strands	$1,275.03
67031	Laser surgery eye strands	$309.25
67036	Removal of inner eye fluid	$2,199.05
67039	Laser treatment of retina	$2,199.05
67040	Laser treatment of retina	$2,199.05
67041	Vit for macular pucker	$2,199.05
67042	Vit for macular hole	$2,199.05
67043	Vit for membrane dissect	$2,199.05
67101	Repair detached retina crtx	$209.21
67105	Repair detached retina pc	$174.57
67107	Repair detached retina	$2,199.05
67108	Repair detached retina	$2,199.05
67110	Repair detached retina	$518.63
67113	Repair retinal detach cplx	$2,759.76
67115	Release encircling material	$2,199.05
67120	Remove eye implant material	$1,275.03
67121	Remove eye implant material	$1,275.03
67141	Proph rta dtchmnt crtx dthrm	$168.12
67145	Proph rta dtchmnt pc	$152.50

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

65865	Incise inner eye adhesions	$1,275.03
65870	Incise inner eye adhesions	$1,275.03
65875	Incise inner eye adhesions	$1,275.03
65880	Incise inner eye adhesions	$2,199.05
65900	Remove eye lesion	$1,275.03
65920	Remove implant of eye	$1,275.03
65930	Remove blood clot from eye	$1,275.03
66020	Injection treatment of eye	$1,275.03
66030	Injection treatment of eye	$1,275.03
66130	Remove eye lesion	$1,077.30
66150	Glaucoma surgery	$2,199.05
66155	Glaucoma surgery	$2,199.05
66160	Glaucoma surgery	$1,275.03
66170	Glaucoma surgery	$1,275.03
66172	Incision of eye	$1,275.03
66174	Trluml dil aq o/f can w/o st	$2,199.05
66175	Trluml dil aq o/f can w/st	$4,466.30
66179	Aqueous shunt eye w/o graft	$3,479.56
66180	Aqueous shunt eye w/graft	$3,595.05
66183	Insert ant drainage device	$3,141.08
66184	Revision of aqueous shunt	$1,275.03
66185	Revise aqueous shunt eye	$1,275.03
66225	Repair/graft eye lesion	$2,759.76
66250	Follow-up surgery of eye	$1,077.30
66500	Incision of iris	$1,275.03
66505	Incision of iris	$1,275.03
66600	Remove iris and lesion	$2,199.05
66605	Removal of iris	$1,275.03
66625	Removal of iris	$1,275.03
66630	Removal of iris	$1,275.03
66635	Removal of iris	$1,275.03
66680	Repair iris & ciliary body	$1,275.03
66682	Repair iris & ciliary body	$1,275.03
66683	Implantation iris prosthesis	$14,579.83
66700	Destruction ciliary body	$1,275.03
66710	Ciliary transsleral therapy	$1,077.30
66711	Ecp ciliary body destruction	$1,275.03
66720	Destruction ciliary body	$1,077.30
66740	Destruction ciliary body	$1,077.30
66761	Revision of iris	$189.51
66762	Revision of iris	$284.28
66770	Removal of inner eye lesion	$309.25
66820	Incision secondary cataract	$1,275.03

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

65130	Insert ocular implant	$1,666.39
65135	Insert ocular implant	$1,666.39
65140	Attach ocular implant	$1,666.39
65150	Revise ocular implant	$1,666.39
65155	Reinsert ocular implant	$1,666.39
65175	Removal of ocular implant	$1,666.39
65235	Remove foreign body from eye	$1,275.03
65260	Remove foreign body from eye	$1,275.03
65265	Remove foreign body from eye	$1,275.03
65270	Repair of eye wound	$1,077.30
65272	Repair of eye wound	$1,077.30
65275	Repair of eye wound	$1,666.39
65280	Repair of eye wound	$2,759.76
65285	Repair of eye wound	$2,759.76
65286	Repair of eye wound	$454.09
65290	Repair of eye socket wound	$1,666.39
65400	Removal of eye lesion	$520.77
65410	Biopsy of cornea	$1,077.30
65420	Removal of eye lesion	$1,077.30
65426	Removal of eye lesion	$1,077.30
65435	Curette/treat cornea	$49.93
65436	Curette/treat cornea	$216.69
65450	Treatment of corneal lesion	$168.12
65600	Revision of cornea	$287.00
65710	Corneal transplant	$2,759.76
65730	Corneal transplant	$2,199.05
65750	Corneal transplant	$2,759.76
65755	Corneal transplant	$2,199.05
65756	Corneal trnspl endothelial	$2,199.05
65770	Keratoprosthesis	$11,600.61
65772	Correction of astigmatism	$520.77
65775	Correction of astigmatism	$1,077.30
65780	Ocular reconst transplant	$1,666.39
65781	Ocular reconst transplant	$3,726.48
65782	Ocular reconst transplant	$1,666.39
65785	Implt ntrstrml crnl rng seg	$3,130.06
65800	Drainage of eye	$1,275.03
65810	Drainage of eye	$1,275.03
65815	Drainage of eye	$1,275.03
65820	Goniotomy	$2,199.05
65850	Trabeculotomy ab externo	$1,275.03
65855	Trabeculoplasty laser surg	$137.21
65860	Severing ads ant sgm laser	$178.65

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

64790	Removal of nerve lesion	$971.18
64792	Removal of nerve lesion	$3,244.10
64795	Biopsy of nerve	$971.18
64802	Sympathectomy cervical	$971.18
64820	Sympathectomy digital artery	$971.18
64821	Sympathectomy radial artery	$1,658.12
64822	Sympathectomy ulnar artery	$1,658.12
64823	Sympathectomy supfc palmar	$1,658.12
64831	Repair of digit nerve	$971.18
64834	Repair of hand or foot nerve	$3,244.10
64835	Repair of hand or foot nerve	$3,244.10
64836	Repair of hand or foot nerve	$3,244.10
64840	Repair of leg nerve	$3,244.10
64856	Repair/transpose nerve	$3,244.10
64857	Repair arm/leg nerve	$3,244.10
64858	Repair sciatic nerve	$971.18
64861	Repair of arm nerves	$971.18
64862	Repair of low back nerves	$3,244.10
64864	Repair of facial nerve	$3,244.10
64865	Repair of facial nerve	$4,111.79
64885	Nerve graft head/neck <4 cm	$3,244.10
64886	Nerve graft head/neck >4 cm	$4,111.79
64890	Nrv grf 1strnd hnd/foot <4cm	$4,111.79
64891	Nrv grf 1strnd hnd/foot >4cm	$4,111.79
64892	Nrv grf 1strnd arm/leg <4cm	$4,817.97
64893	Nrv grf 1strnd arm/leg >4 cm	$3,244.10
64895	Nrv grf mltst hnd/foot <4 cm	$3,244.10
64896	Nrv grf mltst hnd/foot >4 cm	$3,244.10
64897	Nrv grf mltst arm/leg <4 cm	$3,244.10
64898	Nrv grf mltst arm/leg >4 cm	$3,244.10
64905	Nerve pedicle transfer	$3,244.10
64907	Nerve pedicle transfer	$3,244.10
64910	Nerve repair w/allograft	$4,652.27
64912	Nrv rpr w/nrv algrft 1st	$4,792.78
65091	Revise eye	$1,666.39
65093	Revise eye with implant	$1,666.39
65101	Removal of eye	$1,666.39
65103	Remove eye/insert implant	$1,666.39
65105	Remove eye/attach implant	$1,666.39
65110	Removal of eye	$1,666.39
65112	Remove eye/revise socket	$1,666.39
65114	Remove eye/revise socket	$1,666.39
65125	Revise ocular implant	$1,077.30

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

64630	Injection treatment of nerve	$501.84
64632	N block inj common digit	$48.23
64633	Destroy cerv/thor facet jnt	$971.18
64635	Destroy lumb/sac facet jnt	$971.18
64640	Injection treatment of nerve	$178.65
64642	Chemodenerv 1 extremity 1-4	$87.97
64644	Chemodenerv 1 extrem 5/> mus	$106.98
64646	Chemodenerv trunk musc 1-5	$87.97
64647	Chemodenerv trunk musc 6/>	$95.78
64650	Chemodenerv eccrine glands	$61.48
64653	Chemodenerv eccrine glands	$68.61
64680	Injection treatment of nerve	$501.84
64681	Injection treatment of nerve	$501.84
64702	Revise finger/toe nerve	$971.18
64704	Revise hand/foot nerve	$971.18
64708	Revise arm/leg nerve	$971.18
64712	Revision of sciatic nerve	$971.18
64713	Revision of arm nerve(s)	$971.18
64714	Revise low back nerve(s)	$971.18
64716	Revision of cranial nerve	$971.18
64718	Revise ulnar nerve at elbow	$971.18
64719	Revise ulnar nerve at wrist	$971.18
64721	Carpal tunnel surgery	$971.18
64722	Relieve pressure on nerve(s)	$971.18
64726	Release foot/toe nerve	$971.18
64732	Incision of brow nerve	$971.18
64734	Incision of cheek nerve	$971.18
64736	Incision of chin nerve	$971.18
64738	Incision of jaw nerve	$971.18
64740	Incision of tongue nerve	$971.18
64742	Incision of facial nerve	$971.18
64744	Incise nerve back of head	$971.18
64746	Incise diaphragm nerve	$971.18
64763	Incise hip/thigh nerve	$971.18
64766	Incise hip/thigh nerve	$1,230.94
64771	Sever cranial nerve	$971.18
64772	Incision of spinal nerve	$971.18
64774	Remove skin nerve lesion	$971.18
64776	Remove digit nerve lesion	$971.18
64782	Remove limb nerve lesion	$971.18
64784	Remove nerve lesion	$971.18
64786	Remove sciatic nerve lesion	$3,244.10
64788	Remove skin nerve lesion	$971.18

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

64454	Njx aa&/strd gnclr nrv brnch	$390.34
64455	Njx aa&/strd pltr com dg nrv	$23.44
64461	Pvb thoracic single inj site	$390.34
64463	Pvb thoracic cont infusion	$390.34
64479	Njx aa&/strd tfrm epi c/t 1	$501.84
64483	Njx aa&/strd tfrm epi l/s 1	$501.84
64490	Inj paravert f jnt c/t 1 lev	$501.84
64493	Inj paravert f jnt l/s 1 lev	$501.84
64505	N block spenopalatine gangl	$89.66
64510	N block stellate ganglion	$501.84
64517	N block inj hypogas plxs	$501.84
64520	N block lumbar/thoracic	$501.84
64530	N block inj celiac pelus	$501.84
64553	Implant neuroelectrodes	$9,545.01
64555	Implant neuroelectrodes	$6,145.88
64561	Implant neuroelectrodes	$5,478.62
64566	Neuroeltrd stim post tibial	$92.38
64568	Opn impltj crnl nrv nea&pg	$28,182.16
64569	Revise/repl vagus n eltrd	$11,948.66
64570	Remove vagus n eltrd	$3,244.10
64575	Opn impltj nea perph nerve	$10,419.18
64580	Opn impltj nea neuromuscular	$21,207.25
64581	Opn impltj nea sacral nerve	$5,747.76
64582	Opn mpltj hpglsl nstm ary pg	$27,123.88
64583	Rev/rplct hpglsl nstm ary pg	$8,905.46
64584	Rmvl hpglsl nstim ary pg	$3,244.10
64585	Rev/rmv perph nstim eltrd ra	$2,041.55
64590	Ins/rpl prph sac/gstr npg/r	$20,655.84
64595	Rev/rmv prph sac/gstr npg/r	$2,601.50
64596	Ins/rplcmt prq eltrd ra pn 1	$8,905.46
64598	Revj/rmvl nea pn w/int nstim	$2,041.55
64600	Injection treatment of nerve	$501.84
64605	Injection treatment of nerve	$971.18
64610	Injection treatment of nerve	$971.18
64611	Chemodenerv saliv glands	$87.62
64612	Destroy nerve face muscle	$83.21
64615	Chemodenerv musc migraine	$72.00
64616	Chemodenerv musc neck dyston	$72.68
64617	Chemodener muscle larynx emg	$90.34
64620	Injection treatment of nerve	$501.84
64624	Dstrj nulyt agt gnclr nrv	$971.18
64625	Rf abltj nrv nrvtg si jt	$971.18
64628	Trml dstrj ios bvn 1st 2 l/s	$10,000.21

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

62380	Ndsc dcmprn 1 ntrspc lumbar	$3,686.38
63001	Remove spine lamina 1/2 crvl	$3,686.38
63003	Remove spine lamina 1/2 thrc	$3,686.38
63005	Remove spine lamina 1/2 lmbr	$3,686.38
63020	Neck spine disk surgery	$3,686.38
63030	Low back disk surgery	$3,686.38
63042	Laminotomy single lumbar	$3,686.38
63045	Lam facetec & foramot crv	$3,686.38
63046	Lam facetec & foramot thrc	$3,686.38
63047	Lam facetec & foramot lumbar	$3,686.38
63055	Decompress spinal cord thrc	$3,686.38
63056	Decompress spinal cord lmbr	$3,686.38
63600	Remove spinal cord lesion	$971.18
63610	Stimulation of spinal cord	$1,372.72
63650	Implant neuroelectrodes	$5,338.46
63655	Implant neuroelectrodes	$19,009.91
63661	Remove spine eltrd perq aray	$971.18
63662	Remove spine eltrd plate	$2,041.55
63663	Revise spine eltrd perq aray	$5,417.42
63664	Revise spine eltrd plate	$9,588.66
63685	Ins/rplc spi npg/rcvr pocket	$27,595.75
63688	Rev/rmv imp sp npg/r dtch cn	$2,041.55
63744	Revision of spinal shunt	$4,515.68
63746	Removal of spinal shunt	$971.18
64400	Njx aa&/strd trigeminal nrv	$81.86
64405	Njx aa&/strd gr ocpl nrv	$37.70
64408	Njx aa&/strd vagus nrv	$52.98
64415	Njx aa&/strd brch plxs img	$501.84
64416	Njx aa&/strd brch pl nfs img	$636.06
64417	Njx aa&/strd ax nerve img	$501.84
64418	Njx aa&/strd sprscap nrv	$45.85
64420	Njx aa&/strd ntrcost nrv 1	$390.34
64421	Njx aa&/strd ntrcost nrv ea	$501.84
64425	Njx aa&/strd ii ih nerves	$74.05
64430	Njx aa&/strd pudendal nerve	$501.84
64435	Njx aa&/strd paracrv nrv	$50.95
64445	Njx aa&/strd sciatic nrv img	$106.30
64446	Njx aa&/strd sc nrv nfs img	$501.84
64447	Njx aa&/strd femoral nrv img	$68.27
64448	Njx aa&/strd fem nrv nfs img	$638.78
64449	Njx aa&/strd lmbr plex nfs	$501.84
64450	Njx aa&/strd other pn/branch	$47.55
64451	Njx aa&/strd nrv nrvtg si jt	$390.34

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

61791	Treat trigeminal tract	$971.18
61880	Revise/remove neuroelectrode	$2,041.55
61885	Insrt/redo neurostim 1 array	$21,107.56
61886	Implant neurostim arrays	$27,604.04
61888	Revise/remove neuroreceiver	$11,185.44
62194	Replace/irrigate catheter	$971.18
62225	Replace/irrigate catheter	$3,244.10
62230	Replace/revise brain shunt	$3,244.10
62252	Csf shunt reprogram	$42.45
62263	Epidural lysis mult sessions	$501.84
62264	Epidural lysis on single day	$501.84
62267	Interdiscal perq aspir dx	$396.48
62268	Drain spinal cord cyst	$501.84
62269	Needle biopsy spinal cord	$743.69
62270	Dx lmbr spi pnxr	$390.34
62272	Ther spi pnxr drg csf	$390.34
62273	Inject epidural patch	$390.34
62280	Treat spinal cord lesion	$501.84
62281	Treat spinal cord lesion	$501.84
62282	Treat spinal canal lesion	$501.84
62287	Dcmprn px perq 1/mlt lumbar	$971.18
62292	Njx chemonucleolysis lmbr	$971.18
62294	Injection into spinal artery	$501.84
62320	Njx interlaminar crv/thrc	$390.34
62321	Njx interlaminar crv/thrc	$390.34
62322	Njx interlaminar lmbr/sac	$501.84
62323	Njx interlaminar lmbr/sac	$390.34
62324	Njx interlaminar crv/thrc	$501.84
62325	Njx interlaminar crv/thrc	$501.84
62326	Njx interlaminar lmbr/sac	$501.84
62327	Njx interlaminar lmbr/sac	$501.84
62328	Dx lmbr spi pnxr w/fluor/ct	$390.34
62329	Ther spi pnxr csf fluor/ct	$390.34
62350	Implant spinal canal cath	$4,500.85
62355	Remove spinal canal catheter	$971.18
62360	Insert spine infusion device	$15,426.65
62361	Implant spine infusion pump	$16,314.02
62362	Implant spine infusion pump	$15,234.44
62365	Remove spine infusion device	$3,244.10
62367	Analyze spine infus pump	$14.61
62368	Analyze sp inf pump w/reprog	$20.38
62369	Anal sp inf pmp w/reprg&fill	$67.92
62370	Anl sp inf pmp w/mdreprg&fil	$59.44

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

59076	Fetal shunt placement w/us	$171.23
59100	Remove uterus lesion	$2,336.86
59150	Treat ectopic pregnancy	$3,003.34
59151	Treat ectopic pregnancy	$3,003.34
59160	D & c after delivery	$1,757.97
59200	Insert cervical dilator	$82.53
59300	Episiotomy or vaginal repair	$125.66
59320	Revision of cervix	$1,757.97
59412	Antepartum manipulation	$1,757.97
59414	Deliver placenta	$1,757.97
59812	Treatment of miscarriage	$1,757.97
59820	Care of miscarriage	$1,757.97
59821	Treatment of miscarriage	$1,757.97
59840	Induced abortion d&c	$1,757.97
59841	Induced abortion dilat&evac	$1,757.97
59866	Abortion (mpr)	$171.23
59870	Evacuate mole of uterus	$1,757.97
59871	Remove cerclage suture	$1,757.97
60000	Drain thyroid/tongue cyst	$690.25
60100	Biopsy of thyroid	$53.32
60200	Remove thyroid lesion	$3,003.34
60210	Partial thyroid excision	$3,003.34
60212	Partial thyroid excision	$3,003.34
60220	Partial removal of thyroid	$3,003.34
60225	Partial removal of thyroid	$3,003.34
60240	Removal of thyroid	$3,003.34
60260	Repeat thyroid surgery	$3,063.22
60280	Remove thyroid duct lesion	$3,003.34
60281	Remove thyroid duct lesion	$3,003.34
60300	Aspir/inj thyroid cyst	$68.61
60500	Explore parathyroid glands	$3,063.22
60660	Abltj 1/+thyr ndul 1lobe prq	$743.69
61000	Remove cranial cavity fluid	$390.34
61001	Remove cranial cavity fluid	$390.34
61020	Remove brain cavity fluid	$501.84
61026	Injection into brain canal	$390.34
61050	Remove brain canal fluid	$166.40
61055	Injection into brain canal	$166.40
61070	Brain canal shunt procedure	$390.34
61215	Ins subq rsvr pmp/nfs sys	$3,244.10
61330	Dcmprn orbit only transcrnl	$1,464.17
61770	Incise skull for treatment	$3,244.10
61790	Treat trigeminal nerve	$971.18

Saint Joseph Medical Center

July 1, 2025

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

Re: Assurances - Prime Healthcare ASC – Joliet, LLC

Dear Mr. Kniery,

As a representative of Prime Healthcare ASC - Joliet, LLC ("Prime ASC"), I, Colleen Pawlik, MSN, BSN, hereby attest that it is 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,

Colleen Pawlik, MSN, BSN
Interim Chief Executive Officer
Saint Joseph Medical Center – Joliet

ATTACHMENT 33
Availability of Funds

The total estimated project cost is $5,468,243. The applicants have sufficient resources to fund the cash portion of this project. The applicant has previously provided Board Staff with a copy of its audited financial report as evidence which reflects that the Applicant has sufficient funds on hand to complete the project.

Saint Joseph Medical Center

July 1, 2025

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

Re: Prime Healthcare ASC – Joliet, LLC
77 Ill. Admin. Code Section 1120.120 (a) Available Funds Certification
77 Ill. Admin. Code Section 1120.140 (a) Reasonableness of Financing Arrangements

Dear Mr. Kniery,

As a representative of Prime Healthcare Services, Inc., Saint Joseph Medical Center-Joliet, LLC, and Prime Healthcare ASC - Joliet, LLC ("Prime ASC"), I, Colleen Pawlik, MSN, BSN, hereby attest that the project costs will be $5,468,243. Prime Healthcare Services Inc. will fund the entirety of the construction of the project and the necessary working capital and operating deficits through the second full fiscal year. Prime Healthcare Services, Inc. has sufficient and readily accessible internal resources to fund the obligation required by the project, and to fully fund their other ongoing obligations.

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

Sincerely,

Colleen Pawlik, MSN

Colleen Pawlik, MSN, BSN
Interim Chief Executive Officer
Saint Joseph Medical Center – Joliet

ATTACHMENT 34
Financial Viability

The applicants meet the requirements for a financial viability waiver in accordance with 77 Ill. Adm. Code § 1120.130, as the proposed project will be funded by internal sources of the Applicant.

ATTACHMENT 34
Financial Viability

Full Year Projection													
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Year 1
Cases	55	81	97	101	106	114	123	127	137	148	152	161	1402
	19	28	33	35	36	39	42	43	47	51	52	55	480
D&M GI/case	$121	$121	$121	$121	$121	$121	$121	$121	$121	$121	$121	$121	
	$2,299	$3,388	$3,993	$4,235	$4,356	$4,719	$5,082	$5,203	$5,687	$6,171	$6,292	$6,655	
	2	3	4	4	4	4	5	5	5	6	6	6	54
D&M Orthopedics/case	$1,819	$1,819	$1,819	$1,819	$1,819	$1,819	$1,819	$1,819	$1,819	$1,819	$1,819	$1,819	
	$3,638	$5,457	$7,277	$7,277	$7,277	$7,277	$9,096	$9,096	$9,096	$10,915	$10,915	$10,915	
	2	2	3	3	3	3	3	4	4	4	4	5	40
D&M Podiatry	$1,331	$1,331	$1,331	$1,331	$1,331	$1,331	$1,331	$1,331	$1,331	$1,331	$1,331	$1,331	
	$2,662	$2,662	$3,993	$3,993	$3,993	$3,993	$3,993	$5,324	$5,324	$5,324	$5,324	$6,655	
	6	9	11	11	12	12	13	14	15	16	17	18	154
D&M General	$484	$484	$484	$484	$484	$484	$484	$484	$484	$484	$484	$484	
	$2,904	$4,356	$5,324	$5,324	$5,808	$5,808	$6,292	$6,776	$7,260	$7,744	$8,228	$8,712	
	17	26	31	33	34	37	40	41	44	48	49	52	452
D&M Pain	$605	$605	$605	$605	$605	$605	$605	$605	$605	$605	$605	$605	
	$10,285	$15,730	$18,755	$19,965	$20,570	$22,385	$24,200	$24,805	$26,620	$29,040	$29,645	$31,460	
ENT Cases	3	5	6	6	7	7	8	8	9	9	9	10	87
	$605	$605	$605	$605	$605	$605	$605	$605	$605	$605	$605	$605	
	$1,815	$3,025	$3,630	$3,630	$4,235	$4,235	$4,840	$4,840	$5,445	$5,445	$5,445	$6,050	
GYN Cases	2	3	3	3	3	4	4	4	4	5	5	5	45
	$605	$605	$605	$605	$605	$605	$605	$605	$605	$605	$605	$605	
	$1,210	$1,815	$1,815	$1,815	$1,815	$2,420	$2,420	$2,420	$2,420	$3,025	$3,025	$3,025	
Cardiac Cases	1	1	1	1	2	2	2	2	2	2	2	2	20
	$2,904	$2,904	$2,904	$2,904	$2,904	$2,904	$2,904	$2,904	$2,904	$2,904	$2,904	$2,904	
	$2,904	$2,904	$2,904	$2,904	$5,808	$5,808	$5,808	$5,808	$5,808	$5,808	$5,808	$5,808	
Ophthalmology Cases	3	4	5	5	5	6	6	6	7	7	8	8	70
	$545	$545	$545	$545	$545	$545	$545	$545	$545	$545	$545	$545	
	$1,634	$2,178	$2,723	$2,723	$2,723	$3,267	$3,267	$3,267	$3,812	$3,812	$4,356	$4,356	
Salaries and Benefits	$34,503	$50,814	$60,851	$61,014	$64,034	$66,218	$71,446	$70,819	$73,212	$79,090	$77,696	$82,297	$791,994
Total D&M	$27,657	$34,618	$42,972	$44,424	$46,239	$48,417	$53,503	$56,044	$59,432	$64,639	$65,849	$70,447	$614,237
Total Other Operating Expense	$26,400	$38,880	$46,560	$48,480	$50,880	$54,720	$59,040	$52,705	$56,855	$61,420	$63,080	$66,815	$625,835
Total Expenses	$88,560	$124,312	$150,383	$153,917	$161,153	$169,355	$183,989	$179,567	$189,499	$205,149	$206,625	$219,558	$2,032,067
Total Expense per case	$1,610	$1,535	$1,550	$1,524	$1,520	$1,486	$1,496	$1,414	$1,383	$1,386	$1,359	$1,364	$1,469

ATTACHMENT 34
Financial Viability

	Full Year Projection												
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Year 1
Total Monthly Cases	55	81	97	101	106	114	123	127	137	148	152	161	1402
NET REVENUE	$85,868	$122,967	$147,258	$152,073	$165,798	$176,484	$190,845	$197,154	$210,318	$226,910	$231,734	$245,284	$2,152,694
Total NR/case	$1,561	$1,518	$1,518	$1,506	$1,564	$1,548	$1,552	$1,552	$1,535	$1,533	$1,525	$1,524	$1,535
													Year 1
Salaries and Benefits	$34,503	$50,814	$60,851	$61,014	$64,034	$66,218	$71,446	$70,819	$73,212	$79,090	$77,696	$82,297	$791,994
D&M	$27,657	$34,618	$42,972	$44,424	$46,239	$48,417	$53,503	$56,044	$59,432	$64,639	$65,849	$70,447	$614,237
Other Expenses	$26,400	$38,880	$46,560	$48,480	$50,880	$54,720	$59,040	$52,705	$56,855	$61,420	$63,080	$66,815	$625,835
Total Expense	$88,560	$124,312	$150,383	$153,917	$161,153	$169,355	$183,989	$179,567	$189,499	$205,149	$206,625	$219,558	$2,032,067
Total Expense/case	$1,610	$1,535	$1,550	$1,524	$1,520	$1,486	$1,496	$1,414	$1,383	$1,386	$1,359	$1,364	$1,449
													EBITDA
EBITDA	-$2,692	-$1,345	-$3,124	-$1,844	$4,645	$7,129	$6,856	$17,587	$20,820	$21,761	$25,109	$25,725	$120,627
EBIDTA/case	-$49	-$17	-$32	-$18	$44	$63	$56	$138	$152	$147	$165	$160	$86
Service not currently be paid by center (Anesthesia, Biomed, etc...)	$4,125	$6,075	$7,275	$7,575	$7,950	$8,550	$9,225	$8,255	$8,905	$9,620	$9,880	$10,465	$97,900
Additional Expense/case (not covered)	$75	$75	$75	$75	$75	$75	$75	$65	$65	$65	$65	$65	
Total Expense/case adding Purchased Services (not covered)	$1,685	$1,610	$1,625	$1,599	$1,595	$1,561	$1,571	$1,479	$1,448	$1,451	$1,424	$1,429	$1,540
													EBITDA
EBITDA adding Purchased Services (not covered)	-$6,817	-$7,420	-$10,399	-$9,419	-$3,305	-$1,421	-$2,369	$9,332	$11,915	$12,141	$15,229	$15,260	$22,727
EBITDA/case adding Purchased Services (not covered)	-$124	-$92	-$107	-$93	-$31	-$12	-$19	$73	$87	$82	$100	$95	$16

ATTACHMENT 36
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	H	Total Cost (G + H)
	Cost/Square Foot New	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
ASC	$66.72	-	8,370	-	-	-	$558,407	-	$558,407
Contingency	$19.22	-	2,602	-	-	-	$50,000	-	$50,000
TOTALS	$85.94	-	10,972	-	-	-	$608,407	-	$608,407
* 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 $495.41 GSF. This project is slated to be completed in the 4th quarter of 2026 and the applicable RS Means standard is $495.41 per GSF. The proposed cost per GSF for this project is $85.94, and thus this project meets the Board's criteria.

ATTACHMENT 37
Safety Net Impact Statement
Ascension Saint Joseph – Joliet (for reference)

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2021**	**2022**	**2023**
Inpatient	299	267	183
Outpatient	5875	5936	4180
Total	**6174**	**6203**	**4363**
Charity (cost in dollars)			
Inpatient	$4,493,201	$3,436,556	$3,671,268
Outpatient	$5,208,329	$4,475,892	$5,301,876
Total	**$9,701,530**	**$7,912,448**	**$8,973,144**
MEDICAID			
Medicaid (# of patients)	**2021**	**2022**	**2023**
Inpatient	3433	3035	3180
Outpatient	42148	42931	43224
Total	**45,581**	45966	46404
Medicaid (revenue)			
Inpatient	$28,596,389	$32,950,510	$38,482,477
Outpatient	$37,668,163	$34,743,259	$45,855,039
Total	**$66,264,552**	**$67,693,769**	**$84,337,516**

ATTACHMENT 38
Charity Care

Prime ASC is a new entity and has no applicable historical data for this section of the application. The projected patient mix by payer source by the end of its second year of operation is included below. These figures were estimated based on existing patient's payor mix treated at Saint Joseph Medical Center. The physicians associated with this project are already contracted providers with Illinois Medicaid Managed Care Organizations, such as BlueCross Blue Shield, CountyCare Health Plan, Molina Healthcare, and Meridian Health Plan. Those physicians will continue to treat patients with those plans at the proposed facility and all patients will be treated regardless of their ability to pay.

Projected Payor Mix

Payor Type	Estimated Number of Patients
Commercial	21%
Medicare	57%
Medicaid/ Medicaid MCO	22%

Please find below the historical charitable care for Asencion Saint Joseph - Joliet.

CHARITY CARE			
Charity (# of patients)	**2021**	**2022**	**2023**
Inpatient	299	267	183
Outpatient	5875	5936	4180
Total	**6174**	**6203**	**4363**
Charity (cost in dollars)			
Inpatient	$4,493,201	$3,436,556	$3,671,268
Outpatient	$5,208,329	$4,475,892	$5,301,876
Total	**$9,701,530**	**$7,912,448**	**$8,973,144**

Saint Joseph Medical Center

July 1, 2025

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

Re: – Flood Plain Requirements -Prime Healthcare ASC – Joliet, LLC

Dear Mr. Kniery:

As a representative of Saint Joseph Medical Center – Joliet, I, Colleen Pawlik, MSN, BSN, affirm that the proposed location for the Prime Healthcare ASC – Joliet, LLC ("Prime ASC") ambulatory surgical treatment center complies with Illinois Executive Order #2005-5. The facility location at 301 Madison Street, Suite 100, Joliet, Illinois 60435 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 is true and is based upon my personal knowledge under penalty of perjury and in accordance with 735 ILCS 5/1-109.

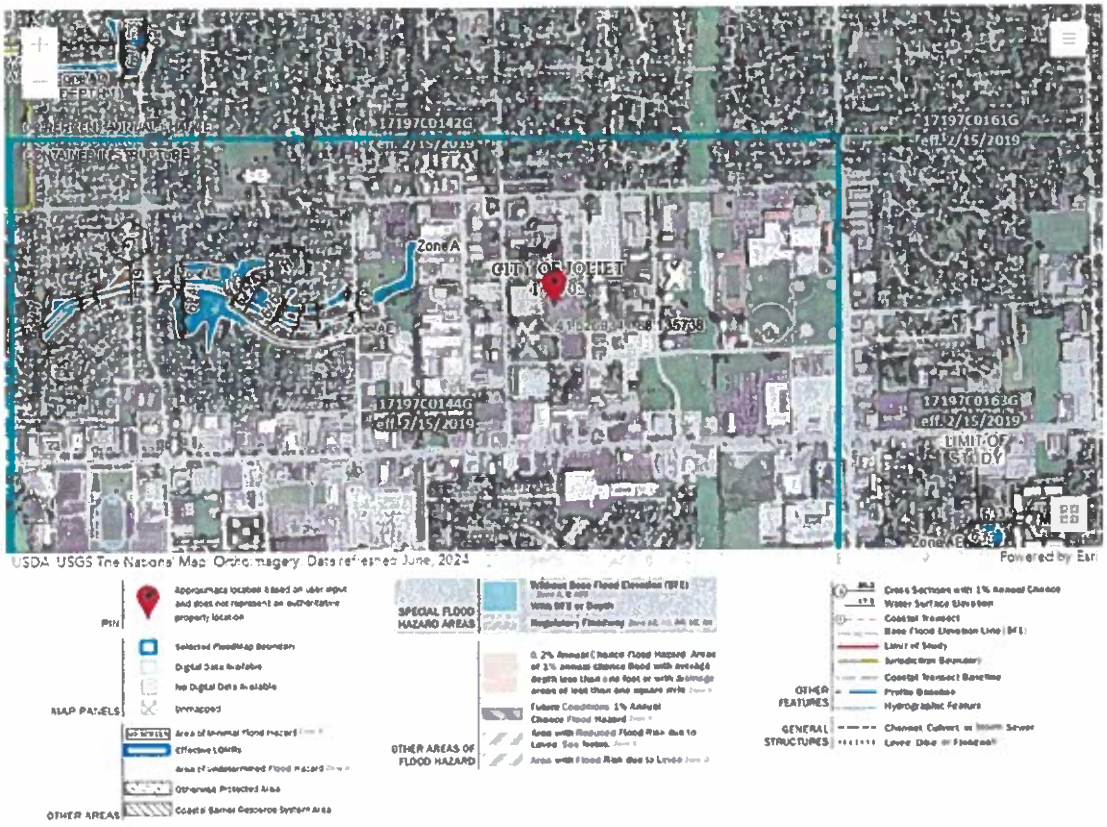
Sincerely,

Colleen Pawlik, MSN, BSN
Interim Chief Executive Officer
Saint Joseph Medical Center – Joliet

ATTACHMENT 39
Flood Zone Letter

Saint Joseph Medical Center

Flood Plain Attestation
Page Two



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