LEGAL NOTICE
Notice of Proposed Rulemaking
Public Hearing

Pursuant to Chapter 91, Hawaii Revised Statutes (HRS), notice is hereby given that the Department of Labor and Industrial Relations (DLIR) will hold a public hearing to amend Title 12, Chapter 15, Hawaii Administrative Rules (HAR), relating to the Workers' Compensation Medical Fee Schedule, and billing codes in Exhibit A, Workers' Compensation Supplemental Medical Fee Schedule. The hearing will be held on the following date, time, and location:

HONOLULU, OAHU	October 26, 2017, 8:30 a.m. Keelikolani Building 830 Punchbowl Street Rooms 310, 313, and 314 Honolulu, Hawaii 96813

The proposed changes to the Workers' Compensation Medical Fee Schedule in Title 12, Chapter 15, HAR, and Exhibit A are 1) to implement Act 101, effective June 21, 2016 (SLH 2016), which allows physicians and providers of service other than physicians to transmit a workers' compensation treatment plan by mail or facsimile to an address or facsimile number provided by the employer; and 2) pursuant to section 386-21(c), HRS, which requires the director to update the fee schedule every three years or annually, as required.

The proposed changes to the Workers' Compensation Medical Fee Schedule rules in Title 12, Chapter 15, HAR, include the following:

1. Sections 12-15-32 and 12-15-34, HAR, Workers' Compensation Medical Fee Schedule, is amended by allowing physicians and providers of service other than physicians (respectively) to transmit a treatment plan by mail or facsimile to an address or facsimile number provided by the employer.

2. Section 12-15-90, HAR, Workers' Compensation Medical Fee Schedule, is amended by specifying that the Workers' Compensation Supplemental Medical Fee Schedule, known as Exhibit A, will be dated January 1, 2018.

3. Codes in Exhibit A at the end of Title 12, Chapter 15, Workers' Compensation Supplemental Medical Fee Schedule are amended.

A copy of the proposed rule changes will be made available for public viewing from the first working day that the legal notice appears in the Honolulu Star-Advertiser, Hawaii Tribune-Herald, West Hawaii Today, The Maui News, and The Garden Island, through the day the public hearing is held, from Monday - Friday between the hours of 8:00 a.m. - 4:00 p.m., at the following locations of the Department of Labor and Industrial Relations, Disability Compensation Division:

830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813
2264 Aupuni Street, Wailuku, Hawaii 96793
75 Aupuni Street, Room 108, Hilo, Hawaii 96720
81-990 Halekii Street, Room 2087, Kealakekua, Hawaii 96750
3060 Eiwa Street, Room 202, Lihue, Hawaii 96766.

A copy of the proposed rules may be viewed at **http://hawaii.gov/labor**. Copies can also be mailed to any interested party, upon written request to the Department of Labor and Industrial Relations, Disability Compensation Division, 830 Punchbowl Street, Room 209, Honolulu, HI 96813. Please enclose a self-addressed stamped envelope with $.91 postage on it.

Interested persons may present written or oral testimony at the time of the public hearing. All persons wishing to submit written testimony are requested to submit 5 copies of their written testimony before the public hearing to the Department of Labor and Industrial Relations, Disability Compensation Division, 830 Punchbowl Street, Room 209, Honolulu, HI 96813, or 5 copies may be submitted to the presiding officer at the public hearing. The public hearing will be continued, if necessary, to a time, date, and place announced at the scheduled hearing.

Interested persons unable to attend the public hearing shall submit 5 copies of their written testimony concerning the proposals to the Department of Labor and Industrial Relations, Disability Compensation Division, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813. All submissions for the record must be received at or prior to the scheduled public hearing.

Auxiliary aids and services are available upon request by calling the Disability Compensation Division at (808) 586-9151 or by e-mail to "dlir.workcomp@hawaii.gov". A request for reasonable accommodations should be made no later than ten working days prior to the needed accommodations.

Dated: September 25, 2017

LINDA CHU TAKAYAMA
Director
Department of Labor and Industrial Relations

DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

Amendments to Chapter 12-15
Hawaii Administrative Rules
Workers' Compensation
Relating to Medical Fee Schedule

August 23, 2017

1. Section 12-15-32, Hawaii Administrative Rules, is amended to read as follows:

"§12-15-32 Physicians. (a) Frequency and extent of treatment shall not be more than the nature of the injury and the process of a recovery requires. Authorization is not required for the initial fifteen treatments of the injury during the first sixty calendar days.

(b) If the physician believes treatments in addition to that allowed by subsection (a) are required, the physician shall [~~mail~~] transmit a treatment plan to the employer by mail or facsimile under separate cover at least seven calendar days prior to the start of the additional treatments to an address or facsimile number provided by the employer. A treatment plan shall be for one hundred twenty calendar days and shall not exceed fifteen treatments within that period. Treatments provided with less than seven calendar days notice are not authorized. A complete treatment plan shall contain the following elements:

(1) Projected commencement and termination dates of treatment;

(2) A clear statement as to the impression or diagnosis;

(3) A specific time schedule of measurable objectives to include baseline measurements at the start of the treatment plan and projected goals by the end of the treatment plan;

(4) Number and frequency of treatments;

(5) Modalities and procedures to be used; and

(6) An estimated total cost of services.

Treatment plans which do not include the above specified elements but which are reasonable and necessary may not be denied by the employer, but upon written notification from the employer, the physician shall correct the deficiency(s) and the employer's liability is deferred as long as the treatment plan remains deficient. Neither the injured employee nor the employer shall be liable for services provided under a treatment plan that remains deficient. Both the front page of the treatment plan and the envelope in which the plan is mailed or the cover sheet if the plan is sent by facsimile shall be clearly identified as a "WORKERS' COMPENSATION TREATMENT PLAN" in capital letters and in no less than ten point type.

(c) A treatment plan shall be deemed received by an employer when the plan is sent by mail or facsimile with reasonable evidence showing that the treatment plan was received.

[~~(c)~~](d) The employer may file an objection to the treatment plan with documentary evidence supporting the denial and a copy of the denied treatment plan with the director, copying the physician and the injured employee. Both the front page of the denial and the envelope in which the denial is filed shall be clearly identified as a "TREATMENT PLAN DENIAL" in capital letters and in no less than ten point type. The employer shall be responsible for payment for treatments provided under a complete treatment plan until the date the objection is filed with the director. Furthermore, the employer's objection letter must explicitly state that if the attending physician or the injured employee does not agree with the denial, they may request a review by the director of the employer's denial within fourteen calendar days after postmark of the employer's denial, and failure to do so shall be construed as acceptance of the employer's denial.

[~~(d)~~](e) The attending physician or the injured employee may request in writing that the director review the employer's denial of the treatment plan. The request for review shall be filed with the director, copying the employer, within fourteen calendar days after postmark of the employer's denial. A copy of the denied treatment plan shall be submitted with the request for review. Both the front page of the request for review and the envelope in which the request is filed shall be clearly identified

as a "REQUEST FOR REVIEW OF TREATMENT PLAN DENIAL" in capital letters and in no less than ten point type. For cases not under the jurisdiction of the director at the time of the request, the injured employee shall be responsible to have the case remanded to the director's jurisdiction. Failure to file a request for review of the employer's denial with the director within fourteen calendar days after postmark of the employer's denial shall be deemed acceptance of the employer's denial.

[~~(e)~~](f) The director shall issue a decision, after a hearing, either requiring the employer to pay the physician within thirty-one calendar days in accordance with the medical fee schedule if the treatments are determined to be reasonable and necessary or disallowing the fees for treatments determined to be unreasonable or unnecessary. Disallowed fees shall not be charged to the injured employee.

[~~(f)~~](g) The decision issued pursuant to subsection [~~(e)~~](f) shall be final unless appealed pursuant to section 386-87, HRS. The appeal shall not stay the director's decision.

[~~(g)~~](h) The psychiatric evaluation or psychological testing with the resultant reports shall be limited to four hours unless the physician submits prior documentation indicating the necessity for more time and receives pre-authorization from the employer. Fees shall be calculated on an hourly basis as allowed under Medicare.

[~~(h)~~](i) For physical medicine, treatments may include up to four procedures, up to four modalities, or a combination of up to four procedures and modalities, and the visit shall not exceed sixty minutes per injury. When treating more than one injury, treatments may include up to six procedures, up to six modalities, or a combination of up to six procedures and modalities, and the entire visit shall not exceed ninety minutes.

[~~(i)~~](j) Any physician who exceeds the treatment guidelines without proper authorization shall not be compensated for the unauthorized services.

[~~(j)~~](k) No compensation shall be allowed for preparing treatment plans and written justification for treatments which exceed the guidelines.

[~~(k)~~](l) Failure to comply with the requirements in this section may result in denial of fees.

[~~(l)~~](m) Treatment, prescribed on an in-patient basis in a licensed acute care hospital where the injured employee's level of care is medically appropriate for an acute setting as determined by community standards, are excluded from the frequency of treatment guidelines specified herein." [Eff 1/1/96; am 1/1/97; am] (Auth: HRS §§386-21, 386-21.2, 386-26, 386-72) (Imp: HRS §§386-21, 386-21.2, 386-26, 386-27)

2. Section 12-15-34, Hawaii Administrative Rules, is amended to read as follows:

"§12-15-34 Providers of service other than physicians. (a) Frequency and extent of treatment shall not be more than the nature of the injury and the process of a recovery require. Any health care treatment or service performed by a Hawaii licensed or certified provider of service other than a physician shall be directed by the attending physician based on a written prescription signed, dated, and approved by the attending physician. The prescription may authorize up to an initial fifteen treatments of the injury during the first sixty calendar days. For therapists, the prescription may authorize up to an initial twenty treatments of the injury during the first sixty calendar days.

(b) If the attending physician believes treatments in addition to that allowed by subsection (a) are required, the provider of service other than a physician, in lieu of the attending physician, may [~~mail~~] transmit a treatment plan for review and approval to the attending physician who shall, after approval, [~~mail~~] transmit the treatment plan to the employer by mail or facsimile under separate cover at least seven calendar days prior to the start of the additional treatments to an address or facsimile number provided by the employer. A treatment plan shall be for one hundred twenty calendar days and shall not exceed fifteen treatments within that period. Treatments provided with less than seven calendar days notice are not authorized. A complete treatment plan shall contain the following elements:

(1) Projected commencement and termination dates of treatment;
(2) A clear statement as to the impression or diagnosis;
(3) A specific time schedule of measurable objectives to include baseline measurements at the start of the treatment plan and projected goals by the end of the treatment plan;
(4) Number and frequency of treatments;
(5) Modalities and procedures to be used; and

Treatment plans which do not include the above specified elements but which are reasonable and necessary may not be denied by the employer, but upon written notification from the employer, the physician or the provider of service, with approval by the attending physician, shall correct the deficiency(s) and the employer's liability is deferred as long as the treatment plan remains deficient. Neither the injured employee nor the employer shall be liable for services provided under a treatment plan that remains deficient. Both the front page of the treatment plan and the envelope in which the plan is mailed or the cover sheet if the plan is sent by facsimile shall be clearly identified as a "WORKERS' COMPENSATION TREATMENT PLAN" in capital letters and in no less than ten point type.

(c) A treatment plan shall be deemed received by an employer when the plan is sent by mail or facsimile with reasonable evidence showing that the treatment plan was received.

[~~(c)~~](d) The employer may file an objection to the treatment plan with documentary evidence supporting the denial and a copy of the denied treatment plan with the director, copying the attending physician, the provider of service and the injured employee. Both the front page of the denial and the envelope in which the denial is filed shall be clearly identified as a "TREATMENT PLAN DENIAL" in capital letters and in no less than ten point type. The employer shall be responsible for payment for treatments provided under a complete treatment plan until the date the objection is filed with the director. Furthermore, the employer's objection letter must explicitly state that if the attending physician or the

injured employee does not agree with the denial, they may request a review by the director of the employer's denial within fourteen calendar days after postmark of the employer's denial, and failure to do so shall be construed as acceptance of the employer's denial.

[~~(d)~~](e) The attending physician or the injured employee may request in writing that the director review the employer's denial of the treatment plan. The request for review shall be filed with the director, copying the employer, within fourteen calendar days after postmark of the employer's denial. A copy of the denied treatment plan shall be submitted with the request for review. Both the front page of the request for review and the envelope in which the request is filed shall be clearly identified as a "REQUEST FOR REVIEW OF TREATMENT PLAN DENIAL" in capital letters and in no less than ten point type. For cases not under the jurisdiction of the director at the time of the request, the injured employee shall be responsible to have the case remanded to the director's jurisdiction. Failure to file a request for review of the employer's denial with the director within fourteen calendar days after postmark of the employer's denial shall be deemed acceptance of the employer's denial.

[~~(e)~~](f) The director shall issue a decision, after a hearing, either requiring the employer to pay the provider of service other than a physician within thirty-one calendar days in accordance with the medical fee schedule if the treatments are determined to be reasonable and necessary or disallowing the fees for treatments determined to be unreasonable or unnecessary. Disallowed fees shall not be charged to the injured employee.

[~~(f)~~](g) The decision issued pursuant to subsection [~~(e)~~](f) shall be final unless appealed pursuant to section 386-87, HRS. The appeal shall not stay the director's decision.

[~~(g)~~](h) The provider of service other than a physician shall submit reports at least monthly to the attending physician and employer regarding an injured employee's progress. The preparation and submission of written reports or progress notes to the employer by the provider of service other than a physician are an integral part of the service fee.

[~~(h)~~](i) Treatments may include up to four procedures, up to four modalities, or a combination of up to four procedures and modalities, and the visit shall not exceed sixty minutes per injury. When treating more than one injury, treatments may include up to six procedures, up to six modalities, or a combination of up to six procedures and modalities, and the entire visit shall not exceed ninety minutes. This section applies to providers of service other than physicians including physical therapists, occupational therapists, massage therapists, and acupuncturists.

[~~(i)~~](j) Any provider of service other than a physician who exceeds the treatment guidelines without proper authorization shall not be compensated for the unauthorized services.

[~~(j)~~](k) No compensation shall be allowed for preparing treatment plans and written justification for treatments which exceed the guidelines.

[~~(k)~~](l) Failure to comply with the requirements in this section may result in denial of fees.

[~~(l)~~](m) Therapy by physical therapists and occupational therapists, prescribed on an in-patient basis in a licensed acute care hospital where the injured employee's level of care is medically appropriate for an acute setting as determined by community standards or, prescribed on an out-patient post-surgery basis not to exceed thirty calendar days, are excluded from the frequency of treatment guidelines specified herein." [Eff 1/1/96; am 1/1/97; am] (Auth: HRS §§386-21, 386-21.2, 386-26, 386-72) (Imp: HRS §§386-21, 386-21.2, 386-26, 386-27)

3. Section 12-15-90, Hawaii Administrative Rules, is amended to read as follows:

"**§12-15-90 Workers' compensation medical fee schedule.** (a) Charges for medical services shall not exceed one hundred ten per cent of participating fees prescribed in the Medicare Resource Based Relative Value Scale System fee schedule (Medicare Fee Schedule) applicable to Hawaii or listed in exhibit A, located at the end of this chapter and made a part of this chapter, entitled "Workers' Compensation

Supplemental Medical Fee Schedule", dated [~~January 1, 2014~~] January 1, 2018. The Medicare Fee Schedule in effect on January 1, 1995 shall be applicable through June 30, 1996. Beginning July 1, 1996 and each calendar year thereafter, the Medicare Fee Schedule in effect as of January 1 of that year shall be the effective fee schedule for that calendar year.

(b) If maximum allowable fees for medical services are listed in both the Medicare Fee Schedule and the Workers' Compensation Supplemental Medical Fee Schedule, dated [~~January 1, 2014~~] January 1, 2018, located at the end of this chapter as exhibit A, charges shall not exceed the maximum allowable fees allowed under the Workers' Compensation Supplemental Medical Fee Schedule, dated [~~January 1, 2014~~] January 1, 2018, located at the end of this chapter as exhibit A.

(c) If the charges are not listed in the Medicare Fee Schedule or in the Workers' Compensation Supplemental Medical Fee Schedule, dated [~~January 1, 2014~~] January 1, 2018, located at the end of this chapter as exhibit A, the provider of service shall charge a fee not to exceed the lowest fee received by the provider of service for the same service rendered to private patients. Upon request by the director or the employer, a provider of service shall submit a statement to the requesting party, itemizing the lowest fee received for the same health care, services, and supplies furnished to any private patient during the one-year period preceding the date of a particular charge. Requests shall be submitted in writing within twenty calendar days of receipt of a questionable charge. The provider of service shall reply in writing within thirty-one calendar days of receipt of the request. Failure to comply with the request of the employer or the director shall be reason for the employer or the director to deny payment.

(d) Fees listed in the Medicare Fee Schedule shall be subject to the current Medicare Fee Schedule bundling and global rules if not specifically addressed in these rules. The Health Care Financing

Administration Common Procedure Coding System (HCPCS) alphabet codes adopted by Medicare will not be allowed, except for injections and durable medical equipment, unless specifically adopted by the director. The director may defer to a fee listed in the Medicare HCPCS Fee Schedule when a fee is not listed in the Workers' Compensation Supplemental Medical Fee Schedule, Exhibit A.

(e) Providers of service will be allowed to add the applicable Hawaii general excise tax to their billing." [Eff 1/1/96; am 1/1/97; am 11/22/97; am 12/17/01; am 12/13/04; am 11/6/06; am 12/14/07; am 2/28/11; am 12/30/13; am] (Auth: HRS §§386-21, 386-26, 386-72) (Imp: HRS §§386-21, 386-26)

4. Material, except source notes, to be repealed is bracketed. New material is underscored.

5. Additions to update source notes to reflect these amendments are not underscored.

6. These amendments to Title 12, Chapter 15, Hawaii Administrative Rules, relating to the Hawaii Workers' Compensation Medical Fee Schedule shall take effect ten days after filing with the Office of the Lieutenant Governor.

I certify that the foregoing are copies of the rules drafted in the Ramseyer format, pursuant to the requirements of section 91-4.1, Hawaii Revised Statutes, which were adopted on (date to be inserted upon adoption) and filed with the Office of the Lieutenant Governor.

_____
Director

APPROVED AS TO FORM:

_____
Deputy Attorney General

EXHIBIT A

Chapters 12-15
Hawaii Administrative Rules

WORKERS' COMPENSATION SUPPLEMENTAL MEDICAL FEE SCHEDULE

January 1, 2018

The codes in the Workers' Compensation Supplemental Medical Fee Schedule are obtained from the American Medical Association, the American Dental Association or the State Department of Labor and Industrial Relations.

The five character codes included in the Workers' Compensation Supplemental Medical Fee Schedule are obtained from 2017 Current Procedural Terminology (CPT®), copyright 2016 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physicians.

The responsibility for the content of the Workers' Compensation Supplemental Medical Fee Schedule is with DLIR and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in the Workers' Compensation Supplemental Medical Fee Schedule. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT outside of the Workers' Compensation Supplemental Medical Fee Schedule should refer to the most current CPT codes and descriptive terms. Applicable FARS/DFARS apply.

CPT is a registered trademark of the American Medical Association

The five character codes starting with the letter "D" included in the Workers' Compensation Supplemental Medical Fee Schedule are obtained from Current Dental Terminology 2017, copyright 2016 by the American Dental Association (ADA). CDT is developed by the ADA to achieve uniformity, consistency and accurate reporting of dental treatment.

TABLE OF CONTENTS

SURGERY

Integumentary System

Code	Maximum Fee	Code	Maximum Fee	Code	Maximum Fee
10060	$157.64	12007	$362.23	13133	$231.43
10061	$275.03	12011	$189.70	13151	$613.78
10120	$207.95	12013	$209.90	13152	$791.54
10121	$389.06	12014	$234.78	13153	$254.90
11000	$77.14	12015	$285.09	13160	$980.01
11001	$30.19	12031	$365.59	14040	$1,120.24
11010	$704.34	12032	$486.33	15004	$478.26
11043	$311.92	12034	$472.91	15050	$675.48
11044	$435.71	12035	$550.06	15100	$1,021.38
11055	$61.93	12041	$352.17	15101	$223.27
11056	$74.47	12042	$456.14	15120	$1,136.58
11601	$280.48	12044	$533.29	15240	$1,119.97
11602	$309.48	12051	$385.71	15260	$1,428.80
11719	$17.85	12052	$432.67	15738	$1,716.06
11730	$144.22	12053	$526.58	16000	$93.91
11740	$73.79	12054	$566.83	16020	$114.04
11750	$335.40	13100	$446.08	16025	$201.24
11760	$315.28	13101	$603.72	16030	$244.84
12001	$177.25	13121	$630.55	17003	$11.57
12002	$188.55	13122	$167.70	17004	$190.91
12004	$214.66	13131	$513.16		
12005	$268.32	13132	$818.38		

Musculoskeletal System

20520	$275.03	21407	$804.03	23130	$771.72
20525	$741.23	21408	$1,105.80	23350	$181.12
20526	$90.56	21423	$981.30	23405	$765.14
20550	$80.50	21470	$1,492.05	23410	$1,204.09
20551	$80.50	22551	$2,623.25	23412	$1,203.42
20552	$73.79	22552	$575.17	23420	$1,425.45
20553	$83.85	22554	$1,846.24	23430	$1,056.51
20600	$77.14	22558	$2,143.21	23440	$924.08
20605	$90.56	22585	$480.17	23455	$1,428.80
20610	$103.97	22600	$1,612.67	23500	$274.66
20612	$73.79	22612	$2,015.75	23552	$805.59
20900	$653.33	22614	$523.22	23570	$288.42
20902	$611.91	22630	$1,947.78	23620	$327.14
20924	$647.67	22632	$380.07	23650	$415.90
20926	$522.86	22633	$2,224.80	23655	$586.95
20930	$230.30	22634	$589.95	23700	$241.74
20931	$132.37	22830	$988.38	24149	$1,445.40
20936	$212.96	22840	$975.65	24305	$712.82
20937	$228.07	22842	$1,076.63	24340	$755.24
21310	$177.76	22845	$1,072.27	24341	$1,113.53
21320	$402.48	22849	$1,565.01	24342	$1,044.47
21360	$673.04	22850	$879.71	24343	$896.22
21365	$1,369.05	22852	$843.51	24344	$1,337.40
21390	$989.27	22856	$1,961.79	24357	$607.07
21395	$1,232.63	23120	$722.81	24358	$707.69

Code	Maximum Fee	Code	Maximum Fee	Code	Maximum Fee
24359	$882.10	26541	$990.84	27724	$1,536.89
24366	$836.02	26548	$964.87	27750	$422.90
24515	$1,075.75	26560	$724.92	27758	$1,091.92
24600	$496.39	26567	$843.41	27759	$1,301.35
24605	$707.69	26600	$409.19	27760	$400.96
24665	$807.11	26605	$390.09	27766	$812.38
24666	$933.53	26608	$604.42	27786	$383.95
24685	$807.82	26686	$766.57	27792	$932.41
25000	$494.63	26720	$292.03	27810	$572.21
25024	$950.44	26725	$466.21	27814	$1,116.88
25105	$598.10	26727	$670.80	27823	$1,279.56
25111	$440.34	26735	$868.69	27827	$1,436.56
25118	$501.82	26742	$440.86	27828	$1,677.54
25240	$532.00	26750	$258.26	27840	$455.45
25246	$204.80	26756	$521.87	27842	$608.22
25260	$910.33	26765	$684.22	27870	$1,260.53
25270	$734.92	26770	$368.94	28002	$562.94
25272	$816.43	26860	$709.98	28008	$534.81
25290	$541.39	26951	$812.42	28090	$583.33
25295	$648.49	26952	$802.24	28122	$769.79
25310	$765.83	27096	$308.57	28222	$628.86
25320	$1,221.89	27130	$2,049.29	28238	$818.88
25337	$1,101.29	27216	$1,306.30	28300	$801.64
25390	$946.95	27227	$2,020.01	28400	$303.94
25400	$985.62	27228	$2,290.97	28415	$1,382.88
25405	$1,268.46	27235	$1,161.20	28445	$1,423.67
25440	$945.86	27236	$1,460.79	28475	$318.49
25447	$1,021.81	27245	$1,843.43	28485	$623.84
25505	$768.07	27248	$972.95	28510	$154.60
25545	$841.64	27350	$801.09	28725	$960.18
25605	$828.44	27370	$200.54	28730	$905.27
25606	$819.26	27380	$754.00	29065	$140.87
25607	$922.97	27385	$811.67	29075	$127.45
25608	$1,094.27	27403	$786.02	29105	$127.45
25609	$1,327.47	27405	$860.78	29125	$100.62
25628	$925.74	27427	$872.96	29130	$60.37
25645	$728.49	27446	$1,412.69	29200	$37.76
25825	$969.31	27447	$2,190.16	29240	$35.84
26020	$539.71	27457	$1,154.99	29260	$35.88
26035	$1,052.64	27486	$1,715.47	29280	$36.10
26055	$788.19	27487	$2,259.18	29405	$120.74
26075	$405.17	27506	$1,891.66	29425	$124.10
26080	$486.92	27524	$1,069.93	29445	$168.01
26105	$415.26	27530	$482.72	29515	$103.97
26110	$402.15	27535	$1,157.13	29520	$39.68
26115	$705.01	27536	$1,452.54	29530	$35.84
26145	$634.34	27560	$435.24	29540	$32.27
26320	$439.73	27570	$198.82	29550	$23.80
26340	$432.67	27603	$741.23	29580	$64.03
26350	$1,026.32	27625	$713.94	29581	$82.88
26356	$1,703.83	27640	$1,021.38	29584	$93.24
26410	$811.67	27650	$972.66	29700	$78.97
26418	$831.79	27652	$931.79	29806	$1,509.30
26426	$768.16	27658	$463.51	29807	$1,472.41
26433	$664.43	27675	$605.33	29820	$707.69
26440	$780.74	27680	$562.20	29821	$778.13
26445	$730.00	27687	$562.38	29822	$751.30
26480	$943.79	27691	$923.08	29823	$895.52
26525	$820.08	27695	$591.50	29824	$859.14
26540	$942.47	27698	$842.56	29825	$747.56

Code	Maximum Fee	Code	Maximum Fee	Code	Maximum Fee
29826	$297.00	29873	$686.88	29888	$1,401.97
29827	$1,517.72	29874	$700.13	29891	$829.79
29828	$1,304.71	29875	$670.75	29897	$620.41
29835	$620.55	29876	$832.92	29898	$746.85
29837	$647.07	29877	$885.46	29905	$837.86
29838	$754.47	29879	$942.47	29906	$853.65
29844	$636.24	29880	$960.01	29914	$1,219.87
29846	$665.85	29881	$896.85	29915	$1,243.14
29848	$644.78	29882	$929.52	29916	$1,244.58
29862	$996.51	29884	$788.02		
29867	$1,623.86	29887	$910.84		

Respiratory System

31231	$295.15	31570	$408.32	32551	$187.59
31240	$195.12	31575	$139.42		

Cardiovascular System

35206	$930.99	36247	$1,969.13	36569	$321.58
35207	$962.38	36410	$23.76	36600	$40.25
36245	$1,676.00	36415	$4.34	36620	$60.85
36246	$1,063.21	36430	$46.91		

Digestive System

45378	$516.23	49568	$315.26	49652	$891.84
49505	$670.38	49585	$545.80	49653	$1,111.71
49507	$704.11	49587	$574.68		
49520	$774.58	49650	$528.36		
49560	$884.14	49651	$672.45		

Urinary System

51700	$93.90	51798	$25.86

Male Genital System

55520	$550.26

Female Genital System

57288	$869.84

Maternity Care and Delivery

59025	$59.78

Nervous System

62270	$202.86	63047	$1,560.24	64421	$189.60
62362	$469.40	63048	$301.63	64445	$164.79
62368	$70.76	63075	$1,949.94	64450	$147.58
62369	$154.95	63655	$1,002.58	64455	$59.00
62370	$162.36	63663	$997.19	64479	$299.22
63030	$1,368.43	63685	$446.50	64480	$142.36
63035	$271.67	63688	$453.26	64483	$345.46
63042	$1,654.98	64405	$129.38	64484	$187.82
63045	$1,545.83	64415	$146.81	64491	$113.76

Code	Maximum Fee	Code	Maximum Fee	Code	Maximum Fee
64492	$115.25	64634	$243.72	64718	$805.79
64495	$104.69	64635	$531.08	64721	$607.07
64510	$163.33	64636	$222.21	64772	$691.03
64520	$236.08	64640	$169.41	64776	$505.52
64550	$23.48	64646	$182.63	64782	$561.69
64616	$153.36	64702	$622.43	64831	$906.97
64617	$222.68	64704	$448.22	64832	$410.15
64633	$536.70	64708	$601.10	64856	$1,236.90

Eye and Ocular Adnexa

65205	$80.50	65435	$107.33	68720	$946.84
65210	$97.27	67036	$1,125.88	68810	$200.71
65222	$100.62	67145	$650.54	68815	$514.53
65426	$972.66	67820	$62.56		
65430	$137.61	67917	$767.01		

Auditory System

69200	$191.18	69210	$73.79

Operating Microscope

69990	$305.21

RADIOLOGY

Fees include both the technical and professional components. In the absence of any prior agreement, the professional component shall be thirty-five percent of the scheduled fee.

Diagnostic Radiology (Diagnostic Imaging)

70030	$40.25	70547	$740.74	72074	$70.43
70100	$46.96	70548	$730.72	72080	$57.02
70110	$57.02	70551	$300.55	72100	$57.02
70140	$46.96	70553	$492.15	72110	$80.50
70150	$67.08	71010	$40.25	72114	$103.97
70160	$46.96	71020	$50.31	72120	$73.79
70200	$67.08	71035	$50.31	72125	$409.19
70220	$63.73	71100	$50.31	72128	$409.19
70250	$53.66	71101	$60.37	72131	$409.19
70260	$77.14	71110	$63.73	72132	$523.22
70330	$70.43	71111	$80.50	72133	$623.84
70336	$673.55	71120	$53.66	72141	$291.72
70355	$40.25	71130	$57.02	72142	$425.24
70360	$40.25	71250	$425.96	72146	$292.19
70450	$345.46	71260	$523.22	72148	$290.76
70470	$529.93	71270	$637.26	72149	$420.22
70480	$368.39	71275	$391.50	72156	$495.50
70486	$181.30	71550	$669.54	72157	$496.45
70488	$590.30	71552	$1,210.74	72158	$493.57
70491	$486.33	72020	$36.89	72170	$43.60
70496	$382.38	72040	$53.66	72190	$57.02
70498	$381.41	72050	$77.14	72192	$405.83
70540	$656.55	72052	$97.27	72193	$506.45
70543	$545.87	72070	$53.66	72195	$670.30
70544	$660.51	72072	$60.37	72197	$665.03

Code	Maximum Fee	Code	Maximum Fee	Code	Maximum Fee
72200	$43.60	73220	$658.28	73723	$618.59
72202	$53.66	73221	$309.76	74000	$43.60
72220	$46.96	73222	$497.73	74020	$60.37
72265	$264.97	73223	$618.10	74022	$70.43
72275	$171.05	73525	$157.64	74150	$405.83
72295	$385.71	73560	$43.60	74160	$533.29
73000	$43.60	73562	$50.31	74175	$400.59
73010	$43.60	73564	$57.02	74176	$258.28
73020	$36.89	73565	$44.97	74178	$461.83
73030	$46.96	73580	$194.53	74181	$669.89
73040	$167.70	73590	$43.60	74183	$666.46
73050	$54.08	73600	$40.25	75635	$849.89
73060	$46.96	73610	$46.96	75710	$643.97
73070	$40.51	73620	$40.25	75716	$677.51
73080	$50.31	73630	$46.96	75736	$643.97
73090	$43.60	73650	$40.25	75774	$560.12
73100	$43.60	73660	$40.25	76000	$62.36
73110	$50.31	73700	$382.36	76001	$211.30
73115	$147.58	73701	$479.62	76100	$118.89
73120	$40.25	73706	$465.16	76376	$29.87
73130	$46.96	73718	$567.99	76377	$90.31
73200	$382.36	73720	$661.63		
73201	$479.62	73721	$309.28		
73218	$656.66	73722	$502.05		

Diagnostic Ultrasound

76512	$164.55	76775	$150.93	76881	$151.10
76513	$150.93	76801	$160.58	76882	$43.49
76514	$19.06	76815	$110.54	76937	$40.24
76519	$122.71	76817	$126.92	76942	$76.68
76700	$197.89	76856	$167.70		
76705	$147.58	76857	$61.49		
76770	$187.82	76870	$167.70		

Radiologic Guidance

77001	$110.55	77012	$158.81

Bone/Joint Studies

77073	$45.95	77080	$53.78

Radiation Oncology

77290	$674.15	77334	$264.97	77336	$140.87

Nuclear Medicine

78104	$348.82	78305	$318.63	78452	$646.29
78122	$258.26	78306	$355.52	78805	$271.67
78300	$234.78	78320	$415.90	78806	$496.39

Code	Maximum Fee	Code	Maximum Fee	Code	Maximum Fee

MEDICINE

Fees include both the technical and professional components. In the absence of any prior agreement, the professional component shall be thirty-five percent of the scheduled fee.

Vaccines, Toxoids

90636	$99.07	90715	$46.96	90746	$63.32
90714	$21.90	90732	$86.62		

Psychiatry

90791	$154.68	90834	$99.69	90847	$151.70
90792	$173.73	90837	$167.74		
90832	$84.86	90846	$126.80		

Biofeedback

90901	$53.27				

Gastroenterology

91035	$626.61	91110	$1,217.70		

Ophthalmology

92002	$110.68	92071	$45.43	92225	$34.44
92004	$201.24	92082	$62.57	92235	$169.72
92012	$110.68	92083	$83.46	92250	$86.01
92014	$160.99	92132	$39.75	92284	$82.71
92015	$23.50	92133	$47.73	92285	$27.47
92020	$42.42	92134	$52.21	92286	$49.17
92025	$48.21	92136	$115.85	92310	$78.69

Special Otorhinolaryngologic Services

92507	$97.37	92550	$25.24	92590	$74.94
92511	$144.51	92551	$13.52	92591	$99.11
92526	$106.68	92557	$63.40	92592	$35.51
92541	$69.74	92567	$26.83	92595	$51.33
92542	$67.08	92570	$38.42	92610	$106.71
92545	$50.39	92577	$29.60	92611	$107.45
92547	$23.48	92587	$69.43		
92548	$140.87	92588	$96.86		

Cardiovascular

93000	$33.45	93040	$16.84	93289	$82.28
93005	$20.12	93042	$10.06	93306	$298.79
93010	$11.21	93224	$187.96	93308	$137.15
93015	$135.82	93225	$57.02	93325	$80.50
93016	$26.86	93226	$93.91	93351	$353.39
93017	$83.85	93280	$73.19		
93018	$20.12	93282	$79.37		

Code	Maximum Fee	Code	Maximum Fee	Code	Maximum Fee
Noninvasive Vascular Diagnostic Studies					
93926	$171.42	93971	$158.92	93976	$250.52
Pulmonary					
94010	$46.80	94645	$18.48	94727	$54.02
94060	$80.14	94664	$23.22	94729	$69.46
94150	$47.46	94667	$35.44	94760	$6.71
94640	$24.64	94726	$69.18	94762	$43.60
Neurology and Neuromuscular Procedures					
95805	$721.28	95907	$147.58	95929	$277.90
95810	$821.21	95908	$157.64	95930	$172.20
95811	$862.70	95909	$214.66	95951	$2,089.25
95851	$27.00	95910	$285.09	95957	$397.70
95852	$20.13	95911	$342.11	95971	$61.93
95861	$224.72	95912	$399.13	95972	$72.10
95885	$87.20	95913	$462.85		
95887	$107.33	95925	$182.99		
Central Nervous System Assessments/Tests					
96101	$97.27				
Health and Behavior Assessment/Intervention					
96150	$25.59	96152	$23.15		
Hydration, Therapeutic, Prophylactic, Diagnostic Injections and Infusions, and Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration					
96360	$92.58	96366	$24.00	96376	$20.77
96361	$24.07	96367	$39.97		
96365	$91.06	96375	$29.03		
Physical Medicine and Rehabilitation					
97010	$5.04	97116	$36.89	97542	$38.34
97012	$20.12	97124	$33.54	97545	$119.69
97014	$16.77	97140	$36.89	97546	$51.17
97016	$24.15	97150	$20.67	97605	$51.27
97024	$8.49	97530	$46.96	97606	$61.71
97032	$23.48	97532	$32.90	97750	$40.25
97110	$43.60	97535	$43.90	97760	$50.31
97112	$43.60	97537	$37.31		
Acupuncture					
97810	$52.39	97813	$55.95		
97811	$35.31	97814	$39.55		
Chiropractic Manipulative Treatment					
98940	$30.19				

Code	Maximum Fee	Code	Maximum Fee	Code	Maximum Fee
Special Services, Procedures and Reports					
99000	$8.17	99050	$48.25		
99002	$10.89	99053	$70.50		
Qualifying Circumstances for Anesthesia					
99100	$44.79				
Other Services and Procedures					
99173	$3.42	99183	$131.33		

DENTAL SERVICES

Diagnostic					
D0120	$41.81	D0210	$94.66	D0272	$30.96
D0140	$52.13	D0220	$19.29	D0330	$83.69
D0150	$57.69	D0230	$15.07	D0470	$64.96
Preventive					
D1110	$68.87				
Restorative					
D2160	$115.71	D2335	$183.74	D2940	$73.72
D2330	$84.86	D2391	$106.64	D2950	$179.19
D2331	$127.28	D2740	$837.28	D2954	$204.42
D2332	$158.31	D2750	$789.63		
Endodontics					
D3310	$412.71				
Periodontics					
D4211	$211.85				
Prosthodontics, Removable					
D5110	$988.75	D5211	$776.37	D5820	$395.17
D5130	$1,048.91	D5212	$806.73		
Implant Services					
D6010	$1,712.90	D6059	$1,131.93	D6104	$296.69
D6057	$566.15	D6065	$1,074.45		
Prosthodontics, Fixed					
D6240	$752.13	D6245	$756.50	D6750	$786.07

Code	Maximum Fee	Code	Maximum Fee	Code	Maximum Fee

Oral & Maxillofacial Surgery

D7140	$92.58	D7880	$490.00		
D7210	$198.03	D7953	$307.20		

Adjunctive General Services

D9110	$76.43	D9430	$55.53	D9942	$102.80
D9310	$91.08	D9940	$408.83		

EVALUATION AND MANAGEMENT

Office or Other Outpatient Services

99201	$70.36	99205	$304.83	99214	$158.77
99202	$114.00	99211	$37.07	99215	$212.24
99203	$165.55	99212	$66.32		
99204	$245.01	99213	$107.83		

Hospital Inpatient Services

99232	$124.79				

Consultations

99241	$66.58	99245	$237.19	99254	$183.81
99242	$99.81	99251	$53.76	99255	$222.85
99243	$143.46	99252	$83.10		
99244	$186.63	99253	$126.71		

Emergency Department Services

99281	$50.31	99283	$133.00	99285	$322.51
99282	$90.19	99284	$225.58		

Critical Care Services

99292	$147.36				

Case Management Services

99366	$65.67	99367	$85.93	99368	$55.55

Preventive Medicine Services

99395	$116.14	99408	$40.23		

Non-Face-to-Face Services

99441	$22.23	99443	$60.50		
99442	$40.98				

Code	Maximum Fee	Code	Maximum Fee	Code	Maximum Fee

Special Evaluation and Management Services

Code	Description	Maximum Fee
99456A*	Complex consultation pursuant to Section 386-79, HRS - work related or medical disability examination by other than the treating physician that includes: ▪ completion of a medical history commensurate with the patient's condition; ▪ performance of an examination commensurate with the patient's condition; ▪ formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; ▪ development of future medical treatment plan; ▪ completion of necessary documentation/certificates and report; and ▪ review of records relating to the patient's condition. First hour	$207.25
99456B*	Each additional 30 minute increment (an increment must be at least 30 minutes.)	$103.63

*Department of Labor Code

Bundled Services: Certain codes, such as telephone calls, are considered by the Health Care Financing Administration (HCFA) to be "bundled" services. Bundled services are not payable, nor should they be billed, when performed incident to or in conjunction with another service even if the other service is performed on a different day. When services that are designated as bundled are denied, the physician may not collect from the patient.