

PROVIDER SERVICES AGREEMENT

THIS PROVIDER SERVICES AGREEMENT (“**Agreement**”), effective as of October 1, 2026 (the “**Effective Date**”), is made and entered into by and between MCC Health, PBC, contracting on behalf of the health benefit plan sponsor(s) identified on Attachment C (each a “**Plan Sponsor**”) and PSN Services, LLC on behalf of the facilities listed on Attachment A (individually and collectively referred to herein as “**Provider**”).

WHEREAS, each Plan Sponsor identified on Attachment C is contracting individually with Provider through its agent MCC Health, PBC, and this Agreement shall be interpreted as a separate agreement for each Plan Sponsor;

WHEREAS, Plan Sponsor sponsors a self-funded health benefit plan regulated by ERISA, as defined below (“**Plan**”), for its employees and their dependents who are eligible for and enrolled in the Plan (“**Participants**”);

WHEREAS, Provider consists of one or more licensed health care providers; and

WHEREAS, each party wishes to enter into this Agreement to facilitate the delivery of Covered Services (as defined below) by Provider to Participants.

NOW THEREFORE, in consideration of the terms and conditions set forth herein, the parties agree as follows:

SECTION 1. DEFINITIONS

- 1.1 Clean Claim means an industry-standard claim form that has been completed without any defect, error, or other impropriety or circumstance that may prevent timely processing.
- 1.2 Covered Services means those health care items and services for which the Plan is financially responsible. An item or service is only a Covered Service if it is medically necessary as determined by the plan and in accordance with generally accepted standards in the health care industry.
- 1.3 ERISA means the Employee Retirement Income Security Act of 1974, as amended.

SECTION 2. DUTIES OF PROVIDER

- 2.1 Provider Services. Provider shall furnish Covered Services to Participants pursuant to the terms and conditions set forth in this Agreement, including Attachment A. Provider shall verify the eligibility of Participant(s) prior to furnishing Covered Services, in accordance with Section 3.1. Provider shall bind its employees, health care providers, directors, officers, representatives, contractors, and agents (“**Personnel**”) to the applicable requirements of this Agreement. Provider retains full authority to control its business operations, locations, equipment, Personnel, and scope of services, provided that it also satisfies its obligations under this Agreement.

- 2.2 Standards. Provider shall furnish Covered Services in accordance with applicable law, ethical guidelines, and standards of care. Provider shall not differentiate or discriminate in the treatment of any Participant because of (i) the person's status as a Participant; or (ii) any protected classification, including but not limited to race, national origin, sex, gender, sexual orientation, and disability. For the benefit of Participants, Provider shall make commercially reasonable efforts to refer Participants to other in-network providers of Plan. Provider shall ensure after-hours coverage for Participants in a manner that is appropriate to Provider's specialty. Provider shall participate in any quality improvement, case management, or similar programs offered by Plan Sponsor for the benefit of Participants, in accordance with Provider's medical staff bylaws and applicable law.
- 2.3 Credentialing. Provider and its Personnel shall maintain all necessary licenses, accreditations, certifications and/or training required by law and the Plan in order to furnish Covered Services. Provider shall (i) provide Plan Sponsor or its designee with evidence of such qualifications prior to the Effective Date and upon request; and (ii) notify Plan Sponsor within ten (10) business days of any material adverse change to such information or the occurrence of any event identified in Section 5.2(b) as to Provider, any Personnel, or a facility location. Personnel who are subject to credentialing must have their credentials verified by Provider prior to furnishing Covered Services under this Agreement.
- 2.4 Participating Locations and Providers. Provider shall render Covered Services to Participants at the service locations and through the individual health care providers, if applicable, listed on Attachment A. Provider shall notify Plan Sponsor or its designee promptly of any changes in its providers, services, and/or service locations.
- 2.5 Records. Provider shall maintain medical records and documents relating to Participants as required by applicable law and for the period of time required by law. Medical records of Provider and any other records containing individually identifiable information relating to Participants shall be regarded as confidential, and Provider and Plan Sponsor shall comply with applicable federal and state law regarding such records. Subject to Section 6.2, Provider shall provide Plan Sponsor and government agencies with access to and/or copies of any records related to Participants or this Agreement at no additional charge as reasonably necessary or as required by law.
- 2.6 Data. The parties shall cooperate in exchanging such data as may be necessary to fulfill the purposes of this Agreement, subject to Section 6.2.

SECTION 3. DUTIES OF PLAN SPONSOR

- 3.1 Participant Identification; Benefits. Plan Sponsor or its designee shall provide a readily-accessible means for verification of Participants' eligibility and benefits.
- 3.2 Cost Share. For Covered Services rendered by Provider under this Agreement, Plan Sponsor shall either (i) ensure that the Plan does not require any cost share amounts from Participants; or (ii) collect any such cost share amounts directly from Participant.
- 3.3 Relationship to Plan. MCC Health, PBC shall bind each Plan Sponsor and its Plans to comply with all applicable provisions of this Agreement. Provider acknowledges and

agrees that each Plan Sponsor is singularly responsible for its own compliance under this Agreement, and there is no joint and several liability among Plan Sponsors by virtue of this Agreement.

- 3.4 Addition of Plan Sponsors. MCC Health, PBC may, from time to time and in its sole discretion, propose the addition of one or more Plan Sponsors to Attachment C; provided, however, that nothing in this Agreement shall be construed as a commitment or obligation by MCC Health, PBC to add any Plan Sponsor or to deliver any minimum volume of Participants, utilization, or business to Provider. MCC Health, PBC shall provide Provider with at least sixty (60) days' prior written notice of any proposed addition of a Plan Sponsor. Such notice may be delivered by electronic mail to the email address(es) set forth in the notice provisions or signature block of this Agreement and shall be deemed effective upon transmission. If Provider does not object in writing within such sixty (60) day period, the Plan Sponsor shall be deemed added to Attachment C effective as of the date specified in the notice. MCC Health, PBC may remove any Plan Sponsor from this Agreement at any time upon written notice, which may be delivered by electronic mail as described above.
- 3.5 Policies and Procedures. Plan Sponsor reserves the right to adopt and amend policies and procedures for administration of the Plan and this Agreement. Plan Sponsor shall make any such policies and procedures available to Provider, and, to the extent such policies and procedures are not in conflict with this Agreement, Provider agrees to comply with the same. Notwithstanding the foregoing, any policies, procedures or rules which materially increase the administrative procedures which Provider must follow or otherwise impose an additional material administrative burden on Provider, including but not limited to coding, medical necessity determinations, or utilization management shall require the prior written agreement of Provider. In the event of a conflict between this Agreement and the Plan Sponsor's policies and procedures, this Agreement shall prevail.
- 3.6 Plan Document. Plan Sponsor retains sole responsibility for ensuring that (i) its Plan(s) and its operations comply with ERISA and any other applicable law; and (ii) its Plan document(s) are consistent with the requirements of this Agreement, such that the terms and conditions of this Agreement may be given full force and effect without violating the Plan document(s). Plan Sponsor is also solely responsible for ensuring that its designee(s), including but not limited to any third-party administrator, comply with the terms of this Agreement.

SECTION 4. PAYMENTS

- 4.1 Payments. Provider agrees to accept the applicable rate set forth in Attachment B as payment in full for Covered Services furnished to Participant. Provider shall submit claims to Plan Sponsor's third-party administrator, as directed by Plan Sponsor, or as otherwise set forth in Attachment B. Provider shall use the claim and coding guidelines published by the Centers for Medicare & Medicaid Services ("CMS"). Without limiting the generality of the foregoing, Provider shall make best efforts to follow the then-current coding guidelines published by CMS's National Correct Coding Initiative. Provider shall submit claims within one hundred eighty (180) days of the date of service, the date of discharge,

or the date of adjudication by the primary payor, as applicable. Provider shall make best efforts to submit claims electronically. Provider shall not seek reimbursement from Participant(s) for Covered Services, except as may be described in Attachment B. Plan Sponsor shall pay, or arrange for payment of, any undisputed amounts to Provider within thirty (30) calendar days of receipt of a Clean Claim. MCC Health, PBC is not responsible for any payment to Provider.

- 4.2 Non-Covered Services. Provider may bill Participant for any item or service that is not considered a Covered Service by the Plan, provided that (i) Provider has informed Participant in advance that the specified item or service is not a Covered Service; and (ii) Participant has agreed in writing to receive, and be financially responsible for, that particular item or service prior to it being provided.
- 4.3 Coordination of Benefits. Provider shall follow coordination of benefits rules as directed by Plan Sponsor. Where Plan is the secondary payor, Provider shall bill and collect from the primary payor before submitting a claim under Section 4.1.
- 4.4 Overpayments; Underpayments. Plan Sponsor will not engage in routine prepayment utilization management activities for Covered Services rendered by Provider under this Agreement. Nevertheless, in the event Plan Sponsor determines based on documented findings consistent with generally accepted health care industry standards and applicable CMS guidelines, and following written notice to Provider specifying the basis for such determination and a thirty (30) day cure and response period that it has made payment for item(s) and/or service(s) that are not Covered Services, or that were provided to a patient who was not a Participant on the date of service, or where there is a finding of fraud, waste or abuse by Provider, Provider shall refund such overpayment within thirty (30) days of demand from Plan Sponsor provided Plan Sponsor notified Provider of such overpayment within one year of Plan Sponsor's initial payment date. In the event Plan Sponsor reasonably determines it has underpaid Provider, Plan Sponsor shall pay the difference between the amount paid and the correct payment rate as specified in Attachment B within thirty (30) days of Plan Sponsor's discovery of such underpayment, provided such underpayment was discovered within one year of Plan Sponsor's initial payment date. Notwithstanding the foregoing, the parties shall not use any extrapolation calculation method to calculate any overpayments or underpayments. Disagreements about such overpayments or underpayments shall be subject to the dispute resolution procedures set forth in Section 6.8.

SECTION 5. TERM AND TERMINATION

- 5.1 Term. This Agreement shall commence as of the Effective Date and shall remain in full force and effect until the end of the then-current calendar year, unless earlier terminated as provided in Section 5.2. Thereafter, the Agreement shall automatically renew for additional one (1) year terms, unless either party provides notice of non-renewal at least ninety (90) days prior to the end of the then-current contract year. Nothing in this Section 5.1 shall prohibit Provider from implementing new services and/or rate adjustment at any point during the Term of this Agreement, with all such rate adjustments and service line additions to be mutually agreed upon in writing, which may be communicated via email.

5.2 Termination.

- a. Either party may terminate this Agreement for cause due to a material breach by the other party by giving thirty (30) days' prior written notice. The notice of termination for cause shall not be effective if the breaching party cures the breach to the reasonable satisfaction of the non-breaching party within such notice period.
- b. MCC Health, PBC may terminate this Agreement, or remove Personnel or facility locations from Attachment A, immediately by written notice in the event Provider, any Personnel, or a facility location, as applicable, (i) fails to maintain licensure or accreditation; (ii) fails to maintain insurance as required by this Agreement; (iii) is convicted of a crime; (iv) is excluded from a federal health care program; (v) is found liable for malpractice in a final, non-appealable judgment with a material adverse impact on licensure or patient safety; (vi) is insolvent; (vii) engages in fraud, waste or abuse; (viii) acts, or fails to act, in a manner that places Plan, Plan Sponsor or a Participant at material risk.
- c. Either Party (or any Plan Sponsor as to its Plan(s) only) may terminate this Agreement without cause upon ninety (90) days' prior written notice to the other Party. Provider may terminate a specific Plan or Plan Sponsor without having any effect on this entire Agreement.
- d. Any obligation arising prior to the date of termination, and any provision that by its nature is intended to survive, shall survive termination. Further, this Agreement shall continue to apply to Covered Services for Participants who are existing patients of Provider on the date of termination for the greatest of the following periods: (i) for up to ninety (90) days following termination to the extent necessary to allow Participants to transition to other health care providers; (ii) until the date of discharge, for any Participant with inpatient status as of the date of termination; (iii) the period of time specified by continuity of care requirements under applicable law; or (iv) through the end of the calendar year during which the termination takes effect.
- e. Each Plan Sponsor may exercise these termination rights individually as to its participation in the Agreement. MCC Health, PBC may also exercise these termination rights as party to the Agreement.

SECTION 6. GENERAL PROVISIONS

- 6.1 Disclaimer. MCC Health, PBC is not responsible to any individual or entity for any damages arising from Plan Sponsor or Provider's acts or omissions hereunder. Provider shall defend and hold harmless MCC Health, PBC from any damages arising from Provider's acts or omissions related to this Agreement.
- 6.2 HIPAA, Confidentiality, Non-Disclosure.
 - a. MCC Health, PBC, Provider and Plan Sponsors shall comply with all applicable laws and regulations regarding maintenance and disclosure of Participants' medical

records and other individually identifiable health information. In particular, the parties shall comply with the applicable provisions of the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, and the applicable rules and regulations promulgated thereunder, all as amended from time to time (collectively, “HIPAA”).

- b. Each party shall keep strictly confidential any and all proprietary information of the other party that may be given or disclosed, or that may be learned directly or indirectly, pursuant to this Agreement. In addition, neither party shall use such confidential information for its own benefit (other than to implement this Agreement) or disclose such confidential information to any other person or entity (except those professional advisors who are bound to confidentiality) without the express prior written consent of the other party or as required by law. Notwithstanding the foregoing, this Agreement and its attachments shall not be considered confidential information hereunder.
 - c. This Section 6.2 shall survive the termination of this Agreement.
- 6.3 Patient Choice/Discussion of Treatment Options. The parties acknowledge and agree that nothing in this Agreement shall be construed to (i) interfere with a Participant’s freedom of choice to receive medical services from Provider or any other health care provider; or (ii) prohibit, impede, or interfere in discussions between Participants and health care providers regarding medical treatment options.
 - 6.4 Professional Judgment. Neither MCC Health, PBC nor Plan Sponsor shall exercise control or direction over the manner or method by which Provider renders Covered Services under this Agreement and shall not interfere with the professional medical judgment of any health care provider. Accordingly, Provider shall indemnify and hold harmless Plan Sponsor and its agents for any and all damages arising from the acts or omissions of Provider or its Personnel under this Section 6.4. Provider shall notify Plan Sponsor or its designee immediately upon receipt of a written, substantive grievance from a Participant.
 - 6.5 Independent Contractors. Each party acts as an independent contractor to the other party. Neither party has express or implied authority to assume or create any obligation on behalf of the other. Neither party’s employees, agents, or representatives have any right to the employee benefits offered by the other party solely by virtue of this Agreement.
 - 6.6 Insurance. Provider represents and warrants that it has and shall maintain professional, general liability, cyber security and other applicable industry-standard insurance coverage against claims arising out of Provider’s or its Personnel’s acts or omissions hereunder, at minimum amounts standard for a similarly-situated provider in Provider’s industry or specialty.
 - 6.7 Audits. MCC Health, PBC and Plan Sponsor have the right to conduct reasonable audits, including a review of the coding applied to a Participant’s medical record. Audits may not be conducted on a pre-payment basis.

- 6.8 Dispute Resolution. In the event that a dispute arises between the parties regarding the performance or interpretation of this Agreement, the parties agree that they shall first meet and attempt in good faith to resolve the dispute prior to the initiation of any other legal action. Such informal dispute resolution process may include mediation, upon the mutual agreement of the parties. If such efforts fail to produce a mutually acceptable resolution of the dispute, either party may initiate binding arbitration in Dallas County, Texas, in accordance with the rules of the American Health Law Association. Further, each Plan Sponsor may participate in dispute resolution individually if no other Plan Sponsor is affected by the dispute.
- 6.9 Modification for Change in Law. To the extent that any law, rule, regulation or standard of any authority having jurisdiction over a party to this Agreement or the subject matter of this Agreement (including an applicable accrediting agency) shall raise question as to the legality, enforceability, or appropriateness of this Agreement or any provision hereof, the parties agree to negotiate promptly regarding any modification needed to bring this Agreement into compliance with such applicable law, rule, regulation or standard. Should the parties be unable to agree upon such modification within a period of thirty (30) days from the date either party gave notice of the issue to the other party, or within such shorter period of time necessary to avoid illegality, this Agreement may be terminated by either party upon notice to the other party.
- 6.10 Entirety and Modification. This Agreement, together with the exhibits which are hereby incorporated by reference, constitutes the entire agreement between the parties with respect to the subject matter hereof, and as of the Effective Date, shall supersede any previous agreements or understandings, written or oral, between the parties. If Plan Sponsor has access to Provider's services under another agreement, e.g., a wrap network participation agreement, this Agreement shall prevail. Except as otherwise set forth herein, all modifications of the Agreement shall be in writing and signed by both parties.
- 6.11 Governing Law. This Agreement shall be interpreted and governed by the laws of the State of Texas, without regard to any conflicts of law principles, and without regard to any construction in favor of either party by reason of the drafting of this Agreement.
- 6.12 Assignment; Subcontracting. Except as otherwise permitted herein, neither party shall have the right to assign, delegate, or otherwise transfer any or all of its rights and/or obligations under this Agreement to any third party without the prior written consent of the other party, which consent shall not be unreasonably withheld; provided that MCC Health, PBC, or Provider may assign to an affiliate or successor-in-interest. Further, each Plan Sponsor may assign its participation under this Agreement to any affiliate or successor-in-interest. Provider may not subcontract with third parties to furnish Covered Services under this Agreement, unless otherwise authorized in writing by Plan Sponsor or its designee.
- 6.13 Compliance with Laws. Each party will conduct itself in full compliance with applicable federal, state and local law. This Agreement has been negotiated in an arms-length transaction and (i) does not require or guarantee any minimum level of Covered Services to be provided hereunder; and (ii) does not take into account any referrals or other business that may exist between the parties.

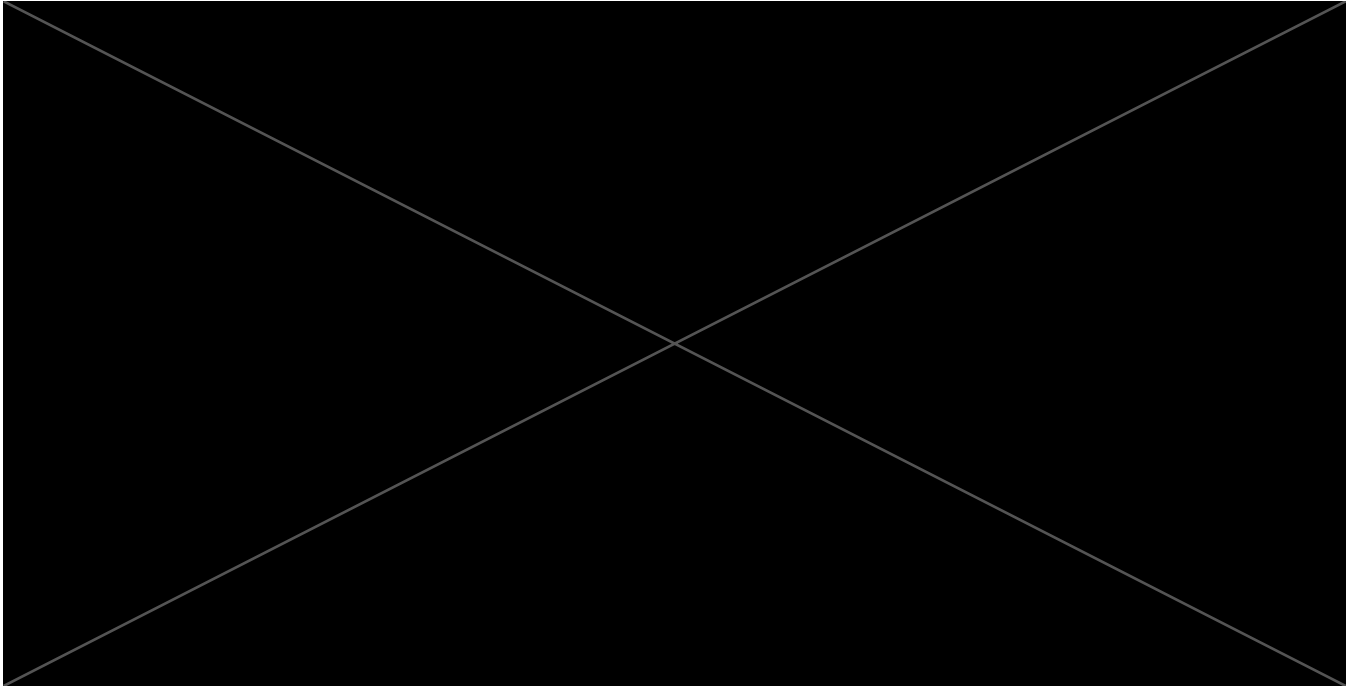
- 6.14 Use of Name and Other Information. Provider agrees that Plan Sponsor may include information about Provider on a publicly available website and in literature distributed to existing or potential Participants.
- 6.15 Notices. Any notice required under this Agreement must be in writing and delivered via electronic mail, or by hand, or sent by United States mail postage prepaid or overnight courier to the applicable party at the address listed on the signature page. Either party may change its address for notices by giving written notice of the change to the other party in the same manner. Notwithstanding the foregoing, Plan Sponsor or its designee may send routine communications regarding this Agreement and/or the Plan to Provider via electronic means.
- 6.16 Waiver of Breach; Severability. If either party waives a breach of any provision of this Agreement, it shall not operate as a waiver of any subsequent breach. If any portion of this Agreement is deemed unenforceable for any reason, it shall not affect the enforceability of any remaining portions.
- 6.17 Multiple Counterparts. This Agreement may be executed in multiple counterparts, each of which shall be deemed an original for all purposes and all of which shall be deemed, collectively, one Agreement for each Plan Sponsor.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement as set forth below.

MCC HEALTH, PBC,
contracting on behalf of the Plan Sponsor(s)
identified on Attachment C

PSN SERVICES, LLC



ATTACHMENT A
Covered Services and Participating Locations

The parties anticipate that Provider will furnish Covered Services at the following locations:

Facility Name	Address
Austin	
Legent Outpatient Surgery Austin	3107 Oak Creek Dr., Ste. 100, Austin, TX 78727
Legent Oak Creek Surgery Center	3107 Oak Creek Dr., Ste. 120, Austin, TX 78727
Corpus Christi	
Legent Outpatient Surgery Corpus Christi	5734 Spohn Dr., Corpus Christi, TX 78414
Dallas/Fort Worth	
Legent Orthopedic Hospital	1401 E. Trinity Mills Rd., Carrollton, TX 75006
Legent Surgical Hospital Plano	4100 Mapleshade Ln., Plano, TX 75093
Coppell Surgery Center	731 Plaza Blvd, Coppell, TX 75019
Legent Outpatient Surgery Euless	461 Westpark Way, Euless, TX 76040
Legent Outpatient Surgery Frisco	8350 Dallas Pkwy, Ste. 100, Frisco, TX 75034
Fredericksburg	
Legent Hill Country ASC	811 South Milam St., Fredericksburg, TX 78624
Houston	
Legent North Houston Surgical Hospital	24429 State Highway 249, Tomball, TX 77375
Legent Orthopedic and Spine Hospital	4801 Bissonnet St, Bellaire, TX 77401
Houston Premier Surgery Center at LNHS	8731 Katy Freeway, Ste. 350, Houston, TX 77024
Legent Houston Medical Center	6655 Travis St., Ste. 200, Houston, TX 77030
Delray Beach, Florida	
Delray Beach Surgical Suites	555 SE 5th Ave, Delray Beach, FL 33483

ATTACHMENT B
Reimbursement Rates

Plan Sponsor shall pay Provider for Covered Services the lesser of total billed charges submitted on a claim or in accordance with the attached Bundled Rate Sheet. For services rendered in which there is no published rate on the Bundled Rate Sheet, the parties will mutually agree upon a rate and execute a single-case agreement or contract amendment prior to services being rendered.

Billing for Multiple Concurrent Outpatient Procedures. In the event that multiple concurrent Outpatient Procedures are performed, they will be reimbursed as follows in order of each procedure's respective Bundled Rates from highest to lowest:

- First Outpatient Procedure: 100% of Bundled Rate
- All Subsequent Procedures: 50% of Bundled Rate
- Add-on Codes: Add-on procedure codes will be reimbursed at 100% of the contracted rate for that add-on code when associated with an allowed primary CPT procedure code.
- Bilateral Surgical Procedures: If the same surgical procedure is performed bilaterally during the same surgical episode, the second surgical procedure will be reimbursed at 50% of the Contract Rate for the first surgical procedure.

Episode Period. The Bundled Rate shall include all services provided to a Participant beginning on the date of surgery and through the global surgical period as defined by CMS's global surgery indicator on the Medicare Physician Fee Schedule ("000"; "010"; "090"; "YYY").

Bundled services shall include:

- Facility costs from admission to discharge, including the cost of implants, medications and supplies rendered during the Participant's stay at any facility;
- All inpatient and outpatient professional services that are attributed to or result from the Procedure, including the surgeon, assistant surgeon, anesthesia, radiology, pathology, interoperative monitoring, and any other treating or consulting physician;
- Any other Medically Necessary services or supplies ordered by Provider's medical and professional staff and considered appropriate and related to the standard of care for the Procedure; and
- Any services provided to treat patient complications provided at a Facility listed in Attachment A;
- Typical and anticipated post-operative follow-up care with the surgeon;
- Any professional services rendered by a provider contracted with Provider to perform professional services under this Agreement

Bundled services shall not include the following:

- Any new or established patient office visit or consultation with a physician or professional provider prior to the Episode Period;
- X-rays provided by physician or professional provider during any office visit or consultation prior to the Episode Period;

- Pre-admission testing and any type of medical clearance that per relevant clinical guidelines cannot be rendered at Provider's location on the date of admission, including but not limited to labs, x-rays, and EKG;
- Admissions to providers not subject to this Agreement, including but not limited to inpatient rehabilitation facilities, skilled nursing facilities, or long-term care hospitals;
- Durable medical equipment (braces, walker, cane, scooter, etc.) will be reimbursed at invoice cost when dispensed by a participating surgeon.
- Physical therapy and/or home health services.
- Unrelated Covered Services;
- Non-Covered Services;
- Prescription drugs (excluding drugs rendered during Participant's stay at Provider facility);
- Any charges related to the Participant's travel and lodging.

Provider shall not schedule Covered Services for Participants that will require charges to be rendered by a provider not employed by or contracted with Provider under this agreement without providing written notice to Plan Sponsor.

The parties acknowledge and agree that Provider shall not collect any coinsurance or other payment from any Participant for Covered Services furnished under this Agreement, except as otherwise directed by Plan Sponsor.

At its discretion, Plan Sponsor may offer Provider an option to request payment prior to or immediately following the provision of a Covered Service ("Date of Service Payment"). In such case, Provider must still submit a claim for the Covered Service in accordance with Section 4.1 of the Agreement.

ATTACHMENT C

Plans / Plan Sponsors

- Radical Ventures, LLC (DBA Mark Cuban Companies)
- Mark Cuban Cost Plus Drug Company, PBC (DBA Cost Plus Drugs)

Inpatient Rates

<u>DRG</u>	<u>Procedure Description</u>	<u>Bundled Rate</u>
402	Single level combined anterior & posterior spinal fusion except cervical	\$76,750
426	Multiple level combined anterior & posterior spinal fusion except cervical with MCC or custom-made anatomically designed interbody fusion device	\$163,175
427	Multiple level combined anterior & posterior spinal fusion except cervical with CC	\$113,725
428	Multiple level combined anterior & posterior spinal fusion except cervical without CC/MCC	\$89,400
429	Combined anterior & posterior cervical spinal fusion with MCC	\$140,720
430	Combined anterior & posterior cervical spinal fusion without MCC	\$89,400
447	Multiple level spinal fusion except cervical with MCC or custom-made anatomically designed interbody fusion device	\$110,175
448	Multiple level spinal fusion except cervical without MCC	\$62,550
450	Single level spinal fusion except cervical with MCC or custom-made anatomically designed interbody fusion device	\$74,900
451	Single level spinal fusion except cervical without MCC	\$52,617
457	Spinal fusion except cervical with spinal curvature, malignancy, infection or extensive fusions with CC/MCC	\$87,700
458	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, Infection or Extensive Fusions without CC/MCC	\$76,170
466	Revision of a hip or knee replacement with MCCs	\$83,225
467	Revision of hip or knee replacement with CC	\$46,985
468	Revision of hip or knee replacement without CC/MCC	\$46,350
469	Major hip and knee joint replacement or reattachment of lower extremity with MCC or Total Ankle Replacement	\$51,275
470	Major hip and knee joint replacement or reattachment of lower extremity without MCC	\$28,498
471	Cervical spinal fusion with MCC	\$80,000
472	Cervical spinal fusion with CC	\$51,025
473	Cervical spinal fusion without CC/MCC	\$36,061
518	Back & neck procedures except spinal fusion with MCC or disc device or neurostimulator	\$59,150
519	Back & neck procedures except spinal fusion with CC	\$31,725
520	Back & neck procedures except spinal fusion without CC/MCC	\$20,650

Outpatient Rates

Evaluation and Management Services Prior to Episode Period

<u>CPT Code</u>	<u>Procedure Description</u>	<u>Bundled Rate</u>
99202 - 99215	Evaluation and Management (E/M) office visit codes	\$250.00
99242 - 99245	Consultation Evaluation and Management	\$250.00

Orthopedic Surgery

<u>CPT Code</u>	<u>Procedure Description</u>	<u>Bundled Rate</u>
20680	Removal of a deep implant of the musculoskeletal system	\$6,150
23120	Partial claviclectomy	\$6,915
23410	Open surgical repair of an acute rotator cuff tear in the shoulder	\$13,825
23412	Open surgical repair of a chronic rotator cuff tear in the shoulder	\$15,333
23430	Open biceps tenodesis; repair or reattach the long tendon of the biceps muscle in the shoulder	\$14,575
23470	Shoulder hemiarthroplasty (partial shoulder replacement)	\$28,550
23472	Total shoulder arthroplasty or reverse total shoulder arthroplasty	\$38,200
24105	Excision of the olecranon bursa	\$6,915
24342	Reinsertion of a ruptured distal biceps or triceps tendon	\$14,575
24359	Lateral or medial elbow tenotomy	\$6,915
24363	Total elbow arthroplasty	\$43,275
25111	Excision of a ganglion cyst on the wrist; dorsal or volar	\$5,000
25575	ORIF of the radius and ulna	\$19,575
25607	ORIF of extra-articular distal radius fracture	\$16,575
25608	ORIF of intra-articular distal radius fracture; 2 or more fragments	\$16,575
25609	ORIF of intra-articular distal radius fracture; 3 or more fragments	\$16,575
26055	Trigger finger release	\$4,100
27130	Total hip arthroplasty	\$32,000
27130	Total hip arthroplasty	\$33,500
27134	Revision of a hip or knee replacement with CC	\$46,350
27446	Unicompartmental (partial) knee arthroplasty	\$29,000
27447	Total knee arthroplasty	\$29,000
27486	Revision of a total knee arthroplasty with or without allograft, for a single component	\$46,350
27570	Manipulation of the knee joint under anesthesia (MUA)	\$2,750
29806	Surgical shoulder procedure; capsulorrhaphy	\$16,575
29807	Arthroscopic shoulder surgery to repair a SLAP lesion	\$14,575
29827	Arthroscopic rotator cuff repair in the shoulder	\$15,333
29848	Endoscopic carpal tunnel release	\$5,500

29866	Knee arthroscopy to treat focal cartilage defects by transplanting the patient's own tissue (an osteochondral autograft or OATS procedure)	\$14,381
29870	Diagnostic arthroscopy of the knee; synovial biopsy	\$6,900
29871	Surgical knee arthroscopy for infection, lavage, & drainage	\$6,900
29873	Knee arthroscopy with lateral release	\$6,900
29874	Knee arthroscopy performed to remove a loose body or foreign body from the joint space	\$6,900
29875	Arthroscopic limited synovectomy of the knee	\$6,900
29876	Major arthroscopic synovectomy of the knee involving two or more compartments	\$6,900
29877	Knee arthroscopy with surgical debridement or shaving of articular cartilage (chondroplasty)	\$6,900
29879	Surgical knee arthroscopy to repair damaged joint cartilage	\$6,900
29880	Surgical knee arthroscopy that involves the removal of both the medial & lateral meniscus (meniscectomy)	\$6,900
29881	Surgical knee arthroscopy that involves the removal of either the medial or lateral meniscus (meniscectomy)	\$6,900
29882	Surgical knee arthroscopy involving a meniscus repair of either the medial or lateral meniscus	\$6,900
29883	Surgical knee arthroscopy involving a meniscus repair in both the medial and lateral compartments	\$6,900
29884	Surgical knee arthroscopy to remove scar tissue (lysis of adhesions) in the knee joint	\$6,900
29885	Surgical knee arthroscopy involving drilling for osteochondritis dissecans (OCD)	\$15,310
29886	Surgical knee arthroscopy involving drilling on an intact osteochondritis dissecans (OCD) lesion	\$6,900
29887	Surgical knee arthroscopy involving drilling on an intact osteochondritis dissecans (OCD) lesion accompanied by internal fixation	\$15,310
29888	Knee arthroscopy involving anterior cruciate ligament (ACL) repair, augmentation, or reconstruction	\$17,000
29889	Knee arthroscopy involving posterior cruciate ligament (PCL) repair, augmentation, or reconstruction	\$27,500
64718	Open surgical decompression, neurolysis, and/or transposition of the ulnar nerve of the elbow	\$5,500
64721	Open carpal tunnel release surgery; neuroplasty and/or transposition of the median nerve at the carpal tunnel	\$4,126

Pain Management

<u>CPT Code</u>	<u>Procedure Description</u>	<u>Bundled Rate</u>
20605	Arthrocentesis, aspiration, and/or injection of an intermediate joint or bursa, without ultrasound guidance	\$1,700

20610	Arthrocentesis, aspiration, and/or injection of a major joint or bursa (shoulder, hip knee, or subacromial bursa), without ultrasound guidance	\$1,700
27096	Injection to sacroiliac joint	\$1,700
62321	Epidural steroid injection (ESI) - cervical or thoracic	\$1,850
62323	Epidural steroid injection (ESI) - lumbar or sacral	\$1,850
64483	Transforaminal epidural steroid injection (TFESI) - lumbar or sacral; single level	\$2,100
64484	Transforaminal epidural steroid injection (TFESI) - lumbar or sacral; each additional level	\$350
64490	Facet injection or medial branch block (MBB) - cervical or thoracic; single level	\$2,100
64491	Facet injection or medial branch block (MBB) - cervical or thoracic; each additional level	\$350
64492	Facet injection or medial branch block (MBB) - cervical or thoracic; third and any additional levels	\$350
64493	Facet injection or medial branch block (MBB) - lumbar or sacral; single level	\$2,100
64494	Facet injection or medial branch block (MBB) - lumbar or sacral; each additional level	\$350
64495	Facet injection or medial branch block (MBB) - lumbar or sacral; third and any additional levels	\$350
64520	Nerve block into the lumbar or thoracic paravertebral sympathetic nerves	\$2,100
64633	Rhizotomy (radiofrequency ablation) of a nerve at a cervical or thoracic facet joint; single level	\$4,125
64634	Rhizotomy (radiofrequency ablation) of a nerve at a cervical or thoracic facet joint; each additional level	\$375
64635	Rhizotomy (radiofrequency ablation) of a nerve, lumbar or sacral; single level	\$4,125
64636	Rhizotomy (radiofrequency ablation) of a nerve, lumbar or sacral; each additional level	\$375

Spine

<u>CPT Code</u>	<u>Procedure Description</u>	<u>Bundled Rate</u>
22551	Anterior cervical discectomy and fusion (ACDF)	\$28,500
22552	Each additional cervical spinal fusion level	Add \$5,000
22600	Posterior or posterolateral spinal fusion on a single cervical interspace below the C2 vertebra	\$37,000
22614	Each additional vertebral segment	Add \$5,000
22856	Total disc arthroplasty (artificial disc replacement) - cervical; single level, anterior approach	\$38,239
22857	Total disc arthroplasty (artificial disc replacement) - lumbar; single level	\$38,239
22858	Total disc arthroplasty (artificial disc replacement) - cervical; second level, anterior approach	\$7,500
22860	Total disc arthroplasty (artificial disc replacement) - lumbar; second level	\$7,500

63042	Revision surgery - lumbar, single level, nerve root decompression, partial facetectomy, foraminotomy, excision of a recurrent herniated intervertebral disc; single level	\$15,333
63044	Revision surgery - lumbar, single level, nerve root decompression, partial facetectomy, foraminotomy, excision of a recurrent herniated intervertebral disc; each additional level	\$1,000
63056	Transpedicular approach with decompression of spinal cord, equina, and/or nerve root (eg. Herniated intervertebral disc) - lumbar, single level	\$14,575
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s) including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace cervical	\$15,310
63020, 63035	Each additional interspace	Add \$1,000
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s) including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace lumbar	\$15,310
63030, 63035	Each additional interspace	Add \$1,000
63046	Laminectomy, facetectomy, and foraminotomy with decompression; single vertebral segment; thoracic	\$15,310
63046, 63048	Each additional vertebral segment	Add \$1,000
63047	Laminectomy, facetectomy, and foraminotomy with decompression; single vertebral segment; lumbar	\$15,310
63047, 63048	Each additional vertebral segment	Add \$1,000
63650	Percutaneous implantation of a neurostimulator electrode array in the epidural space; trial	\$13,500
63650, 63685	Surgical insertion, replacement, or revision of a spinal neurostimulator pulse generator or receiver; permanent placement of spinal cord stimulator (SCS)	\$72,500

Foot & Ankle

<u>DRG/CPT Code</u>	<u>Procedure Description</u>	<u>Bundled Rate</u>
27601	Decompression fasciotomy in the posterior compartment of the leg	\$6,915
27640	Partial excision of the tibia, such as craterization, saucerization, or diaphysectomy	\$6,915
27641	Partial removal of the fibula bone	\$6,915
27650	Repair, primary, open or percutaneous, ruptured Achilles tendon	\$15,333
27654	Repair, secondary, Achilles tendon, with or without graft	\$15,333
27680	Surgical release of a single flexor or extensor tendon in the leg or ankle (tenolysis)	\$6,915
27685	Surgical procedure to lengthen or shorten a single tendon in the leg or ankle	\$6,915

27687	Gastrocnemius recession	\$6,915
27696	Primary repair on both collateral ligaments of the ankle	\$15,335
27698	Secondary repair or reconstruction of a disrupted collateral ligament in the ankle	\$15,335
27702	Total ankle arthroplasty with implant	\$57,335
27703	Arthroplasty, ankle; revision, total ankle	\$37,050
27704	Surgical removal of an ankle implant	\$6,915
27745	Prophylactic (preventive) surgical treatment of the tibia to reinforce or strengthen a weak or diseased area	\$15,335
28112	Complete excision of the metatarsal head of the second, third or fourth toe	\$6,915
28119	Osteotomy, calcaneus, for spur, with or without plantar fascial release	\$6,915
28120	Partial excision of the heel bone (calcaneus) or the ankle bone (talus)	\$6,915
28122	Partial excision (removal) of a bone in the foot	\$6,915
28234	Open tenotomy of the extensor tendon in the foot or toe, performed on each individual tendon involved	\$3,400
28285	Surgical correction of a hammertoe	\$6,915
28288	Partial removal of the metatarsal head	\$6,915
28296	Surgical correction of a bunion (hallux valgus) that includes a distal metatarsal osteotomy and bunionectomy	\$6,915
28297	Lapidus procedure; correction of a hallux valgus (bunionectomy) with removal of sesamoid bones	\$22,848
28300	Osteotomy of the calcaneus (heel bone)	\$15,335
28306	Osteotomy of the first metatarsal bone in the foot	\$14,052
28308	Osteotomy performed on one of the metatarsal bones in the foot, excluding the first (great toe)	\$6,915
28730	Midfoot or tarsometatarsal arthrodesis (fusion)	\$27,130
29892	Repair of the ankle, arthroscopically; repair of a large osteochondritis dissecans (OCD) lesion, talar dome fracture, or a tibial plafond fracture	\$15,335
29898	Extensive surgical debridement of the ankle joint performed via arthroscopy	\$6,915

General Surgery Procedures

<u>CPT Code</u>	<u>Procedure Description</u>	<u>Bundled Rate</u>
11770	Simple excision of a pilonidal cyst or sinus	\$2,600
47562	Laparoscopic cholecystectomy	\$8,400
47563	Laparoscopic cholecystectomy that involves a cholangiogram	\$12,750
49507	Surgical procedure to repair an initial inguinal hernia in a patient 5 years or older	\$7,550

49592	Initial open or minimally invasive repair of an incarcerated or strangulated anterior abdominal hernia (e.g., ventral, incisional, epigastric, spigelian, or umbilical) with total defect less than 3 cm, including mesh implantation	\$12,750
49594	Surgical procedure to repair an intial incarcerated or strangulated anterior abdominal hernia (e.g., ventral, incisional, epigastric, spigelian, or umbilical) with total defect between 3 cm and 10 cm, including mesh implantation	\$12,750
49650	Laparoscopic surgical repair of an initial inguinal hernia	\$7,550
49651	Laparoscopic surgical repair of a recurrent inguinal hernia	\$12,750

Ear, Nose and Throat Surgery Procedures

<u>CPT Code</u>	<u>Procedure Description</u>	<u>Bundled Rate</u>
69436	Tympanostomy with Tube Insertion (General Anesthesia)	\$2,108
31253	Total Ethmoidectomy w/ Frontal Sinus Exploration	\$6,917
31254	Partial Ethmoidectomy	\$4,972
31255	Total Ethmoidectomy	\$5,234
31257	Total Ethmoidectomy w/ Sphenoidotomy	\$5,509
31259	Total Ethmoidectomy w/ Sphenoidotomy with tissue removal from the sphenoid sinus	\$7,281
30117	Excision/Destruction Intranasal Lesion (Internal)	\$3,569
30140	Submucous Resection of Inferior Turbinate	\$3,091

Durable Medical Equipment Dispensed by Surgeon

Durable medical equipment will be reimbursed at cost when dispensed by a participating surgeon.
