

DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation

WORKERS' COMPENSATION RULES OF PROCEDURE WITH TREATMENT GUIDELINES

MEDICAL FEE SCHEDULE

7 CCR 1101-3 Rule 18 (no exhibits)

[Editor's Notes follow the text of the rules at the end of this CCR Document.]

18-1 STATEMENT OF PURPOSE

Pursuant to § 8-42-101(3)(a)(I), C.R.S., and § 8-47-107, C.R.S., the Director promulgates this Medical Fee Schedule to review and establish maximum allowable fees for health care services falling within the purview of the Act. The Director adopts and hereby incorporates by reference, as modified and published by Medicare in January 2016, National Physician Fee Schedule Relative Value file (RBRVS-Resource Based Relative Value Scale); the Current Procedural Terminology CPT® 2016, Professional Edition, published by the American Medical Association (AMA); and Medicare Severity Diagnosis Related Groups (MS-DRGs) Definitions Manual, Version 34 using MS-DRGs effective after October 1, 2016. The incorporation is limited to the specific editions named and does not include later revisions or additions. For information about inspecting or obtaining copies of the incorporated materials, contact the Medical Policy Unit Supervisor, 633 17th Street, Suite 400, Denver, Colorado 80202-3626. These materials may be examined at any state publications depository library. All guidelines and instructions are adopted as set forth in the RBRVS, CPT® and MS-DRGs, and all CPT® modifiers, unless otherwise specified in this Rule.

This Rule applies to all services rendered on or after January 1, 2017. All other bills shall be reimbursed in accordance with the fee schedule in effect at the time service was rendered.

18-2 STANDARD TERMINOLOGY FOR THIS RULE

- (A) CPT® - Current Procedural Terminology CPT® 2016, copyrighted and distributed by the AMA and incorporated by reference in 18-1.
- (B) DoWC Zxxxx – Colorado Division of Workers' Compensation created codes.
- (C) MS-DRGs – version 34.0 incorporated by reference in 18-1.
- (D) Medicare's January 2016 National Physician Fee Schedule Relative Value file (RBRVS)
- (E) For other terms, see Rule 16, Utilization Standards.

18-3 HOW TO OBTAIN COPIES

All users are responsible for the timely purchase and use of Rule 18 and its supporting documentation as referenced herein. The Division shall make available for public review and inspection the copies of all materials incorporated by reference in Rule 18. Copies of the RBRVS may be obtained from Medicare's website, www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/PhysicianFeeSched/Index.html. The Current Procedural Terminology, 2016 Edition, may be purchased from the AMA. The MS-DRGs Definitions Manual may be purchased from 3M Health Information Systems. The Colorado Workers' Compensation Rules of Procedures with Treatment Guidelines, 7 CCR 1101-3, may be purchased from

LexisNexis Matthew Bender & Co., Inc., Albany, NY. Interpretive Bulletins and unofficial copies of all rules, including Rule 18, are available on the Colorado Department of Labor and Employment web site. An official copy of the rules is available on the Secretary of State's webpage.

18-4 CONVERSION FACTORS (CF)

The following CFs shall be used to determine the maximum allowed fees. The maximum fee is determined by multiplying the following section CFs by the established facility or non-facility total relative value unit(s) (RVUs) found in the corresponding RBRVS sections:

RBRVS SECTION	CF
Anesthesia	\$55.61/RVU
Surgery	
\$68.01/RVU	
Radiology	\$71.99/RVU
Pathology	\$68.31/RVU
Medicine	\$67.00/RVU
Physical Medicine and Rehabilitation (Includes Medical Nutrition Therapy and Acupuncture)	\$41.14/RVU
Evaluation & Management (E&M)	\$50.20/RVU

Table #1 lists the place of service codes used with the RBRVS facility RVUs. All other maximum fee calculations shall use the non-facility RVUs listed in the RBRVS.

Table #1	
Place of Service Code	Place of Service Code Description
19	Off Campus – Outpatient Hospital
21	Inpatient Hospital
22	On Campus - Outpatient Hospital
23	Emergency Room-Hospital
24	Ambulatory Surgery Center (ASC)
26	Military Treatment Facility
31	Skilled Nursing Facility
34	Hospice
41	Ambulance - Land
42	Ambulance - Air or Water
51	Inpatient Psychiatric Hospital
52	Psychiatric Facility-Partial Hospitalization
53	Community Mental Health Center
56	Psychiatric Residential Treatment Center
61	Comprehensive Inpatient Rehabilitation Facility

18-5 INSTRUCTIONS AND/OR MODIFICATIONS INCORPORATED BY REFERENCE IN RULE 18-1

(A) MAXIMUM ALLOWANCE

Maximum allowance for all providers under Rule 16-5 is 100% of the RBRVS value or as specified in this Rule. The maximum fee schedule value for professional services provided by a Physician Assistants (PAs) and Nurse Practitioners (NPs) shall be 85% of the Medical Fee Schedule. However, PAs and NPs may be allowed 100% of the Medical Fee Schedule value if the requirements of Rule 16-5(A)(6) have been met and one of the following conditions applies:

- (1) The service is provided in a rural area. Rural area means:
 - (a) a county outside a Metropolitan Statistical Area (MSA) or
 - (b) a Health Professional Shortage Area, either located outside of an MSA or in a rural census tract, as determined by the Office of Rural Health Policy, Health Resources and Services Administration, United States Department of Health and Human Services.
- (2) The "incident to" criteria found in 42 CFR §§ 410.26(a) and (b), 410.27, and 410.32(b)(3) have been met.

(B) RBRVS, CPT AND Z CODES

- (1) Unless modified herein, the RBRVS is adopted for RVUs. Division-created codes (Zxxxx) and values supersede the CPT® or RBRVS codes. Those codes listed with RVUs of "BR" (by report), not listed, or listed with a zero value and not included by Medicare in another procedure(s), require prior authorization pursuant to Rule 16. The CPT® 2016 is adopted for codes, descriptions, parenthetical notes and coding guidelines, unless modified in this Rule.
- (2) When billing for services reported with time-based codes, practitioners are required to document in the medical record the duration of the encounter. The time considered is time spent face-to-face with the patient, performing the billed service (e.g., 60 minutes of psychotherapy) and/or the time spent performing non-face-to-face services/procedures (e.g., prolonged record review).
- (3) Any billed CPT® code identified as a "separate procedure" in CPT® shall have an appropriate modifier appended to the code for the payer to allow separate payment (i.e., modifier 59 or one of the below applicable X modifiers).

One of the following descriptive modifiers may be used in place of modifier 59:

- (a) XE - Separate Encounter: a service that is distinct because it occurred during a separate encounter.
- (b) XS – Separate Structure: a service that is distinct because it was performed on a separate organ/structure.
- (c) XP – Separate Practitioner: a service that is distinct because it was performed by a different practitioner.
- (d) XU – Unusual Non-Overlapping Service: the use of a service that is distinct because it does not overlap usual components of the main service.

-
- (4) No code listed in CPT® identified as an “add-on” code is payable unless an appropriate primary code is billed with the “add-on” code in the same episode of care.
 - (5) The National Physician Fee Schedule Relative Value file, as modified, are the only fields recognized in the Colorado Workers' Compensation Medical Fee Schedule:
 - (a) HCPCS (Healthcare Common Procedure Coding System) –including any non-listed CPT® codes;
 - (b) Level I (CPT®) and Level II (HCPCS) Modifiers (listed and unlisted);
 - (c) Description – short description as listed in the file and long description as specified in CPT®;
 - (d) Total Non-Facility RVU;
 - (e) Total Facility RVU;
 - (f) PC/TC (Professional Component/Technical Component) Indicators:
 - (i) “0” – Physician Services Only – PC/TC distinction does not apply to these service codes;
 - (ii) “1” – Diagnostic Radiology Tests/Services - diagnostic test codes for radiology service may be billed with or without modifiers 26 or TC;
 - (iii) “2” – Professional Component Only Codes – stand-alone professional service codes only (no modifier is appropriate because the code description dictates the service is professional only, e.g., CPT® 93010 Electrocardiogram represents “interpretation and report only”);
 - (iv) “3” - Technical Component Only Codes - stand-alone technical service codes only (no modifier is appropriate because the code description dictates the service is technical only, e.g., CPT® 93005 Electrocardiogram represents “tracing only”);
 - (v) “4” – Global Test Only Codes - modifiers 26 and TC cannot be used with these codes because the values equal to the sum of the total RVUs (work, practice expense and malpractice);
 - (vi) “5” - Incident To Codes - do not apply to workers' compensation;
 - (vii) “6” - Laboratory Physician Interpretation Codes – clinical laboratory codes for which separate payments for interpretations by laboratory physicians may be made (these codes represent the professional component of a clinical laboratory service and cannot be billed with a modifier TC);
 - (viii) “7” - Physical Therapy Services – these codes are not recognized by DoWC;

- (ix) "8" - Physician Interpretation Codes –clinical laboratory codes for which separate payments may be made only when a physician interprets an abnormal smear for a hospital in-patient. This indicator applies to CPT® codes 88411, 85060, and HCPCS code P3001-26. No TC component is recognized;
- (x) "9" - Not Applicable – PC/TC component does not apply to this indicator;
- (g) Global Days;
- (h) Conversion factors as specified in Rule 18-4.
- (6) CPT® Category III codes listed in the RBRVS may be used for billing with agreement of the payer as to reimbursement. Payment shall be in compliance with Rule 16-6(C).

(C) ANESTHESIA

- (1) All anesthesia base values shall be established by the use of the codes as set forth in Medicare's 2016 Anesthesia Base Values. Anesthesia services are only reimbursable if the anesthesia is administered by a physician, a Certified Registered Nurse Anesthetist (CRNA), or an anesthesiologist assistant (AA) who remains in constant attendance during the procedure for the sole purpose of rendering anesthesia.

When anesthesia is administered by a CRNA or AA:

- (a) CRNAs not under the medical direction of an anesthesiologist, reimbursement shall be 90% of the maximum anesthesia value;
- (b) If billed separately, CRNAs and AAs, under the medical direction of an anesthesiologist, shall be reimbursed 50% of the maximum anesthesia value. The other 50% is payable to the anesthesiologist providing the medical direction to the CRNA or AA;
- (c) Medical direction for administering the anesthesia includes performing the following activities:
 - (i) Performs a pre-anesthesia examination and evaluation,
 - (ii) Prescribes the anesthesia plan,
 - (iii) Personally participates in the most demanding procedures in the anesthesia plan including induction and emergence,
 - (iv) Ensures that any procedure in the anesthesia plan that s/he does not perform is performed by a qualified anesthetist,
 - (v) Monitors the course of anesthesia administration at frequent intervals,
 - (vi) Remains physically present and available for immediate diagnosis and treatment of emergencies, and
 - (vii) Provides indicated post-anesthesia care.

- (2) The following modifiers are to be used when billing for anesthesia services:
- (a) AA – anesthesia services performed personally and billed by the anesthesiologist. Maximum allowance is 100% of maximum anesthesia calculated fees.
 - (b) AD – greater than four (4) concurrent (occurring at the same time) anesthesia service cases being supervised by an anesthesiologist. Maximum allowance for supervising multiple cases is calculated using three (3) base anesthesia units to each case, regardless of the number of base anesthesia units assigned to each specific anesthesia episode of care.
 - (c) QK – anesthesiologist providing direction to qualified individuals of two (2) to four (4) concurrent anesthesia cases. Maximum allowance is 50% of maximum anesthesia calculated fees for the billing anesthesiologist providing direction.
 - (d) QX – CRNA or AA service; with medical direction by a physician. Maximum allowance is 50% of the maximum anesthesia calculated fees for the CRNA or AA administering the anesthesia.
 - (e) QZ – CRNA service; without medical direction by a physician. Maximum allowance is 90% of maximum anesthesia calculated fees for the CRNA.
 - (f) QY – Medical direction of one CRNA or AA by an anesthesiologist. Maximum allowance is 50% of maximum anesthesia calculated fees for the anesthesiologist providing direction.
 - (g) QS – Monitored anesthesia care service (MAC).
 - (h) G8 – Monitored anesthesia care (MAC) for deep complex complicated, or markedly invasive surgical procedure.
 - (i) G9 – Monitored anesthesia care (MAC) of a patient who has a history of severe cardiopulmonary disease.
- (3) The supervision of AAs shall be limited in accordance with the Medical Practice Act.
- (4) Physical status modifiers are reimbursed as follows, using the anesthesia conversion factor:
- | | | | |
|-----|-----|---|--------|
| (a) | P-1 | Healthy patient | 0 RVUs |
| (b) | P-2 | Patient with mild systemic disease | 0 RVUs |
| (c) | P-3 | Patient with severe systemic disease | 1 RVU |
| (d) | P-4 | Patient with severe systemic disease that is a constant threat to life | 2 RVUs |
| (e) | P-5 | A moribund patient who is not expected to survive without the operation | 3 RVUs |
| (f) | P-6 | A declared brain-dead patient | 0 RVUs |

- (5) Qualifying circumstance codes are reimbursed using the anesthesia conversion factor:

- | | | |
|-----|--|--------|
| (a) | Anesthesia complicated by extreme age;
under 1 year old or > 70 years old | 1 RVU |
| (b) | Anesthesia complicated by utilization of
total body hypothermia | 5 RVUs |
| (c) | Anesthesia complicated by utilization of
controlled hypotension | 5 RVUs |
| (d) | Anesthesia complicated by emergency
conditions (specify) | 2 RVUs |

- (6) When more than one surgical procedure is performed during a single episode, only the highest valued base anesthesia procedure value is billed with the total anesthesia time for all procedures.

- (7) Anesthesia time begins when the anesthesiologist prepares the patient for the induction of anesthesia and ends when the anesthesiologist is no longer in personal attendance and the patient is placed under postoperative supervision. Total minutes are reported for reimbursement. Each 15-minutes of anesthesia time equals 1 additional RVU. Five minutes or more is considered significant time and adds 1 RVU to the payment calculation.

- (8) Calculation of Maximum Fees for Anesthesia

Base Anesthesia value from the Medicare's 2016 Anesthesia Base Values

+1 Unit/15 minutes of anesthesia time
+Any physical status modifier units
Total Relative Value Anesthesia Units
Multiplied by the Anesthesia CF in section 18-4
Total Maximum Anesthesia Fees

- (9) Non-time based Anesthesia Procedures

Modifier -47 shall be used by surgeons performing non-time based anesthesia.

(D) SURGERY

- (1) The use of assistant surgeons shall be limited according to the American College Of Surgeons' Physicians as Assistants at Surgery: 2016 Update (April 2016), available from the American College of Surgeons, Chicago, IL, or from their web page. The incorporation is limited to the edition named and does not include later revisions or additions. Copies of the material incorporated by reference may be inspected at any State publications depository library. For information about inspecting or obtaining copies of the incorporated material, contact the Medical Policy Unit Supervisor, 633 17th Street, Suite 400, Denver, Colorado, 80202-3626.

Where the publication restricts use of such assistants to "almost never" or a procedure is not referenced in the publication, prior authorization for payment (see Rule 16-10) is required.

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

- (3) No payment shall be made for more than one (1) assistant surgeon or minimum assistant surgeon without prior authorization for payment (see Rule 16-10).
- (4) The payer may use available billing information such as provider credential(s) and clinical record(s) to determine if an appropriate modifier should be used on the bill. To modify a billed code refer to Rule 16-12(B)(4).
- (5) When an operation requires two primary surgeons performing two distinct portions of the operation, modifier -62 is used with the procedure in question and reimbursement is increased to 125% of the value, apportioned in relation to the responsibilities and work of each surgeon or 50% of the total increased maximum fee to each surgeon.

Surgical team reimbursement requires prior authorization and the use of modifier - 66 on the surgical codes.

Assistant Surgeon, indicated by modifier -80 has a maximum allowance of 20 % of the surgeon's fees.

Assistant Surgeon (when qualified resident surgeon is not available), indicated by modifier -82, is also reimbursed at 20% of the surgeon's fees.

Minimum Assistant Surgeon's maximum fees are 10% of the surgeon's fees. Modifiers should be appended as follows:

- (a) –AS for services performed by NPs or PAs (the 85% adjustment in section 18-5(A) does not apply);
 - (b) –81 for services performed by clinical nurse specialists, surgical technicians, or any other non-physician providers;
- (6) Global Period
- (a) All surgical procedures include the following:
 - (i) Local infiltration, metacarpal/metatarsal/digital block or typical anesthesia;
 - (ii) One related E&M encounter on the date immediately prior to or on the date of the procedure (including history and physical);
 - (iii) Intraoperative services that are normally a usual and necessary part of a surgical procedure;
 - (iv) Immediate postoperative care, including dictating operative notes, talking with the family and other physicians;
 - (v) Evaluating the patient in the post-anesthesia recovery room;
 - (vi) Post-surgical pain management by the surgeon;
 - (vii) Typical postoperative follow-up care during the global period of the surgery that is related to recovery from the surgery as identified in RBRVS as global:

- 000 –are endoscopies or some minor surgical procedures, typically a 0 day postoperative period. Visits on the same day of procedures are generally included in the allowance for the procedure, unless a separately identifiable service is performed and billed with the appropriate modifier.
 - 010 - are other minor procedures, 10 day postoperative period.
 - 090 - are major surgeries, 90 day postoperative period.
 - XXX – does not apply
 - ZZZ – are covered under another procedure's global days
 - MMM – global service day's concept does not apply. (See Medicare's Global Maternity Care reporting rule.)
 - Global period, defined RBRVS, begins the day after surgery and continues for the defined period.
- (viii) Supplies – Except for those identified as exclusions;
- (ix) Miscellaneous Services – Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts and splints; insertion, irrigation and removal of urinary catheters, routine peripheral IV lines, nasogastric and rectal tubes; changes and removal of tracheostomy tubes;
- (x) Applicable Surgical Modifiers:
- 24 - Unrelated E&M service by the same physician during a postoperative period.
 - 25 - Significant and separately identifiable E&M service on the same day of the procedure within the global period of minor surgical procedures (0 or 10 days).
 - 54 - Surgical Care only. Fee is 60% of the billed surgery code Maximum Fee Schedule value.
 - 55 - Postoperative management only. Fee is 30% of the billed surgery code Maximum Fee Schedule value.
 - 56 - Preoperative management only. Fee is 10% of the billed surgery code Maximum Fee Schedule value.
 - 57 - Decision for surgery.
 - 58 - Staged or related procedure or service by the same physician during the postoperative period.
 - 76 - Repeat procedure or service by the same physician.

- 78 - Unplanned Return to the Operating/Procedure Room by the same physician following initial procedure for a related procedure during the postoperative period.
 - 79 - Un-related procedure or service by the same physician during the postoperative period.
- (b) The following services performed during a global period would warrant separate billing if documentation demonstrates significant identifiable services were involved, such as:
- (i) E&M services unrelated to the primary surgical procedure.
 - (ii) Services necessary to stabilize the patient for the primary surgical procedure.
 - (iii) Services not considered part of the surgical procedure, including an E&M visit by an authorized treating physician for disability management. The E&M service shall have an appropriate modifier appended to the E&M level of the service code when the surgeon is performing services during the global period. If at all possible, an appropriate identifying diagnosis code shall identify the E&M service as unrelated to the surgical global period. In addition, the reasonableness and necessity for an E&M service that is separate and identifiable from the surgical global period shall be clearly documented in the medical record.
 - (iv) Disability management of an injured worker for the same diagnosis requires the managing physician to clearly identify in the medical record the specific disability management detail that was performed during that visit. The definitions of what is considered disability counseling can be located under 18-5(l)(1) and in Exhibit #7 of this Rule.
 - (v) Unusual circumstances, complications, exacerbations, or recurrences.
 - (vi) Unrelated diseases or injuries.
 - (vii) If a patient is seen for the first time or an established patient is seen for a new problem and the "decision for surgery" is made the day of the procedure or the day before the procedure is performed, then the surgeon can bill both the procedure code and an E&M code, using a -57 modifier or -25 modifier on the E&M code.
- (c) Separately identifiable services shall use an appropriate CPT®/ modifier in conjunction with the billed service.
- (7) Multiple Procedures (modifier -51) and Bilateral Procedures (modifier -50)
- Multiple procedure guidelines (modifier -51) do not apply to codes specifically identified in CPT® as add-on procedures "+" or to those specifically identified as exempt from modifier -51.
- Bilateral procedures not identified by CPT® as bilateral shall be billed on one line with one (1) unit and modifier -50 shall be appended to the CPT® code. The maximum fee is calculated at 150% of the Maximum Fee Schedule value.

When multiple procedures are performed by the same surgeon during the same surgical setting, modifier -51 shall be appended to the lower valued procedure(s). When multiple surgical procedures are performed in a single surgical setting, the highest valued or primary procedure is allowed 100% of the maximum fee and all other valued procedures, appended with a modifier -51, are allowed at 50% of the maximum fee.

- (8) If a surgical arthroscopic procedure is converted to the same surgical open procedure on the same joint, only the open procedure is payable. If an arthroscopic procedure and open procedure are performed on different joints, the two (2) procedures may be separately payable with anatomic modifiers or modifier -50.

- (9) Use code G0289 to report any combination of surgical knee arthroscopies for removal of loose body, foreign body, and/or debridement/shaving of articular cartilage.

G0289 shall not be paid when reported in conjunction with other knee arthroscopy codes in the same compartment of the same knee.

G0289 shall be paid when reported in conjunction with other knee arthroscopy codes in a different compartment of the knee.

- (10) Venipuncture maximum fee allowance is covered under Exhibit #8 of this Rule.

- (11) Platelet Rich Plasma (PRP) Injections

The Medical Treatment Guidelines promulgated by the Director of the Division of Workers' Compensation (Rule 17) govern when PRP injections are appropriate. Any PRP injections outside of the Medical Treatment Guidelines require prior authorization.

The provider shall bill DoWC Z0813, maximum total all-inclusive allowance of \$735.00, for PRP injections to any body part. This includes imaging guidance, harvesting and preparation (if performed), the injection itself, as well as kits and supplies.

(E) RADIOLOGY

- (1) General Policies

- (a) The professional component (PC) represents the supervision and interpretation of a procedure provided by the physician or other healthcare professional. It is identified by appending modifier 26 to the procedure code.

- (b) The technical component (TC) represents the cost of equipment, supplies and personnel to perform the procedure. It is identified by appending modifier TC to the procedure code.

- (c) A global service includes both professional and technical components. The global service is identified by reporting the eligible code without modifier 26 or TC.

A stand-alone procedure code describes the selected diagnostic tests for which there are associated codes that describe (a) the professional component of a test only, (b) the technical component of a test only and (c) the global test only. Modifiers 26 and TC cannot be billed with these codes.

(2) Payments

- (a) The Division recognizes the value of accreditation for quality and safe radiological imaging. Only offices/facilities that have attained accreditation from American College of Radiology (ACR), Intersocietal Accreditation Commission (IAC), RadSite, or The Joint Commission (TJC) may bill the technical component for advanced diagnostic imaging procedures (magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine scan). Providers separately reporting Z9999 certify accreditation status.
- (b) The professional component for MRIs, CTs, and nuclear medicine scans is reimbursable at 130% of the fee schedule.
- (c) The cost of dyes and contrast shall be reimbursed in accordance with 18-6(H)).
- (d) Copying charges for x-rays and MRIs shall be \$15.00/film regardless of the size of the film.
- (e) The payer may use available billing information such as provider credential(s) and clinical record(s) to determine if an appropriate CPT®/RBRVS modifier should have been used on the bill. To modify a billed code, refer to Rule 16-12(B)(4).
- (f) In billing radiology services, the applicable radiology procedure code shall be billed using the appropriate modifier to bill either the professional component (26) or the technical component (TC). If a physician bills the total or professional component, a separate written interpretive report is required.

If a physician interprets the same radiological image more than once, or if multiple physicians interpret the same radiological image, only one (1) interpretation shall be reimbursed. If an X-ray consultation is requested, the consultant's report shall include the name of the requesting provider, the reason for the request, and documentation that the report was sent to the requesting provider. The maximum fee for an X-ray consultation shall be no greater than the maximum fee for the professional component of the original X-ray.

The time a physician spends reviewing and/or interpreting an existing radiological image is considered a part of the physician's evaluation and management service code.

(3) Thermography

- (a) The provider supervising and interpreting the thermographic evaluation shall be board certified by the examining board of one (1) of the following national organizations and follow their recognized protocols:

American Academy of Thermology;

American Chiropractic College of Infrared Imaging.

- (b) Indications for diagnostic thermographic evaluation must be one (1) of the following:

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

Sympathetically Maintained Pain (SMP);

Autonomic neuropathy;

(c) General Protocols for Stress Testing

Cold Water Autonomic Functional Stress Testing – Baseline infrared images are obtained in a 68° F +/- 1 degree steady state environment following equilibration for 15 minutes. After the quantitative and qualitative baseline images are captured, cold water autonomic functional stress testing is performed by submersing the asymptomatic extremity in 68° F +/- 1 degree cold water bath for 5 minutes while imaging and evaluating the autonomic response.

Whole Body Autonomic Stress Testing – Refer to the thermogram discussion section found in the Complex Regional Pain Syndrome Medical Treatment Guidelines.

(d) Thermography Billing Codes:

DoWC Z0200 Upper body w/ Autonomic Stress Testing \$865.37

DoWC Z0201 Lower body w/Autonomic Stress Testing \$865.37

(e) Prior authorization for payment (see Rule 16-10) is required for thermography services only if the requested study does not meet the indicators for thermography as outlined in this radiology section. The billing shall include a report supplying the thermographic evaluation and reflecting compliance with 18-5(E)(2).

(4) Urea breath test C-14 (Isotopic); acquisition for analysis and the analysis maximum fees are listed under Exhibit #8 of this Rule.

(F) PATHOLOGY

(1) General Policies

(a) The professional component (PC) represents the supervision and interpretation of a procedure provided by the physician or other healthcare professional. It is identified by appending modifier 26 to the procedure code.

(b) The technical component (TC) represents the cost of equipment, supplies and personnel to perform the procedure. It is identified by appending modifier TC to the procedure code.

(c) A global service includes both professional and technical components. The global service is identified by reporting the eligible code without modifier 26 or TC.

A standalone procedure code describes the selected diagnostic tests for which there are associated codes that describe (a) the professional component of a test only, (b) the technical component of a test only and (c) the global test only. Modifiers 26 and TC cannot be billed with these codes.

(2) Clinical Laboratory Improvement Amendments (CLIA)

Laboratories with a CLIA certificate of waiver may perform only those tests cleared by the Food and Drug Administration (FDA) as waived tests. Laboratories with a CLIA certificate of waiver, or other providers billing for services performed by these laboratories, shall bill using the QW modifier.

Laboratories with a CLIA certificate of compliance or accreditation may perform non-waived tests. Laboratories with a CLIA certificate of compliance or accreditation, or other providers billing for services performed by these laboratories, do not append the QW modifier to claim lines.

(3) Payments

All clinical pathology laboratory tests, except as allowed by this rule, are reimbursed at the total component dollar value listed under Exhibit #8 of this Rule or billed charges, whichever is less. No separate technical or professional component maximum dollar split is separately payable by the payer. However the technical and professional component billing parties may agree upon a dollar value split of the total maximum fees listed in Exhibit #8 of this Rule.

When a physician clinical pathologist is required for consultation and interpretation, and a separate written report is created, the maximum fee is determined by using the RBRVS values and the pathology conversion factors. Maximum Fee Schedule value is determined by the Pathology Conversion Factor when the Pathology CPT® code description includes "interpretation" and "report" or the following Pathology CPT® code description is from:

- (a) physician blood bank services,
- (b) cytopathology and cell marker study interpretations,
- (c) cytogenetics or molecular cytogenetics interpretation and report,
- (d) surgical pathology gross and microscopic and special stain groups 1 and 2 and histochemical stain, blood or bone marrow interpretations, and
- (e) Skin tests for "unlisted antigen each, coccidioidomycosis, histoplasmosis, TB intradermal.

When ordering automated laboratory tests, the ordering physician may seek verbal consultation with the pathologist in charge of the laboratory's policy, procedures and staff qualifications. The consultation with the ordering physician is not payable unless the ordering physician requested additional medical interpretation and judgment and requested a separate written report. Upon such a request, the pathologist may bill using the proper CPT® code and values from the RBRVS, not DoWC Z0755.

(4) Clinical Drug Screening/Testing Codes and Values

(a) Clinical drug screening/testing evaluates whether:

- (i) Prescribed medications are at or below therapeutic or toxic levels (Therapeutic Drug Monitoring); or
- (ii) The patient is taking prescribed controlled substance medication(s); or

- (iii) The patient is taking any illicit or non-prescribed drugs.
- (b) Billing requirements for Clinical Drug Testing:
 - (i) The ordering physician shall document the medical necessity of the clinical drug test.
 - (ii) The ordering physician shall specify which drugs require definitive testing to meet the patient's medical needs.
 - (iii) Quantification of illicit or non-prescribed drugs or drug classes requires a physician order.
 - (iv) Medicare codes used in the 2016 Medicare Fee Schedule shall be billed for presumptive and definitive urine drug tests.
 - (v) All recognized codes and maximum fee values are listed in Exhibit #8 to this rule.
- (c) Presumptive Tests

Presumptive drug class assays identify possible use or non-use of drug(s) or drug class(es), but may not identify the specific drug or metabolite. All drug class immunoassays or enzymatic methods are considered to be presumptive. Providers may ONLY bill for one (1) of the three presumptive codes per date of service, regardless of the number of drug classes tested:

- (i) Drug test(s), presumptive, any number of drug classes; any number of devices or procedures (e.g. immunoassay) capable of being read by a direct optical observation only (e.g. dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service (G0477).
- (ii) Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g. immunoassay) read by instrument-assisted direct optical observation (e.g. dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service (G0478).
- (iii) Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers (e.g. immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service (G0479).

Presumptive drug class screening shall be billed using one of three codes - G0477, G0478 or G0479.

- (d) Definitive Tests – Gas Chromatography/Mass Spectrometry (GC/MS) or Liquid Chromatography/Mass Spectrometry (LC/MS) – no immunoassays or enzymatic methods.
 - (i) Definitive qualitative or quantitative tests identify specific drug(s) and any associated metabolites, providing sensitive and specific results expressed as a concentration in ng/mL or as the identity of a specific drug. Definitive quantitative tests must be ordered by a physician. The reasons for ordering a definitive quantification drug test may include:

- Unexpected positive presumptive or qualitative test results inadequately explained by the injured worker;
- Unexpected negative presumptive or qualitative test results and suspected medication diversion;
- Differentiate drug compliance:
 - Buprenorphine vs. norbuprenorphine
 - Oxycodone vs. oxymorphone, noroxycodone and oxycodone
- Need for quantitative levels to compare with established benchmarks for clinical decision-making, such as tetrahydrocannabinol (THC) quantitation to document discontinuation of a drug.
- Chronic Opioid Management
 - Drug testing shall be done prior to the implementation of the initial long-term drug prescription and randomly repeated at least annually.
 - While the injured worker is receiving chronic opioid management, additional drug screens with documented justification may be conducted. Examples of documented justification include the following:
 - Concern regarding the functional status of the patient
 - Abnormal results on previous testing
 - Change in management of dosage or pain
 - Chronic daily opioid dosage above 150 mg of morphine or equivalent
- The following four definitive drug testing codes replace the G6030 - G6058 HCPCS codes. Providers may ONLY bill for one (1) of the four definitive codes per day:
 - G0480- Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed.
 - G0481- Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays

(e.g. IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g. alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 8-14 drug class(es), including metabolite(s) if performed.

- G0482- Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g. IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g. alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 15-21 drug class(es), including metabolite(s) if performed.)
- G0483- Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 22 or more drug class(es), including metabolite(s) if performed.

- (ii) The table below should be used to determine the appropriate drug class(es) when billing G0480-G0483. The AMA CPT Manual may be consulted for examples of individual drugs within each class. Each class of drug can only be billed once per day.

Definitive classes			
Alcohol(s)	Antiepileptics, not otherwise specified	Gabapentin, non-blood	Phencyclidine
Alcohol Biomarkers	Antipsychotics, not otherwise specified	Heroin metabolite	Pregabalin
Alkaloids, not otherwise specified	Barbiturates	Ketamine and Norketamine	Propoxyphene
Amphetamines	Benzodiazepines	Methadone	Sedative Hypnotics (nonbenzodiazepines)
Anabolic steroids	Buprenorphine	Methylenedioxymphetamines	Skeletal Muscle Relaxants
Analgesics, non-opioids	Cannabinoids, natural	Methylphenidate	Stereoisomer (enantiomer) analysis
Antidepressants, serotonergic class	Cannabinoids, synthetic	Opiates	Stimulants, synthetic
Antidepressants, Tricyclic and other cyclicals	Cocaine	Opioids and Opiate analogs	Tapentadol
Antidepressants, not otherwise specified	Fentanyl	Oxycodone	Tramadol
Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified			

(G) MEDICINE

- (1) Medicine home therapy services in the RBRVS are not adopted. For appropriate codes see section 18-6(M) Home Care Services.
- (2) Anesthesia qualifying circumstance values are reimbursed in accordance with the section 18-5(C)(5).
- (3) Biofeedback

Licensed medical and mental health professionals who provide biofeedback must practice within the scope of their training. Non-licensed biofeedback providers must hold Clinical Certification from the BCIA, practice within the scope of their training, and receive a prior approval of their biofeedback treatment plan from the patient's authorized treating physician, psychologist, or psychiatrist. Professionals integrating biofeedback with any form of psychotherapy must be licensed as a psychologist, a social worker, a marriage or a family therapist, or a licensed professional counselor. For purposes of this rule, "licensed" means holding a license issued by the Colorado Medical Board, the Colorado Board of Chiropractic Examiners, the Colorado Podiatry Board, the Colorado Dental Board, or a board of the Colorado Department of Regulatory Agencies (DORA).

Biofeedback treatment must be provided in conjunction with other psychosocial or medical interventions.

All biofeedback providers shall document biofeedback instruments used during each visit (including, but not limited to, surface EMG, HRV, EEG, or temperature training), placement of instruments, and patient response, if sufficient time has passed.

Maximum Fee Schedule values for biofeedback services shall be as follows:

CPT® Code 90901, Biofeedback training by any modality:

Non-facility RVU is 2.14, Facility RVU is 1.14

CPT® Code 90911, Biofeedback peri/uro/rectal:

Non-facility RVU is 4.76, Facility RVU is 2.48

- (4) Appendix J of the 2016 CPT® identifies mixed, motor and sensory nerve conduction studies and their appropriate billing.
- (5) Manipulation -- Chiropractic (DC), Medical (MD) and Osteopathic (DO):
 - (a) Prior authorization for payment (see Rule 16-10) shall be obtained before billing for more than four body regions in one (1) visit. Manipulative therapy is limited to the maximum allowed in Rule 17, Medical Treatment Guidelines. The provider's medical records shall reflect medical necessity and prior authorization for payment (see Rule 16-10) if treatment exceeds these limitations.
 - (b) An office visit may be billed on the same day as manipulation codes when the documentation meets the E&M requirement and an appropriate modifier is used.
 - (c) Facility RVU is 0.79 and non-facility RVU is 1.00 for CPT® code 98940.

(6) Psychiatric/Psychological Services:

- (a) A licensed psychologist (PsyD, PhD, EdD) is reimbursed a maximum of 100% of the medical fee listed in the RBRVS. Other non-physician providers performing psychological/psychiatric services shall be paid at 85% of the fee allowed for physicians.
- (b) Prior authorization for payment (see Rule 16-10) is required any time the limitations discussed in this rule are exceeded on a single day.

The relative value weights for psychiatric diagnostic evaluations, with or without medical services, including time for internal records review, are as follows:

- (i) Without Evaluation & Management Service:
Non-facility is 9.91 RVUs
Facility is 9.6 RVUs
- (ii) With Evaluation and Management Service
Non-facility is 11.12 RVUs
Facility is 10.8 RVUs

Psychiatric diagnostic evaluation code(s) are limited to one per provider, per admitted claim, unless prior authorization is received from the payer.

- (c) Central Nervous System (CNS) Assessments/Tests, (neuro-cognitive, mental status, speech) requiring more than six (6) hours require prior authorization.

Brief psychological screens (including, but not limited to, the Distress Risk and Assessment Method (DRAM), Primary Care Evaluation of Mental Disorders (PRIME-MD), Zung Self-Rating Depression Scale, Beck Depression Inventory, and CES-D (Center for Epidemiologic Studies Depression Scale) are not equivalent to psychological testing, CPT® codes 96101-96127.

The RVUs for the following psychological and neuropsychological tests and for health and behavior assessments/interventions shall be modified to:

CPT® code	Non-facility Relative Value Units	Facility Relative Value Units
96101	3.00	2.91
96102	1.79	0.65
96103	1.36	1.33
96116	3.40	3.16
96118	4.11	3.31
96119	2.51	0.74
96120	2.30	1.24
96150	0.80	0.79
96151	0.78	0.77
96152	0.74	0.73
96153	0.18	0.17
96154	0.74	0.73
96155	0.73	0.73

Most initial evaluations for delayed recovery, exclusive of testing, can be completed in two (2) hours.

- (d) The limit for psychotherapy services is 60 min. per visit.

Prior authorization for payment (see Rule 16-10) is required any time the 60 minutes per visit limitation is exceeded. The time for internal record review/documentation is included in this limit.

Psychotherapy for work-related conditions requiring more than 20 visits or continuing for more than three (3) months after the initiation of therapy, whichever comes first, requires prior authorization for payment (see Rule 16-10) except where specifically addressed in Rule 17, Medical Treatment Guidelines.

- (e) When billing an evaluation and management (E&M) code in addition to psychotherapy:

- (1) Both services must be separately identifiable;
- (2) The level of E&M is based on history, exam and medical decision making;
- (3) Time may not be used as the basis for the E&M code selection; and
- (4) Add-on psychotherapy codes are to be used by psychiatrists to indicate both services were provided.

Non-medical disciplines cannot bill most E&M codes.

- (f) Upon request of a party to a workers' compensation claim and pursuant to HIPAA Privacy regulations, a psychiatrist, psychologist or other qualified health care professional may generate a separate report and bill for that service using CPT® code 90889. A party to a claim may bill for any separate documentation under CPT® code 90889. The relative value for this code is 1.4 RVUs for both facility and non-facility billings.

(7) Qualified Non-Physician Provider Telephone or On-Line Services

Reimbursement to qualified non-physician providers for coordination of care with professionals shall be based upon the telephone codes for qualified non-physician providers found in the RBRVS Medicine Section. Coordination of care reimbursement is limited to telephone calls made to professionals outside of the non-physician provider's employment facility(ies) and/or to the injured worker or their family.

(8) Quantitative Autonomic Testing Battery (ATB) and Autonomic Nervous System Testing.

- (a) Quantitative Sudomotor Axon Reflex Test (QSART) is a diagnostic test used to diagnose Complex Regional Pain Syndrome. This test is performed on a minimum of two (2) extremities, and encompasses the following components:
- (i) Resting Sweat Test
 - (ii) Stimulated Sweat Test
 - (iii) Resting Skin Temperature Test
 - (iv) Interpretation of clinical laboratory scores. Physician must evaluate the patient specific clinical information generated from the test and quantify it into a numerical scale. The data from the test and a separate report interpreting the results of the test must be documented.

- (b) Maximum fee when all of the services outlined in 18-5(G)(9)(a) are completed and documented.

QSART Billing Code

DoWC Z0401 QSART \$1,007.00

Z0401 may only be billed once per workers' compensation claim, regardless of the number of limbs tested.

(9) Intra-Operative Monitoring (IOM)

IOM is used to identify compromise to the nervous system during certain surgical procedures. Evoked responses are constantly monitored for changes that could imply damage to the nervous system.

(a) Clinical Services for IOM: Technical and Professional

- (i) Technical staff: A qualified specifically trained technician shall setup the monitoring equipment in the operating room and is expected to be in constant attendance in the operating room with the physical or electronic capacity for real-time communication with the supervising neurologist or other physician trained in neurophysiology. The technician shall be specifically trained/registered with:

- The American Society of Neurophysiologic Monitoring; or
- The American Society of Electrodiagnostic Technologists

(ii) Professional/Supervisory /Interpretive

A specifically neurophysiology trained Colorado licensed physician shall monitor the patient's nervous system throughout the surgical procedure. The monitoring physician's time is billed based upon the actual time the physician devotes to the individual patient, even if the monitoring physician is monitoring more than one (1) patient. The monitoring physician's time does not have to be continuous for each patient and may be cumulative. The monitoring physician shall not monitor more than three (3) surgical patients at one time. The monitoring physician shall provide constant neuromonitoring at critical points during the surgical procedure as indicated by the surgeon or any unanticipated testing responses. There must be a neurophysiology trained Colorado licensed physician backup available to continue monitoring the other two patients if one of the patients being monitored has complications and/or requires the monitoring physician's undivided attention for any reason. There is no additional payment for the back-up neuromonitoring physician, unless he/she is utilized in a specific case.

- (iii) Technical Electronic Capacity for Real-time Communication requirements

The electronic communication equipment shall use a 16-channel monitoring and minimum real-time auditory system, with the possible addition of video connectivity between monitoring staff, operating surgeon and anesthesia. The equipment must also provide for all of the monitoring modalities that may be applied with the IOM procedure code.

- (b) Procedures and Time Reporting

Physicians shall include an interpretive written report for all primary billed procedures.

- (c) Billing Restrictions

The technical component (equipment, technical certified staff) is only payable to the person who owns the equipment.

The monitoring physician is the only billing party allowed to report the intraoperative neuro-monitoring codes (95940 or 95941).

- (10) Speech Therapy/Evaluation and Treatment

Speech-language therapist/pathology or any care rendered under a speech-language therapist/pathology plan of care shall be billed with a "GN" modifier appended to all billing codes.

Reimbursement shall be according to the unit values as listed in the RBRVS, multiplied by their section's respective CF.

- (11) Vaccine and Toxoids

Shall be billed using the appropriate J code or CPT® code listed in the Medicare Part B Drug Average Sale Price (ASP), or at cost to the billing provider if no dollar value is listed in ASP.

- (12) IV Infusions Performed in Physicians' Offices or Sent Home with Patient

IV infusion therapy performed in a physician's office shall be billed under the "Therapeutic, Prophylactic, and Diagnostic Injections and Infusions" and the "Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration" in the Medicine Section of CPT®. The appropriate CPT®/RBRVS code units multiplied by the Medicine conversion factor is the Maximum Fee Schedule value for the infusion service. The infused therapeutic drugs are payable at cost to the provider's office.

Maximum fees for supplies and medications provided by a physician's office for self-administered home care infusion therapy is covered under section 18-6(M)(1).

- (13) Special Services, Procedures and Reports in the Medicine Section of CPT®
- (a) Handling and conveyance of specimens in connection with a transfer from an office to a laboratory is a flat rate of \$25.00 (CPT® codes 99000 and/or 99001). Any other handling and conveyance in connection with implementation of an order involving devices (such as orthotics) is a flat rate of \$13.00 (CPT® code 99002).
 - (b) Postoperative follow-up visit, CPT® code 99024, is included in the global package and is not separately payable.
 - (c) Educational supplies are considered “at cost” to the provider and may be billed based upon an agreement between the payer and provider (CPT® codes 99070, 99071 or 99078).
 - (d) Any stored clinical or physiological data analysis is not recognized unless the provider shows the reasonableness and necessity of these services and obtains prior authorization from the payer (CPT® codes 99090 and 99091).
 - (e) The charges for services performed after regular business hours, during holidays, or during scheduled disruptions of regular office services are not separately payable unless the provider shows the reasonableness and necessity of these services and obtains prior authorization (CPT® codes 99026, 99027, 99050, 99051, 99053, 99056, 99058, and 99060).
 - (f) Unusual travel expenses require prior authorization by the payer. The payer and billing provider shall agree upon maximum fees (CPT® code 99082).
 - (g) Medical testimony is covered under Rule 18-6(D) and special reports are covered under Rule 18-6(G)(3)&(4) (CPT® codes 99075 and 99080).

(H) PHYSICAL MEDICINE AND REHABILITATION (PM&R)

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

(1) Billing and documentation requirements:

Physical therapy or any care provided under a physical therapist's plan of care shall be billed with a “GP” modifier appended to all billed codes.

Occupational therapy or any care provided under an occupational therapist's plan of care shall be billed with a “GO” modifier appended to all billed codes.

Each PM&R billed service must be clearly identifiable. The provider must clearly document the time spent performing each billed service and the beginning and ending time for each session.

Functional objectives shall be included in the PM&R plan of care for all injured workers, in compliance with Rule 16-8. Any request for additional treatment must be supported by evidence of positive objective functional gains or PM&R treatment plan changes. The ordering PM&R ATP must also agree with the PM&R continuation or changes to the treatment plan.

(2) Prior authorization for payment (see Rule 16-10) is required for medical nutrition therapy.

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

- (4) Special Note to All Physical Medicine and Rehabilitation Providers:

The authorized treating provider shall obtain prior authorization for payment (see Rule 16-10) from the payer for any physical medicine or rehabilitation treatment not listed in or exceeding the frequency or duration recommendations in Rule 17, Medical Treatment Guidelines.

The injured worker shall be re-evaluated by the prescribing physician within 30 calendar days from the initiation of the prescribed treatment and at least once every month while that treatment continues to establish achievement of functional goals. Prior authorization for payment (see Rule 16-10) shall be required for treatment of a condition not covered under Rule 17, Medical Treatment Guidelines and exceeding 60 calendar days from the initiation of treatment.

- (5) Interdisciplinary Rehabilitation Programs – Requires Prior Authorization for Payment (see Rule 16-10).

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

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

If there is a single billing provider for the entire interdisciplinary rehabilitation program and a daily per diem rate is mutually agreed upon, use billing code Z0500.

If the individual interdisciplinary rehabilitation professionals bill separately for their participation in an interdisciplinary rehabilitation program, the applicable CPT® codes shall be used to bill for their services. Demonstrated participation in an interdisciplinary rehabilitation program allows the use of the frequencies and durations listed in the relevant Medical Treatment Guideline's recommendations.

- (6) Procedures (therapeutic exercises, neuromuscular re-education, aquatic therapy, gait training, massage, acupuncture, dry needling of trigger points, manual therapy techniques, therapeutic activities, cognitive development, sensory integrative techniques and any unlisted physical medicine procedures.)

The provider's medical records shall reflect the medical necessity and the provider shall obtain prior authorization for payment (see Rule 16-10) if the procedures are not recommended or the frequency and duration exceeds the recommendations of the Rule 17, Medical Treatment Guidelines. The maximum amount of time allowed is one (1) hour of procedures per day, per discipline; unless medical necessity is documented and prior authorization is obtained from the payer.

Unlisted procedure CPT® code 97139 value is equal to the value for therapeutic exercises.

Dry Needling of Trigger Points, Single or multiple needles,

DoWC Z0501 -	initial 15 minutes of dry needling	1.3 non-facility RVUs .77 facility RVUs
DoWC Z0502 -	each add'l 15 minutes of dry needling	.77 non-facility RVUs .72 facility RVUs

(7) Modalities

RBRVS Timed and Non-timed Modalities

Billing Restrictions: There is a total limit of two (2) modalities (whether timed or non-timed) per visit, per discipline, per day.

NOTE: Instruction and application of a transcutaneous electric nerve stimulation (TENS) unit for the patient's independent use at home shall be billed only once using CPT® code 64550. Rental or purchase of a TENS unit requires prior authorization for payment (see Rule 16-10). For Maximum Fee Schedule value, see 18-6(H).

The maximum value for any unlisted modality, CPT® code 97039, is equal to the value of ultrasound CPT® code 97035.

(8) Evaluation Services for Therapists: Physical Therapy (PT), Occupational Therapy (OT) and Athletic Trainers (ATC).

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

If a new problem or abnormality is encountered that requires a new evaluation and treatment plan, the professional may perform and bill for another initial evaluation. A new problem or abnormality may be caused by a surgical procedure being performed after the initial evaluation has been completed.

A reexamination, reevaluation, or reassessment (CPT® codes 97002, 97004, or 97006) are different from a progress note. Therapists should not bill these codes for a progress note. Therapists may bill CPT® codes 97002, 97004, or 97006 for a reevaluation only in the following cases:

- (i) Professional assessment indicates a significant improvement or decline or change in the patient's condition or a functional status that was not anticipated in the Plan of Care (POC) for that time interval.
 - (ii) New clinical findings come to light.
 - (iii) The patient fails to respond to the treatment outlined in the current POC.
- (b) PT and OT and Athletic Trainer Evaluation and Re-Evaluation RVU changes are as follows:

- (i) CPT® code 97001 PT and 97003 OT Initial Evaluation = 2.48 RVUs, facility and non-facility;
- (ii) CPT® code 97005 Athletic Trainer Initial Evaluation is 85% of the PT/OT initial evaluation service value;
- (iii) CPT® code 97002 PT and 97004 OT Re-Evaluation = 1.68 RVUs, facility and non-facility;
- (iv) CPT® code 97006 Athletic Trainer re-evaluation is 85% of the PT/OT reevaluation value.

- (c) A PT or OT may utilize a Rehabilitation Communication Form (WC196) in addition to a progress note no more than every 2 weeks for the first 6 weeks, and once every 4 weeks thereafter. The WC196 form should not be used for an evaluation, reevaluation or reassessment. The WC196 form must be completed and include which of the approved functional tools, from the Division's Quality Performance and Outcomes Payments (QPOP) list, was used for assessing the patient. The form shall be sent to the referring physician before or at the patient's follow up appointment with the physician, to aid in communication.

Billing code DoWC Z0817 - \$15.00

- (d) Payers are only required to pay for evaluation services directly performed by a PT, OT, or ATC. All evaluation notes or reports must be written and signed by the PT, OT or ATC.
- (e) A patient may be seen by more than one (1) health care professional on the same day. An evaluation service with appropriate documentation may be charged by each professional per patient, per day.
- (f) Reimbursement to PTs and OTs for coordination of care with professionals shall be based upon the telephone codes for qualified non-physician providers found in the RBRVS Medicine Section. Coordination of care reimbursement is limited to telephone calls made to outside professionals and/or to the injured worker or their family.
- (g) All interdisciplinary team conferences shall be billed in compliance with section18-5(H)(5).

(9) Special Tests

- (a) The following respective tests are considered special tests:
 - (i) Job Site Evaluation
 - (ii) Functional Capacity Evaluation
 - (iii) Assistive Technology Assessment
 - (iv) Speech
 - (v) Computer Enhanced Evaluation (DoWC Z0503)
 - (vi) Work Tolerance Screening (DoWC Z0504)

The facility and non-facility RVUs for DoWC Z0503 and DoWC Z0504 shall be 0.93.

- (b) Billing Restrictions:
 - (i) Job Site Evaluations require prior authorization for payment (see Rule 16-10) if exceeding two (2) hours. Computer-Enhanced Evaluations and Work Tolerance Screenings require prior authorization for payment for more than four (4) hours per test or more than three (3) tests per claim. Functional Capacity Evaluations require prior authorization for payment for more than four (4) hours per test or two (2) tests per claim.
 - (ii) The provider shall specify the time required to perform the test in 15-minute increments.
 - (iii) The value for the analysis and the written report is included in the code's value.
 - (iv) No E&M services or PT, OT, or acupuncture evaluations shall be charged separately for these tests.
 - (v) Data from computerized equipment shall always include the supporting analysis developed by the physical medicine professional before it is payable as a special test.
- (c) Provider Restrictions: all special tests must be fully supervised by a physician, PT, OT, speech language pathologist/therapist or audiologist. Final reports must be written and signed by the physician, PT, OT, speech language pathologist/therapist or audiologist.

(10) Supplies

Physical medicine supplies are reimbursed in accordance with section 18-6(H).

(11) Unattended Treatment

When a patient uses a facility or its equipment for unattended procedures, in an individual or a group setting, bill:

DoWC Z0505	fixed fee per day	0.232 RVU
------------	-------------------	-----------

(12) Non-Medical Facility

Fees, such as gyms, pools, etc., and training or supervision by non-medical providers require prior authorization for payment (see Rule 16-10) and a written negotiated fee.

(13) Unlisted Service Physical Medicine

All unlisted services or procedures require a report.

(14) Work Conditioning, Work Hardening, Work Simulation

- (a) Work conditioning is a non-interdisciplinary program that is focused on the individual needs of the patient to return to work. Usually one (1) discipline oversees the patient in meeting goals to return to work. Refer to Rule 17, Medical Treatment Guidelines.

Restriction: Maximum daily time is two (2) hours per day without additional prior authorization for payment (see Rule 16-10).

- (b) Work Hardening is an interdisciplinary program that uses a team of disciplines to meet the goal of employability and return to work. This type of program entails a progressive increase in the number of hours a day that an individual completes work tasks until they can tolerate a full workday. In order to do this, the program must address the medical, psychological, behavioral, physical, functional and vocational components of employability and return to work. Refer to Rule 17, Medical Treatment Guidelines.

Restriction: Maximum daily time is six (6) hours per day without additional prior authorization for payment (see Rule 16-10).

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

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

- (i) The provider shall submit a treatment plan including expected frequency and duration of treatment. If requested by the provider, the payer will prior authorize payment for the treatment plan services or shall identify any concerns including those based on the reasonableness or necessity of care.
- (ii) If the frequency and duration is expected to exceed the Medical Treatment Guidelines' recommendation, prior authorization for payment is required (see Rule 16-10).
- (iii) Provider Restrictions: All procedures must be performed by or under the onsite supervision of a physician, psychologist, PT, OT, speech language pathologist or audiologist.

- (e) Work Hardening/Conditioning/Simulation Billing codes and RVUs:

- (i) CPT® code 97545 Initial 2 hours, 3.4 RVUs
- (ii) CPT® code 97546 Each additional hour, 1.7 RVUs

(15) Wound Care

Wound care is separately payable only when devitalized tissue is debrided using a recognized method (chemical, water, vacuums). CPT® code 97602 is not recognized for payment.

(I) EVALUATION AND MANAGEMENT (E&M)

- (1) Evaluation and management codes may be billed by medical providers as defined in Rule 16-5(A)(1)(a) as well as nurse practitioners (NP) and physician assistants (PA). Medical record documentation shall encompass the "E&M Documentation Guidelines" criteria as adopted in Exhibit #7 of this Rule or Medicare's 1997 Evaluation and Management Documentation Guidelines, to justify the billed level of E&M service.

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

- (2) New or Established Patients

An E&M visit shall be billed as a "new" patient service for each "new injury" even though the provider has seen the patient within the last three (3) years. Any subsequent E&M visits are to be billed as an "established patient" and reflect the level of service indicated by the documentation when addressing all of the current injuries.

Transfer of care from one physician to another with the same tax ID and the same specialty shall be billed as an "established patient" regardless of the location.

- (3) Number of Office Visits

All providers are limited to one (1) office visit per patient, per day, per workers' compensation claim, unless prior authorization for payment is obtained (see Rule 16-10). The E&M Guideline criteria as specified in the RBRVS E&M Section shall be used in all office visits to determine the appropriate level.

- (4) Treating Physician Telephone or On-line Services

Telephone or on-line services may be billed if:

- (a) The service is performed more than one (1) day prior to a related E&M office visit, or
- (b) The service is performed more than seven (7) days following a related E&M office visit, and
- (c) The medical records/documentation specifies all the following:
 - (i) The amount of time and date;
 - (ii) The patient, family member, or healthcare provider talked to; and
 - (iii) The specifics of the discussion and/or decision made during the communication.

- (5) Face-to-Face or Telephonic Treating Physician or Qualified Non-physician Medical Team Conferences

A medical team conference can only be billed if all of the criteria are met under CPT®. A medical team conference shall consist of medical professionals caring for the injured worker. The billing statement shall be prepared in accordance with Rule 16, Utilization Standards.

- (6) Consultation/Referrals/Transfers of Care/Independent Medical Examinations

A consultation occurs when a treating physician seeks an opinion from another physician regarding a patient's diagnosis and/or treatment.

A transfer of care occurs when one physician turns over the responsibility for the comprehensive care of a patient to another physician.

An independent medical exam (IME) occurs when a physician is requested to evaluate a patient by any party or party's representative and is billed in accordance with section 18-6(G).

In order to bill for any of the inpatient or outpatient consultation codes (CPT® 99241-99255) the following criteria must be documented in the billing providers report:

- (a) Identification of the requesting physician for the opinion.
- (b) Documentation in the report supports the need for a consultant's opinion.
- (c) Identification the report was submitted to the requesting provider (either carbon copied or written directly to the requesting provider).

Outpatient Consultation RVUs:

CPT® 99241 non-facility = 2.57; facility = 2.15

CPT® 99242 non-facility = 3.77; facility = 3.18

CPT® 99243 non-facility = 4.71; facility = 3.96

CPT® 99244 non-facility = 6.39; facility = 5.57

CPT® 99245 non-facility = 8.15; facility = 7.23

Inpatient Consultation facility RVUs:

CPT® 99251 = 2.79

CPT® 99252 = 3.83

CPT® 99253 = 4.95

CPT® 99254 = 6.39

CPT® 99255 = 8.47

Subsequent Hospital RVU changes are as follows:

CPT® 99231 = 2.21 RVUs

CPT® 99232 = 3.15 RVUs

CPT® 99233 = 4.22 RVUs

- (7) When billing for prolonged services, either face-to-face or non-face-to-face, the provider shall provide a report that documents time distinguishable from the E&M visit.

(J) TELEHEALTH

- (1) "Telehealth" is defined in Rule 16-2(X). All healthcare services provided through telehealth shall comply with the applicable requirements found in the Colorado Medical Practice Act and Colorado Mental Health Practice Act, as well as the rules and policies adopted by the Colorado Medical Board and the Colorado State Board of Psychologist Examiners.

- (2) Telehealth facilities can bill for the originating fee as follows:

Q3014 \$35.00 /per 15 minutes

A private residence at which an injured worker is located when he or she is receiving healthcare services through telehealth may not bill for the originating fee.

- (3) HIPAA privacy and electronic security standards are required for both the originating site and the rendering providers.
- (a) Protecting patient health information, and patient / client decision making and consent are vital.
 - (b) Policies and procedures need to be in place to protect the electronic security of data, and the physical security of telehealth equipment so that patient health information is protected.
 - (c) Compliance with accreditation requirements, regulations, and relevant legislation is necessary.
 - (d) Health professionals providing telehealth services shall be fully licensed, registered, and credentialed by the appropriate governing agency.
- (4) All telehealth procedures are required to be at an originating site that is deemed appropriate with the appropriate HIPAA privacy and electronic security standards in place. The originating site is responsible for establishing and verifying injured worker and provider identity. Authorized originating sites include:
- (a) The office of a physician or practitioner
 - (b) A hospital (inpatient or outpatient)
 - (c) A critical access hospital (CAH)
 - (d) A rural health clinic (RHC)
 - (e) A federally qualified health center (FQHC)

- (f) A hospital based or critical access hospital based renal dialysis center (including satellites)
 - (g) A skilled nursing facility (SNF)
 - (h) A community mental health center (CMHC)
- (5) The physician-patient / psychologist-patient relationship needs to be established.
 - (a) This relationship is established through assessment, diagnosis and treatment of the patient. Two way live audio / video services are among acceptable methods to 'establish' a patient relationship.
 - (b) Physicians / psychologists need to meet standard of care.
 - (c) The patient is required to provide the appropriate consent for treatment.
- (6) Payment for telehealth services from distant site practitioners
 - (a) The medical providers shall bill codes G0425-G0427 for telehealth consultations, emergency department or initial inpatient. The maximum fee values are determined by multiplying the RBRVS RVUs and the E&M conversion factor listed in Rule 18-4.
 - (b) The medical providers shall bill codes G0406-G0408 for follow up inpatient telehealth consultations. The maximum fee values are determined by multiplying the RBRVS RVUs and the E&M conversion factor listed in Rule 18-4.
 - (c) For all telehealth services, the provider shall bill the appropriate RBRVS CPT® code with the GT modifier. Reimbursement is the RVU value for the CPT® code times the appropriate CF + \$5.00 when modifier GT is appended to the appropriate CPT® code(s).

GT – Attached to the distance (rendering) provider billed CPT® or HCPCS indicates the service was performed via telehealth. Using the modifier certifies that the patient was present at an eligible originating site when the telehealth service was furnished.

18-6 DIVISION ESTABLISHED CODES AND VALUES

(A) FACE-TO-FACE OR TELEPHONIC MEETINGS

- (1) Face-to-face or telephonic meeting by a treating physician with the employer, claim representatives, or any attorney, and with or without the injured worker. Claim representatives may include physicians or qualified medical personnel performing payer-initiated medical treatment reviews, but this code does not apply to requests initiated by a provider for prior authorization for payment (see Rule 16-10).

Before the meeting is separately payable, the following requirements must be met:

- (a) Each meeting shall be at a minimum 15 minutes.
- (b) A report or written record signed by the physician is required and shall include the following:

- (i) Who was present at the meeting and their role at the meeting;
- (ii) Purpose of the meeting;
- (iii) A brief statement of recommendations and actions at the conclusion of the meeting;
- (iv) Documented time (both start and end times); and
- (v) Billing code DoWC Z0701.

\$75.00 per 15 minutes for time attending the meeting and preparing the report (no travel time or mileage is separately payable). The fee includes the cost of the report for all parties, including the injured worker.

- (2) Face -to-face or telephonic meeting by a non-treating physician with the employer, claim representatives or any attorney in order to provide a medical opinion on a specific workers' compensation case, which is not accompanied by a specific report or written record.

Billing Code DoWC Z0601: \$65.00 per 15 minutes billed to the requesting party.

- (3) Face-to-face or telephonic meeting by a non-treating physician with the employer, claim representatives or any attorney in order to provide a medical opinion on a specific workers' compensation case, which is accompanied by a report or written record, shall be billed as a special report (see section 18-6(G)(4)).

(B) CANCELLATION FEES FOR PAYER-MADE APPOINTMENTS

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

One-half of the usual fee for the scheduled services, or \$150.00, whichever is less.

Cancellation Fee Billing Code: DoWC Z0720

- (2) Missed Appointments:

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

(C) COPYING FEES

The payer, payer's representative, injured worker and injured worker's representative shall pay a reasonable fee for the reproduction of the injured worker's medical record. If the requester and provider agree, the copy may be provided on a disc. If the requester and provider agree and appropriate security is in place, including, but not limited to, compatible encryption, the copies may be submitted electronically. Requester and provider should attempt to agree on a reasonable fee. Absent an agreement to the contrary, the fee shall be \$0.10 per page.

Copying charges do not apply for the initial submission of records that are part of the required documentation for billing.

Copying Fee Billing Codes and Maximum Fees:

DoWC Z0721 - \$18.53 for first 10 or fewer paper page(s)

DoWC Z0725 - \$0.85 per paper page for the next 11-40 paper page(s)

DoWC Z0726 - \$0.57 per paper page for remaining paper page(s)

DoWC Z0727 - \$1.50 per microfilm page

DoWC Z0728 - \$14.00 per computer disc or as agreed

DoWC Z0729 - \$0.10 per electronic page or as agreed

DoWC Z0802 – actual postage paid

(D) DEPOSITION AND TESTIMONY FEES

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

If, in an individual case, a party can show good cause to an Administrative Law Judge (ALJ) for exceeding the Maximum Fee Schedule value, that ALJ may allow a greater fee than listed in section 18-6(D) for that case.

- (2) By prior agreement, the provider may charge for preparation time for a deposition, for reviewing and signing the deposition or for preparation time for testimony.

Preparation Time:

Treating or Non-treating Provider: DoWC Z0730 \$325.00 per hour

- (3) Deposition:

Payment for a treating or non-treating provider's testimony at a deposition shall not exceed \$325.00 per hour, billed in half-hour increments. Calculation of the provider's time shall be "portal to portal."

If requested, the provider is entitled to a full hour deposit in advance in order to schedule the deposition.

If the provider is notified of the cancellation of the deposition at least seven (7) business days prior to the scheduled deposition, the provider shall be paid the number of hours s/he has reasonably spent in preparation and shall refund to the deposing party any portion of an advance payment in excess of time actually spent preparing and/or testifying. Bill using code DoWC Z0731.

If the provider is notified of the cancellation of the deposition at least five (5) business days but less than seven (7) business days prior to the scheduled deposition, the provider shall be paid the number of hours s/he has reasonably spent in preparation and one-half the time scheduled for the deposition. Bill using code DoWC Z0732.

If the provider is notified less than five (5) business days in advance of a cancellation, or the deposition is shorter than the time scheduled, the provider shall be paid the number of hours s/he has reasonably spent in preparation and has scheduled for the deposition. Bill using code DoWC Z0733.

Deposition:

Treating or Non-treating provider: DoWC Z0734 \$325.00 per hr.

Billed in half-hour increments

(4) Testimony:

Calculation of the provider's time shall be "portal to portal" (includes travel time and mileage in both directions).

For testifying at a hearing, if requested, the provider is entitled to a four (4) hour deposit in advance in order to schedule the testimony.

If the provider is notified of the cancellation of the testimony at least seven (7) business days prior to the scheduled testimony, the provider shall be paid the number of hours s/he has reasonably spent in preparation and shall refund any portion of an advance payment in excess of time actually spent preparing and/or testifying. Bill using code DoWC Z0735.

If the provider is notified of the cancellation of the testimony at least five (5) business days but less than seven (7) business days prior to the scheduled testimony, the provider shall be paid the number of hours s/he has reasonably spent in preparation and one-half the time scheduled for the testimony. Bill using code DoWC Z0736.

If the provider is notified of a cancellation less than five (5) business days prior to the date of the testimony or the testimony is shorter than the time scheduled, the provider shall be paid the number of hours s/he has reasonably spent in preparation and has scheduled for the testimony. Bill using code DoWC Z0737.

Testimony:

Treating or Non-treating provider: DoWC Z0738 \$450.00 per hour

(E) INJURED WORKER TRAVEL EXPENSES

The payer shall pay an injured worker for reasonable and necessary expenses for travel to and from medical appointments and reasonable mileage to obtain prescribed medications. The rate for mileage shall be 53 cents per mile. The injured worker shall submit a request to the payer showing the date(s) of travel and mileage, with an explanation for any other reasonable and necessary travel expenses incurred or anticipated.

Mileage Expense Billing Code: DoWC Z0723

Other Travel Expenses Billing Code: DoWC Z0724

(F) PERMANENT IMPAIRMENT RATING

- (1) The payer is only required to pay for one (1) combined whole-person permanent impairment rating per claim, except as otherwise provided in the Workers' Compensation Rules of Procedures. Exceptions that may require payment for an additional impairment rating include, but are not limited to, reopened cases, as ordered by the Director or an Administrative Law Judge, or a subsequent request to review apportionment. The authorized treating provider is required to submit in writing all permanent restrictions and future maintenance care related to the injury or occupational disease.

(2) Provider Restrictions

The permanent impairment rating shall be determined by the Level II Accredited Authorized Treating Physician (see Rule 5-5(D)).

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

If a physician determines the injured worker is at MMI and has no permanent impairment, the physician should be reimbursed for the examination at the appropriate level of E&M service, as defined in the RBRVS. The authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient should complete the Physician's Report of Workers' Compensation Injury (Closing Report), WC164 (see section 18-6(G)(2)).

(4) MMI Determined with a Calculated Permanent Impairment Rating

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

Extensive medical records take longer than one (1) hour to review and a separate report is created. The separate report must document each record reviewed, specific details of the record reviewed and the dates represented by the record(s) reviewed. The separate record review can be billed under special reports for written reports only and requires prior authorization and agreement from the payer for the separate record review fees.

- (b) Use the appropriate DoWC code:

- (i) Fee for the Level II Accredited Authorized Treating Physician Providing Primary Care:
Bill DoWC Z0759 \$355.00.
- (ii) Fee for the Referral, Level II Accredited Authorized Physician:
Bill DoWC Z0760 \$575.00.
- (iii) A return visit for a range of motion (ROM) validation shall be reimbursed using the appropriate separate procedure CPT® code in the medicine section of the RBRVS.
- (iv) Fee for a Multiple Impairment Evaluation Requiring More Than One Level II Accredited Physician:

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

(G) REPORT PREPARATION

(1) Routine Reports

Providers shall submit routine reports free of charge as directed in Rule 16-7(E) and by statute. Requests for additional copies of routine reports and for reports not in Rule 16-7(E) or in statute are reimbursable under the copying fee section of this Rule. Routine reports include:

- (a) Diagnostic testing
- (b) Procedure reports
- (c) Progress notes
- (d) Office notes
- (e) Operative reports
- (f) Supply invoices, if requested by the payer

(2) Completion of the Physician's Report of Workers' Compensation Injury (WC164)

(a) Initial Report

The authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient completes the initial WC164 and submits it to the payer and to the injured worker after the first visit with the injured worker. When applicable, the emergency department or urgent care authorized treating physician for this workers' compensation injury may also create a WC164 initial report. Unless requested or prior authorized by the payer in a specific workers' compensation claim, no other authorized physician should complete and bill for the initial WC164 form. This form shall include completion of items 1-7 and 10. Note that certain information in Item 2 (such as Insurer Claim #) may be omitted if not known by the provider.

(b) Closing Report

The WC164 closing report is required from the authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient when the injured worker is at maximum medical improvement for all injuries or diseases covered under this workers' compensation claim, with or without a permanent impairment. The form requires the completion of items 1-5, 6 b-c, 7, 8 and 10. If the injured worker has sustained a permanent impairment, then item 9 must be completed and the following additional information shall be attached to the bill at the time MMI is determined:

- (i) All necessary permanent impairment rating reports, medical reports and narrative relied upon by the authorized treating physician (ATP), when the ATP (generally the designated or selected physician) managing the total workers' compensation claim of the patient is Level II Accredited, or
 - (ii) The name of the Level II Accredited Physician requested to perform the permanent impairment rating when a rating is necessary and the ATP (generally the designated or selected physician) managing the total workers' compensation claim of the patient is not determining the permanent impairment rating.
- (c) Payer Requested WC164 Report

If the payer requests a provider complete the WC164 report, the payer shall pay the provider for the completion and submission of the completed WC164 report.
- (d) Provider Initiated WC164 Report

If a provider wants to use the WC164 report as a progress report or for any purpose other than those designated in section 18-6(G)(2)(a), (b) or (c), and seeks reimbursement for completion of the form, the provider shall get prior approval from the payer.
- (e) Billing Codes and Maximum Allowance for completion and submission of WC164 report

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

DoWC Z0750 \$47.00 Initial Report

DoWC Z0751 \$47.00 Progress Report (Payer Requested or Provider Initiated)

DoWC Z0752 \$47.00 Closing Report

DoWC Z0753 \$47.00 Initial and Closing Reports are completed on the same form for the same date of service
- (3) Request for physicians to complete additional forms sent to them by a payer or employer shall be paid by the requesting party. A form requiring 15 minutes or less of a physician's time shall be billed pursuant to (a) and (b) below. Forms requiring more than 15 minutes shall be paid as a special report.
 - (a) Billing Code Z0754
 - (b) Maximum fee is \$47.00 per form completion

(4) Special Reports

Description: The term special reports includes reports not otherwise addressed under Rule 16, Utilization Standards, Rule 17, Medical Treatment Guidelines and Rule 18, including any form, questionnaire or letter with variable content. This includes, but is not limited to, independent medical evaluations (Z0756, Z0770 and Z0768) or reviews when the physician is requested to review files and examine the patient to provide an opinion for the requesting party, performed outside C.R.S. §8-42-107.2 (the Division IME process) and treating or non-treating medical reviewers or evaluators producing written reports pertaining to injured workers not otherwise addressed. Special reports also include payment for meeting, reviewing another's written record, and amending or signing that record (see section 18-5(l)(8)). Reimbursement for preparation of special reports or records shall require prior agreement with the requesting party.

Billable Hours: Because narrative reports may have variable content, the content and total payment shall be agreed upon by the provider and the report's requester before the provider begins the report.

Advance Payment: If requested, the provider is entitled to a two (2) hour deposit in advance in order to schedule any patient exam associated with a special report.

Cancellation:

Written Reports Only: In cases of cancellation for those special reports not requiring a scheduled patient exam, the provider shall be paid for the time s/he has reasonably spent in preparation up to the date of cancellation. Bill the cancellation using DoWC code Z0761.

IME/report with patient exam: In cases of special reports requiring a scheduled patient exam, if the provider is notified of a cancellation at least seven (7) business days prior to the scheduled patient exam, the provider shall be paid for the time s/he has reasonably spent in preparation and shall refund to the party requesting the special report any portion of an advance payment in excess of time actually spent preparing. Bill the cancellation using DoWC code Z0762.

In cases of special reports requiring a scheduled patient exam, if the provider is notified of a cancellation at least five (5) business days but less than seven (7) business days prior to the scheduled patient exam, the provider shall be paid for the time s/he has reasonably spent in preparation and one-half the time scheduled for the patient exam. Any portion of a deposit in excess of this amount shall be refunded. Bill the cancellation using DoWC code Z0763.

In cases of special reports requiring a scheduled patient exam, if the provider is notified of a cancellation less than five (5) business days prior to the scheduled patient exam, the provider shall be paid for the time s/he has reasonably spent in preparation and has scheduled for the patient exam. Bill the cancellation using DoWC code Z0764.

Billing Codes:

Written Report Only DoWC Code: Z0755

Respondent requested Independent Medical Examination (RIME)/Report with patient exam DoWC Code: Z0756

CRS 8-43-404 requires RIMEs to be recorded in audio in their entirety and retained by the examining physician until requested by any party.

IME Audio Recording DoWC Code: Z0766 \$30.00 per exam

IME Audio copying fee DoWC Code: Z0767 \$20.00 per copy

Claimant requested Independent Medical Examination (CIME)/Report with patient exam DoWC Code: Z0770

Division Independent Medical Examination (DIME)/Report with patient exam DoWC Code: Z0768

IME Fees are established in Rule 11.

Lengthy Form Completion DoWC Code: Z0757

18-5(l)(8) meeting and report with Non-treating Physician DoWC Code: Z0758

Special Report Maximum Fees: \$325.00 per hour billed in 15- minute increments.

(H) SUPPLIES, DURABLE MEDICAL EQUIPMENT, ORTHOTICS AND PROSTHESES

- (1) Supplies necessary to perform a service or procedure are considered inclusive and not separately reimbursable. Only supplies that are not an integral part of a service or procedure are considered to be over and above those usually included in the service or procedure.

- (2) Unless other limitations exist in this Rule, medical professionals shall bill supplies, including "Supply et al.," orthotics, prostheses, durable medical equipment (DME) or drugs, including injectables, using Medicare's HCPCS Level II codes, when one exists, as established in the January 2016 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) schedule for rural (R) or non-rural (NR). Rural is identified in Medicare's DME Rural Zip and Formats file on their website or the January 2016 Medicare's Part B Drug Average Sale Price (ASP). Otherwise, the billing provider shall identify their cost by submitting a copy of their invoice with their bill. The DMEPOS schedule can be found at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html>. The Medicare Part B Drug Average Sale Price (ASP) fees can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html?redirect=/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp

Maximum fees for any orthotic created using casting materials shall be billed using Medicare's Q codes and values listed under Medicare's DMEPOS fee schedule for Colorado. The therapist time necessary to create the orthotic shall be billed using CPT® code 97760.

- (3) Payers shall pay medical professionals using Medicare's January 2016 DMEPOS Colorado HCPCS Level II maximum fee values or Medicare's Part B Drug ASP values listed for the codes billed. If no code exists, the payer shall pay 120% of the cost for the item as indicated on the provider's invoice. Payers shall not recognize the KE modifier.
- (4) Unless other limitations exist in this Rule, DMEPOS suppliers shall be reimbursed using Medicare's HCPCS Level II codes, when one exists, as established in the January 2016 DMEPOS schedule. Otherwise, the supplier shall be reimbursed at 100% of Colorado Medicaid's January 2016 fee schedule. The Colorado Medicaid Fee Schedule can be found at: <https://www.colorado.gov/hcpf/provider-rates-fee-schedule>. If no Medicare or Medicaid fee schedule value exists, payers shall reimburse Suppliers the published Manufacturers Suggested Retail Price (MSRP), the item will be reimbursed at MSRP less 20%. If there is no established fee schedule value or MSRP, reimbursement shall be based on 120% of the cost of the item as indicated on the supplier's invoice. Shipping and handling charges are not separately payable.
- (5) The payer shall not pay for rental fees once the purchase price of the rented item has been reached. When the item is purchased, all rental fees shall be deducted from the purchase price.
- (6) Reimbursement of supplies to facilities shall be in compliance with sections 18-6 (I) – (O).
- (7) Payment for professional services associated with the fabrication and/or modification of orthotics, custom splints, adaptive equipment, and/or adaptation and programming of communication systems and devices shall be paid in accordance with the Colorado Medicare HCPCS Level II values.
- (8) Take home exercise supplies with a total cost of \$50 or less may be billed without an invoice at a maximum fee of actual billed charges; however, payers reserve the right to request an invoice, at any time, to validate the provider's cost. Home exercise supplies can include, but are not limited to the following items: therabands, theratubes, band/tube straps, theraputty, bow-tie tubing, fitness cables/trainers, overhead pulleys, exercise balls, cuff weights, dumbbells, ankle weight bands, wrist weight bands, hand squeeze balls, flexbars, digiflex hand exercisers, power webs, plyoballs, spring hand grippers, hand helper rubber band units, ankle stretchers, rocker boards, balance paws, and aqua weights.
- (9) Complex Rehabilitation Technology dispensed and billed by Non-Physician DMEPOS Suppliers
 - (a) Complex rehabilitation technology (CRT) items, including products such as complex rehabilitation power wheelchairs, highly configurable manual wheelchairs, adaptive seating and positioning systems, and other specialized equipment, such as standing frames and gait trainers, enable individuals to maximize their function and minimize the extent and costs of their medical care.
 - (b) Complex Rehabilitation Technology products must be provided by suppliers who are specifically accredited by a Center for Medicare and Medicaid Services (CMS) deemed accreditation organization as a supplier of CRT and licensed as a DMEPOS Supplier with the Colorado Secretary of State.
 - (c) CRT shall be reimbursed as set out in section 18-6(H)(4).

(I) INPATIENT HOSPITAL FACILITY FEES

(1) Provider Restrictions

All non-emergency, inpatient admissions require prior authorization for payment (see Rule 16-10).

(2) Bills for Services

(a) Inpatient hospital facility fees shall be billed on the UB-04 and require summary level billing by revenue code. The provider must submit itemized bills along with the UB-04.

(b) The maximum inpatient facility fee is determined by applying the Center for Medicare and Medicaid Services (CMS) "Medicare Severity Diagnosis Related Groups" (MS-DRGs) classification system in effect at the time of discharge. Exhibit #1 of this Rule shows the relative weights per MS-DRGs that are used in calculating the maximum allowance.

The hospital shall indicate the MS-DRG code number FL 71 of the UB-04 billing form and maintain documentation on file showing how the MS-DRG was determined. The hospital shall determine the MS-DRG using the MS-DRGs Definitions Manual in effect at the time of discharge. The attending physician shall not be required to certify this documentation unless a dispute arises between the hospital and the payer regarding MS-DRG assignment. The payer may deny payment for services until the appropriate MS-DRG code is supplied.

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

(d) Any inpatient admission requiring the use of both an acute care hospital (admission/discharge) and its Medicare certified rehabilitation facility (admission/discharge) is considered as one (1) admission and MS-DRG. This does not apply to long term care and licensed rehabilitation facilities.

(3) Inpatient Facility Reimbursement:

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

- (i) Children's hospitals
- (ii) Veterans' Administration hospitals
- (iii) State psychiatric hospitals

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

- (i) Medicare certified Critical Access Hospitals (CAH) (listed in Exhibit #3 of this Rule)
- (ii) Colorado Department of Public Health and Environment (CDPHE) licensed rehabilitation facilities,
- (iii) CDPHE licensed psychiatric facilities that are privately owned.
- (iv) CDPHE licensed skilled nursing facilities (SNF).

(c) Medicare Long Term Care Hospitals (MLTCH)

MLTCHs are reimbursed at \$3,200 per day, not to exceed 75% of billed charges. If total billed charges exceed \$300,000, reimbursement shall be at 75% of billed charges. All charges shall be submitted on a final bill and no interim bills are payable.

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

Retrieve the relative weights for the assigned MS-DRG from the MS-DRG table in effect at the time of discharge in Exhibit #1 of this Rule and locate the hospital's base rate in Exhibit #2 of this Rule.

The "Maximum Fee Allowance" is determined by calculating:

- (i) (MS-DRG Relative Wt x Specific hospital base rate x 185%) + (trauma center activation allowance) + (organ acquisition, when appropriate).
- (ii) For trauma center activation allowance, (revenue codes 680-685) see section 18-6(J)(6)(b)5).
- (iii) For organ acquisition allowance, (revenue codes 810-819) see section 18-6(I)(3)(h).

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

- (i) Determine the "Hospital's Cost":
Total billed charges (excluding any trauma center activation or organ acquisition billed charges) multiplied by the hospital's cost-to-charge ratio.
- (ii) Each hospital's cost-to-charge ratio is given in Exhibit #2 of this Rule.
- (iii) The "Difference" = "Hospital's Cost" – "Maximum Fee Allowance" excluding any trauma center activation or organ acquisition allowance (see (c) above).
- (iv) If the "Difference" is greater than \$23,570.00, additional reimbursement is warranted. The additional reimbursement is determined by the following equation:

$$\text{"Difference"} \times .80 = \text{additional fee allowance}$$

(f) Inpatient combined with Emergency Department (ED), Trauma Center or organ acquisition reimbursement.

- (i) If an injured worker is admitted to the hospital, the ED reimbursement is included in the inpatient reimbursement under section 18-6 (I)(3),
- (ii) Trauma Center activation fees (see section 18-6(J)(6)(b)5)) and organ acquisition allowance (see section 18-6(I)(3)(h)) are paid in addition to inpatient fees (see sections 18-6(I)(3)(c-d)).

- (g) If an injured worker is admitted to one hospital and is subsequently transferred to another hospital, the payment to the transferring hospital will be based upon a per diem value of the MS-DRG maximum value. The per diem value is calculated based upon the transferring hospital's MS-DRG relative weight multiplied by the hospital's specific base rate (Exhibit #2 of this Rule) divided by the MS-DRG geometric mean length of stay (Exhibit #1 of this Rule). This per diem amount is multiplied by the actual LOS. If the patient is admitted and transferred on the same day, the actual LOS equals one (1). The receiving hospital shall receive the appropriate MS-DRG maximum value.
- (h) To comply with Rule 16-6(B), the payer shall compare each billed charge type:
 - (i) The MS-DRG adjusted billed charges to the MS-DRG allowance (including any outlier allowance);
 - (ii) The trauma center activation billed charge to the trauma center activation allowance; and
 - (iii) The organ acquisition charges to the organ acquisition maximum fees
 - (iv) under section 18-6(I)(3)(h).

The MS-DRG adjusted billed charges are determined by subtracting the trauma center activation billed charges and the organ acquisition billed charges from the total billed charges. The final payment is the sum of the lesser of each of these comparisons.

- (i) The organ acquisition allowance will be calculated using the most recent filed computation of organ acquisition costs and charges for hospitals which are certified transplant centers (CMS Worksheet D-4 or subsequent form) plus 20%.

(J) OUTPATIENT HOSPITAL FACILITY FEES

(1) Provider Restrictions

- (a) All non-emergency outpatient surgeries require prior authorization for payment (see Rule 16-10).
- (b) A separate facility fee is only payable if the location of where the services are provided is licensed as a hospital, or ASC for surgical episodes, by the Colorado Department of Public Health and Environment (CDPHE) or applicable out of state governing agency and statute.

(2) Types of Bills for Service

- (a) Outpatient facility fees shall be billed on the UB-04 and require summary level billing by revenue code. The provider must submit itemized bills along with the UB-04.
- (b) All professional charges (professional services include, but are not limited to, PT/OT, anesthesia, speech therapy, etc.) are subject to the RBRVS and Dental Fee Schedules as incorporated by this Rule and applicable to all facilities regardless of whether the facility fees are based upon Exhibit #4 of this Rule or a percentage of billed charges.

- (c) Outpatient hospital facility bills include all outpatient surgery, ED, Clinics, Urgent Care (UC) and diagnostic testing in the Radiology, Pathology or Medicine section of CPT®/RBRVS.
- (3) Outpatient Facility Reimbursement:
 - (a) The following types of outpatient facilities are reimbursed at 100% of billed outpatient charges, except for any associated professional fees (see (J)(2)(b) above):
 - (i) Children's hospitals
 - (ii) Veterans' Administration hospitals
 - (iii) State psychiatric hospitals
 - (b) The CAHs listed in Exhibit #3 to this Rule are reimbursed at 80% of billed outpatient facility charges, except for any associated professional fees.
 - (c) Exhibit #4 to this Rule:

Hospital reimbursement is based upon Medicare's 2016 Outpatient Prospective Payment System (OPPS) as modified in Exhibit #4 of this Rule. Exhibit #4 lists Medicare's Outpatient Hospital Ambulatory Prospective Payment (APC) Codes and the Division's established rates for hospitals and other types of providers as follows:

 - (i) Column 1 lists the APC code number.
 - (ii) Column 2 lists APC code description.
 - (iii) Column 3 is used to determine maximum fees for all hospital facilities not listed under sections 18-6(J)(3)(a) and (b).
 - (iv) Column 4 is used to determine maximum fees for all Ambulatory Surgery Centers (ASC) when outpatient surgery is performed in an ASC.

To identify which APC grouper is aligned with an Exhibit #4 APC code # and dollar value, use Medicare's 2016 Addendum B. Spinal fusion CPT® codes listed with a "C" status indicator in Medicare's Addendum B, shall have an equivalent value no greater than APC 5123.
- (4) The APC Exhibit #4 values include the services and revenue codes listed below, therefore, these are generally not separately payable. Drugs and devices having a status indicator of G and H receive a pass-through payment. In some instances, the procedure code may have an APC code assigned. These are separately payable based on APC values if given in Exhibit #4 or cost to the facility.
 - (a) nursing, technician, and related services;
 - (b) use of the facility where the surgical procedure(s) was performed;
 - (c) drugs and biologicals for which separate payment is not allowed;
 - (d) medical and surgical supplies, durable medical equipment and orthotics not listed as a "pass through";
 - (e) surgical dressings;
 - (f) equipment;

- (g) splints, casts and related devices;
- (h) radiology services when not allowed under Exhibit #4;
- (i) administrative, record keeping and housekeeping items and services;
- (j) materials, including supplies and equipment for the administration and monitoring of anesthesia;
- (k) supervision of the services of an anesthetist by the operating surgeon; and
- (l) post-operative pain blocks.
- (m) implanted items.

Packaged Services	
Revenue Code	Description
0250	Pharmacy; General Classification
0251	Pharmacy; Generic Drugs
0252	Pharmacy; Non-Generic Drugs
0254	Pharmacy; Drugs Incident to Other Diagnostic Services
0255	Pharmacy; Drugs Incident to Radiology
0257	Pharmacy; Non-Prescription
0258	Pharmacy; IV Solutions
0259	Pharmacy; Other Pharmacy
0260	IV Therapy; General Classification
0261	IV Therapy; Infusion Pump
0262	IV Therapy; IV Therapy/Pharmacy Services
0263	IV Therapy; IV Therapy/Drug/Supply Delivery
0264	IV Therapy; IV Therapy/Supplies
0269	IV Therapy; Other IV Therapy
0270	Medical/Surgical Supplies and Devices; General Classification
0271	Medical/Surgical Supplies and Devices; Non-sterile Supply
0272	Medical/Surgical Supplies and Devices; Sterile Supply
0275	Medical/Surgical Supplies and Devices; Pacemaker
0276	Medical/Surgical Supplies and Devices; Intraocular Lens
0278	Medical/Surgical Supplies and Devices
0279	Medical/Surgical Supplies and Devices
0280	Oncology; General Classification
0289	Oncology; Other Oncology
0343	Nuclear Medicine; Diagnostic Radiopharmaceuticals
0344	Nuclear Medicine; Therapeutic Radiopharmaceuticals
0370	Anesthesia; General Classification
0371	Anesthesia; Anesthesia Incident to Radiology
0372	Anesthesia; Anesthesia Incident to Other DX Services
0379	Anesthesia; Other Anesthesia
0390	Administration, Processing and Storage for Blood and Blood Components; General Classification
0392	Administration, Processing and Storage for Blood and Blood Components; Processing and Storage
0399	Administration, Processing and Storage for Blood and Blood Components; Other Blood Handling

Packaged Services	
Revenue Code	Description
0621	Medical Surgical Supplies - Extension of 027X; Supplies Incident to Radiology
0622	Medical Surgical Supplies - Extension of 027X; Supplies Incident to Other DX Services
0623	Medical Supplies - Extension of 027X, Surgical Dressings
0624	Medical Surgical Supplies - Extension of 027X; FDA Investigational Devices
0630	Pharmacy - Extension of 025X; Reserved
0631	Pharmacy - Extension of 025X; Single Source Drug
0632	Pharmacy - Extension of 025X; Multiple Source Drug
0633	Pharmacy - Extension of 025X; Restrictive Prescription
0700	Cast Room; General Classification
0710	Recovery Room; General Classification
0720	Labor Room/Delivery; General Classification
0721	Labor Room/Delivery; Labor
0732	EKG/ECG (Electrocardiogram); Telemetry
0821	Hemodialysis-Outpatient or Home; Hemodialysis Composite or Other Rate
0824	Hemodialysis-Outpatient or Home; Maintenance - 100%
0825	Hemodialysis-Outpatient or Home; Support Services
0829	Hemodialysis-Outpatient or Home; Other OP Hemodialysis
0942	Other Therapeutic Services (also see 095X, an extension of 094x); Education/Training
0943	Other Therapeutic Services (also see 095X, an extension of 094X), Cardiac Rehabilitation
0948	Other Therapeutic Services (also see 095X, an extension of 094X), Pulmonary Rehabilitation

- (5) Recognized Status Indicators from Medicare's Addendum B are applied as follows:
- (a) "A" means use another fee schedule instead of Exhibit #4, i.e., 18-4 Conversion Factors and RBRVS RVUs, 18-6(R) Ambulance Fee Schedule, or Exhibit #8.
 - (b) "B" means it is not recognized by Medicare for Outpatient Hospital services Part B bill type (12x and 130x) and therefore is not separately payable unless separate fees are applicable under another section of this Rule, such as home health.
 - (c) "C" means recognized by Medicare as inpatient only procedures; however, the Division does recognize these procedures can be done outpatient if prior authorization is obtained per Rule 16-10.
 - (d) "D" means discontinued code and not paid under OPPS by Medicare. Therefore, this code is not separately payable in OPPS by DoWC.
 - (e) "E" means not paid by Medicare when submitted on any outpatient bill type. However, services could still be reasonable and necessary, thus requiring hospital or ASC level of care. The billing party shall submit documentation to substantiate the billed service codes and any similar established codes with fees in Exhibit #4.
 - (f) "F" means corneal tissue acquisition and certain CRNA services and Hepatitis A vaccines are allowed at a reasonable cost to the facility. The facility must provide a separate invoice identifying their cost.
 - (g) "G" means "Pass-Through Drugs and Biologicals" that are separately payable under Exhibit #4 as an APC value.

- (h) "H" means a "Pass-Through Device" that is separately payable based upon cost to the facility.
 - (i) "J1" or "J2" means the services are paid through a "comprehensive APC" for Medicare. However, the DoWC has not adopted the "comprehensive APC." Therefore, an agreement between the payer and the provider is necessary to implement "comprehensive APCs."
 - (j) "K" means a separately payable "Pass-Through Drug or Biological or Device," for therapeutic radiopharmaceuticals, brachytherapy sources, blood and blood products as listed under Exhibit #4's APC value.
 - (k) "L" represents Influenza Vaccine and therefore, is generally not considered workers' compensation related.
 - (l) Any "Packaged Codes" with Q1, Q2, Q3, Q4 or STVX combinations are not recognized unless the payer and provider make a prior agreement.
 - (m) "M" means not separately payable.
 - (n) "N" means the service is bundled and is not separately payable.
 - (o) "P" means partial hospitalization and is paid based upon observation fees as outlined in section 18-6(J).
 - (p) "R" means separate payment for blood and blood products under Exhibit #4 APC value.
 - (q) "S" and "T" mean there are multiple procedures, the highest valued code allowed at 100% of the Exhibit #4 value and up to three (3) additional codes allowed at 50% of the Exhibit #4 value, per episode of care.
 - (r) "U" means brachytherapy source and is separately payable under Exhibit #4 APC value.
 - (s) "V" represents a clinic or Emergency Department visit and is separately payable for hospitals as specified in section 18-6(J).
 - (t) "Y" represents non-implantable Durable Medical Equipment and is paid according to Medicare's Durable Medical Equipment Regional Carrier (DMERC) fee schedule for Colorado.
- (6) Total maximum facility value for an outpatient hospital episode of care includes:
- (a) The highest valued CPT® code aligned to APC code per Exhibit #4 plus 50% of any lesser-valued CPT® code aligned APC code values.
- Facility fee reimbursement is limited to a maximum of four (4) CPT® procedure codes per episode, with a maximum of only one (1) procedure reimbursed at 100% of the allowed Exhibit #4 value for the type of facility:
- (i) Hospitals are reimbursed based upon Column 3.
 - (ii) ASCs are reimbursed based upon Column 4.

- (b) Hospitals billing type "A" or "B" Emergency Department (ED) visits shall meet one of the following hospital licensure and billing criteria:
- (i) The EDs must be physically located within a hospital licensed by the CDPHE as a general hospital or meet the out-of-state facility's state's licensure requirements and billed using revenue code 450 with level of care CPT® codes 99281-99285; or
 - (ii) A free-standing type "B" ED, must have equivalent operations and staffing as a licensed ED, must be physically located inside of a hospital, and meet Emergency Medical Treatment and Active Labor Act (EMTALA) regulations. All type "B" outpatient ED visits must be billed using revenue code 456 with level of care HCPCS codes G0380-G0384, even though the facility may not be open 24/7;
- (c) Emergency Department (ED) level of care criteria includes:
- (i) The ED "Level of Care" is identified based upon one (1) of five (5) levels of care for either a type "A" (CPT® 99281-99285, 99291 or 99292) or type "B" (G0380-G0384) ED visit. The level of care is defined by CPT® E&M definitions and internal level of care guidelines developed by the hospital in compliance with Medicare regulations. The hospital's guidelines should establish an appropriate graduation of hospital resources (ED staff and other resources) as the level of service increases. Upon request the provider shall supply a copy of their level of care guidelines to the payer. (Only the higher one (1) of any ED levels or critical care codes shall be paid).
 - (d) APC 5045, Trauma Response with Critical Care, is not recognized for separate payment. Trauma Center fees are not paid for alerts. Trauma activation fees are as follows:
 - Revenue Code 681 \$3,000.00
 - Revenue Code 682 \$2,500.00
 - Revenue Code 683 \$1,000.00
 - Revenue Code 684 \$0
 - These fees are in addition to ED and inpatient fees.
 - Activation fees mean a trauma team has been activated, not just alerted.
 - The level of trauma activation shall be determined by CDPHE's assigned hospital trauma level designation.
- (e) If an injured worker is admitted to the hospital through that hospital's ED, the ED reimbursement is included in the inpatient reimbursement under section 18-6(l)(3).
- (f) Multiple APCs identified by multiple CPT® codes are to be indicated by the use of modifier -51. Bilateral procedures require each procedure to be billed on separate lines using RT and LT for the procedure to be correctly paid. The 50% reduction applies to all lower valued procedures, even if they are identified in the CPT® as modifier -51 exempt. The reduction also applies to the second "primary" procedure of bilateral procedures.

- (i) All surgical procedures performed in one (1) operating room, regardless of the number of surgeons, are considered one (1) outpatient surgical episode of care for purposes of facility fee reimbursement.
- (ii) If an arthroscopic procedure is converted to an open procedure on the same joint, only the open procedure is payable. If an arthroscopic procedure and open procedure are performed on different joints, the two (2) procedures may be separately payable with anatomic modifiers.
- (iii) When reported in conjunction with other knee arthroscopy codes, any combination of surgical knee arthroscopies for removal of loose body, foreign body, and/or debridement/shaving of articular cartilage shall be paid only if performed in a different compartment of the knee using G0289.
- (iv) Discontinued surgeries require the use of modifier -73 (discontinued prior to administration of anesthesia) or modifier -74 (discontinued after administration of anesthesia). Modifier -73 results in a reimbursement of 50% of the APC value for the primary procedure only. Modifier -74 allows reimbursement of 100% of the primary procedure value only.
- (v) In compliance with Rule 16-6(B), the sum of section 18-6(J)(3)(c) Columns 1-5 is compared to the total facility fee billed charges. The lesser of the two amounts shall be the maximum facility allowance for the surgical episode of care. A line by line comparison of billed charges to the calculated maximum fee schedule allowance of section 18-6(J)(3)(c) is not appropriate.
- (g) Any diagnostic testing clinical labs or therapies with a status indicator (SI) of "A" may be reimbursed using Exhibit #8 of this Rule or the appropriate CF to the unit values for the specific CPT® code as listed in the RBRVS. Hospital bill types 13x are allowed payment for any clinical laboratory services (even if the SI is "N" for the specific clinical laboratory CPT® code) when these laboratory services are unrelated to any other outpatient services performed that day. Modifier L1 should be appended to the billed laboratory services. The maximum fees are based upon Exhibit #8.
- (h) Observation room Maximum Fee Schedule value is limited to six (6) hours without prior authorization for payment (see Rule 16-10). Documentation should support the medical necessity for observation or convalescent care. Observation time begins when the patient is placed in a bed for the purpose of initiating observation care in accordance with the physician's order. Observation or daily outpatient convalescence time ends when the patient is actually discharged from the hospital or ASC or admitted into a licensed facility for an inpatient stay. Observation time would not include the time patients remain in the observation area after treatment is finished for reasons such as waiting for transportation home. Hospital or convalescence licensure is required for billing observation or convalescence time beyond 23 hours.

Billing Codes:

G0378 Observation/Convalescence rate: \$45.00 per hour, round to the nearest hour.

- (i) Professional fees are reimbursed according to the fee schedule times the appropriate conversion factor regardless of the facility type. Additional reimbursement is payable for the following services not included in the values found in Exhibit #4 of this Rule:
 - (i) ambulance services (Revenue Code 540), see section 18-6(R)
 - (ii) blood, blood plasma, platelets (Revenue Codes 380X)
 - (iii) Physician or physician assistant services
 - (iv) Nurse practitioner services
 - (v) Licensed clinical psychologist
 - (vi) Licensed social workers
 - (vii) Rehabilitation services (PT, OT, Respiratory or Speech/Language, Revenue Codes 420, 430, 440) are paid based upon the RBRVS unit value multiplied by the applicable conversion factor. Modifiers are required to indicate the type of care plan or therapist being billed. See Rule 18-5(H) Physical Medicine & Rehabilitation for appropriate modifiers.
- (j) Any prescription for a drug supply to be used longer than a 24 hour period, filled at any clinic, shall fall under the requirements of and be reimbursed as a pharmacy fee, see section 18-6(N).
- (k) Clinics (part of a hospital or a freestanding clinic) (Form Locator (FL) 4 are 07xx and revenue codes 51x-53x):
 - (i) Provider Restrictions - types of facilities that are recognized for separate clinic facility fees:
 - Rural Health Clinics as identified under Rule 18, Exhibit #5 and/or as certified by the Colorado Department of Public Health and Environment;
 - Critical Access Hospitals as identified under Rule 18, Exhibit #3 and/or as certified by the Colorado Department of Public Health and Environment;
 - Any specialty care clinic (wound/infections) that requires expensive drugs/supplies that are not typically provided in a physician's office.
 - (ii) Billing and Maximum Fees
 - Clinics designated as rural health facilities and listed in Exhibit #5 to this Rule may be reimbursed a single separate clinic fee at 80% of billed charges per date of service, regardless of whether the clinic has been designated by the employer, the urgency of the episode of care, or the time of day.
 - CAHs listed in Exhibit #5 of this Rule may be reimbursed a single separate clinic fee at 80% of billed charges per date of service.
 - Any specialty care clinic (wound/infections) that requires drugs/supplies that are typically not provided in a physician's office may be allowed a separate clinic fee with prior approval from the payer, as outlined in Exhibit #4

- No other clinic facility fees are payable except those listed in sections 18-6(I), (J), (K) or (L).
- Maximum fees for hospital urgent care facilities or services are covered under section 18-6(L). These are identified by either place of service code 20, as billed on a CMS-1500 or by revenue code(s) 456, 516 or 526 on a UB-04.

(iii) Clinic fees are paid based upon Exhibit #4 and as outlined in this Rule.

(I) IV Infusions Performed in Outpatient Hospital Facilities

IV infusion therapy performed in an outpatient hospital facility is reimbursed per section 18-6(J).

- (m) Off campus (place of service code 19) freestanding imaging center facilities shall be reimbursed using the RBRVS TC value(s), instead of the APC value.

(K) AMBULATORY SURGERY CENTERS

(1) Provider Restrictions

- (a) A separate facility fee is only payable if the facility is licensed as an Ambulatory Surgery Center (ASC) by the Colorado Department of Public Health and Environment (CDPHE) or applicable out of state governing agency and statute.
- (b) All outpatient surgical procedures performed in an ASC shall be reasonable and necessary and warrant the performance of the procedure at an ASC level.

(2) Billing Codes and Maximum Fees

ASCs are reimbursed in accordance with section 18-6(J) for any surgical episodes of care. Column 4 from Exhibit #4 of this Rule lists the dollar value used to determine the maximum fees.

(L) URGENT CARE FACILITIES (hospital - revenue codes 516, 526 or non-hospital)

(1) Provider Restrictions

Facility fees are only payable if the facility qualifies as an Urgent Care facility. All Urgent Care facilities shall be certified by the Urgent Care Association of America (UCAOA) to be recognized for a separate facility payment for the initial visit.

(2) Billing and Maximum Fees:

- (a) Prior authorization is recommended for all facilities billing a separate Urgent Care fee. Facilities must provide documentation of the required Urgent Care facility certification if requested by the payer.
- (b) Urgent Care Facility fee is HCPCS code S9088, \$75.00.
- (i) No separate facility fees are allowed for follow-up care. To receive a separate facility fee, a subsequent diagnosis shall be based on a new acute care situation and not the initial diagnosis.

- (ii) No facility fee is appropriate when the injured worker is sent to the employer's designated provider for a non-urgent episode of care during regular business hours of 8 am to 5 pm, Monday through Friday.
 - (iii) Hospitals may bill on the UB-04 using revenue code 516 or 526 and the facility HCPCS code S9088 with 1 unit. All maximum fees for other services billed on the UB-04 shall be in accordance with CPT® relative weights from RBRVS, multiplied by the appropriate conversion factor.
 - (iv) Hospital and non-hospital based urgent care facilities may bill for the facility fee, HCPCS code S9088, on the CMS-1500 with professional services. All other services and procedures provided in an urgent care facility, including a freestanding facility, are reimbursed according to the appropriate CPT® code relative weight from RBRVS multiplied by the appropriate Rule 18-4 conversion factor.
- (c) All professional physician or non-physician fees shall be billed on a CMS-1500 with a Place of Service Code #20. The maximum fees shall be in accordance with the appropriate CPT® code relative weight from RBRVS multiplied by the appropriate Rule 18-4 conversion factor.
- (d) The Observation Room allowance shall not exceed \$45.00 per hour and is limited to a maximum of three (3) hours without prior authorization for payment (see Rule 16-10).
- G0378 Observation rate: \$45.00 per hour
- (e) All supplies are included in the facility fee for urgent care facilities.
- (f) Any prescription for a drug supply to be used for longer than 24 hours, filled at any clinic, shall fall under the requirements of and be reimbursed as a pharmacy fee. See Rule 18-6(N).

(M) HOME CARE SERVICES

Prior authorization for payment (see Rule 16-10) is required for all home care services. All skilled home care service providers shall be licensed by the Colorado Department of Public Health and Environment (CDPHE) as Type A or B providers. The payer and the home health entity should agree in writing on the type of care, the type and skill level of provider, frequency of care and duration of care at each visit, and any financial arrangements to prevent disputes.

(1) Home Infusion Therapy

The per day or refill rates for home infusion therapy shall include all reasonable and necessary products, equipment, IV administration sets, supplies, supply management, and delivery services necessary to perform the infusion therapy. Per diem rates are only payable when licensed professionals (RNs) are providing "reasonable and necessary" skilled assessment and evaluation services in the patient's home.

Skilled Nursing fees are separately payable when the nurse travels to the injured workers home to perform initial and subsequent patient evaluation(s), education, and coordination of care. Skilled nursing fees are billed and payable as indicated under section 18-6(L)(2).

(a) Parenteral Nutrition:

S9364 <1 Liter	\$160.00/ day
S9365 1 liter	\$174.00/ day
S9366 1.1 - 2.0 liter	\$200.00/ day
S9367 2.1 - 3.0 liter	\$227.00/ day
S9368 > 3.0 liter	\$254.00/ day

The per day rates include the standard total parenteral nutrition (TPN) formula. Lipids, specialty amino acid formulas, and drugs other than in standard formula are separately payable under section 18-6(N).

(b) Antibiotic Therapy per day rate by professional + drug cost at Medicare's Average Sale Price (ASP). If ASP is not available, bill using the drug cost at Average Wholesale Price (AWP).

S9494 hourly	\$158.00/ day
S9497 once every 3 hours	\$152.00/ day
S9500 every 24 hours	\$97.00/ day
S9501 once every 12 hours	\$110.00/ day
S9502 once every 8 hours	\$122.00/ day
S9503 once every 6 hours	\$134.00/ day
S9504 once every 4 hours	\$146.00/ day

(c) Chemotherapy per day rate + drug cost at Medicare's Average Sale Price (ASP). If ASP is not available, bill using the drug cost at Average Wholesale Price (AWP).

S9329 Administrative Services	\$0.00/ day
S9330 Continuous (24 hrs. or more) chemotherapy	\$91.00/ day
S9331 Intermittent (less than 24 hrs.)	\$103.00/ day

(d) Enteral nutrition (enteral formula and nursing services separately billable):

S9341 Via Gravity	\$44.09/ day
S9342 Via Pump	\$24.23/ day
S9343 Via Bolus	\$24.23/ day

(e) Pain Management per day or refill + drug cost at Medicare's Average Sale Price (ASP). If ASP is not available, bill using the drug cost at Average Wholesale Price (AWP).

S9326 Continuous (24 hrs. or more) \$ 79.00/ day

S9327 Intermittent (less than 24 hrs.) \$103.00/ day

S9328 Implanted pump \$116.00/ refill (No separate daily rate is applicable when the patient has an implanted pain pump.)

- (f) Fluid Replacement per day rate + drug cost at Medicare's Average Sale Price (ASP). If ASP is not available, bill using the drug cost at Average Wholesale Price (AWP).

S9373 < 1 liter per day \$61.00/ day

S9374 1 liter per day \$85.00/ day

S9375 >1 but <2 liters per day \$85.00/ day

S9376 >2 liters but <3 liters \$85.00/ day

S9377 >3 liters per day \$85.00/ day

- (g) Multiple Therapies:

Highest cost per day or refill only + drug cost at Medicare's Average Sale Price (ASP). If ASP is not available, bill using the drug cost at Average Wholesale Price (AWP).

Medication/Drug Restrictions - the payment for drugs may be based upon Medicare's Average Sale Price (ASP). If ASP is not available, bill using the drug cost at Average Wholesale Price (AWP).

AWP (see section 18-6(N)) of the drug is determined through the use of industry publications such as the monthly Price Alert, First Databank, Inc.

(2) Nursing Services

- (a) Skilled Nursing (LPN & RN)

S9123 RN \$111.00/hr.

S9124 LPN \$89.00/hr.

There is a limit of two (2) hours without prior authorization for payment (see Rule 16-10).

- (b) Certified Nurse Assistant (CNA):

S9122 CNA \$ 45.00/hr.

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

(3) Physical Medicine

Physical medicine procedures are payable at the same rate as provided in section 185(H), Physical Medicine and Rehabilitation.

(4) Mileage

Travel allowances should be agreed upon with the payer and the mileage rate should not exceed \$0.53 per mile, portal to portal.

DoWC code: Z0772

(5) Travel Time

Travel is typically included in the fees listed. Travel time greater than one (1) hour one-way shall be reimbursed. The fee shall be agreed upon at the time of prior authorization for payment (see Rule 16-10) and shall not exceed \$30.00 per hour.

DoWC code: Z0773

(6) Drugs/Supplies/DME/Orthotics/Prosthetics Used For At-Home Care

As defined in Rule 18-6(H), any drugs/supplies/DME/Orthotics/Prosthetics considered integral to any at-home professional's service are not separately payable.

The maximum fees for non-integral drugs/supplies/DME/Orthotics/Prosthetics used during a professional's home care visits are listed in Rule 18-6(H). All IV infusion supplies are included in the per diem or refill rates listed in this rule.

(N) DRUGS AND MEDICATIONS

(1) Drugs (brand name or generic) shall be reported on bills using the applicable identifier from the National Drug Code (NDC) Directory as published by the Food and Drug Administration (FDA).

(2) Average Wholesale Price (AWP)

(a) AWP for brand name and generic pharmaceuticals may be determined through the use of such monthly publications as Price Alert, Red Book, or Medispan. In case of a dispute on AWP values for a specific NDC, the parties should take the lower of their referenced published values.

(b) If published AWP data becomes unavailable, substitute Wholesale Acquisition Cost (WAC) + 20% for AWP everywhere it is found in this Rule.

(3) Reimbursement for Drugs & Medications

(a) For prescription medications, except topical compounds, reimbursement shall be AWP + \$4.00. If drugs have been repackaged, use the original AWP and NDC that was assigned by the source of the repackaged drugs to determine reimbursement.

- (b) The entity packaging two or more products together makes an implied claim that the products are safe and effective when used together and shall be billed as individual line items identified by their original AWP and NDC. This original AWP and NDC shall be used to determine reimbursement. Supplies are considered integral to the package are not separately reimbursable.
 - (c) Reimbursement for an opiate antagonist prescribed or dispensed under §§ 12-36-117.7, 12-38-125.5, 12-42.5-120, 13-21-108.7, C.R.S. (2015), to injured worker at risk of experiencing an opiate-related drug overdose event, or to a family member, friend, an employee or volunteer of a harm reduction organization, or other person in a position to assist the injured worker shall be AWP plus \$4.00.
 - (d) Drugs administered in the course of the provider's direct care (injectables) shall be reimbursed at the provider's actual cost incurred or Medicare's Part B Drug Average Sale Price (ASP).
- (4) Prescription Strength Topical Compounds

In order to qualify as a compound under this section, the medication must require a prescription; the ingredients must be combined, mixed, or altered by a licensed pharmacist or a pharmacy technician being overseen by a licensed pharmacist, a licensed physician, or, in the case of an outsourcing facility, a person under the supervision of a licensed pharmacist; and it must create a medication tailored to the needs of an individual patient. All topical compounds shall be billed using the DoWC Z code corresponding with the applicable category as follows:

Category I Z0790 Fee \$ 75.00 per 30 day supply

Any anti-inflammatory medication or any local anesthetic single agent.

Category II Z0791 Fee \$150.00 per 30 day supply

Any anti-inflammatory agent or agents in combination with any local anesthetic agent or agents.

Category III Z0792 Fee \$250.00 per 30 day supply

Any single agent other than anti-inflammatory agent or local anesthetic, either alone, or in combination with anti-inflammatory or local anesthetic agents.

Category IV Z0793 Fee \$350.00 per 30 day supply

Two (2) or more agents that are not anti-inflammatory or local anesthetic agents, either alone or in combination with other anti-inflammatory or local anesthetic agents.

All ingredient materials must be listed by quantity used per prescription. If the Medical Treatment Guidelines approve some but not all of the active ingredients for a particular diagnosis, the insurer shall count only the number of the approved ingredients to determine the applicable category. In addition, the initial prescription containing the approved ingredients shall be reimbursed without a medical review. Continued use (refills) may require documentation of effectiveness including functional improvement.

Category fees include materials, shipping and handling, and time. Regardless of how many ingredients or what type, compounded drugs cannot be reimbursed higher than the Category IV fee. The 30 day Maximum Fee Schedule value shall be fractioned down to the prescribed and dispensed amount given to the injured worker. Automatic refilling is not allowed.

(5) Over-the-Counter Medications

- (a) Over-the-counter medications, drugs that are safe and effective for use by the general public without a prescription, are reimbursed at NDC/AWP and are not eligible for dispensing fees. If drugs have been repackaged, use the original AWP and NDC that was assigned by the source of the repackaged drugs to determine reimbursement.
- (b) The maximum reimbursement for any topical muscle relaxant, analgesic, anti-inflammatory and/or anti-neuritic medications containing only active ingredients available without a prescription shall be reimbursed at cost to the billing provider up to \$30.00 per 30 day supply for any application (excludes patches). Maximum reimbursement for a patch is cost to the billing provider up to \$70.00 per 30 day supply.

(6) Injured Worker Reimbursement

In the event the injured worker has directly paid for authorized prescriptions, the payer shall reimburse the injured worker for the amounts actually paid for authorized prescriptions or authorized over-the-counter drugs within 30 days after submission of the injured worker's receipt. See Rule 16-12(G).

(7) Dietary Supplements, Vitamins and Herbal Medicines

Reimbursement for outpatient dietary supplements, vitamins and herbal medicines dispensed in conjunction with acupuncture and complementary alternative medicine are authorized only by prior agreement of the payer, except if specifically provided for in Rule 17, Medical Treatment Guidelines.

(8) Prescription Writing

- (a) Physicians shall indicate on the prescription form that the medication is related to a workers' compensation claim.
- (b) All prescriptions shall be filled with bio-equivalent generic drugs unless the physician indicates "Dispense As Written" (DAW) on the prescription. In addition to the requirements outlined in Rule 16-5(B)(2), providers using pharmacies and prescribing a brand name compounded topical drug with a DAW indication shall provide a written medical justification explaining the reasonableness and necessity of the brand name over the generic equivalent. This rule applies to all pharmacies, whether located in-state or out-of-state.
- (c) The provider shall prescribe no more than a 60-day supply per prescription.

(9) Required Billing Forms

- (a) All parties shall use one (1) of the following forms:

- (i) CMS-1500 – the dispensing provider shall bill by using the metric quantity and NDC number of the drug being dispensed; or, if one does not exist, the RBRVS supply code; or
- (ii) With the agreement of the payer, the National Council for Prescription Drug Programs (NCPDP) or ANSI ASC 837 (American National Standards Institute Accredited Standards Committee) electronic billing transaction containing the same information as in (1) or (2) in this subsection may be used for billing.

NCPDP Workers' Compensation/Property and Casualty (P&C) Universal Claim Form, version 1.1, for prescription drugs billed on paper shall be used by dispensing pharmacies and pharmacy benefit managers (PBMs). Physicians may use the CMS-1500 billing form as described in Rule 16-7(B)(1).

Physicians shall list the "repackaged" and the "original" NDC numbers in field 24 of the CMS-1500. List the "repackaged" NDC number first and the "original" NDC number second, with the prefix 'ORIG' appended.

- (b) Items prescribed for the work-related injury that do not have an NDC code shall be billed as a supply, using the RBRVS supply code (see section 18-6(H)).
 - (c) The payer may return any prescription billing form if the information is incomplete.
 - (d) A signature shall be kept on file indicating that the injured worker or his/her authorized representative has received the prescription.
- (10) A line-by-line itemization of each drug billed and the payment for that drug shall be made on the payment voucher by the payer.

(O) COMPLEMENTARY ALTERNATIVE MEDICINE (CAM)

CAM is a term used to describe a broad range of treatment modalities, some of which are generally accepted in the medical community and others that remain outside the accepted practice of conventional western medicine. Non-physician providers of CAM may be both licensed and non-licensed health practitioners with training in one (1) or more forms of therapy and certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in acupuncture and/or Chinese herbology. CAM requires prior authorization for payment (see Rule 16-10). Refer to Rule 17, Medical Treatment Guidelines for the specific types of CAM modalities.

(P) ACUPUNCTURE

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

(1) Provider Restrictions

All non-physician providers must be a Licensed Acupuncturist (LAc) by the Colorado Department of Regulatory Agencies as provided in Rule 16, Utilization Standards. All physician and non-physician providers must provide evidence of training, and licensure upon request of the payer.

(2) Billing Restrictions

- (a) For treatment frequencies exceeding the maximum allowed in Rule 17, Medical Treatment Guidelines, the provider must obtain prior authorization for payment (see Rule 16-10).
- (b) Unless the provider's medical records reflect medical necessity and the provider obtains prior authorization for payment (see Rule 16-10), the maximum amount of time allowed for acupuncture and procedures is one (1) hour of procedures, per day, per discipline.

(3) Billing Codes:

- (a) Reimburse acupuncture, including or not including electrical stimulation, as listed in the RBRVS.
- (b) Non-Physician evaluation services
 - (i) New or established patient services are reimbursable only if the medical record specifies the appropriate history, physical examination, treatment plan or evaluation of the treatment plan. Payers are only required to pay for evaluation services directly performed by an LAc. All evaluation notes or reports must be written and signed by the LAc. Without appropriate supporting documentation, the payer may deny payment. (See Rule 16-12)
 - (ii) LAc new patient visit: DOWC Z0800
Maximum value \$99.80
 - (iii) LAc established patient visit: DOWC Z0801
Maximum value \$67.60
- (c) Herbs require prior authorization for payment (see Rule 16-10) and fee agreements as per section 18-6(N)(7).
- (d) See the appropriate Physical Medicine and Rehabilitation section of the RBRVS for other billing codes and limitations (see also section 18-5(H)).
- (e) Acupuncture supplies are reimbursed in accordance with section 18-6(H).

(Q) USE OF AN INTERPRETER

Rates and terms shall be negotiated. Prior authorization for payment (see Rule 16-10) is required except for emergency treatment. Use DoWC Z0722 to bill.

(R) AMBULANCE FEE SCHEDULE

(1) Billing Requirements:

Payment under the fee schedule for ambulance services is comprised of a base rate payment plus a payment for mileage. Both the transport of the injured worker to the nearest facility and all items and services associated with such transport are considered inclusive with the base rate and mileage rate.

(2) General Claims Submission:

- (a) All hospitals billing for ground or air ambulance services shall bill on the UB-04 and all other ambulance providers shall bill on the CMS-1500.
- (b) Use the appropriate HCPCS code plus the HCPCS origin/destination modifier.
- (c) The transporting supplier's name, complete address and provider number should be listed in Item 33 (CMS-1500).
- (d) The zip code for the origin (point of pickup) must be in Item 23 (CMS-1500). If billing on the UB-04 use FL 39-41 with an "AO" and the point of pick up zip code. If billing for multiple trips and the zip code for each origin is the same, services can be submitted on the same claim. If the zip codes are different, a separate claim must be submitted for each trip.

(3) Ground and Air Ambulance Vehicle and Crew Requirements

As required by the Colorado Department of Public Health and Environment.

(4) HCPCS Procedure Codes and Maximum Allowances for Ambulance Services:

(a) Ground (both water and land) Ambulance Base Rates and Mileage

The selection of the base code is based upon the condition of the injured worker at the time of transport, not the vehicle used and includes services and supplies used during the transport.

Ground Ambulance	HCPCS Code Description	<u>Urban</u> Medicare Rate *250%	<u>Rural</u> (R = Zip Code) First 17 miles or > if not a Super Rural Medicare Rate *250%	<u>Super Rural</u> (B = Zip code) Medicare Rate *250%
A0425	Ground mileage, per statute mile	\$ 18.11	\$ 18.28	\$ 18.28
A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1-Non-Emergency)	\$ 680.67	\$ 687.34	\$ 842.68
A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS1-Emergency)	\$1,077.72	\$1,088.29	\$1,334.24
A0428	Ambulance service, basic life support, non-emergency transport (BLS)	\$ 567.22	\$572.28	\$ 702.23
A0429	Ambulance service, basic life support, emergency transport (BLS-Emergency)	\$ 907.55	\$ 916.45	\$1,123.57

Ground Ambulance	HCPCS Code Description	<u>Urban</u> Medicare Rate *250%	<u>Rural</u> (R = Zip Code) First 17 miles or > if not a Super Rural Medicare Rate *250%	<u>Super Rural</u> (B = Zip code) Medicare Rate *250%
A0432	Paramedic intercept (PI), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers.	\$992.64	\$1002.37	\$1002.37
A0433	Advanced life support, level 2 (ALS2)	\$1,559.86	\$1,575.15	\$1,931.14
A0434	Specialty care transport (SCT)	\$1,843.47	\$1,861.54	\$2,282.25

The "urban" base rate(s) and mileage rate(s) as indicated in section 18-6(R) shall be applied to all relevant/applicable ambulance services unless the zip code range area is "Rural" or "Super Rural." Medicare MSA zip code grouping is listed on Medicare's webpage with an "R" indicator for "Rural" and "B" indicator for "Super Rural." See Medicare's Zip Code to Carrier Locality File- Updated 08/27/2014.

(5) Modifiers

Modifiers identify place of origin and destination of the ambulance trip. The modifier is to be placed next to the HCPCS code billed. The following is a list of current ambulance modifiers. Each of the modifiers may be utilized to make up the first and/or second half of a two-letter modifier. The first letter must describe the origin of the transport, and the second letter must describe the destination (Example: if a patient is picked up at his/her home and transported to the hospital, the modifier to describe the origin and destination would be – RH).

Code Description

- D Diagnostic or therapeutic site other than "P" or "H"
- E Residential, domiciliary, custodial facility, nursing home other than SNF (other than 1819 facility)
- G Hospital-based dialysis facility (hospital or hospital-related) which includes:
 - Hospital administered/Hospital located
 - Non-Hospital administered/Hospital located
- H Hospital
- I Site of transfer (e.g., airport, ferry, or helicopter pad) between modes of ambulance transport
- J Non-hospital-based dialysis facility
 - Non-Hospital administered/Non-Hospital located
 - Hospital administered/Non-Hospital located
- N Skilled Nursing Facility (SNF) (1819 Facility)

- P Physician's Office (includes HMO non-hospital facility, clinic, etc.)
- R Residence
- S Scene of Accident or Acute Event
- X Destination Code Only (Intermediate stop at physician's office en route to the hospital, includes HMO non-hospital facility, clinic, etc.)

(6) Mileage

Charges for mileage must be based on loaded mileage only, i.e., from the pickup of a patient to his/her arrival at the destination. Payment is allowed for all medically necessary mileage. If mileage is billed, the miles must be in whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number. Use code "1" as the mileage for trips of less than a mile.

18-7 DENTAL FEE SCHEDULE

The dental fee schedule is adopted using the American Dental Association's Current Dental Terminology, 2016 (CDT-2016). However, surgical treatment for dental trauma and subsequent, related procedures may be billed using medical codes from the RBRVS. If billed using medical codes as listed in the RBRVS, reimbursement shall be in accordance with the Surgery/Anesthesia section of the RBRVS and its corresponding conversion factor. All dental billing and reimbursement shall be in accordance with the Division's Rule 16, Utilization Standards, and Rule 17, Medical Treatment Guidelines. See Exhibit #6 of this Rule for the listing and Maximum Fee Schedule value for CDT-2016 dental codes.

Regarding prosthetic appliances, the provider may bill and be reimbursed for 50% of the allowed fee at the time the master casts are prepared for removable prosthodontics or the final impressions are taken for fixed prosthodontics. The remaining 50% may be billed on insertion of the final prosthesis.

18-8 QUALITY INITIATIVES

(A) CHRONIC OPIOID MANAGEMENT

- (1) When the authorized treating physician prescribes long-term opioid treatment, s/he shall use the Division of Workers' Compensation Chronic Pain Disorder Medical Treatment Guidelines and review the Colorado Medical Board Policy #40-26, "Policy for Prescribing and Dispensing Opioids." Urine drug tests for chronic opioid management shall employ testing methodologies that meet or exceed industry standards for sensitivity, specificity and accuracy. The test methodology must be capable of identifying and quantifying the parent compound and relevant metabolites of the opioid prescribed. In-office screening tests designed to screen for drugs of abuse are not appropriate for chronic opioid compliance monitoring.
 - (a) Drug testing shall be done prior to the initial long-term drug prescription being implemented and randomly repeated at least annually.
 - (b) When drug screen tests are ordered, the authorized treating physician shall utilize the Colorado Prescription Drug Monitoring Program (PDMP).

- (c) While the injured worker is receiving chronic opioid management, additional drug screens with documented justification may be conducted. Examples of documented justification include the following:
 - (i) Concern regarding the functional status of the patient
 - (ii) Abnormal results on previous testing
 - (iii) Change in management of dosage or pain
 - (iv) Chronic daily opioid dosage above 100 mg of morphine or equivalent
 - (d) The opioids classified as Schedule II or Schedule III controlled substances that are prescribed for treatment longer than 30 days shall be provided through a pharmacy.
 - (e) The authorized treating physician may consider whether the injured worker experienced an opiate-related drug overdose event that resulted in an opiate antagonist being prescribed or dispensed pursuant to §§ 12-36-117.7, 12-38-125.5, 12-42.5-120, or 13-21-108.7, C.R.S. (2015). For reimbursement for an opiate antagonist, please see Rule 18-6(N)(3)(c).
 - (f) The prescribing authorized treating physician shall review and integrate the screening results, PDMP, and the injured worker's past and current functional status on the prescribed levels of medications. A written report will document the treating physician's assessment of the patient's past and current functional status of work, leisure activities and activities of daily living competencies.
- (2) Codes and maximum fees for the authorized treating physician for a written report with all the following review services completed and documented:
- (a) Ordering and reviewing drug tests
 - (b) Ordering and reviewing PDMP results
 - (c) Reviewing the medical records
 - (d) Reviewing the injured workers' current functional status
 - (e) Determining what actions, if any, need to be taken
 - (f) Appropriate chronic pain diagnostic code (ICD-10)

Bill using code DoWC Z0765 \$75.00 per 15 minutes – maximum of 30 minutes per report

NOTE: This code is not to be used for acute or sub-acute pain management.

(B) FUNCTIONAL ASSESSMENTS

- (1) Pre-and post-injection assessments by a trained physician, nurse, physician's assistant, occupational therapist, physical therapist, chiropractor or a medical assistant may be billed with spinal or sacroiliac (SI) joint injection codes. The following 3 elements are required:
 - (a) A brief commentary on the procedures, including the anesthesia used in the injection and verification of the needle placement by fluoroscopy, CT or MRI.

- (b) Pre-and post-injection procedure shall have at least 3 objective, diagnostically appropriate, functional measures identified, measured and documented. These may include spinal range of motion; tolerance and time limits for sitting, walking and lifting; straight leg raises for herniated discs; a variety of provocative SI joint maneuvers such as Patrick's sign, Gaeslen, distraction or gapping and compression tests. Objective descriptions, preferably with measurements, shall be provided initially and post procedure at the appropriate time for medication effect, usually 30 minutes post procedure.
 - (c) There shall be a trained physician or trained non-physician health care professional detailed report with a pre- and post-procedure pain diagram, normally using a 0-10 point scale. The patient(s) should be instructed to keep a post injection pain diary that details the patient's pain level for all pertinent body parts, including any affected limbs. The patient pain diary should be kept for at least 8 hours post injection and preferably up to seven (7) days. The patient should be encouraged to also report any changes in activity level post injection.
- (2) If all three elements are documented, the billing codes and maximum fees are as follows:
- DOWC Z0811 \$60.00 per episode for the initial functional assessment of pre-injection care, billed along with the appropriate E&M code, related to spinal or SI joint injections.
- DOWC Z0812 \$31.44 for a subsequent visit of therapeutic post-injection care (preferably done by a non-injectionist and at least seven (7) days after the injection), billed along with the appropriate E&M code, related to follow-up care of spinal or SI joint injections. The injured worker should provide post injection pain data, including a pain diary.
- DOWC Z0814 \$31.44 for post-diagnostic injection care (repeat functional assessment within the time period for the effective agent given).

(C) QUALITY PERFORMANCE AND OUTCOMES PAYMENTS (QPOP)

- (1) Medical providers who are Level I or II accredited, or who have completed the Division-sponsored Level I or II accreditation program and have successfully completed the QPOP training may bill separately for documenting functional progress made by the injured worker. The medical providers must utilize both a validated psychological screen and the validated functional data provided by the injured worker or another health care provider. The medical provider also must document whether the injured worker's perception of function correlates with clinical findings. The documentation of functional progress should assist the provider in preparing a successful plan of care, including specific goals and expected time frames for completion, or for modifying a prior plan of care. The documentation must include:
- (a) Specific testing that occurred, interpretation of testing results, and the weight given to these results in forming a reasonable and necessary plan of care;
 - (b) Explanation of how the testing goes beyond the evaluation and management (E&M) services typically provided by the provider;
 - (c) Meaningful discussion of actual or expected functional improvement between the provider and the injured worker.

If these elements have been met, the billing code and maximum fee are as follows:

DOWC Z0815 \$ 80.00 for the initial assessment during which the injured worker provides functional data and completes the validated psychological screen, which the provider considers in preparing a plan of care. This code also may be used for the final assessment that includes review of the functional gains achieved during the course of treatment and documentation of MMI.

DOWC Z0816 \$ 40.00 for subsequent visits during which the injured worker provides follow-up functional data which could alter the treatment plan. The provider may use this code if the analysis of the data causes him or her to modify the treatment plan. The provider should not bill this code more than once every 2 to 4 weeks.

- (2) QPOP for post-MMI patients requires prior authorization based on clearly documented functional goals.

(D) PILOT PROGRAMS

- (1) Payers may submit a proposal to conduct a pilot program(s) to the Director for approval. Pilot programs authorized by this rule shall be designed to improve quality of care, determine the efficacy of clinic or payment models and to provide a basis for future development and expansion of such models.

The proposal for a pilot program shall meet the minimum standards set forth in C.R.S. 8-43-602 and shall include:

- (a) Beginning and end date for the pilot program.
- (b) Population to be managed (e.g. size, specific diagnosis codes).
- (c) Provider group(s) participating in the program.
- (d) Proposed codes and fees.
- (e) Process for evaluating the program's success.

Participating payers must submit data and other information as required by the Division to examine such issues as the financial implications for providers and patients, enrollment patterns, utilization patterns, impact on health outcomes, system effects and the need for future health planning.

Editor's Notes

7 CCR 1101-3 has been divided into smaller sections for ease of use. Versions prior to 01/01/2011 and rule history are located in the first section, 7 CCR 1101-3. Prior versions can be accessed from the All Versions list on the rule's current version page. To view versions effective on or after 01/01/2011, select the desired part of the rule, for example 7 CCR 1101-3 Rules 1-17, or 7 CCR 1101-3 Rule 18: Exhibit 1.

History

[For history of this section, see Editor's Notes in the first section, 7 CCR 1101-3]