

DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation

WORKERS' COMPENSATION RULES OF PROCEDURE

MEDICAL FEE SCHEDULE

7 CCR 1101-3 Rule 18 (Rule 18 exhibits published separately)

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

18-1 INTRODUCTION

Pursuant to § 8-42-101(3)(a)(I) and § 8-47-107, the Director promulgates this Medical Fee Schedule to review and establish maximum fees for healthcare services falling within the purview of the Workers' Compensation Act of Colorado. This Rule applies to services rendered on or after January 1, 2024. All other bills shall be reimbursed in accordance with the fee schedule in effect on the date of service. This Rule shall be read together with Rule 16, Utilization Standards, and Rule 17, the Medical Treatment Guidelines (MTGs).

The unofficial copies of Rule 18, other Colorado Workers' Compensation Rules of Procedure, and Interpretive Bulletins are available on the Division's website. The rules also may be purchased from LexisNexis. An official copy of this Rule is available on the Colorado Secretary of State's webpage, 7 CCR 1101-3.

18-2 INCORPORATION BY REFERENCE

The Director adopts and incorporates by reference the following materials:

- (A) National Physician Fee Schedule Relative Value file (RBRVS-Resource Based Relative Value Scale), as modified and published by Medicare in April 2023.
- (B) The Current Procedural Terminology CPT® 2023, Professional Edition, published by the American Medical Association (AMA). All CPT® modifiers are adopted, unless otherwise specified in this Rule.
- (C) Medicare Severity Diagnosis Related Groups (MS-DRGs) Definitions Manual, Version 40.1 using MS-DRGs from CMS-1771-F Table 5. MS-DRGs Definitions Manual may be purchased from 3M Health Information Systems.
- (D) Hospital Outpatient Prospective Payment System (OPPS) Addenda A and B, January 2023; 2023 NFRM OPPS Addendum J; Table 3 (The OPPS Imaging Families and Multiple Imaging Procedure Composite APCs of the 2023 OPPS Final Rule); and Table 2 of the 2023 NFRM OPPS Claims Accounting.
- (E) Medicare Part B April 2023 Average Sales Price (ASP) Pricing File.
- (F) Health Care Common Procedure Coding System (HCPCS) Level II Professional 2023, published by the AMA.
- (G) Medicare's Clinical Laboratory Fee Schedule File, CY 2023 Q2 Release.

- (H) The Current Dental Terminology, CDT® 2023, published by the American Dental Association.
- (I) Medicare's 2022 Anesthesia Base Units by CPT® Code.

All guidelines and instructions in the referenced materials are adopted, unless otherwise specified in this Rule. The incorporation is limited to the specific editions named and does not include later revisions or additions.

The Division shall make available for public review and inspection the copies of all materials incorporated by reference in Rule 18. Please contact the Medical Services Manager, 633 17th Street, Suite 400, Denver, Colorado 80202-3626. These materials also are available at any state publications depository library. All users are responsible for the timely purchase and use of these materials.

18-3 GENERAL POLICIES

(A) BILLING CODES AND FEE SCHEDULE:

- (1) The Division establishes the Medical Fee Schedule based on RBRVS, as modified by Rule 18 and its Exhibits.
- (2) The Division incorporates CPT®, HCPCS, CDT® and National Drug Code (NDC) codes and values, unless otherwise specified in Rule 18. The providers may use CPT® Category III codes listed in the RBRVS with Payer agreement. Payment for the Category III codes shall comply with Rule 16 policy for unpriced codes.
- (3) Division-created codes and values (DoWC ZXXXX) supersede CPT®, HCPCS, CDT® and NDC codes and values. The CPT® mid-point rule for attaining a unit of time applies to these codes, unless otherwise specified in this Rule.
- (4) Codes listed with values of "BR" (by report), not listed, or listed with a zero value and not included by Medicare in another procedure(s), require prior authorization.

(B) PLACE OF SERVICE CODES:

The table below lists the place of service codes corresponding to the RBRVS facility RVUs. All other maximum fee calculations shall use the non-facility RVUs listed in the RBRVS

Place of Service Code	Place of Service Code Description
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

(C) CORRECT REPORTING AND PAYMENT POLICIES:

- (1) Providers shall report codes and number of units based on all applicable code descriptions and this Rule. In addition, providers shall document all services/ procedures in the medical record.
- (2) Providers shall report the most comprehensive code that represents the entire service.
- (3) Providers shall report only the primary services and not the services that are integral to the primary services.
- (4) Providers shall document the time spent performing all time-based services or procedures in accordance with applicable code descriptions.
- (5) Providers shall apply modifiers to clarify services rendered and/or adjust the maximum allowances as indicated in this Rule. When correcting a modifier, Payers shall comply with Rule 16.

18-4 PROFESSIONAL FEES AND SERVICES

(A) GENERAL INSTRUCTIONS

(1) Conversion Factors (CFs):

Maximum allowances are determined by multiplying the following CFs by the established facility or non-facility total relative value units (RVUs) found in the corresponding RBRVS sections:

RBRVS SECTION	CF
Anesthesia	\$44.00
Surgery/Radiology/Pathology/Medicine (SRPM)	\$68.00
Physical Medicine and Rehabilitation	\$49.00
(Includes Medical Nutrition Therapy and Acupuncture)	
Evaluation & Management (E&M)	\$56.00

(2) Maximum Allowance:

- (a) Maximum allowance for most providers shall be 100% of the Medical Fee Schedule unless otherwise specified in this Rule.
- (b) The maximum allowance for Physician Assistants (PAs) and Nurse Practitioners (NPs) shall be 85% of the Medical Fee Schedule. However, PAs and NPs are allowed 100% of the Medical Fee Schedule if the requirements of Rule 16 have been met and one of the following conditions applies:
 - (i) The service is provided in a rural area. Rural area means:
 - a county outside a Metropolitan Statistical Area (MSA) or
 - a Health Professional Shortage Area, located either 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.
 - (ii) The PA or NP is Level I Accredited.
- (c) The Payer may negotiate reimbursement of travel expenses not addressed in the fee schedule (including transit time) with providers traveling to a rural area to serve an injured worker. Rural area is defined in subsection (2)(b)(i) above. This reimbursement shall be in addition to the maximum allowance for services addressed in the fee schedule.

(3) The Division adopts the following RBRVS attributes or modifies them as follows:

- (a) HCPCS (Healthcare Common Procedure Coding System) –including any CPT® codes; Level I (CPT®) and Level II (HCPCS) Modifiers (listed and unlisted).
- (b) Description – short description as listed in the file and long description as specified in CPT®.
- (c) Status Code

Status	Meaning
A	Separately Payable
B & P	Bundled Code
C	Priced per Rule 16-10-1
E	HCPCS J0120 to J9999 and CPT® 90296-90750 are payable. HCPCS Q4074-Q4255 require prior authorization for payment. All other codes are not payable unless otherwise specified in this Rule.
I	HCPCS A0021-A0998 and S0012-S0199 (see section 18-4(B)(6)(c)) are payable. Dental codes are paid per Exhibit #3; All other codes are not payable unless otherwise specified in this Rule. There may be another code for reporting and payment of these services.
J	Anesthesia Code
M & Q	Measurement or Functional Information Codes - No Value
N	HCPCS A4210-A9300 are payable when these supplies are issued for home use. Dental codes are paid per Exhibit #3. HCPCS V2025-V5290 are payable per section 18-6(A). There may be another code for reporting and payment of services associated with V-codes. Codes found in the Medicine Section of CPT® with an assigned RBRVS value (section 18-2(A)) are payable. All other codes are not payable unless otherwise specified in this Rule.
R	Dental codes are paid per Exhibit #3. All other codes require prior authorization for payment unless otherwise specified in this Rule.

T	Paid When It Is the Only Payable Service Performed
X	Codes with an assigned RBRVS or DMEPOS value (section 18-2(A)) are payable. All other codes are not payable unless otherwise specified in this Rule.

- (d) Increment of Service/Billable (when specified).
- (e) Anesthesia Base Unit(s), see section 18-4(C).
- (f) Non-Facility (NF) Total RVUs.
- (g) Facility (F) Total RVUs.
- (h) Professional Component/Technical Component Indicators.

Indicator	Meaning
0	Physician Service Codes – professional component/ technical component (PC/TC) distinction does not apply.
1	Diagnostic Radiology Tests - may be billed with or without modifiers 26 or TC.
2	Professional Component Only Codes – standalone professional service code (no modifier is appropriate because the code description dictates the service is professional only).
3	Technical Component Only Codes - standalone technical service code (no modifier is appropriate because the code description dictates the service is technical only).
4	Global Test Only Codes - modifiers 26 and TC cannot be used because the values equal to the sum of the total RVUs (work, practice expense, and malpractice).
5	Incident To Codes - do not apply.
6	Laboratory Physician Interpretation Codes – separate payments may be made (these codes represent the professional component of a clinical laboratory service and cannot be billed with modifier TC).
7	Physical Therapy Service – not recognized.
8	Physician Interpretation Codes – separate payments may be made only if a physician interprets an abnormal smear for a hospital inpatient.
9	Concept of PC/TC distinction does not apply.

- (i) Global Days: a period of time starting with the preoperative period of a surgical procedure and ending some period of time after the procedure was performed.

Indicator	Meaning
000	Endoscopies or some minor surgical procedures, typically a zero day post-operative period. E&M visits on the same day as procedures generally are included in the procedure, unless a separately identifiable service is reported with an appropriate modifier.
010	Other minor procedures, 10-day post-operative period. E&M visits on the same day as procedures and during the 10-day post-operative period generally are included in the procedure, unless a separately identifiable service is reported with an appropriate modifier.
090	Major surgeries, 90-day post-operative period. E&M visits the day before and on same day as procedures, as well as during the 90-day post-operative period generally are included in the procedure, unless a separately identifiable service is reported with an appropriate modifier.
MMM	Global service days concept does not apply (see Medicare's Global Maternity Care reporting rule).
XXX	Global concept does not apply.
YYY	Identifies primarily "BR" procedures where "global days" need to be determined by the Payer.
ZZZ	Code is related to another service and always included in the global period of the other service. Identifies "add-on" codes.

- (j) Pre-Operative Percentage Modifier: percentage of the global surgical package payable when pre-operative care is rendered by a provider other than the surgeon.

Indicator	Meaning
%	The physician shall append modifier 56 when performing only the pre-operative portion of any surgical procedure. This modifier can be combined with either modifier 54 or 55, but not both. This column lists the allowed percentage of the total surgical relative value unit.

- (k) Intra-Operative Percentage Modifier: percentage of the global surgical package payable when the surgeon renders only intra-operative care.

Indicator	Meaning
%	The surgeon shall append modifier 54 when performing only the intra-operative portion of a surgical procedure. This modifier can be combined with either modifier 55 or 56, but not both. This column lists the allowed percentage of the total surgical relative value unit.

- (l) Post-Operative Percentage Modifier: percentage of the global surgical package payable when post-operative care is rendered by a provider other than the surgeon.

Indicator	Meaning
%	The surgeon shall append modifier 55 when performing only the post-operative portion of a surgical procedure. This modifier can be combined with either modifier 54 or 56, but not both. This column lists the allowed percentage of the total surgical relative value unit.

- (m) Multiple Procedure Modifier: the maximum allowance for the highest-valued procedure is 100% of the fee schedule, even if the provider appends modifier 51. The maximum allowance for the lesser-valued procedures performed in the same operative setting is 50% of the fee schedule.

Indicator	Meaning
0	No payment adjustment for multiple procedures applies. These codes are generally identified as "add-on" codes in CPT®.
1, 2, or 3	Standard payment reduction applies (100% for the highest-valued procedure and 50% for all lesser-valued procedures performed during the same operative setting).
4, 5, 6, or 7	Not subject to the multiple procedure adjustments.
9	Multiple procedure concept does not apply.

- (n) Bilateral Procedure Modifier.

Indicator	Meaning
0	Not eligible for the bilateral payment adjustment. Either the procedure cannot be performed bilaterally due to the anatomical constraints or another code more adequately describes the procedure.
1	Eligible for bilateral payment adjustment and shall be reported on one line with modifier 50 and "1" in the units box. Providers performing the same bilateral procedure during the same operative setting on multiple sites shall report the second and subsequent procedures with modifiers 50 and 59. Report on one line with one unit for each bilateral procedure performed. The maximum allowance is increased to 150%. If provider performs multiple bilateral procedures during the same setting, Payer shall apply the bilateral payment adjustment rule first, and then apply other applicable payment adjustments (e.g., multiple surgery).
2	Not eligible for the bilateral payment adjustment. These procedure codes are already bilateral.

3	Not eligible for the bilateral payment adjustment. Report these codes on two lines with RT and LT modifiers. There is one payment per line.
9	Not eligible for the bilateral payment adjustment because the concept does not apply.

- (o) Assistant Surgeon, Modifiers 80, 81, 82, or AS: the designation of "almost always" for a surgical code in the Physicians as Assistants at Surgery: 2023 Update (February 2023), published by the American College of Surgeons shall indicate that separate payment for an assistant surgeon is allowed for that code. If that publication does not make a recommendation on a surgical code or lists it as "sometimes" or "almost never," then RBRVS indicators shall determine whether separate payment for assistant surgeons is allowed.

Indicator	Meaning
0	Documentation of medical necessity and prior authorization is required to allow an assistant at surgery.
1	No assistant at surgery is allowed.
2	Assistant at surgery is allowed.
9	Concept does not apply.

No separate assistant surgeon or minimum assistant fees shall be paid if a co-surgeon is paid for the same operative procedure during the same surgical episode. See section 18-4(D)(1) for additional payment policies.

- (p) Co-Surgeon, Modifier 62.

Indicator	Meaning
1 or 2	Indicators may require two primary surgeons performing two distinct portions of a procedure. Modifier 62 is used with the procedure and maximum allowance is increased to 125% of the fee schedule value. The payment is apportioned to each surgeon in relation to the individual responsibilities and work, or it is apportioned equally between the co-surgeons.
0 or 9	Not eligible for co-surgery fee allowance adjustment. These procedures are either straightforward or only one surgeon is required or the concept does not apply.

- (q) Team Surgeon, Modifier 66.

Indicator	Meaning
0	Team surgery adjustments are not allowed.
1	Prior authorization is required for team surgery adjustments.

2	Team surgery adjustments may occur as a "BR." Each team surgeon must bill modifier 66. Payer must adjust the values in consultation with the billing surgeon(s).
9	Concept does not apply.

(r) Endoscopy base codes are not recognized for payment adjustments except when other modifiers apply.

(s) All other fields are not recognized.

(B) EVALUATION AND MANAGEMENT (E&M)

- (1) E&M codes may be billed by Physicians, NPs, and PAs, as defined in Rule 16. To justify the billed level of E&M service, medical records shall utilize CPT® E&M Services Guidelines and Exhibit #1 for office or other outpatient services.

To justify the level of E&M service billed based on time, the provider shall not count the time spent on other reportable codes.

- (2) New or Established Patients

An E&M visit shall be billed as a "new" patient service for each new injury or new Colorado workers' compensation claim even if the provider has seen the injured worker within the last three years.

Any subsequent E&M visits for the same injury billed by the same provider or another provider of the same specialty or subspecialty in the same group practice shall be billed as an "established patient" visit.

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

- (3) Number of Office Visits

All providers are limited to one office visit per injured worker, per day, per workers' compensation claim, unless prior authorization is obtained.

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

Minimum required documentation elements include:

- (a) Total time spent on medical discussion and date;
- (b) The injured worker, family member, or healthcare provider spoken with; and
- (c) Specific discussion and/or decision(s) made during the discussion.

Telephone or on-line services may be billed even if performed within the one day and seven day timelines listed in CPT®.

(5) Consultation/Referrals/Transfers of Care/Independent Medical Examinations:

A consultation occurs when a treating Physician seeks an opinion from another Physician regarding an injured worker's diagnosis and/or treatment beyond the treating Physician's expertise. CPT® 99242-99245 are payable codes.

To bill for a consultation, the Physician must document the following:

- (a) Identity of the Physician requesting the opinion;
- (b) The need for a consultant's opinion;
- (c) Statement that the report was submitted to the requesting Physician.

A transfer of care occurs when one Physician turns over the responsibility for the comprehensive care of an injured worker to another Physician.

An independent medical exam (IME) occurs when a Physician is requested to evaluate an injured worker by any party or party's representative and is billed in accordance with section 18-7(G).

(6) Prolonged Services:

Providers shall document the medical necessity of prolonged services utilizing patient-specific information. Providers shall comply with all applicable CPT® requirements and the following additional requirements.

- (a) Physicians or other qualified healthcare professionals (MDs, DOs, DCs, DMPs, NPs, and PAs) billing for extensive record review shall document the names of providers and dates of service reviewed, as well as briefly summarize each record reviewed.
- (b) Prolonged clinical staff services (RNs or LPNs) with physician or other qualified healthcare professional supervision:
 - (i) The supervising physician or other qualified healthcare professional may not bill for the time spent supervising clinical staff.
 - (ii) Clinical staff services cannot be provided in an urgent care or emergency department setting.
- (c) Providers shall bill the CPT® code for prolonged services.

CPT® 99417 Non-facility RVU is .92, facility RVU is .89

CPT® 99418 Non-facility and facility RVUs are 1.16

(C) ANESTHESIA

- (1) All anesthesia base values are set forth in Medicare's Anesthesia Base Units by CPT® code, as incorporated by section 18-2. 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 a CRNA or AA administers anesthesia:

- (a) CRNAs not under the medical direction of an Anesthesiologist shall be reimbursed 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 anesthesia means the Anesthesiologist performs the following:
- (i) examines and evaluates the injured worker before administering anesthesia
 - (ii) prescribes the anesthesia plan;
 - (iii) personally participates in the most demanding procedures in the anesthesia plan including, if applicable, induction and emergence;
 - (iv) ensures that any procedure in the anesthesia plan is performed by a qualified anesthetist;
 - (v) monitors 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) HCPCS Level II modifiers are required when billing for anesthesia services. Modifier AD shall be used when an Anesthesiologist supervises more than four concurrent (occurring at the same time) anesthesia service cases. Maximum allowance for supervising multiple cases is calculated using three base anesthesia units for each case, regardless of the number of base anesthesia units assigned to each specific anesthesia episode of care.
- (3) Physical status modifiers are reimbursed as follows, using the Anesthesia CF:

P-1	Healthy patient	0 RVUs
P-2	Patient with mild systemic disease	0 RVUs
P-3	Patient with severe systemic disease	1 RVU

P-4	Patient with severe systemic disease that is a constant threat to life	2 RVUs
P-5	A moribund patient who is not expected to survive without the operation	3 RVUs
P-6	A declared brain-dead patient whose organs are being removed for donor purposes	0 RVUs

- (4) Qualifying circumstance codes are reimbursed using the Anesthesia CF:

Anesthesia complicated by extreme age (under one or over 70 yrs)	1 RVU
Anesthesia complicated by utilization of total body hypothermia	5 RVUs
Anesthesia complicated by utilization of controlled hypotension	5 RVUs
Anesthesia complicated by emergency conditions (specify)	2 RVUs

- (5) Multiple procedures are billed in accordance with CPT®. When more than one surgical procedure is performed during a single episode, only the highest-valued base anesthesia procedure value is added to the total anesthesia time for all procedures.
- (6) Total minutes are reported for reimbursement. Each 15-minutes of anesthesia time equals one additional RVU. Five minutes or more is considered significant time and adds one RVU to the payment calculation.
- (7) Calculation of Maximum Allowance for Anesthesia:
- (a) Add the anesthesia base units, one unit for each 15 minutes of anesthesia time, and any physical status modifier units to calculate total relative value anesthesia units;
 - (b) Multiply the total relative value anesthesia units by the Anesthesia CF to calculate the total maximum anesthesia allowance.
- (8) Non-time based anesthesia procedures shall be billed with modifier 47.

(D) SURGERY

- (1) Assistant Surgeons Payment Policies and Modifiers:
- (a) The use of assistant surgeons shall be limited according to the American College of Surgeons' Physicians as Assistants at Surgery: 2023 Update (February 2023), available from the American College of Surgeons, Chicago, IL, or from its web page.

Provider shall document the medical necessity for any assistant surgeon in the operative report.
 - (b) Payment for more than one assistant surgeon or minimum assistant surgeon requires prior authorization.
 - (c) Maximum allowance for an assistant surgeon reported by a physician, as indicated by modifier 80, 81, or 82 is 20% of the fee schedule allowance.

- (d) Maximum allowance for a minimum assistant surgeon, reported by a non-physician, as indicated by modifier AS is 10% of the fee schedule allowance (the 85% adjustment in section 18-4(A)(2)(b) does not apply).
- (e) The services performed by registered surgical technologists are bundled fees and are not separately payable.

See section 18-4(A)(3) for additional payment policies applicable to assistant surgeons.

(2) Global Package:

- (a) Global surgical package rules apply in any setting, including inpatient and outpatient hospitals, ambulatory surgical centers, and physicians' offices. The payment rules for global surgical packages apply to surgical procedure codes with global surgery indicators of 000, 010, 090, and sometimes YYY. In addition to the services included pursuant to CPT®, the following services, when provided within the global period by a provider with the same specialty reporting the same Federal Employer Identification Number (FEIN), are included in the global surgical package:
 - (i) Pre-operative services performed within the global period (the day before surgery for procedures with global surgery indicators of 090, and the day of the surgery for all other procedures);
 - (ii) Complications following a procedure that require services of the physician, but not a return trip to the operating room;
 - (iii) Post-operative visits, including follow-up E&Ms, related to the patient recovery;
 - (iv) Post-surgical pain management;
 - (v) Supplies related to the procedure, unless otherwise addressed in this Rule;
 - (vi) Miscellaneous services related to the procedure such as dressing changes; local incision care; removal of operative pack; removal of cutaneous sutures, staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, and nasogastric and rectal tubes; and changes/removal of tracheostomy tubes.
- (b) Services not included in the global surgical package:
 - (i) Services by a provider who is not the same specialty unless the surgeon and the other provider agree on the transfer of care (for transfers of care, see pre-, intra-, and post-operative percentage modifiers);
 - (ii) The E&M service that resulted in the initial decision to perform the surgery. billed with modifier 57;

- (iii) Visits that are unrelated to the diagnosis for which the procedure was performed, billed with modifier 24 or 25;
 - (iv) Diagnostic tests and procedures (including lab and x-ray);
 - (v) Staged or related procedures or services that occur on the same day or staged over a couple of days, billed with modifier 58. The maximum allowance is 100% of the fee schedule.
 - (vi) Clearly distinct procedures during the post-operative period that are not re-operations or treatment for complications;
 - (vii) Treatment for post-operative complications requiring a return trip to the operating room or another place of service specifically equipped and staffed for the sole purpose of performing procedures, billed with modifier 78. The maximum allowance is the intra-operative value of the procedure(s) performed only and the original post-operative global days continue from the initial surgical procedure(s).
 - (viii) Increased procedural services (the work required to provide a service is substantially greater than typically required), billed with modifier 22. The Payer and Provider shall negotiate the value based on the fee schedule and the amount of additional work.
 - (ix) Significant and separately identifiable services, billed with modifier 24 or 25. These services are not considered part of the surgical procedure, but may be necessary to stabilize the patient for the procedure. These services may involve unusual circumstances, complications, exacerbations, or recurrences; and/or unrelated diseases or injuries. This category also includes an E&M visit by an ATP for disability management. Disability management for the same diagnosis requires the physician to identify specific disability management detail performed during that visit.
 - (x) Casting supplies if a related fracture or surgical care code is not billed. The HCPCS Level II "Q" code(s) are used for reporting any associated DMEPOS fees.
 - (xi) Immunosuppressive therapy for organ transplants.
- (3) General Surgical Payment Policies:
- (a) Exploration of a surgical site is not separately payable except in cases of a traumatic wound or an exploration performed in a separate anatomic location.
 - (b) An arthroscopy performed as a "scout" procedure to assess the surgical field or extent of disease is bundled into the surgical procedure performed on the same body part during the same surgical encounter and is not separately payable.

- (c) An arthroscopy converted to an open procedure is bundled into the open procedure and is not separately payable. In this circumstance, providers shall not report either a surgical arthroscopy or a diagnostic arthroscopy code.
 - (d) Only the joints/compartments listed in subsections (4) through (6) below are recognized for separate payment purposes.
 - (e) Providers shall report only one removal code for removal of implants through the same incision, same anatomical site, or a single implant system during the same episode of care.
- (4) Knee Arthroscopies:
- (a) Medial, lateral, and patella are the knee compartments recognized for purposes of separate payment of debridement and synovectomies.
 - (b) Chondroplasty is separately payable with another knee arthroscopy only if performed in a different knee compartment or to remove a loose/foreign body during a meniscectomy. The separate payment must comply with all applicable CPT® guidelines.
 - (c) Limited synovectomy involving one knee compartment is not separately payable with another arthroscopic procedure on the same knee.
 - (d) Separate payment for a major synovectomy procedure requires a synovial diagnosis and two or more knee compartments without any other arthroscopic surgical procedures performed in the same compartment.
- (5) Shoulder Arthroscopies:
- CPT® 29822 is not separately payable when another shoulder arthroscopy procedure is billed and paid on the same shoulder at the same encounter. CPT® 29823 is bundled with CPT® 29806 and 29807.
- (6) Spine and Nervous System:
- (a) Spinal manipulation is integral to spinal surgical procedures and is not separately payable.
 - (b) Surgeon performing a spinal procedure shall not report intra-operative neurophysiology monitoring/testing codes.
 - (c) If multiple procedures from the same CPT® code family are performed at contiguous vertebral levels, provider shall append modifier 51 to all lesser-valued primary codes. See section 18-4(A)(3) for applicable payment policies.
 - (d) Fluoroscopy is separately payable with spinal procedures only if indicated by a specific CPT® instruction.

- (e) Lumbar laminotomies and laminectomies performed with arthrodesis at the same interspace are separately payable if the surgeon identifies the additional work performed to decompress the thecal sac and/or spinal nerve(s). If these procedures are performed at the same level, provider shall append modifier 51 to the lesser-valued procedure(s). If procedures are performed at different interspaces, provider shall append modifier 59 to the lesser-valued procedure(s). See section 18-4(A)(3) for applicable payment policies.
 - (f) Only one anterior or posterior instrumentation performed through a single skin incision is payable.
 - (g) Anterior instrumentation performed to anchor an inter-body biomechanical device to the intervertebral disc space is not separately payable.
 - (h) Anterior instrumentation unrelated to anchoring the device is separately payable with modifier 59 appended.
 - (7) Venipuncture maximum fee allowance is addressed in section 18-4(F)(2).
 - (8) Platelet Rich Plasma (PRP) Injections:

The maximum allowance includes and applies to all body parts, imaging guidance, harvesting, preparation, the injection itself, kits, and supplies.

CPT® 0232T Non-facility RVU is 11.16, facility RVU is 4.04
 - (9) Functional Assessments:

If all requirements of the Medical Treatment Guidelines for pre- and post-injection functional assessments have been met and documented, the billing codes and maximum allowances are as follows:

DOWC Z0811, \$64.26, per episode for the initial functional assessment of pre-injection care, related to spinal or SI joint injections (may be performed by injectionist or non-injectionist no more than seven days prior to the injection).

DOWC Z0812, \$35.29, for a subsequent visit of therapeutic post-injection care (preferably done by a non-injectionist and at least seven 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 data.

DOWC Z0814, \$35.29, for post-diagnostic injection care (repeat functional assessment within the time period for the effective agent given).
- (E) RADIOLOGY
- (1) 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 (ADI) procedures (magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine scan). Providers reporting technical or total component of these services certify accreditation status. The provider shall supply proof of accreditation upon Payer request.
- (b) The cost of dye and contrast materials shall be reimbursed in accordance with section 18-6(A).
- (c) Copying charges for X-rays and MRIs shall be \$15.00/film regardless of the size of the film.
- (d) Providers using film instead of digital X-rays shall append the FX modifier. The allowance is 80% of the Maximum Fee Schedule.

If a physician interprets the same radiological image more than once, or if multiple physicians interpret the same radiological image, only one 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 allowance for an X-ray consultation shall be no greater than the maximum allowance 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 E&M service code.

- (2) Thermography:
 - (a) The provider supervising and interpreting the thermographic evaluation shall be certified by the examining board of one of the following national organizations and follow their recognized protocols, or have equivalent documented training:
 - (i) American Academy of Thermology;
 - (ii) American Chiropractic College of Infrared Imaging; or
 - (iii) American Academy of Infrared Imaging.
 - (b) Thermography Billing Codes:
 - DoWC Z0200 Upper Body w/ Autonomic Stress Testing \$980.00
 - DoWC Z0201 Lower Body w/Autonomic Stress Testing \$980.00
 - (c) Documentation must include:

- (i) Method of stress thermography supporting it was accomplished in a guideline-consistent fashion (cold water stress test, warm water stress test, or whole body thermal stress);
- (ii) Temperature readings via infrared thermography and their locations on the affected and contralateral extremity and/or copies of any pictures or graphics obtained; and
- (iii) Interpretation of the results.

(F) PATHOLOGY

(1) Clinical Laboratory Improvement Amendments (CLIA):

Only laboratories with a CLIA certificate of waiver may perform 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.

(2) Payments:

All clinical pathology laboratory tests, except as allowed by this Rule, are reimbursed at 170% of the rate listed in the CMS Clinical Diagnostic Laboratory Fee Schedule, as incorporated by section 18-2.

Technical or professional component maximum split is not separately payable, and therefore should be negotiated between billing parties when applicable.

When a physician clinical pathologist is required for consultation and interpretation, and a separate written report is created, the maximum allowance is determined by using RBRVS values and the Pathology CF. The Pathology CF also determines the maximum allowance when the Pathology CPT® code description includes "interpretation" and "report" or when billing CPT® codes for the following services:

- (a) physician blood bank services;
- (b) cytopathology and cell marker study interpretations;
- (c) cytogenics or molecular cytogenics 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 physician requested additional medical interpretation, judgment, and a separate written report. Upon such a request, the pathologist may bill using the appropriate CPT® code, not DoWC Z0755.

The maximum allowance for CPT® 80050 is \$39.95 (equal to the total allowance for CPT® 80053, 85004, and 85027).

(3) Clinical Drug Screening and Testing:

Clinical drug screening and testing may be appropriate for therapeutic drug monitoring, to assess compliance, or to identify illicit or non-prescribed drug use.

(a) Billing requirements for clinical drug testing:

- (i) documentation of medical necessity by the ordering Physician.
- (ii) the ordering Physician shall specify which drugs require definitive testing to meet the injured worker's medical needs.
- (iii) a Physician order for quantification of illicit or non-prescribed drugs or drug classes.

(b) Presumptive Tests:

All drug class immunoassays or enzymatic methods are considered presumptive. Payers shall only pay for one presumptive test per date of service, regardless of the number of drug classes tested.

(c) 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.

- These tests may be billed using G0480-G0483.
- Providers may only bill one definitive HCPCS Level II code per day.

A Physician must order definitive quantitative tests. 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 and noroxycodone

- Need for quantitative levels to compare with established benchmarks for clinical decision-making, such as tetrahydrocannabinol 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 receives chronic opioid management, additional drug screens with documented justification may be conducted (see section 18-9(A) for examples).

CPT® lists definitive drug classes and examples of individual drugs within each class. Each class of drug can only be billed once per day.

(G) MEDICINE

(1) 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 Biofeedback Certification International Alliance (BCIA), practice within the scope of their training, and receive prior approval of their biofeedback treatment plan from the injured worker's authorized treating Physician, or Psychologist. Professionals integrating biofeedback with any form of psychotherapy must be a Psychologist, a Clinical Social Worker, a Marriage and Family Therapist, or a Professional Counselor.

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

The modified RVUs for biofeedback are:

CPT® 90901 Non-facility RVU is 1.78, facility RVU is 1.76

CPT® 90875 Non-facility RVU is 2.13, facility RVU is 1.82

Psychophysiological therapy incorporating biofeedback is not subject to a reduction when performed by non-physician providers.

- (2)** Appendix J of CPT® identifies mixed, motor, and sensory nerve conduction studies and applicable billing requirements. For purposes of Appendix J, each nerve branch listed in that appendix counts as a separate nerve. Electromyography (EMG) and nerve conduction velocity values generally include an E&M service. However, an E&M service may be separately payable if the requirements listed in Appendix A of CPT® for billing modifier 25 have been met.
- (3)** Manipulation -- Chiropractic (DC), Medical (MD) and Osteopathic (DO):

- (a) Prior authorization shall be obtained before billing for more than four body regions in one visit.
- (b) Osteopathic Manipulative Treatment and Chiropractic Manipulative Treatment codes include manual therapy techniques, unless the Physician performs manual therapy in a separate region and meets modifier 59 requirements.
- (c) The modified RVUs for chiropractic spinal manipulative treatment are:

CPT® 98940	Non-facility RVU is 1.03, facility RVU is 0.81
CPT® 98941	Non-facility RVU is 1.48, facility RVU is 1.26

(4) Psychiatric/Psychological Services:

- (a) The maximum allowance for services performed by a Psychologist is 100% of the Medical Fee Schedule. The maximum allowance for psychological/ psychiatric services performed by other non-physician providers is 85% of the Medical Fee Schedule.
- (b) Psychological diagnostic evaluation code(s) are limited to one per provider, per admitted claim, unless it is authorized by the Payer or is necessary to complete an impairment rating recommendation as determined by the ATP.
- (c) Central Nervous System (CNS) Assessments/Tests:

When testing, evaluation, administration, and scoring services are provided across multiple dates of service, all codes should be billed on the last date of service when the evaluation process is completed. A base code shall be billed only for the first unit of service of the evaluation process, and add-on codes shall be used to capture services provided during subsequent dates of service. The limit for these services is 16 hours unless the provider obtains prior authorization.

Documentation shall include the total time and the approximate time spent on each of the following activities, when performed:

- face-to-face time with the patient;
- reviewing and interpreting standardized test results and clinical data;
- integrating patient data;
- clinical decision-making and treatment planning;
- report preparation.

If there is a delay in scheduling the feedback session, the provider may incorporate feedback into the first psychotherapy session.

The modified RVUs for psychological and neuropsychological services are:

CPT® 96116 Non-facility RVU is 3.50, facility RVU is 3.07

CPT® 96127 Non-facility and facility RVUs are 0.19

CPT® 96130 Non-facility RVU is 3.74, facility RVU is 3.50

CPT® 96131 Non-facility RVU is 3.00, facility RVU is 2.81

CPT® 96132 Non-facility RVU is 4.23, facility RVU is 3.29

CPT® 96133 Non-facility RVU is 3.20, facility RVU is 2.51

CPT® 96146 Non-facility and facility RVUs are 0.10

CPT® 90791 Non-facility RVU is 10.2, facility RVU is 8.80

CPT® 90792 Non-facility RVU is 11.45, facility RVU is 10.3

- (d) The limit for psychotherapy services is 60 minutes per visit, unless the Provider obtains prior authorization. The time for internal record review/documentation is included in this limit.

Psychotherapy for work-related conditions continuing for more than three months after the initiation of therapy requires prior authorization unless the MTGs recommend a longer duration.

- (e) When billing an E&M code in addition to psychotherapy:
- (i) both services must be separately identifiable;
 - (ii) the level of E&M must be based on history, exam, and medical decision-making;
 - (iii) time may not be used as the basis for the E&M code selection; and
 - (iv) the Provider must use add-on psychotherapy codes to indicate both services were provided.

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

- (f) A Provider billing for any stored clinical or physiological data analysis must obtain prior authorization.
- (g) Upon request of a party to a workers' compensation claim and pursuant to HIPAA regulations, a psychiatrist, psychologist or other qualified healthcare professional may generate a separate report and bill for that service as a special report.

- (5) Telephone or On-Line Services:

Reimbursement for coordination of care between medical professionals is limited to professionals outside of the Provider's practice.

Telephone services, including those listed in Appendix T and Telephone Services section of CPT®, shall be billed with a modifier 93.

The modified RVUs for the telephone and on-line services are:

CPT® 99421	Non-facility and facility RVUs are 0.38
CPT® 99422	Non-facility and facility RVUs are 0.75
CPT® 99423	Non-facility and facility RVUs are 1.19
CPT® 99441	Non-facility and facility RVUs are 1.03
CPT® 99442	Non-facility and facility RVUs are 1.95
CPT® 99443	Non-facility and facility RVUs are 2.86
CPT® 98966	Non-facility and facility RVUs are 0.27
CPT® 98967	Non-facility and facility RVUs are 0.53
CPT® 98968	Non-facility and facility RVUs are 0.75

For reimbursement of face-to-face or telephonic meetings by a treating Physician or Psychologist with employer, claim representative, or attorney, see section 18-7(A)(1).

- (6) 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 extremities and encompasses the following components:
 - (i) Resting Sweat Test;
 - (ii) Stimulated Sweat Test;
 - (iii) Resting Skin Temperature Test; and
 - (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) DoWC Z0401 QSART, \$1,066.00, is billed when all of the services outlined above are completed and documented. This code may only be billed once per workers' compensation claim, regardless of the number of limbs tested.
- (7) Intra-Operative Monitoring (IOM):
- IOM identifies 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:

- (i) Technical staff: A qualified technician shall set up the monitoring equipment in the operating room. The technician shall 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 in/registered with:
- the American Society of Neurophysiologic Monitoring; or
 - the American Society of Electrodiagnostic Technologists

- (ii) Professional/Supervisory/Interpretive:

A Colorado-licensed Physician trained in neurophysiology 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 Physician is monitoring more than one patient. The monitoring Physician's time does not have to be continuous for each patient and may be cumulative. The Physician shall not monitor more than three surgical patients at one time. The 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. There is no additional payment for the back-up neuro-monitoring Physician, unless utilized.

- (b) Procedures and Time Reporting:

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

- (c) Billing Restrictions:

Intra-operative neurophysiology codes do not have separate professional and technical components. However, certain tests performed in conjunction with these services have separate professional and technical components, which may be separately payable if documented and otherwise allowed in this Rule.

The neuromonitoring Physician is the only party allowed to report these codes.

The maximum allowance for CPT® 95941 is equal to the maximum allowance for CPT® 95940.

- (8) Speech-language therapy/pathology or any care rendered under a speech-language therapy/pathology plan of care shall be billed with a GN modifier.

- (9) Hearing and vision services are separately payable with a code from the Medicine Section of CPT®, in addition to the supplies payable per section 18-6(A)(1)(f). The maximum allowances for the following codes are as follows:

CPT® 92590	Non-facility value is \$165.90, facility value is \$93.80
CPT® 92591	Non-facility value is \$248.78, facility value is \$140.56
CPT® 92592	Non-facility value is \$60.31, facility value is \$34.07
CPT® 92593	Non-facility value is \$90.46, facility value is \$51.11
CPT® 92594	Non-facility value is \$60.31, facility value is \$34.07
CPT® 92595	Non-facility value is \$90.46, facility value is \$51.11

- (10) Vaccines, toxoids, immune globulins (including those with status "I"), serums, or recombinant products shall be billed using the appropriate J code or CPT® code listed in the Medicare Part B Drug Average Sale Price (ASP), as incorporated by Rule 18-2, unless the ASP value does not exist for the drug or the provider's actual cost exceeds the ASP. In these circumstances, the provider may request reimbursement based on the actual cost, after taking into account any discounts/rebates the provider may have received.

The maximum allowance for CPT® 90371 is \$800.

- (11) IV infusion therapy performed in a Physician's office or sent home with the injured worker 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 maximum allowance for infused therapeutic drugs shall be at cost to the billing provider.

Maximum allowance for supplies and medications provided by a Physician's office for self-administered home care infusion therapy are covered in section 18-6(B).

- (12) Moderate (Conscious) Sedation:

Providers billing for moderate sedation services shall comply with all applicable CPT® billing instructions. The maximum allowance is determined using the Medicine CF.

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

- (1) General Policies:

- (a) Modifiers:

- (i) Physical therapy or any care provided under a Physical Therapist's plan of care shall be billed with a GP modifier. Occupational therapy or any care provided under an Occupational Therapist's plan of care shall be billed with a GO modifier.

- (ii) Services provided in whole or in part by a Physical Therapist Assistant shall be billed with a CQ modifier. Services provided in whole or in part by an Occupational Therapist Assistant shall be billed with a CO modifier. "In part" is defined as exceeding the CPT® mid-point. The CQ and CO modifiers shall be billed in addition to the GP or GO modifiers.
 - (b) Each PM&R billed service must be clearly identifiable. The provider must clearly document the time spent performing each service and the beginning and end time for each session.
 - (c) Functional objectives shall be included in the PM&R plan of care for all injured workers. Any request for additional treatment must be supported by evidence of positive objective functional gains or PM&R treatment plan changes. The ordering ATP must also agree with the PM&R continuation or changes to the treatment plan.
 - (d) The injured worker shall be re-evaluated by the prescribing provider within 30 calendar days from the initiation of the prescribed treatment and at least once every month thereafter.
- (2) Medical nutrition therapy requires prior authorization.
- (3) Interdisciplinary Rehabilitation Programs:

As defined in the MTGs, interdisciplinary rehabilitation programs may include, but are not limited to: chronic pain, spinal cord, or brain injury programs.

All billing providers shall detail the services, frequency of services, duration of the program, and proposed fees for the entire program. The billing Provider and Payer shall attempt to 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 code Z0500.

Individual professionals billing separately for their participation in an interdisciplinary rehabilitation program shall use the applicable CPT® codes.

- (4) Procedures and Modalities:
- (a) Definitions:
 - (i) Procedure is any treatment listed in the Medicine/Physical Medicine and Rehabilitation section of CPT® under the sub-heading "Therapeutic Procedures." For purposes of this rule, the term "procedure" includes acupuncture.
- The billing maximums listed below are per discipline per day, unless medical necessity is documented and prior authorization is obtained. The total amount of time spent performing the procedures shall determine the appropriate number of time based units for a particular visit.

- (ii) Modality is any treatment listed in the Medicine/Physical Medicine and Rehabilitation section of CPT® under the sub-heading "Modalities."
- (b) Billing Restrictions:
 - (i) Provider may bill no more than two separate modality codes and no more than 60 minutes or four units of procedure codes on the same visit. This restriction does not apply to Special Tests referenced in subsection (6) below.
 - (ii) The maximum allowance for services billed by a Massage Therapist shall be 72% of the fee schedule.
 - (iii) The maximum allowance for services billed with a CQ or CO modifier shall be 85% of the fee schedule.
 - (iv) If provider performs another service concurrently with a time-based service, the time associated with the concurrent service shall not be included in the time used for reporting the time-based service.
 - (v) Electrical stimulation is not payable when billed with dry needling and performed on the same body part.
 - (vi) Providers shall specify all unlisted treatment in the medical record.

CPT® 97139	Non-facility and facility RVUs are 0.87
CPT® 97039	Non-facility and facility RVUs are 0.42
- (c) Acupuncture:
 - (i) All non-physician acupuncture providers must be Licensed Acupuncturists (L.Ac). Both Physician and L.Acs must provide evidence of training, and licensure upon request of the Payer.
 - (ii) New or established patient evaluation services are payable if the medical record specifies the appropriate history, physical examination, treatment plan, or evaluation of the treatment plan. Only evaluation services directly performed by a Physician or a L.Ac are payable. All evaluation notes or reports must be written and signed by the Physician or the L.Ac.

L.Ac new patient visit:	DOWC Z0800, \$103.84
L.Ac established patient visit:	DOWC Z0801, \$70.33
- (5) Evaluation Services for Physical Therapists (PTs), Occupational Therapists (OTs) and Athletic Trainers (ATs):

- (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, as outlined in CPT®. The provider shall clearly state the reason for the evaluation, the nature and results of the physical examination, and the reason for recommending the continuation or adjustment of the treatment protocol. 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 provider 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 re-examination, re-evaluation, or re-assessment is different from a progress note. Providers shall not bill these codes for a progress note. Providers may bill a re-evaluation code only if:

- (i) professional assessment indicates a significant improvement or decline or change in the injured worker's condition or a functional status that was not anticipated in the plan of care for that time interval;
- (ii) new clinical findings become known; or
- (iii) the injured worker fails to respond to the treatment outlined in the current plan of care.

- (b) A PT or OT may utilize a Rehabilitation Communication Form (WC 196) in addition to a progress note no more than every two weeks for the first six weeks, and once every four weeks thereafter.

The WC 196 form shall not be used for an evaluation, re-evaluation, or re-assessment. The form must be completed and specify which validated functional tool was used for assessing the injured worker. The form shall be sent to the referring physician before or at the injured worker's follow-up appointment with the physician.

DoWC Z0817 \$15.61.

- (c) Only evaluation services directly performed by a PT, OT, or AT are payable. All evaluation notes or reports must be written and signed by the PT, OT, or AT.
- (d) An injured worker may be seen by more than one healthcare professional on the same day. Each professional may charge an evaluation service with appropriate documentation per patient, per day.
- (e) The RVU for evaluation services performed by ATs shall be equal to the RVU for evaluation services performed by PTs.

- (6) Special Tests:

- (a) The following are considered special tests:

- (i) Job Site Evaluation
 - (ii) Functional Capacity Evaluation
 - (iii) Assistive Technology Assessment
 - (iv) Speech
 - (v) Physical performance test or measurement
 - (b) Billing Restrictions:
 - (i) The following services require prior authorization: Job site evaluations exceeding two hours; Assistive Technology Assessments and Work Tolerance Screenings for more than four hours per test or more than three tests per claim; and Functional Capacity Evaluations for more than four hours per test or two tests per claim.
 - (ii) The provider shall specify the time required to perform the test in 15-minute increments.
 - (iii) 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 PM&R professional before it is payable as a special test.
 - (c) All special tests must be fully supervised by a Physician, PT, OT, CCC-SLP, or Audiologist. Final reports must be written and signed by the Physician, PT, OT, CCC-SLP, or Audiologist.
- (7) Non-Medical Facility Fees:
- Gyms, pools, etc., and training or supervision by non-medical providers require prior authorization and a written negotiated fee for every three month period.
- (8) Work Hardening, Conditioning and Simulation:
- These programs and recommendations for coverage are defined in the MTGs. All procedures must be performed by or under the onsite supervision of a Physician, Psychologist, PT, OT, CCC-SLP, or Audiologist.
- | | |
|------------|---|
| CPT® 97545 | Non-facility and facility RVUs are 3.39 |
| CPT® 97546 | Non-facility and facility RVUs are 1.7 |
- (9) Wound Care:
- Wound care is separately payable only when devitalized tissue is debrided using a recognized method (chemical, water, vacuums).

(I) TELEMEDICINE

- (1) In addition to the healthcare services listed in Appendix P of CPT®, and Division Z- codes (when appropriate), services aligning with the following codes may be provided via telemedicine: G0396, G0397, G0406-G0408, G0425-G0427, G0447, G0459, G0508, G0509, 97129, 97130, 97150, 97542, and 97763. Additional services may be provided via telemedicine with prior authorization. The provider shall append modifier 95 to the appropriate code(s) to indicate synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system.

All treatment provided through telemedicine 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 Board of Psychologist Examiners, and shall follow applicable laws, rules, and regulations for informed consent.

- (2) HIPAA privacy and electronic security standards are required for the originating site and the rendering provider.
- (3) Reimbursement:
- (a) The rendering provider may be the only provider involved in the provision of telemedicine services. The rendering provider shall bill place of service (POS) code 02 or 10. Maximum allowance is the appropriate code's non- facility relative weight from RBRVS multiplied by the appropriate CF, unless only a facility weight is established.
- (b) An originating site fee may only be billed when the injured worker is receiving services at an authorized originating site. The originating site is responsible for verifying the injured worker and rendering provider's identities. Originating site must bill with the appropriate facility POS code. Authorized originating sites include::
- A Hospital (inpatient or outpatient)
 - A Critical Access Hospital (CAH)
 - A Rural Health Clinic (RHC)
 - A federally qualified health center (FQHC)
 - A hospital based renal dialysis center (including satellites)
 - A Skilled Nursing Facility (SNF)
 - A community mental health center (CMHC)

Maximum allowance for Q3014 is \$35.00 per 15 minutes. (Equipment, supplies, and professional fees of supporting providers at the originating site are not separately payable.)

- (5) Documentation:

Documentation requirements are the same as for a face-to-face encounter and shall also include the location of both the rendering provider and the injured worker at the time of service, and a statement on how the treatment was rendered through telemedicine (such as secured video).

18-5 FACILITY FEES

(A) INPATIENT FACILITY FEES

(1) Billing:

- (a) Inpatient facility fees shall be billed on a UB-04 and require summary level billing by revenue code. The provider must submit itemized bills along with the UB-04.
- (b) Hospitals reimbursed based on MS-DRGs shall indicate the MS-DRG code 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 per section 18-2 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.

(2) Reimbursement:

- (a) The following types of inpatient facilities, as defined in Rule 16, are allowed a reasonable charge as negotiated by the Provider and Payer:
 - (i) Children's Hospitals
 - (ii) Veterans Administration Hospitals
 - (iii) State-run Psychiatric Hospitals
 - (iv) Psychiatric Hospitals

The provider has the burden of proving reasonableness of reimbursement sought. Veterans Administration Hospital payments must comply with applicable rules promulgated by the United States Department of Veterans Affairs.

- (b) The following inpatient facilities, as defined in Rule 16, are allowed a daily rate:
 - (i) Skilled Nursing Facilities (SNFs) are allowed \$663 per day.
 - (ii) Rehabilitation Hospitals are allowed \$1,479 per day.
 - (iii) Long Term Acute Care Hospitals (LTACHs) are allowed \$3,417 per day.

Each of the daily rates listed above is all-inclusive for services related to the injured worker's compensable conditions. Physician's professional services, ambulance services, and chemotherapy drugs or radioisotopes may be billed separately. In the rare case extraordinary medical care is required, or for treatment of traumatic brain injuries or spinal cord injuries, there shall be an additional payment of \$306 on a per day basis.

All charges shall be submitted on a final bill unless the parties agree on interim billing. The rate in effect on the last date of service covered by an interim or final bill shall determine payment.

The total length of stay includes the date of admission but not the date of discharge. Typically, bed hold days or temporary leaves are not subtracted from the total length of stay.

(c) All other inpatient facilities:

The maximum allowance is determined by the relative weights for the assigned MS-DRG from Table 5 in effect per section 18-2 at the time of discharge and the hospital's base rate in Exhibit #2, calculated as follows:

$(\text{MS-DRG Relative Wt} \times \text{Specific hospital base rate} \times 160\%) + (\text{trauma center activation allowance}) + (\text{organ acquisition, when appropriate})$

- (i) For trauma center activation allowance, (revenue codes 680-684) see subsection (B)(8)(c);
- (ii) For organ acquisition allowance, (revenue codes 810-819) see subsection (A)(2)(g).

Table 5 establishes the maximum length of stay (LOS) using the "arithmetic mean LOS." However, there is no additional allowance for exceeding this LOS, other than through the cost outlier criteria.

An admission requiring the use of both an acute care hospital (admission/discharge) and its Rehabilitation Hospital (admission/discharge) is considered as one admission and MS-DRG.

(d) Outliers for inpatient hospitals identified in Exhibit #2:

Outliers are admissions with extraordinary cost warranting additional reimbursement beyond the maximum allowance. To calculate the additional reimbursement, if any:

- (i) Determine the hospital's cost by multiplying total billed charges (excluding any trauma center activation or organ acquisition billed charges) by the hospital's cost-to-charge ratio located in Exhibit #2;
- (ii) The difference = hospital's cost – maximum allowance excluding any trauma center activation or organ acquisition allowance;
- (iii) If the difference is greater than \$38,859, additional reimbursement is warranted. The additional allowance is determined by multiplying the difference by .80.

(e) If an injured worker is admitted to a hospital through the emergency department (ED), the ED fee is included in the inpatient allowance.

- (f) If an injured worker is admitted to one hospital and is subsequently transferred to another hospital, the payment to each hospital will be based upon a per diem value of the MS-DRG maximum allowance. The per diem value is calculated based upon the individual hospital's MS-DRG relative weight multiplied by the hospital's specific base rate divided by the MS-DRG geometric mean LOS established in Table 5. This per diem amount is multiplied by the actual LOS. If the patient is admitted and transferred on the same day, or transferred and discharged on the same day, the actual LOS equals one. If the LOS is greater than or equal to the geometric mean LOS for the MS-DRG, then the maximum MS-DRG is allowed for that hospital.
- (g) 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 billed charges to the organ acquisition allowance.

The MS-DRG adjusted billed charges are determined by subtracting the trauma center activation billed charge 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.

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

(B) OUTPATIENT FACILITY FEES

- (1) Provider Restrictions:
 - (a) All non-emergency outpatient surgeries require prior authorization unless the MTGs recommend a surgery for the particular condition. All outpatient surgical procedures performed in an ASC shall warrant performance at an ASC level.
 - (b) A facility fee is payable only if the facility is licensed as a hospital or an ASC by the Colorado Department of Public Health and Environment (CDPHE) or applicable out of state governing agency or statute.
- (2) Types of Bills for Service:
 - (a) Outpatient facility fees shall be billed on a 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 including, but not limited to, PT, OT, CCC-SLP, anesthesia, etc.) are subject to the RBRVS and Dental Fee Schedules as incorporated by this Rule. These fee schedules apply to professional services performed in all facilities.
 - (c) Outpatient hospital facility bills include all outpatient surgery, ED, clinics, Urgent Care, and diagnostic testing in the Radiology, Pathology or Medicine Section of CPT®/RBRVS.
- (3) General Reimbursement Instructions:
 - (a) The following outpatient facilities, as defined in Rule 16, are allowed a reasonable charge, as negotiated by the Provider and Payer, except for any associated professional fees that are reimbursed per section 18-4:
 - (i) Children's Hospitals
 - (ii) Veterans Administration Hospitals
 - (iii) State-run Psychiatric Hospitals

The Provider has the burden of proving reasonableness of reimbursement sought. Veterans Administration Hospital payments must comply with applicable rules promulgated by the United States Department of Veterans Affairs.
 - (b) The maximum allowance for Ambulatory Payment Classifications (APC) is calculated at the following percentages of the payment rates listed in Medicare's OPPS Addendum A, as incorporated by 18-2:
 - (i) Outpatient hospital is 160%
 - (ii) CAH is 200%
 - (iii) ASC is 150%

To identify which APC grouper is aligned with a CPT® code and dollar value, use Medicare's Addendum B, as incorporated by 18-2. For comprehensive APCs (C-APCs), see 18-5(B)(6).
 - (c) CPT® codes listed with a "C" status indicator in Medicare's Addendum B shall align to the APC codes as listed in Exhibit #4. The status indicator assigned to the Exhibit #4 APC code, as identified in Medicare's Addendum A, shall apply. These codes are not eligible for complexity-adjusted APC payments.
 - (d) Facilities receive the lesser of the actual charge or the fee schedule allowance. A line-by-line comparison of charges is not appropriate.
- (4) APC values include the services and revenue codes listed in Table 2 of the 2022 NFRM OPPS Claims Accounting, as incorporated by Rule 18-2; 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, or at cost to the facility.

Services and items included in the APC value:

- (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 for which separate payment is not allowed;
- (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;
- (l) post-operative pain blocks; and
- (m) implanted items.

- (5) Status Indicators from Medicare's Addendum B apply as follows:

Indicator	Meaning
A	Use another fee schedule instead of Addendum B, such as conversion factors listed in section 18-4, RBRVS RVUs, Ambulance Fee Schedule, or section 18-4(F)(2).
B	Is not recognized for Outpatient Hospital Services bill type (12x and 13x) and therefore is not separately payable unless separate fees are applicable under another section of this Rule.
C	The Division recognizes these procedures on an outpatient basis with prior authorization.
E	Not generally reimbursable 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 Addendum A, as incorporated by 18-2.
F	Corneal tissue acquisition, certain CRNA services, and Hepatitis B vaccines are allowed at a reasonable cost to the facility. The facility must provide a separate invoice identifying its cost.
G	"Pass-Through Drugs and Biologicals"; separate APC payment.

Indicator	Meaning
H	"Pass-Through Device"; separate APC payment based on cost to the facility.
J1 or J2	The services are paid through a comprehensive APC.
K	"Nonpass-Through Drug or Biological or Device" for therapeutic radiopharmaceuticals, brachytherapy sources, blood and blood products; separate APC payment.
L	Influenza Vaccine/Pneumococcal Pneumonia Vaccine and therefore is generally considered to be unrelated to work injuries.
M	Not separately payable.
N	Items and services packaged into APC rates; not separately payable.
P	Partial hospitalization paid based on observation fees outlined in this section.
Q1-Q4	Packaged services subject to separate payment criteria.
R	Blood and blood products; separate APC payment.
S	Significant procedure, not discounted when multiple.
T	Significant procedure, multiple procedure reduction applies.
U	Brachytherapy source; separate APC payment.
V	Clinic or an ED visit; separate APC payment.
Y	Non-implantable Durable Medical Equipment paid pursuant to Medicare's Durable Medical Equipment Regional Carrier fee schedule for Colorado.

(6) **Multiple Procedures**

- (a) A comprehensive APC treats all individually reported codes as representing components of the comprehensive service, resulting in a single prospective payment.

As defined by status indicator J1, all covered outpatient services on the claim are packaged with the primary J1 service for payment, except services with a status indicator of F, G, H, L, or U; ambulance services; diagnostic and screening mammography; rehabilitation therapy services reported on a separate claim; new technology services; and self-administered drugs.

When multiple codes with J1 status indicators are included on the claim, services are packaged with the primary (highest APC value) J1 code. Certain J1 codes, when billed together, may be eligible for a complexity adjusted APC payment listed on Medicare's Addendum J, as incorporated by 18-2.

Services with a status indicator J2 are assigned to a comprehensive APC (8011) when specific combinations of services are reported on the claim. All levels of emergency department (ED) and clinic visits, if billed in combination with observation time, can trigger this comprehensive composite rate. Payment of APC 8011 requires a minimum of eight units of G0378 *hospital observation service, per hour*; no status T procedure on the claim; and either an E&M visit on the same day or day before the G0378 date of service; or G0379 *direct admit to observation*.

All covered services on the claim shall be considered adjunct to APC 8011 and packaged into a single payment, except those items excluded by rule. Other excluded services include covered screening procedures, preventative services, pass-through drugs and devices (status indicator G or H), PT, OT, and SLP services reported on a separate claim, certain vaccines (status indicator L or F), cornea tissue acquisition, and new technology APCs with status indicator S. If the claim contains a J1 primary service, the J1 C-APC will be the composite under which the services will be paid. There is no complexity adjustment for J2 occurring on the same claim as J1.

If services with a J2 status indicator are provided during an extended assessment and management encounter, including observation care, and do not meet all the requirements for APC 8011 listed above, the usual APC logic will apply.

- (b) Codes with a status Q1 indicator are packaged with the APC payment if billed on the same claim as a HCPCS code assigned status indicator S, T, or V. Otherwise, payment is made through a separate APC.

Codes with a Q2 indicator are packaged with the APC payment if billed on the same claim as a HCPCS code assigned status indicator T. Otherwise, payment is made through a separate APC. When multiple codes with status Q1 or Q2 are billed together, only one unit of the highest-valued Q1 or Q2 code is payable.

Codes with a status Q3 indicator may be paid through a composite APC if billed with another code in the same family listed in Table 3 of the OPPS Imaging Families and Multiple Procedure Composite APCs, of the 2023 OPPS Final Rule. The five multiple imaging composite APCs are:

- APC 8004 (Ultrasound Composite);
- APC 8005 (CT and CTA without Contrast Composite);
- APC 8006 (CT and CTA with Contrast Composite);
- APC 8007 (MRI and MRA without Contrast Composite); and
- APC 8008 (MRI and MRA with Contrast Composite).

Each imaging composite APC is defined as having two or more imaging procedures from the same family performed on the same date of service. If a "without contrast" procedure is performed during the same session as a "with contrast" procedure from the same family, payment would be based on the "with contrast" composite APC. Standard APC assignments apply for single imaging procedures and multiple imaging procedures performed across families.

Codes with a status Q4 indicator are packaged with the APC payment if billed on the same claim as a HCPCS code assigned status indicator S, T, V, Q1, Q2, or Q3. Otherwise, payment is made through a separate APC.

- (c) The maximum allowance for multiple procedures with a T status indicator is limited to four procedure codes per episode. The highest valued APC code is allowed at 100% of the maximum allowance, plus 50% of the maximum allowance for the following three highest valued codes.

- (i) The use of modifier 51 is not a factor in determining which codes are subject to multiple procedure reductions.
- (ii) Bilateral procedures require each procedure to be billed on separate lines using RT and LT modifier(s).
- (iii) When a code is billed with multiple units, multiple procedure reductions apply to the second through fourth units as appropriate. Units may also be subject to other maximum frequency per day policies.

- (7) Other surgical payment policies:

- (a) All surgical procedures performed in one operating room, regardless the number of surgeons, are considered one outpatient surgical episode of care for payment purposes.
- (b) Discontinued surgeries require the use of modifier 73 (discontinued prior to the administration of anesthesia) or modifier 74 (discontinued after administration of anesthesia). Modifier 73 results in an allowance of 50% of the APC value for the primary procedure only. Modifier 74 allows 100% of the primary procedure value only. If a comprehensive APC procedure is discontinued or reduced and modifier 52, 73 or 74 is reported, complexity adjustment will not apply to the claim.
- (c) Facilities shall report G0260 when billing for sacroiliac joint injections, not CPT® 27096.

- (8) Emergency Department (ED) Visits:

- (a) Types of ED Visits:
 - (i) Hospitals billing type "A" ED visits 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 be open 24 hours a day, seven days a week. These EDs bill using revenue code 450 and applicable CPT® codes;

- (ii) A freestanding type "B" ED must have operations and staffing equivalent to a licensed ED, be physically located inside 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 hours a day, seven days a week.
- (b) ED level of care is identified based upon one of five levels of care for either a type "A" or type "B" ED visit. The level of care is defined by CPT® E&M code descriptions and internal level of care guidelines developed by the hospital in compliance with Medicare regulations. The hospital's guidelines should establish an appropriate gradation of hospital resources (ED staff and other resources) as the level of service increases. Upon request, the provider shall supply a copy of its level of care guidelines to the Payer. (Only the higher one of any ED levels or critical care codes shall be paid).
- (c) Trauma activation means a trauma team has been activated, not just alerted. Trauma activation is billed with 068X revenue codes. The level of trauma activation shall be determined by CDPHE's assigned hospital trauma level designation. Trauma activation fees are in addition to ED and inpatient fees and are not paid for alerts. APC 5045, Trauma Response with Critical Care, is not recognized for separate payment.

Trauma activation allowances are as follows:

Revenue Code 681	\$5,534.00
Revenue Code 682	\$2,298.00
Revenue Code 683	\$1,289.00
Revenue Code 684	\$954.00

(9) Ancillary Services:

- (a) Any diagnostic testing, clinical labs, or therapies with a status indicator of "A" shall be reimbursed using section 18-4(F)(2) 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. Off-campus freestanding imaging centers are reimbursed using the RBRVS TC value(s).
- (b) Professional fees are reimbursed in accordance with section 18-4 regardless of the facility type. Additional reimbursement is payable for the following services not included in the APC values, as incorporated by 18-2:
 - (i) ambulance services (revenue code 540), see section 18-6(E)
 - (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 CCC-SLP, revenue codes 420, 430, 440)
- (c) Any prescription for a drug supply to be used for longer than 24 hours, filled at any clinic, shall be reimbursed in accordance with section 18-6(C).
- (d) Clinic facility fees are not separately payable unless otherwise specified in this Rule.
- (e) IV infusion therapy performed in an outpatient hospital facility is separately payable in accordance with this section.

(10) Rural Health Clinics:

Rural Health Clinics are allowed a single separate clinic facility fee at 80% of billed charges per date of service.

Allowed revenue codes for clinic fees are 521 for physical health services and 900 for behavioral health services.

(C) URGENT CARE FACILITIES

(1) Provider Restrictions:

Facility fees are only payable if the facility qualifies as an Urgent Care facility. All Urgent Care facilities shall be accredited or certified by the Urgent Care Association (UCA) or accredited by the Joint Commission to be recognized for a separate facility payment for the initial visit.

(2) Billing and Maximum Allowances:

(a) Facility Fees:

- (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 a UB-04 using revenue code 516 or 526 and the facility HCPCS code S9088, \$76.50, with one unit. All maximum allowances for other services billed on the UB-04 shall be in accordance with CPT® relative weights from RBRVS, multiplied by the appropriate CF.
- (iv) Hospital and non-hospital based urgent care facilities may bill for the facility fee, HCPCS code S9088, \$76.50, on the CMS-1500 with professional services. All other services and procedures provided in an urgent care facility, including a freestanding facility, are allowed according to the appropriate CPT® code relative weight from RBRVS multiplied by the appropriate CF.
- (b) All professional fees shall be billed on a CMS-1500 with a Place of Service Code 20 and reimbursed in accordance with section 18-4.
- (c) All supplies are included in the facility fee.
- (d) Any prescription for a drug to be used for longer than 24 hours, filled at any clinic, shall be reimbursed in accordance with section 18-6(C).

18-6 ANCILLARY SERVICES

(A) DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS)

(1) Durable Medical Equipment (DME):

DME equipment withstands repeated use and allows injured workers accessibility in the home, work, and community. DME can be categorized as:

(a) Purchased Equipment/Capped Rental:

- (i) Items that cost \$100.00 or less may not be rented.
- (ii) Rented items must be purchased or discontinued after ten months of continuous use or once the total fee schedule allowance has been reached.
- (iii) The monthly rental rate cannot exceed 10% of the DMEPOS fee schedule, or if not available, the cost of the item to the provider or the supplier (after taking into account any discounts/rebates the supplier or the provider may have received). When the item is purchased, all rental fees shall be deducted from the total fee scheduled price. If necessary, the parties should use an invoice to establish the purchase price.
- (iv) Purchased items may require maintenance/servicing agreements or fees. The fees are separately payable. Rented items typically include these fees in the monthly rental rates.
- (v) Modifier NU shall be appended for new, UE for used purchased items or modifier RR for rented items.

(b) Take Home Exercise Equipment:

Items with a total invoice cost of \$50 or less may be billed using A9300 at no more than 120% of actual cost, without an invoice. Reimbursement shall be based on billed charges. Payers reserve the right to retroactively review invoices to validate the provider's cost, per Rule 16. 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.

(c) Electrical Stimulators:

Electrical stimulators are bundled kits that include the portable unit(s), two to four leads and pads, initial battery, electrical adapters, and carrying case. Kits that cost more than \$300.00 shall be rented for the first month of use and require documentation of effectiveness prior to purchase (effectiveness means functional improvement and decreased pain).

- (i) TENS (Transcutaneous Electric Nerve Stimulator) machines/kits, IF (Interferential) machines/kits, and any other type of electrical stimulator combination kits: E0720 for a kit with two leads or E0730 for a kit with four leads.
- (ii) Electrical Muscle Stimulation machines/kits: E0744 for scoliosis; or E0745 for neuromuscular stimulator, electric shock unit.
- (iii) Osteogenesis electrical stimulators (E0747-E0760) are not required to be rented before purchase when used in accordance with MTG recommendations.
- (iv) Replacement supplies are limited to once per month and are not eligible with a first month rental.

A4595 - electrical stimulator supplies, two leads.

A4557 - lead wires, pair (reimbursable once every 12 months).

(v) Conductive Garments: E0731.

(d) Continuous Passive Motion Devices (CPMs):

These devices are bundled into the facility fees and not separately payable, unless the MTGs recommend their use after discharge for the particular condition.

E0935 – continuous passive motion exercise device for use on the knee only.

E0936 – continuous passive motion exercise device for use on body parts other than knee.

(e) Intermittent Pneumatic Devices:

These devices (including, but not limited to, cold with compression) are bundled into facility fees and are not separately payable. The use of these devices after discharge requires prior authorization.

E0650-E0676 – Codes based on body part(s), segmental or not, gradient pressure and cycling of pressure, and purpose of use.

A4600 – Sleeve for intermittent limb compression device, replacement only, per each limb.

(f) Hearing and Vision Supplies:

These items are purchased. The maximum allowance is 120% of the cost to the provider as indicated by invoice. The maximum allowance for V2623 (prosthetic eye) and L8045 (auricular prosthesis) shall be based on 120% of the cost of the item as indicated by invoice.

(2) Orthotics:

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

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.

(3) Supplies:

Supplies necessary to perform a service or procedure are 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. Allowances for supplies to facilities shall comply with the appropriate section of this Rule.

(4) Reimbursement:

Unless other limitations exist in this Rule, the maximum allowance for DMEPOS suppliers and medical providers shall be based on Medicare's HCPCS Level II codes, when one exists, as established in the January 2023 DMEPOS schedule for rural (R) or non-rural (NR) areas.

If no Medicare value exists, the maximum allowance shall be based on the total allowable amount listed in Medicaid's Health First Colorado Fee Schedule Effective January 1, 2023.

If no Medicaid fee schedule value exists, the maximum allowance is based on 120% of the cost of the item as indicated by invoice. For inventoried items, "invoice" means a statement given to the Provider by its supplier showing the Provider's cost of obtaining the item. For fabricated/customized items, "invoice" means a statement prepared by the Provider showing the amount due after accounting for fabrication and necessary customization. Shipping and handling charges are not separately payable. Payers shall not recognize the KE modifier.

Auto-shipping of monthly DMEPOS is not allowed. An affirmative request by the injured worker or prescribing provider is required.

- (5) Complex Rehabilitation Technology dispensed and billed by Non-Physician DMEPOS Suppliers:
 - (a) Complex rehabilitation technology (CRT) items, including complex rehabilitation power wheelchairs, highly configurable manual wheelchairs, adaptive seating and positioning systems, 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.

(B) HOME CARE SERVICES

Prior authorization is required for all home care services, unless otherwise specified. 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, 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 injured worker's home.

Skilled Nursing fees are separately payable when the nurse travels to the injured worker's home to perform initial and subsequent evaluation(s), education, and coordination of care.

(a) Parenteral Nutrition:

Code	Quantity	Max Bill Frequency	Daily Rate
S9364	<1 Liter	once per day	\$160.00
S9365	1 liter	once per day	\$174.00
S9366	1.1 - 2.0 liter	once per day	\$200.00
S9367	2.1 - 3.0 liter	once per day	\$227.00
S9368	> 3.0 liter	once per day	\$254.00

The daily rate includes the standard total parenteral nutrition (TPN) formula. Lipids, specialty amino acid formulas, and drugs other than those in standard formula are separately payable under section 18-6(C).

(b) Antibiotic Therapy is allowed a daily rate by professional + drug cost at Medicare's Average Sale Price (ASP), as incorporated by Rule 18-2. If ASP is not available, use Average Wholesale Price (AWP) (see section 18-6(C)).

Code	Time	Max Bill Frequency	Daily Rate
S9494	Per diem	once per day	\$158.00
S9497	once every 3 hours	once per day	\$152.00
S9500	every 24 hours	once per day	\$97.00
S9501	once every 12 hours	once per day	\$110.00
S9502	once every 8 hours	once per day	\$122.00
S9503	once every 6 hours	once per day	\$134.00
S9504	once every 4 hours	once per day	\$146.00

(c) Chemotherapy is allowed a daily rate + drug cost at ASP, as incorporated by Rule 18-2. If ASP is not available, use AWP.

Code	Description	Max Bill Frequency	Daily Rate
S9329	Administrative Services	once per day	\$0.00
S9330	Continuous (24 hrs. or more) chemotherapy	once per day	\$91.00
S9331	Intermittent (less than 24 hrs.)	once per day	\$103.00

- (d) Enteral nutrition (enteral formula and nursing services are separately payable):

Code	Description	Max Bill Frequency	Daily Rate
S9341	Via Gravity	once per day	\$44.09
S9342	Via Pump	once per day	\$24.23
S9343	Via Bolus	once per day	\$24.23

- (e) Pain Management per day or refill + drug cost at ASP, as incorporated by Rule 18-2. If ASP is not available, use AWP.

Code	Description	Max Bill Frequency	Daily Rate
S9326	Continuous (24 hrs. or more)	once per day	\$79.00
S9327	Intermittent (less than 24 hrs.)	once per day	\$103.00
S9328	Implanted pump	per diem	\$116.00/refill.

- (f) Fluid Replacement is allowed a daily rate + drug cost at ASP, as incorporated by Rule 18-2. If ASP is not available, use AWP.

Code	Quantity	Max Bill Frequency	Daily Rate
S9373	< 1 liter per day	once per day	\$61.00
S9374	1 liter per day	once per day	\$85.00
S9375	>1 but <2 liters per day	once per day	\$85.00
S9376	>2 liters but <3 liters	once per day	\$85.00
S9377	>3 liters per day	once per day	\$85.00

- (g) Multiple Therapies:

Highest cost per day or refill only + drug cost at ASP, as incorporated by Rule 18-2. If ASP is not available, use AWP.

- (2) Nursing Services are limited to two hours without prior authorization, unless otherwise indicated in the MTGs:

Code	Type of Nurse	Max Bill Frequency	Hourly Rate
S9123	RN	2 hours	\$127.50
S9124	LPN	2 hours	\$127.50

S9122	CNA	The amount of time spent with the injured worker must be specified in the medical records and on the bill.	\$51.00
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- (3) Physical medicine procedures are payable in accordance with section 18-4(H).

- (4) Mileage:

The parties should agree upon travel allowances and the mileage rate shall not exceed 59 cents per mile, portal to portal. DoWC Z0772.

- (5) Travel Time:

Travel is typically included in the fees listed. Travel time greater than one hour one-way is allowed additional reimbursement not to exceed \$35.37 per hour. DoWC Z0773.

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

As defined in section 18-6(A), any drugs/supplies/DME/Orthotics/Prosthetics integral to a professional's service are not separately payable.

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

(C) DRUGS AND MEDICATIONS

- (1) All medications must be reasonably needed to cure and relieve the injured worker from the effects of the injury. Prior authorization is required for:

- (a) Medications "not recommended" in the MTGs for a particular diagnosis; or
- (b) Any non-steroidal anti-inflammatory drug (NSAID), muscle relaxant, or topical agent for which a significantly lower-cost therapeutic equivalent is available, including commercially or over-the-counter (OTC), even in a different strength/dosage. Significantly lower cost means the therapeutic equivalent costs at least \$100 less, for the same number of days' supply. For example, prior authorization would be required to dispense diclofenac gel 1.5% at an average wholesale price (AWP) of \$689 when diclofenac 1% is available OTC for \$10, or to dispense more than one unit of lidocaine 4.5%-menthol 5% patch at an AWP of \$49 when a lidocaine 4%-menthol 5% patch can be obtained OTC for \$2.

- (2) Prescription Writing:

- (a) This Rule applies to all pharmacies, whether located in or out of state.
- (b) Physicians shall indicate on the prescription form that the medication is related to a workers' compensation claim.

- (c) 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 Rule 16 requirements, providers prescribing a brand name with a DAW indication shall provide a written medical justification explaining the reasonableness and necessity of the brand name over the generic equivalent.
 - (d) The provider shall not exceed a 60-day supply per prescription.
 - (e) Opioids/scheduled controlled substances, including benzodiazepines, shall only be provided through a pharmacy. The prescriber shall comply with applicable provisions of Title 12 and other statutes and rules.
- (3) Billing:
 - (a) 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).
 - (b) All parties shall use one (1) of the following forms:
 - (i) CMS-1500 – dispensing provider shall bill by using the metric quantity (number of tablets, grams, or mls) in column 24.G and NDC number of the drug being dispensed or, if one does not exist, the HCPCS supply code. For repackaged drugs, dispensing provider shall list the “repackaged” and the “original” NDC numbers in field 24 of the CMS-1500. The dispensing provider shall list the “repackaged” NDC number of the actual dispensed medication first and the “original” NDC number second, with the prefix ‘ORIG’ appended. Billing providers shall include the units and days supply for all dispensed medications in field 19, example: ‘60UN/30DY.’
 - (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 above 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.
 - (c) Dispensing provider shall keep a signature on file indicating the injured worker or the injured worker’s authorized representative has received the prescription.
- (4) Average Wholesale Price (AWP):
 - (a) AWP for brand name and generic pharmaceuticals may be determined using such monthly publications as Red Book Online or Medispan. In case of a dispute on AWP values for a specific NDC, the parties shall take the lower of their referenced published values.

- (b) If published AWP data becomes unavailable, substitute Wholesale Acquisition Cost (WAC) + 20% for AWP everywhere in this Rule.
- (5) Reimbursement for Prescription 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 §12-30-110, to an 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) Injectables shall be reimbursed at Medicare's Part B Drug Average Sale Price (ASP), as incorporated by Rule 18-2, unless the ASP value does not exist for the drug or the provider's actual cost exceeds the ASP. In this circumstance, provider may request reimbursement based on the actual cost, after taking into account any discounts/rebates the provider may have received.
 - (e) The provider may bill for the discarded portion of drug from a single use vial or a single use package, appending the JW modifier to the HCPCS Level II code. The provider shall bill for the discarded drug amount and the amount administered to the injured worker on two separate lines. The provider must document the discarded drug in the medical record.
- (6) 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, \$83.23 per 30 day supply

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

Category II Z0791, \$166.46 per 30 day supply

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

Category III Z0792, \$275.71 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, \$384.95 per 30 day supply

Two 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 MTGs 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, 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 allowances 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 allowances. The 30 day maximum allowance value shall be fractioned down to the prescribed and dispensed amount given to the injured worker. Automatic refilling is not allowed.

(7) Over-the-Counter Medications:

- (a) Medications that are available for purchase by the general public without a prescription and listed as over-the-counter in publications such as RedBook Online or Medispan, 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 allowance for any topical agent containing only active ingredients available without a prescription shall be at cost to the billing provider up to \$30.60 per 30 day supply for any application (excludes patches). The maximum allowance for a patch is cost to the billing provider up to \$71.40 per 30 day supply. When less than a 30 day supply is prescribed, these allowances shall be pro-rated to the amount dispensed to the injured worker.

DoWC Z0794 per 30 day supply for any application (excludes patches).
DoWC Z0795 per 30 day supply for patches.

See subsection (6) for prescription-strength topicals and patches.

(8) Dietary Supplements, Vitamins, and Herbal Medicines:

Reimbursement for outpatient dietary supplements, vitamins, and herbal medicines is authorized only by prior agreement of the Payer or if specifically indicated in the MTGs. Reimbursement shall be at cost to the injured worker (see subsection (9) below).

(9) Injured Worker Reimbursement:

In the event the injured worker has directly paid for authorized medications (prescription or over-the-counter), the Payer shall reimburse the injured worker for the amount actually paid within 30 days after submission of the injured worker's receipt. See Rule 16.

(D) COMPLEMENTARY INTEGRATIVE MEDICINE

Complementary integrative medicine describes 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 complementary integrative medicine that are not listed in Rule 16 must have completed training in one or more forms of therapy and certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in Chinese herbology.

(E) AMBULANCE TRANSPORTATION

(1) Maximum Allowance:

The maximum allowance for medical transportation consists of a base rate and a payment for mileage. Both the transport of the injured worker and all items and services associated with such transport are included in 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. All other providers shall bill on the CMS-1500.
- (b) Providers shall use HCPCS codes and origin/destination modifiers.
- (c) Providers shall list their name, complete address, and NPI number.
- (d) Providers shall list the zip code for the place of origin in Item 23 of the CMS-1500 or FL 39-41 of the UB-04 with an "AO" 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 Ambulance Services Billing Codes and Fees:

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.

HCPCS	Base Rate	URBAN BASE RATE/ URBAN MILEAGE	RURAL BASE RATE/ RURAL MILEAGE	RURAL BASE RATE/ SUPER RURAL MILEAGE	RURAL GROUND MILES
A0425	\$17.08	\$17.42	\$17.60	n/a	\$26.40
A0426	\$531.08	\$672.80	\$679.38	\$832.92	n/a
A0427	\$531.08	\$1,065.26	\$1,075.70	\$1,318.80	n/a
A0428	\$531.08	\$560.66	\$566.16	\$694.12	n/a
A0429	\$531.08	\$897.06	\$905.86	\$1,110.58	n/a
A0432	\$531.08	\$981.16	\$990.78	n/a	n/a
A0433	\$531.08	\$1,541.82	\$1,556.94	\$1,908.80	n/a
A0434	\$531.08	\$1,822.14	\$1,840.02	\$2,255.86	n/a

The “urban” base rate(s) and mileage rate(s) shall apply 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, revised May 2023.

(4) **Modifiers:**

HCPCS modifiers identify place of origin and destination of the trip. The modifier is to be placed next to the HCPCS code billed. Each of the modifiers may be utilized to make up the first and/or second half of a two-letter modifier. The first letter describes the origin of the transport, and the second letter describes the destination.

(5) **Mileage:**

Charges for mileage must be based on loaded mileage only, i.e., from pickup to destination.

18-7 DIVISION-ESTABLISHED CODES AND VALUES

(A) **FACE-TO-FACE OR TELEPHONIC MEETINGS**

- (1) Face-to-face or telephonic meeting by a treating Physician or a Psychologist with an employer, claim representative, or any attorney, and with or without the injured worker. Claim representatives include physicians or other qualified medical personnel performing Payer-initiated medical treatment reviews, but this Rule does not apply to provider-initiated requests for prior authorization. The Physician or Psychologist may bill for the time spent 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.

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

- (a) Each meeting (including the time to document) shall be a minimum of 8 minutes.
- (b) A report or written record signed by the Physician or Psychologist 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).
- (c) DoWC Z0701, \$44.22, is payable in 8-minute increments. The CPT® mid-point rule for attaining a unit of time does not apply to this code. The Physician or Psychologist may bill multiple units of this code per date of service.
- (d) For reimbursement to qualified non-physician providers for coordination of care with medical professionals, see section 18-4(H).

- (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.

DoWC Z0601, \$76.99 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 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 18-7(G)(4)).
- (4) Peer-to-peer review by a treating physician with a medical reviewer, following the treating physician's complete prior authorization request pursuant to Rule 16.

DoWC Z0602, \$76.99 per 15 minutes billed to the requesting party.

(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 five days prior to the appointment.

The Payer shall pay one-half of the usual fee for the scheduled services, or \$187.27, whichever is less:

DoWC Z0720. The provider shall indicate the code corresponding to the service that has been cancelled in Box 19 of the CMS-1500 form or electronic billing equivalent.

For Payer-made appointments scheduled for four hours or longer, the Payer shall pay one-half of the usual fee for the scheduled service.

DoWC Z0740. The Provider shall indicate the code corresponding to the service that has been cancelled in Box 19 of the CMS-1500 form or electronic billing equivalent.

(2) Missed Appointments:

When an injured worker fails to keep a scheduled appointment, the Provider should contact the Payer within five days. Upon reporting the missed appointment, the Provider may inquire if the Payer wishes to reschedule the appointment for the injured worker. If the injured worker fails to keep the Payer's rescheduled appointment, the Provider may bill for a cancellation fee according to this section.

(C) REQUESTS FOR MEDICAL RECORDS AND 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. Copying charges do not apply for the initial submission of records that are part of the required documentation for billing. If records are readily producible electronically and appropriate security is in place, including but not limited to compatible encryption, the provider shall provide the requestor with an electronic copy (e.g., email). If the requester and Provider agree, the copy may be provided by fax, on paper, or by disc. Provider may not charge a fee for a records search and retrieval. All records shall be provided no later than 30 days from the date the request is received.

Copying Fee Billing Codes and Maximum Fees:

DoWC Z0721, \$18.53 for first 10 or fewer paper page(s), including faxed documents

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

DoWC Z0726, \$0.57 per paper page for remaining paper page(s), including faxed documents

DoWC Z0727, \$1.50 per microfilm page

DoWC Z0728, \$14.00 per computer disc

DoWC Z0729, \$6.50 per electronic copy

DoWC Z0802, actual postage paid

(D) DEPOSITION AND TESTIMONY FEES

- (1) When requesting deposition or testimony from any Provider, guidance should be obtained from the Interprofessional Code, endorsed 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 periods and/or fees, the deposition and testimony rules and fees listed below shall be used.

If a party shows good cause to an Administrative Law Judge (ALJ) for exceeding the Medical Fee Schedule allowance, that ALJ may allow a greater fee.

(2) Preparation Time:

By prior agreement, the Provider may charge for preparation time for a deposition or testimony, for reviewing and signing the deposition, or for preparation time for testimony.

Treating or non-treating Physician or Psychologist:

DoWC Z0730, \$190.74, billed in half-hour increments. Other Providers are allowed 85% of this fee.

(3) Deposition:

Payment for testimony at a deposition shall not exceed \$190.74, billed in half-hour increments, for a treating or non-treating Physician or a Psychologist. DoWC Z0734, calculating the Provider's time from "portal to portal." Other Providers are allowed 85% of this fee.

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 ten days prior to the scheduled deposition, the Provider shall be paid the number of hours that have been reasonably spent in preparation, less any deposit paid by the deposing party. DoWC Z0731, \$190.74, in half-hour increments.

If the Provider is notified less than ten days in advance of a cancellation or rescheduling, or the deposition is shorter than the time scheduled, the Provider shall be paid the number of hours that have been reasonably spent in preparation and have been scheduled for the deposition. DoWC Z0733, \$190.74, in half-hour increments.

(4) Testimony:

Treating or non-treating Physician or Psychologist:

DoWC Z0738, \$264.18, billed in half-hour increments. Other Providers are allowed 85% of this fee.

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-hour deposit in advance in order to schedule the testimony.

If the Provider is notified of the cancellation of the testimony at least ten days prior to the scheduled testimony, the Provider shall be paid the number of hours that have been reasonably spent in preparation, less any deposit paid by the requesting party. DoWC Z0735, \$264.18, in half-hour increments.

If the Provider is notified less than ten days in advance of a cancellation or rescheduling, or the testimony is shorter than the time scheduled, the Provider shall be paid the number of hours that have been reasonably spent in preparation and has scheduled for the testimony. DoWC Z0737, \$264.18, in half-hour increments.

(E) INJURED WORKER TRAVEL EXPENSES

The Payer shall advance or reimburse the injured worker for reasonable and necessary mileage expenses for travel to and from medical appointments. The injured worker shall submit a request to the Payer showing the date(s) of travel and mileage, incurred or anticipated, and explain any other reasonable and necessary travel expenses. The number of miles shall be in whole numbers and calculated using the most direct route available on the date of service. Advance mileage is available for eligible travel greater than 100 miles round trip, and shall be approved when requested by the injured worker at least seven days in advance.

Mileage Pre-paid Expense: DoWC Z0722, 59 cents per mile

Mileage Expense: DoWC Z0723, 59 cents per mile

Other Travel Expenses: DoWC Z0724, actual paid

(F) PERMANENT IMPAIRMENT RATING

(1) The Payer is only required to pay for one 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 ATP is required to submit in writing all permanent restrictions and future maintenance care related to the injury or occupational disease.

(2) Provider Restrictions:

The Physician determining the permanent impairment rating must be Level II accredited and comply with Rule 5 as applicable.

(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. The ATP managing the total workers' compensation claim should complete the Physician's Report of Workers' Compensation Injury (Closing Report), WC 164 (see section 18-7(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 Physician's Report of Workers' Compensation Injury (Closing Report) WC 164.

Extensive medical records take longer than one hour to review and require a separate report. The separate report must document each record reviewed, specific details of the records reviewed, and the dates represented by the records reviewed. The separate record review can be billed as a special report and requires prior authorization.

- (b) Impairments Requiring Multiple Providers:

All Physicians and Psychologists (including Level II Accredited Physicians) providing consulting services for the completion of a whole person impairment rating shall bill using the appropriate E&M consultation code, or psychological diagnostic evaluation code, and shall forward their portion of the rating to the Physician determining the combined whole person rating.

A return visit for a range of motion (ROM) validation shall be billed with the appropriate code in the Medicine Section of CPT®.

The date the Physician sees the injured worker shall be the date of service billed.

DoWC Z0759, \$612.00, for the Level II Accredited Authorized Treating Physician providing primary care.

DoWC Z0760, \$822.12, for the Referral, Level II Accredited Authorized Physician (the claimant is not a previously established patient to that physician for that workers' compensation injury).

DoWC Z0764, If the injured worker fails to attend the impairment rating appointment or if the parties notify the Physician of a cancellation or rescheduling five days or less prior to the appointment, the Physician shall be paid one-half of the fee for the scheduled service. The Physician shall indicate the code corresponding to the scheduled service in Box 19 of the CMS-1500 form or electronic billing equivalent.

(G) REPORT PREPARATION

- (1) Routine Reports:

Providers shall submit routine reports free of charge as directed in Rule 16 and by statute. Requests for additional copies of routine reports and for reports not in Rule 16 or 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
- (a) Initial Report WC 164:

The ATP and ED/urgent care physician, when applicable, shall complete the first report of injury. Items 1-7 and 11 must be complete. However, item 2 may be omitted if not known by the Provider. If completed by a PA or NP, the ATP must countersign the form.

DoWC Z0750 Initial Report \$51.00
 - (b) Closing Report WC 164:

The ATP managing the workers' compensation claim must complete the WC 164 closing report when the injured worker is at maximum medical improvement (MMI) for all covered injuries or diseases, with or without a permanent impairment. Items 1-5, 6 B-C, 7 (if applicable), and 8-11 must be complete. If completed by a PA or NP, the ATP must countersign the form.

DoWC Z0752 Closing Report \$51.00

If the injured worker has sustained a permanent impairment, the following additional information must be attached to the bill when MMI is determined:

 - (i) All necessary permanent impairment rating reports, medical reports, and narrative relied upon by the ATP, when the ATP managing the workers' compensation claim 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 managing the workers' compensation claim is not determining the permanent impairment rating.
 - (c) Initial and Closing Report WC 164 completed on the same form for the same date of service:

DoWC Z0753 \$51.00

(d) Progress Report WC 164:

Any request from the Payer or the employer for the information provided on this form is deemed authorization for payment. The Provider shall document the name of the person who made the request and the date of the request on the WC 164; complete items 1, 2, 4-7, and 11; and send it to all parties within five days of the request. If completed by a PA or NP, the ATP must countersign the form.

DoWC Z0751 Progress Report \$51.00

(3) Form Completion:

The requesting party shall pay for its request for a physician to complete additional forms requiring 15 minutes or less, including forms sent by a Payer or an employer. This code also may be billed when completing the requirements outlined in § 8-43-404(10)(a) or Desk Aid 15 for a non-medical discharge.

DoWC Z0754 Form Completion \$51.00

(4) Special Reports:

The term special report includes any form, questionnaire, letter or report with variable content not otherwise addressed in Rule. Examples include:

- (a) treating or non-treating medical reviewers or evaluators producing written reports not otherwise addressed in this Rule, or
- (b) meeting with and reviewing another Provider's written record, and amending or signing that record.

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 hour deposit in advance in order to schedule a patient exam associated with a special report.

DoWC Z0755 Written Report, \$95.37 billable in 15 minute increments

DoWC Z0757 Lengthy Form, \$95.37 billable in 15 minute increments

DoWC Z0758 Meeting and Report with Non-treating Physician, \$95.37 billable in 15 minute increments

In cases of cancellation for special reports not requiring a scheduled patient exam, the Provider shall be paid for the time reasonably spent in preparation up to the date of cancellation.

DoWC Z0761 Report Preparation with Cancelled Patient Exam, \$95.37 billable in 15 minute increments

(5) Independent Medical Examinations (IMEs):

An IME is an objective medical examination of an injured worker performed by a Physician who has not previously treated the injured worker, in order to evaluate prior, current, or proposed treatment, or current condition. The Physician may refer a psychological component of the IME to a Psychologist and incorporate that evaluation into the IME report. In some circumstances, the IME Physician must be Level I or Level II accredited.

RIME: Respondent-requested Independent Medical Examination

DoWC Z0756 RIME Report with patient exam, \$95.37 billable in 15 minute increments

Section 8-43-404 requires RIMEs to be recorded in audio in their entirety and retained by the examining Physician for 12 months and made available by request to any party to the case.

DoWC Z0766 RIME Audio Recording, \$35.70 per exam

DoWC Z0767 RIME Audio Copying Fee, \$24.48 per copy

CIME: Claimant-requested Independent Medical Examination, \$95.37 billable in 15 minute increments to the injured worker, DoWC Code Z0770

DIME: Division Independent Medical Examination - see Rule 11

All IME reports must be served concurrently to all parties no later than 20 days after the examination. All IME reports must include an attestation that the billed charges comply with § 8-42-101(3)(a)(I) and Rule 16-8, as well as document the total time spent.

Cancellations:

In cases of a cancelled or rescheduled RIME or CIME, the Provider shall be paid the following fees:

If the Provider is notified of the cancellation of the RIME or CIME at least fourteen days prior to the scheduled examination, the Provider shall be paid the number of hours reasonably spent in preparation, less any deposit paid by the requesting party. DoWC Z0762, \$95.37 billable in 15 minute increments.

If the Provider is notified less than fourteen days in advance of a cancelled or rescheduled RIME or CIME, the Provider shall be paid the number of hours reasonably spent in preparation and scheduled for the examination. DoWC Z0763, \$95.37 billable in 15 minute increments.

(H) USE OF AN INTERPRETER

- (1) Payers shall reimburse for the services of an interpreter when interpretation is reasonable and necessary to provide access to medical benefits. Interpreter services provided in a hospital or ambulatory surgery center are included in the facility reimbursement and are not separately payable.

An interpreter may be provided on-site or via video or audio remote interpreting service, based on availability and the preference of the treating Provider.

- (2) Providers are prohibited from relying on minor children and should refrain from using adult family members and friends as interpreters, except in an emergency.
- (3) Payment requirements:
 - (a) Interpreters for certifiable languages must be listed as certified on the Certification Commission for Healthcare Interpreters or National Board of Certification for Medical Interpreters website directory. Certifiable languages are:
 - Spanish
 - Cantonese
 - Mandarin
 - Russian
 - Korean
 - Vietnamese
 - Arabic
 - (b) For all other languages, or in the event a certified interpreter is unavailable, the interpreter shall be qualified. Qualified means the interpreter has documentation showing completion of at least 40 hours of healthcare interpreter training.
 - (c) When a qualified interpreter is used in lieu of a certified interpreter, Payers must document a good faith effort was made to obtain a certified interpreter and submit this documentation to the Division upon request. By way of example, the payer may document a good faith effort by contacting at least two certified interpreters who are unavailable for the requested date and time.
 - (d) Prior authorization is required for on-site interpreters except for initial and emergency treatment.
- (4) Interpreters shall submit claims using the Interpreter Invoice Form or electronic data interchange (EDI). The codes and maximum allowances are:
 - (a) DoWC Z0710, Certified Spanish Interpreter, on-site, \$15.00, billable in 15 minute increments with a minimum of one hour;
 - (b) DoWC Z0711, Qualified Spanish Interpreter, on-site, \$11.25, billable in 15 minute increments with a minimum of one hour;
 - (c) DoWC Z0712, Interpreter for languages other than Spanish, on-site, rates shall be negotiated;
 - (d) HCPCS T1013, Sign Language, rates shall be negotiated;
 - (e) DoWC Z0713, On-Demand Video or Audio Remote Interpreting, all languages, \$1.35 per minute, with no minimum.

- (f) DoWC Z0773, Travel time for distances 50 miles or greater one-way is separately payable to on-site interpreters and shall not exceed \$35.37 per hour.
- (g) DoWC Z0772, Mileage is separately payable to on-site interpreters, and shall not exceed 59 cents per mile. The reimbursement shall be calculated based on the actual number of miles driven portal to portal or the most direct route available on the date of service, whichever is less.
- (h) If a prior authorized interpreter receives a cancellation notice less than 24 hours prior to the scheduled service, the Payer shall pay one-half of the usual fee for the scheduled service, or \$187.27, whichever is less. DoWC Z0720, plus full reimbursement for incurred mileage and eligible travel time.

(I) GUARDIAN AD LITEM AND CONSERVATOR SERVICES

When reasonably necessary for employees who are legally incapacitated as a result of a work-related injury or occupational disease, the following services are allowed reasonable fees and costs as agreed upon by the parties:

Guardian ad litem
Conservator
Attorney/Paralegal

The parties may submit an invoice or other agreed upon form for these services. If the parties are unable to agree on a reasonable fee, the parties may bring the matter before the Director for resolution.

18-8 DENTAL FEE SCHEDULE

The dental fee schedule is adopted using the American Dental Association's CDT® as incorporated by section 18-2. However, surgical treatment for dental trauma and subsequent related procedures shall be billed using medical codes from RBRVS. If billed using RBRVS, reimbursement shall be in accordance with the values listed in the Surgery/Anesthesia section and the corresponding CF. See Exhibit #3 for the listing and maximum allowance for CDT® 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.

18-9 QUALITY INITIATIVES

(A) OPIOID MANAGEMENT

- (1) Codes and maximum allowances are payable to the prescribing ATP for a written report with all the following opioid review services completed and documented:
 - (a) ordering and reviewing drug tests for subacute or chronic opioid management;
 - (b) ordering and reviewing Colorado Prescription Drug Monitoring Program (PDMP) results;

- (c) reviewing the medical records;
- (d) reviewing the injured worker's current functional status;
- (e) evaluating the risk of misuse and abuse initially and periodically; and
- (f) determining what actions, if any, need to be taken.

In determining the prescribed levels of medications, the ATP shall review and integrate the drug screening results required for subacute and chronic opioid management, as appropriate; the PDMP and its results; an evaluation of compliance with treatment and risk for addiction or misuse; as well as the injured worker's past and current functional status. A written report also must document the ATP's assessment of the injured worker's past and current functional status of work, leisure, and activities of daily living.

The injured worker should initially and periodically be evaluated for risk of misuse or addiction. The ATP 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 § 12-30-110. If the injured worker is deemed to be at risk for an opiate overdose, an opiate antagonist may be prescribed (see section 18-6(C)(5)(c)).

Opioid Management Billing Codes:

Acute Phase: DoWC Z0771, \$86.70, per 15 minutes,
maximum of 30 minutes per report

Subacute/Chronic Phase: DoWC Z0765, \$86.70, per 15 minutes,
maximum of 30 minutes per report

- (2) Definitions:
 - (a) Acute opioid use refers to the prescription of opioid medications (single or multiple) for duration of 30 days or less for non-traumatic injuries, or six weeks or less for traumatic injuries or post-operatively.
 - (b) Subacute opioid use refers to the prescription of opioid medications for longer than 30 days for non-surgical cases and longer than six weeks for traumatic injuries or post-operatively.
 - (c) Chronic opioid use refers to the prescription of opioid medications for longer than 90 days.
- (3) Acute opioid prescriptions generally should be limited to three to seven days and 50 morphine milliequivalents (MMEs) per day. Providers considering repeat opioid refills at any time during treatment are encouraged to perform the actions in this section and bill accordingly.
- (4) When long-term opioid treatment is prescribed, the ATP shall comply with the Division's Chronic Pain Disorder MTG (Rule 17, Exhibit #9), and review the Colorado Medical Board Policy #40-26, "Policy for Prescribing and Dispensing Opioids."

- (5) Urine drug tests are required for subacute and chronic opioid management and shall employ testing methodologies that meet or exceed industry standards for sensitivity, specificity, and accuracy. The testing 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 subacute or chronic opioid compliance monitoring. Refer to section 18-4(F)(3) for clinical drug screening testing codes and values.
 - (a) Drug testing shall be done prior to the initial long-term drug prescription being implemented and randomly repeated at least annually.
 - (b) While the injured worker is receiving opioid management, additional drug screens with documented justification may be conducted. Examples of documented justification include:
 - (i) Concern regarding the functional status of the injured worker;
 - (ii) Abnormal results on previous testing;
 - (iii) Change in management of dosage or pain; and
 - (iv) Chronic daily opioid dosage above 50 MMEs.

(B) 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 Division-approved psychological screen and a Division-approved functional tool. The psychological screen and the functional tool are approved by the Division and are validated for the specific purpose for which they have been created. 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.
- (2) Billing codes and maximum fees:

DOWC Z0815, \$83.23, 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, \$41.62, for subsequent visits during which the injured worker provides follow-up functional data that could alter the treatment plan. The Provider may use this code if the analysis of the data leads to a modification of the treatment plan. The Provider should not bill this code more than once every two to four weeks.

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

(C) APP-BASED INTERVENTIONS

Providers may write an order for app-based interventions for the purpose of patient education and training to aid in curing and/or relieving the injured worker from the effects of the work injury. A duration for use shall be designated on the order and may be reordered as clinically indicated. The app must be payable by invoice and billed directly to the Payer. Providers who write such orders are not permitted to receive any remuneration from the service Provider for the referral. The maximum allowable charge is \$25 per month and may be billed for a maximum duration of three months, or \$75 per order. App-based interventions that exceed this allowance require prior authorization. Examples of app-based interventions include apps that utilize artificial intelligence to educate the user about pain neuroscience, chronic pain management, weight loss, mental well-being, glucose management, and home exercise routines.

(D) PILOT PROGRAMS

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 clinical or payment models, and 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 § 8-43-602 and shall include:

- (1) beginning and end date for the pilot program;
- (2) population to be managed (e.g. size, specific diagnosis codes);
- (3) Provider group(s) participating in the program;
- (4) proposed codes and fees; and
- (5) 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 injured workers, enrollment patterns, utilization patterns, impact on health outcomes, system effects and the need for future health planning.

18-10 LIST OF EXHIBITS

Exhibit #1 - Evaluation and Management (E&M)

Exhibit #2 - Hospital Base Rates and Cost to Charge Ratios (CCRs)

Exhibit #3 - Dental Fee Schedule

Exhibit #4 - APCs for Procedures with Status Indicator C When Performed in an OP Hospital or ASC

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 17, Exhibit 1.

History

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