DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation

WORKERS' COMPENSATION RULES OF PROCEDURE WITH TREATMENT GUIDELINES

MEDICAL FEE SCHEDULE

7 CCR 1101-3 Rule 18 (no exhibits)

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

18-1 STATEMENT OF PURPOSE

Pursuant to § 8-42-101(3)(a)(I) C.R.S. and Section 8-47-107, C.R.S., the Director promulgates this medical fee schedule to review and establish maximum allowable fees for health care services falling within the purview of the Act. The Director adopts and hereby incorporates by reference as modified herein the 2010 edition of the *Relative Values for Physicians* (RVP©), developed by Relative Value Studies, Inc., published by Ingenix® St. Anthony Publishing, the *Current Procedural Terminology CPT® 2010* , Professional Edition, published by the American Medical Association (AMA) and *Medicare Severity Diagnosis Related Groups (MS-DRGs) Definitions Manual, Version 28.0* developed and published by 3M Health Information Systems using MS-DRGs effective after October 1, 2010. The incorporation is limited to the specific editions named and does not include later revisions or additions. For information about inspecting or obtaining copies of the incorporated materials, contact the Medical Fee Schedule Administrator, 633 17th Street, Suite 400, Denver, Colorado 80202-3626. These materials may be examined at any state publications depository library. All guidelines and instructions are adopted as set forth in the RVP©, CPT® and MS-DRGs, unless otherwise specified in this rule.

This rule applies to all services rendered on or after January 1, 2011. All other bills shall be reimbursed in accordance with the fee schedule in effect at the time service was rendered.

18-2 STANDARD TERMINOLOGY FOR THIS RULE

(A) CPT® - *Current Procedural Terminology* CPT® *2010* , copyrighted and distributed by the AMA and incorporated by reference in Rule 18-1.

(B) DoWC Zxxx – Colorado Division of Workers' Compensation created codes.

(C) MS-DRGs – version 28.0 incorporated by reference in Rule 18-1.

(D) RVP© – the 2010 edition incorporated by reference in Rule 18-1.

(E) For other terms, see Rule 16, Utilization Standards.

18-3 HOW TO OBTAIN COPIES

All users are responsible for the timely purchase and use of Rule 18 and its supporting documentation as referenced herein. The Division shall make available for public review and inspection copies of all materials incorporated by reference in Rule 18. Copies of the RVP© may be purchased from Ingenix® St. Anthony Publishing, the *Current Procedural Terminology, 2010 Edition* may be purchased from the AMA, the MS-DRGs Definitions Manual may be purchased from 3M Health Information Systems, and the *Colorado Workers' Compensation Rules of Procedures with Treatment Guidelines* , 7 CCR 1101-3, may be purchased from LexisNexis Matthew Bender & Co., Inc., Albany, NY. Interpretive Bulletins and

unofficial copies of all rules, including Rule 18, are available on the Colorado Department of Labor and Employment web site. An official copy of the rules is available on the Secretary of State's webpage.

18-4 CONVERSION FACTORS (CF)

The following CFs shall be used to determine the maximum allowed fee. The maximum fee is determined by multiplying the following section CFs by the established relative value unit(s) (RVU) found in the corresponding RVP© sections:

RVP© SECTION	CF
Anesthesia	$50.87/RVU
Surgery	$94.64/RVU
Surgery X Procedures (see Rule 18-5(D)(1)(d))	$38.07/RVU .
Radiology	$17.43/RVU
Pathology	$12.99/RVU
Medicine	$7.56 /RVU
Physical Medicine	$5.90/RVU
Physical Medicine and Rehabilitation, Medical Nutrition Therapy and Acupuncture	.
Evaluation & Management (E&M)	$9.62/RVU

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

(A) Maximum allowance for all providers under Rule 16-5 is 100% of the RVP© value or as defined in this Rule 18.

(B) Unless modified herein, the RVP© is adopted for RVUs and reimbursement. Interim relative value procedures (marked by an "I" in the left-hand margin of the RVP©) are accepted as a basis of payment for services; however deleted CPT® codes (marked by an "M" in the RVP©) are not, unless otherwise advised by this rule. The CPT® 2010 is adopted for codes, descriptions, parenthetical notes and coding guidelines, unless modified in this rule.

(C) CPT® Category III codes listed in the RVP© may be used for billing with agreement of the payer as to reimbursement. Payment shall be in compliance with Rule 16-6(C).

(D) Surgery/Anesthesia

(1) Anesthesia Section:

(a) All anesthesia base values shall be established by the use of the codes as set forth in the RVP©, Anesthesia Section. Anesthesia services are only reimbursable if the anesthesia is administered by a physician or Certified Registered Nurse Anesthetist (CRNA) who remains in constant attendance during the procedure for the sole purpose of rendering anesthesia.

When anesthesia is administered by a CRNA:

(1) Not under the medical direction of an anesthesiologist, reimbursement shall be 90% of the maximum anesthesia value,

(2) Under the medical direction of an anesthesiologist, reimbursement shall be 50% of the maximum anesthesia value. The other 50% is payable to the anesthesiologist providing the medical direction to the CRNA,

(3) Medical direction for administering the anesthesia includes performing the following activities:

- Performs a pre-anesthesia examination and evaluation,

- Prescribes the anesthesia plan,

- Personally participates in the most demanding procedures in the anesthesia plan including induction and emergence,

- Ensures that any procedure in the anesthesia plan that s/he does not perform is performed by a qualified anesthetist,

- Monitors the course of anesthesia administration at frequent intervals,

- Remains physically present and available for immediate diagnosis and treatment of emergencies, and

- Provides indicated post-anesthesia care.

(b) Anesthesia physical status modifiers and qualifying circumstances are reimbursed using the anesthesia CF and unit values found in the RVP©, Anesthesia section's Guidelines XI "Physical Status Modifiers" and XII, "Qualifying Circumstances."

(c) The following modifiers are to be used when billing for anesthesia services:

AA – anesthesia services performed personally by the anesthesiologist

QX – CRNA service; with medical direction by a physician

QZ – CRNA service; without medical direction by a physician

QY – Medical direction of one CRNA by an anesthesiologist

(d) Surgery X Procedures

(1) The surgery X procedures are limited to those listed below and found in the table under the RVP©, Anesthesia section's Guidelines XIII, "Anesthesia Services Where Time Units Are Not Allowed" :

- Providing local anesthetic or other medications through a regional IV

- Daily drug management

- Endotracheal intubation

- Venipuncture, including cutdowns

- Arterial punctures

- Epidural or subarachnoid spine injections

- Somatic and Sympathetic Nerve Injections

- Paravertebral facet joint injections and rhizotomies

In addition, lumbar plexus spine anesthetic injection, posterior approach with daily administration = 7 RVUs; paravertebral facet, zygapophyseal joint or nerves with guidance are reimbursed at 10 RVUs for a single level of the cervical or thoracic, 5 RVUs for second level or more, and 8 RVUs for the lumbar or sacral single level, 4 RVUs for the second level or more.

(2) The maximum reimbursement for these procedures shall be based upon the anesthesia value listed in the table in the RVP©, Anesthesia section's Guideline XIII multiplied by $38.07 CF. No additional unit values are added for time when calculating the maximum values for reimbursement.

(3) When performing more than one surgery X procedure in a single surgical setting, multiple surgery guidelines shall apply (100% of the listed value for the primary procedure and 50% of the listed value for additional procedures). Use modifier -51 to indicate multiple surgery X procedures performed on the same day during a single operative setting. The 50% reduction does not apply to procedures that are identified in the RVP© as "Add-on" procedures.

(4) Bilateral injections: see 18-5(D)(2)(g).

(5) Other procedures from Table XIII not described above may be found in another section of the RVP© (e.g., surgery). Any procedures found in the table under the RVP©, Anesthesia section's Guidelines XIII, "Anesthesia Services Where Time Units Are Not Allowed" but not contained in this list (Rule 18-5(D)(1)(d)(1)) are reimbursed in accordance with the assigned units from their respective sections multiplied by their respective CF.

(2) Surgical Section:

(a) The use of assistant surgeons shall be limited according to the American College Of Surgeons' *Physicians as Assistants at Surgery: 2007 Study* (January 2007), available from the American College of Surgeons, Chicago, IL, or from their web page. The incorporation is limited to the edition named and does not include later revisions or additions. Copies of the material incorporated by reference may be inspected at any State publications depository library. For information about inspecting or obtaining copies of the incorporated material, contact the Medical Fee Schedule Administrator, 633 17th Street, Suite 400, Denver, Colorado, 80202-3626.

Where the publication restricts use of such assistants to "almost never" or a procedure is not referenced in the publication, prior authorization for payment (see Rule 16-9 and 16-10) is required.

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

(c) No payment shall be made for more than one assistant surgeon or minimum assistant surgeon without prior authorization for payment (see Rule 16-9 and 16-10) unless a trauma team was activated due to the emergency nature of the injury(ies).

(d) The payer may use available billing information such as provider credential(s) and clinical record(s) to determine if an appropriate modifier should be used on the bill. To modify a billed code refer to Rule 16-11(B)(4).

(e) Non-physician, minimum assistant surgeons used as surgical assistants shall be reimbursed at 10 % of the listed value.

(f) Global Period

(1) The following services performed during a global period would warrant separate billing if documentation demonstrates significant identifiable services were involved, such as:

- E&M services unrelated to the primary surgical procedure,

- Services necessary to stabilize the patient for the primary surgical procedure,

- Services not usually part of the surgical procedure, including an E&M visit by an authorized treating physician for disability management,

- Unusual circumstances, complications, exacerbations, or recurrences, or

- Unrelated diseases or injuries.

- If a patient is seen for the first time or an established patient is seen for a new problem and the “decision for surgery” is made the day of the procedure or the day before the procedure is performed, then the surgeon can bill both the procedure code and an E&M code, using a 57 modifier or 25 modifier on the E&M code.

(2) Separate identifiable services shall use an appropriate RVP© modifier in conjunction with the billed service.

(g) Bilateral procedures are reimbursed the same as all multiple procedures: 100% for the first primary procedure and then 50% for all other procedures, including the 2nd "primary" procedure.

(h) The “Services with Significant Direct Costs” section of the RVP© is not adopted. Supplies shall be reimbursed as set out in Rule 18-6(H).

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

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

G0289 is 11.2 RVUs and is paid using the surgical conversion factor.

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

G0289 shall be paid when reported in conjunction with other knee arthroscopy codes in a different compartment of the knee. G0289 is subject to the 50% multiple surgical reduction guidelines.

(E) Radiology Section:

(1) General

(a) The cost of dyes and contrast shall be reimbursed in accordance with Rule 18-6(H).

(b) Copying charges for X-Rays and MRIs shall be $15.00/film regardless of the size of the film.

(c) The payer may use available billing information such as provider credential(s) and clinical record(s) to determine if an appropriate RVP© modifier should have been used on the bill. To modify a billed code, refer to Rule 16-11(B)(4).

(d) In billing radiology services, the applicable radiology procedure code may be billed using the total component or the appropriate modifier to bill either the professional component or the technical component. If a physician bills the total or professional component, a separate written interpretive report is required.

If a physician interprets the same radiological image more than once, or if multiple physicians interpret the same radiological image, only one interpretation shall be reimbursed.

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

(2) Thermography

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

American Academy of Thermology;

American Chiropractic College of Infrared Imaging.

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

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

Sympathetically Maintained Pain (SMP);

Autonomic neuropathy;

(c) Protocol for stress testing is outlined in the Medical Treatment Guidelines found in Rule 17.

(d) Thermography Billing Codes:

DoWC Z200 Upper body w/ Autonomic Stress Testing $865.37

DoWC Z201 Lower body w/Autonomic Stress Testing $865.37

(e) Prior authorization for payment (see Rule 16-9 and 16-10) is required for thermography services only if the requested study does not meet the indicators for thermography as outlined in this radiology section. The billing shall include a report supplying the thermographic evaluation and reflecting compliance with Rule 18-5(E)(2).

(F) Pathology Section:

Reimbursement for billed pathology procedures includes either a technical and professional component, or a total component. If an automated clinical lab procedure does not have a separate written interpretive report beyond the computer generated values, the biller may receive the total component value as long as no other provider seeks reimbursement for the professional component. The physician ordering the automated laboratory tests may seek verbal consultation with the pathologist in charge of the laboratory's policy, procedures and staff qualifications. The consultation with the ordering physician is not payable unless the ordering physician requested additional medical interpretation and judgment and requested a separate written report. Upon such a request, the pathologist may bill using the proper CPT® code and values from the RVP©, not DoWC Z755.

(G) Medicine Section:

(1) Medicine home therapy services in the RVP© are not adopted. For appropriate codes see Rule 18-6(N), Home Therapy.

(2) Anesthesia qualifying circumstance values are reimbursed in accordance with the anesthesia section of Rule 18.

(3) Biofeedback

Prior authorization for payment (see Rule 16-9 and 16-10) shall be required from the payer for any treatment exceeding the treatment guidelines. A licensed physician or psychologist shall prescribe all services and include the number of sessions. Session notes shall be periodically reviewed by the prescribing physician or psychologist to determine the continued need for the service. All services shall be provided or supervised by an appropriate recognized provider as listed under Rule 16-5. Supervision shall be as defined in an applicable Rule 17 medical treatment guidelines. Persons providing biofeedback shall be certified by the Biofeedback Certification Institution of America, or be a licensed physician or psychologist, as listed under Rule 16-5(A)(1)(a) and (b) with evidence of equivalent biofeedback training.

(4) Appendix J of the *2010* CPT® identifies mixed, motor and sensory nerve conduction studies and their appropriate billing.

(5) Manipulation -- Chiropractic (DC), Medical (MD) and Osteopathic (DO):

(a) Prior authorization for payment (see Rule 16-9 and 16-10) shall be obtained before billing for more than four body regions in one visit. Manipulative therapy is limited to the maximum allowed in the relevant Rule 17 medical treatment guidelines. The provider's medical records shall reflect medical necessity and prior

authorization for payment (see Rule 16-9 and 16-10) if treatment exceeds these limitations.

(b) An office visit may be billed on the same day as manipulation codes when the documentation meets the E&M requirement and an appropriate modifier is used.

(6) Psychiatric/Psychological CNS Tests and Assessment Services:

(a) A licensed psychologist (PsyD, PhD, EdD) is reimbursed a maximum of 100% of the medical fee listed in the RVP©. Other non-physician providers performing psychological/psychiatric services shall be paid at 75 % of the fee allowed for physicians.

(b) Prior authorization for payment (see Rule 16-9 and 16-10) is required any time the following limitations are exceeded on a single day:

Evaluation Procedures limit: 4 hours

Testing Procedures limit: 6 hours

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

(c) Psychotherapy services limit: 50 mins per visit

Prior authorization for payment (see Rule 16-9 and 16-10) is required any time the 50 minutes per visit limitation is exceeded.

Psychotherapy for work-related conditions requiring more than 20 visits or continuing for more than three (3) months after the initiation of therapy, whichever comes first, requires prior authorization for payment (see Rule 16-9 and 16-10) except where specifically addressed in the treatment guidelines.

(7) Hyperbaric Oxygen Therapy Services

The maximum unit value shall be 24 units, instead of 14 units as listed in the RVP©.

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

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

(H) Physical Medicine and Rehabilitation:

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

(1) Prior authorization for payment (see Rule 16-9 and 16-10) is required for medical nutrition therapy. See Rule 18-6(O)(10).

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

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

Prior authorization for payment (see Rule 16-9 and 16-10) shall be obtained from the payer for any physical medicine treatment exceeding the recommendations of the Medical Treatment Guidelines as set forth in Rule 17.

The injured worker shall be re-evaluated by the prescribing physician within thirty (30) calendar days from the initiation of the prescribed treatment and at least once every month while that treatment continues. Prior authorization for payment (see Rule 16-9 and 16-10) shall be required for treatment of a condition not covered under the medical treatment guidelines and exceeding sixty (60) calendar days from the initiation of treatment.

(4) Interdisciplinary Rehabilitation Programs – (Requires Prior Authorization for Payment (see Rule 16-9 and 16-10).

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

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

If there is a single billing provider for the entire interdisciplinary rehabilitation program and a daily per diem rate is mutually agreed upon, use billing code Z500.

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

(5) Procedures (therapeutic exercises, neuromuscular re-education, aquatic therapy, gait training, massage, acupuncture, manual therapy techniques, therapeutic activities, cognitive development, sensory integrative techniques and any unlisted physical medicine procedures)

Unless the provider’s medical records reflect medical necessity and the provider obtains prior authorization for payment (see Rule 16-9 and 16-10), the maximum amount of time allowed is one hour of procedures per day, per discipline.

(6) Modalities

RVP© Timed and Non-timed Modalities

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

NOTE: Instruction and application of a transcutaneous electric nerve stimulation (TENS) unit for the patient's independent use shall be billed using the education code in the Medicine section of the RVP©. Rental or purchase of a TENS unit requires prior authorization for payment (see Rule 16-9 and 16-10). For maximum fee allowance, see

Rule 18-6(H).

Dry Needling of Trigger Points

Bill only one of the dry needling modality codes. See relevant treatment guidelines for limitations on frequencies.

DoWC Z501 Single or multiple needles, one or two muscles, 5.4 RVUs

DoWC Z502 three or more muscles, 5.8 RVUs

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

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

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

(b) Payers are only required to pay for evaluation services directly performed by a PT, OT, or ATC as defined in Title 12 of the C.R.S. All evaluation notes or reports must be written and signed by the PT or OT. Physicians shall bill the appropriate E&M code from the E&M section of the RVP©.

(c) A patient may be seen by more than one health care professional on the same day. An evaluation service with appropriate documentation may be charged for each professional per patient per day.

(d) Reimbursement to PTs, OTs, speech language pathologists and audiologists for coordination of care with professionals shall be based upon the telephone codes for qualified non-physician providers found in the RVP© Medicine Section. Coordination of care reimbursement is limited to telephone calls made to professionals outside of the therapist's/pathologist's/ audiologist's employment facility(ies) and/or to the injured worker or their family.

(e) All interdisciplinary team conferences shall be billed in compliance with Rule 18-5(I)(5).

(8) Special Tests

The following respective tests are considered special tests:

- Job Site Evaluation

- Functional Capacity Evaluation

- Assistive technology assessment

- Speech

- Computer Enhanced Evaluation (DoWC Z503)

- Work Tolerance Screening (DoWC Z504)

(a) Billing Restrictions:

(1) Job Site Evaluations require prior authorization for payment (see Rule 16-9 and 16-10) if exceeding 2 hours. Computer-Enhanced Evaluations, and Work Tolerance Screenings require prior authorization for payment for more than 4 hours per test or more than 6 tests per claim. Functional Capacity Evaluations require prior authorization for payment for more than 4 hours per test or 2 tests per claim.

(2) The provider shall specify the time required to perform the test in 15-minute increments.

(3) The value for the analysis and the written report is included in the code's value.

(4) No E&M services or PT, OT, or acupuncture evaluations shall be charged separately for these tests.

(5) Data from computerized equipment shall always include the supporting analysis developed by the physical medicine professional before it is payable as a special test.

(b) Provider Restrictions: all special tests must be fully supervised by a physician, a PT, an OT, a speech language pathologist/therapist or audiologist. Final reports must be written and signed by the physician, the PT, the OT, the speech language pathologist/therapist or the audiologist.

(9) Speech Therapy/Evaluation and Treatment

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

(10) Supplies

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

(11) Unattended Treatment

When a patient uses a facility or its equipment but is performing unattended procedures, in either an individual or group setting, bill:

DoWC Z505 fixed fee per day 1.5 RVU

(12) Non-Medical Facility

Fees, such as gyms, pools, etc., and training or supervision by non-medical providers require prior authorization for payment (see Rule 16-9 and 16-10) and a written

negotiated fee.

(13) Unlisted Service Physical Medicine

All unlisted services or procedures require a report.

(14) Work Conditioning, Work Hardening, Work Simulation

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

Restriction: Maximum daily time is two (2) hours per day without additional prior authorization for payment (see Rule 16-9 and 16-10).

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

Restriction: Maximum daily time is six (6) hours per day without additional prior authorization for payment (see Rule 16-9 and 16-10).

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

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

(1) The provider shall submit a treatment plan including expected frequency and duration of treatment. If requested by the provider, the payer will prior authorize payment for the treatment plan services or shall identify any concerns including those based on the reasonableness or necessity of care.

(2) If the frequency and duration is expected to exceed the medical treatment guidelines' recommendation, prior authorization for payment (see Rule 16-9 and 16-10) is required.

(3) Provider Restrictions: All procedures must be performed by or under the onsite supervision of a physician, psychologist, PT, OT, speech language pathologist or audiologist.

(I) Evaluation and Management Section (E&M)

(1) Medical record documentation shall encompass the RVP© "E&M Guideline" criteria to justify the billed E&M service. If 50% of the time spent for an E&M visit is disability counseling or coordination of care, then time can determine the level of E&M service. Documented

telephonic or on-line communication time with the patient or other healthcare providers one day prior or seven days following the scheduled E&M visit may be included in the calculation of total time.

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

(2) New or Established Patients

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

(3) Number of Office Visits

All providers, as defined in Rule 16-5 (A-B), are limited to one office visit per patient, per day, per workers' compensation claim unless prior authorization for payment (see Rule 16-9 and 16-10) is obtained. The E&M Guideline criteria as specified in the RVP© E&M Section shall be used in all office visits to determine the appropriate level.

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

Telephone or on-line services may be billed if:

(a) the service is performed more than one day prior to a related E&M office visit, or

(b) the service is performed more than 7 days following a related E&M office visit, and

(c) when the medical records/documentation specifies all the following:

(1) the amount of time and date;

(2) the patient, family member, or healthcare provider talked to, and

(3) the specifics of the discussion and/or decision made during the communication.

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

A medical team conference can only be billed if all of the criteria are met under CPT®. A medical team conference shall consist of medical professionals caring for the injured worker.

The billing statement shall be prepared in accordance with Rule 16, Utilization Standards.

(6) Face -to-face or telephonic meeting by a non-treating physician with the employer, claim representatives or any attorney in order to provide a medical opinion on a specific

workers' compensation case which is not accompanied by a specific report or written record.

Billing Code DoWC Z601: $65.00 per 15 minutes billed to the requesting party.

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

18-6 DIVISION ESTABLISHED CODES AND VALUES

(A) Face-to-face or telephonic meeting by a treating physician with the employer, claim representatives, or any attorney, and with or without the injured worker. Claim representatives may include physicians or qualified medical personnel performing payer-initiated medical treatment reviews, but this code does not apply to requests initiated by a provider for prior authorization for payment (see Rule 16-9 and 16-10).

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

(1) Each meeting shall be at a minimum 15 minutes.

(2) A report or written record signed by the physician is required and shall include the following:

(a) Who was present at the meeting and their role at the meeting

(b) Purpose of the meeting

(c) A brief statement of recommendations and actions at the conclusion of the meeting.

(d) Documented time (both start and end times)

(e) Billing code DoWC Z701

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

(B) Cancellation Fees For Payer Made Appointments

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

One-half of the usual fee for the scheduled services, or

$150.00, whichever is less.

Cancellation Fee Billing Code: DoWC Z720

(2) Missed Appointments:

When claimants fail to keep scheduled appointments, the provider should contact the payer within two (2) business days. Upon reporting the missed appointment, the provider may request whether the payer wishes to reschedule the appointment for the claimant. If

the claimant fails to keep the payer's rescheduled appointment, the provider may bill for a cancellation fee according to this Rule 18-6(B).

(C) Copying Fees

The payer, payer's representative, injured worker and injured worker's representative shall pay a reasonable fee for the reproduction of the injured worker's medical record. Reasonable cost for paper copies shall not exceed $14.00 for the first 10 or fewer pages, $0.50 per page for pages 11-40, and $0.33 per page thereafter. Actual postage or shipping costs and applicable sales tax, if any, may also be charged. The per-page fee for records copied from microfilm shall be $1.50 per page.

If the requester and provider agree, the copy may be provided on a disc. The fee will not exceed $14.00 per disc.

If the requester and provider agree and appropriate security is in place, including, but not limited to, compatible encryption, the copies may be submitted electronically. Requester and provider should attempt to agree on a reasonable fee. Absent an agreement to the contrary, the fee shall be $0.10/page.

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

Copying Fee Billing Code: DoWC Z721

(D) Deposition and Testimony Fees

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

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

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

Preparation Time:

Treating or Non-treating Provider:

DoWC Z730 $325.00 per hour

(3) Deposition:

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

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

If the provider is notified of the cancellation of the deposition at least seven (7) business days prior to the scheduled deposition, the provider shall be paid the number of hours s/he has reasonably spent in preparation and shall refund to the deposing party any portion of an advance payment in excess of time actually spent preparing and/or testifying. Bill using code DoWC Z731.

If the provider is notified of the cancellation of the deposition at least five (5) business days but less than seven (7) business days prior to the scheduled deposition, the provider shall be paid the number of hours he or she has reasonably spent in preparation and one-half the time scheduled for the deposition. Bill using code DoWC Z732.

If the provider is notified less than five (5) business days in advance of a cancellation, or the deposition is shorter than the time scheduled, the provider shall be paid the number of hours he or she has reasonably spent in preparation and has scheduled for the deposition. Bill using code DoWC Z733.

Deposition:

Treating or Non-treating provider:

DoWC Z734 $325.00 per hr. Billed in half-hour increments

(4) Testimony:

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

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

If the provider is notified of the cancellation of the testimony at least seven (7) business days prior to the scheduled testimony, the provider shall be paid the number of hours s/he has reasonably spent in preparation and shall refund any portion of an advance payment in excess of time actually spent preparing and/or testifying. Bill using code DoWC Z735.

If the provider is notified of the cancellation of the testimony at least five (5) business days but less than seven (7) business days prior to the scheduled testimony, the provider shall be paid the number of hours he or she has reasonably spent in preparation and one-half the time scheduled for the testimony. Bill using code DoWC Z736.

If the provider is notified of a cancellation less than five (5) business days prior to the date of the testimony or the testimony is shorter than the time scheduled, the provider shall be paid the number of hours s/he has reasonably spent in preparation and has scheduled for the testimony. Bill using code DoWC Z737.

Testimony:

Treating or Non-treating provider:

DoWC Z738 Maximum Rate of $450.00 per hour

(E) Mileage Expenses

The payer shall reimburse an injured worker for reasonable and necessary mileage expenses for travel to and from medical appointments and reasonable mileage to obtain prescribed

medications. The reimbursement rate shall be 47 cents per mile. The injured worker shall submit a statement to the payer showing the date(s) of travel and number of miles traveled, with receipts for any other reasonable and necessary travel expenses incurred.

Mileage Expense Billing Code: DoWC Z723

(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 authorized treating provider is required to submit in writing all permanent restrictions and future maintenance care related to the injury or occupational disease.

(2) Provider Restrictions

The permanent impairment rating shall be determined by the authorized Level II accredited physician (see Rule 5-5(D)).

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

When physicians determine the injured worker is at MMI and has no permanent impairment, the physicians should be reimbursed an appropriate level of E&M service. The authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient should complete the Physician's Report of Workers' Compensation Injury (Closing Report), WC164 (See Rule 18-6(G)(2)). Reimbursement for the appropriate level of E&M service is only applicable if the physician examines the injured worker and meets the criteria as defined in the RVP©.

(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, determining MMI, completing all required measurements, referencing all tables used to determine the rating, using all report forms from the AMA's *Guide to the Evaluation of Permanent Impairment* , Third Edition (Revised), (AMA *Guides*), and completing the Division form, titled Physician's Report of Workers' Compensation Injury (Closing Report) WC164.

(b) Use the appropriate DoWC code:

(1) Fee for the Level II Accredited Authorized Treating Physician Providing Primary Care:

Bill DoWC Z759 $355.00.

(2) Fee for the Referral, Level II Accredited Authorized Physician:

Bill DoWC Z760 $575.00.

(3) A return visit for a range of motion (ROM) validation shall be reimbursed using the appropriate separate procedure CPT© code in the medicine section of the RVP©.

(4) Fee for a Multiple Impairment Evaluation Requiring More Than One Level II Accredited Physician:

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

(G) Report Preparation

(1) Routine Reports

Completion of routine reports or records are incorporated in all fees for service and include:

Diagnostic testing

Procedure reports

Progress notes

Office notes

Operative reports

Supply invoices, if requested by the payer

Providers shall submit routine reports free of charge as directed in Rule 16-7(E) and by statute. Requests for additional copies of routine reports and for reports not in Rule 16-7(E) or in statute are reimbursable under the copying fee section of Rule 18.

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

(a) Initial Report

The authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient completes the initial WC 164 and submits it to the payer and to the injured worker after the first visit with the injured worker. When applicable, the emergency room or urgent care authorized treating physician for this workers' compensation injury may also create a WC 164 initial report. Unless requested or prior authorized by the payer in a specific workers' compensation claim, no other authorized physician should complete and bill for the initial WC 164 form. This form shall include completion of items 1-7 and 10. Note that certain information in Item 2 (such as Insurer Claim #) may be omitted if not known by the provider.

(b) Closing Report

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

following additional information shall be attached to the bill at the time MMI is determined:

(1) All necessary permanent impairment rating reports when the authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient is Level II Accredited, or

(2) The name of the Level II Accredited physician requested to perform the permanent impairment rating when a rating is necessary and the authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient is not determining the permanent impairment rating.

(c) Payer Requested WC164 Report

If the payer requests a provider complete the WC164 report, the payer shall pay the provider for the completion and submission of the completed WC164 report.

(d) Provider Initiated WC164 Report

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

(e) Billing Codes and Maximum Allowance for completion and submission of WC164 report

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

DoWC Z750	$42.00	Initial Report
DoWC Z751	$42.00	Progress Report (Payer Requested or Provider Initiated)
DoWC Z752	$42.00	Closing Report
DoWC Z753	$42.00	Initial and Closing Reports are completed on the same form for the same date of service

(3) Request for physicians to complete additional forms sent to them by a payer or employer shall be paid by the requesting party. A form requiring 15 minutes or less of a physician's time shall be billed pursuant to a & b below. Forms requiring more than 15 minutes shall be paid as a special report.

(a) Billing Code Z754

(b) Maximum fee is $42.00 per form completion

(4) Special Reports

Description: The term special reports includes reports not otherwise addressed under

Rule 16, Utilization Standards, Rule 17, Medical Treatment Guidelines and Rule 18, including any form, questionnaire or letter with variable content. This includes, but is not limited to, independent medical evaluations or reviews performed outside C.R.S. §8-42-107.2 (the Division IME process), and treating or non-treating medical reviewers or evaluators producing written reports pertaining to injured workers not otherwise addressed. Special reports also include payment for meeting, reviewing another's written record, and amending or signing that record (see Rule 18-5(I)(7)). Reimbursement for preparation of special reports or records shall require prior agreement with the requesting party.

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

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

Cancellation:

Written Reports Only: In cases of cancellation for those special reports not requiring a scheduled patient exam, the provider shall be paid for the time s/he has reasonably spent in preparation up to the date of cancellation. Bill cancellation using code DoWC Z761.

IME/report with patient exam: In cases of special reports requiring a scheduled patient exam, if the provider is notified of a cancellation at least seven (7) business days prior to the scheduled patient exam, the provider shall be paid for the time s/he has reasonably spent in preparation and shall refund to the party requesting the special report any portion of an advance payment in excess of time actually spent preparing. Bill cancellation using code DoWC Z762.

In cases of special reports requiring a scheduled patient exam, if the provider is notified of a cancellation at least five (5) business days but less than seven (7) business days prior to the scheduled patient exam, the provider shall be paid for the time s/he has reasonably spent in preparation and one-half the time scheduled for the patient exam. Any portion of a deposit in excess of this amount shall be refunded. Bill cancellation using code DoWC Z763.

In cases of special reports requiring a scheduled patient exam, if the provider is notified of a cancellation less than five (5) business days prior to the scheduled patient exam, the provider shall be paid for the time s/he has reasonably spent in preparation and has scheduled for the patient exam. Bill cancellation using code DoWC Z764.

Billing Codes:

Written Report Only	DoWC Code: Z755
IME/Report with patient exam	DoWC Code: Z756
Lengthy Form Completion	DoWC Code: Z757
18-5(I)(7) meeting and report with Non-treating Physician	DoWC Code: Z758
Special Report Maximum Fees:	$325.00 per hour.

.	Billed in 15- minute increments.
CRS 8-43-404 IME Audio Recording	DoWC Code: Z766
.	$30.00 per exam
CRS 8-43-404 IME Audio copying fee	DoWC Code: Z767
.	$20.00 per copy

(5) Chronic Opioid Management Report

(a) When the authorized treating physician prescribes long-term opioid treatment, s/he shall use the Division of Workers' Compensation Chronic Pain Disorder Medical Treatment Guidelines and also review the Colorado State Board of Medical Examiners' Policy # 10-14, "Guidelines for the Use of Controlled Substances for the Treatment of Pain." Urine drug tests for chronic opioid management shall employ testing methodologies that meet or exceed industry standards for sensitivity, specificity and accuracy. The test methodology must be capable of identifying and quantifying the parent compound and relevant metabolites of the opioid prescribed. In-office screening tests designed to screen for drugs of abuse are not appropriate for chronic opioid compliance monitoring.

(1) Drug testing shall be done prior to the initial long-term drug prescription being implemented and randomly repeated at least annually.

(2) When drug screen tests are ordered, the authorized treating physician shall utilize the Colorado Prescription Drug Monitoring Program (PDMP).

(3) While the injured worker is receiving chronic opioid management, additional drug screens with documented justification may be conducted. Examples of documented justification include the following:

(i) Concern regarding the functional status of the patient

(ii) Abnormal results on previous testing

(iii) Change in management of dosage or pain

(iv) Chronic daily opioid dosage above 150 mg of morphine or equivalent

(4) The opioids prescribed for long-term treatment shall be provided through a pharmacy.

(5) The prescribing authorized treating physician shall review and integrate the screening results, PDMP, and the injured worker's past and current functional status on the prescribed levels of medications. A written report will document the treating physician's assessment of the patient's past and current functional status of work, leisure activities and activities of daily living competencies.

(b) Codes and maximum fees for the authorized treating physician for a written report with all the following review services completed and documented:

(1) Ordering and reviewing drug tests

(2) Ordering and reviewing PDMP results

(3) Reviewing the medical records

(4) Reviewing the injured workers' current functional status

(5) Determining what actions, if any, need to be taken

(6) Appropriate chronic pain diagnostic code (ICD).

Bill using code DoWC Z765 $75.00 per 15 minutes

- maximum of 30 minutes per report

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

(H) Supplies, Durable Medical Equipment (DME), Orthotics and Prostheses

(1) Unless otherwise indicated in this rule, minimum payment for supplies shall reflect the provider's actual cost with a 20% markup and shipping charges.

(2) Providers may bill supplies, including "Supply et al.," orthotics, prostheses, DMEs or drugs, including injectables, using Medicare's HCPCS Level II codes at the Colorado rate. The billing provider is responsible for identifying their cost for the items they wish to be paid at their cost plus 20% instead of Medicare's Colorado HCPCS Level II maximum fee. This may be done using an advance agreement between the payer and provider or may be done by furnishing an invoice or their supplier's published rate with their bill.

(3) Payers may pay using Medicare's Colorado HCPCS Level II maximum fee values for the codes billed unless the provider has indicated that the item(s) is to be paid at cost plus 20%. The payer may request an invoice or published rate for any items to be paid at cost plus 20%.

(4) If the provider failed to indicate that an item was to be paid at cost plus 20%, and their cost plus 20% is more than the Medicare Colorado HCPCS Level II value, the provider may submit cost information within 60 days following receipt of the Explanation of Benefits (EOB) and is entitled to at least their cost plus 20%.

(5) 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.

(I) Inpatient Hospital Facility Fees

(1) Provider Restrictions

All non-emergency, inpatient admissions require prior authorization for payment (see Rule 16-9 and 16-10).

(2) Bills for Services

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

(b) The maximum inpatient facility fee is determined by applying the Center for Medicare and Medicaid Services (CMS) "Medicare Severity Diagnosis Related Groups" (MS-DRGs) classification system. Exhibit 1 to Rule 18 shows the relative weights per MS-DRGs that are used in calculating the maximum allowance.

The hospital shall indicate the MS-DRG code number in the remarks section (form locator 80) 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* . The attending physician shall not be required to certify this documentation unless a dispute arises between the hospital and the payer regarding MS-DRG assignment. The payer may deny payment for services until the appropriate MS-DRG code is supplied.

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

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

(3) Inpatient Facility Reimbursement:

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

(1) Children's hospital

(2) Veterans' Administration hospital

(3) State psychiatric hospital

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

(1) Medicare certified Critical Access Hospital (CAH) (listed in Exhibit 3 of Rule 18)

(2) Medicare certified long-term care hospital

(3) Colorado Department of Public Health and Environment (CDPHE) licensed rehabilitation facility, and,

(4) CDPHE licensed psychiatric facilities that are privately owned.

(5) CDPHE licensed skilled nursing facilities (SNF).

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

Retrieve the relative weights for the assigned MS-DRG from the MS-DRG table

in Exhibit 1 to Rule 18 and locate the hospital's base rate in Exhibit 2 to Rule 18.

The "Maximum Fee Allowance" is determined by calculating:

(1) (MS-DRG Relative Wt x Specific hospital base rate x 155%) + (reimbursement for all "Supply et al.") + (trauma center activation allowance)

(2) "Supply et al." is defined in Rule 16-2. Reimbursement shall be consistent with Rule 18-6(H). The billing provider is responsible for identifying and itemizing all "Supply et al." items.

(3) For trauma center activation allowance, see Rule 18-6(M)(3)(g).

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

(1) Determine the "Hospital's Cost" :

total billed charges (excluding any "Supply et al." billed charges and trauma center activation billed charges) multiplied by the hospital's cost-to-charge ratio.

(2) Each hospital's cost-to-charge ratio is given in Exhibit 2 of Rule 18.

(3) The "Difference" = "Hospital's Cost" – "Maximum Fee Allowance" excluding any "Supply et al." allowance and trauma center activation allowance (see (c) above)

(4) If the "Difference" is greater than $25,800.00, additional reimbursement is warranted. The additional reimbursement is determined by the following equation:

"Difference" x .80 = additional fee allowance

(e) Inpatient combined with ERD or Trauma Center reimbursement

(1) If an injured worker is admitted to the hospital, the ERD reimbursement is included in the inpatient reimbursement under 18-6 (I)(3),

(2) Except, Trauma Center activation fees (see 18-6(M)(3)(g)) are paid in addition to inpatient fees (18-6(I)(3)(c-d)).

(f) If an injured worker is admitted to one hospital and is subsequently transferred to another hospital, the payment to the transferring hospital will be based upon a per diem value of the MS-DRG maximum value. The per diem value is calculated based upon the transferring hospital's MS-DRG relative weight multiplied by the hospital's specific base rate (Exhibit 2 to Rule 18) divided by the MS-DRG geometric mean length of stay (Exhibit 1 to Rule 18). This per diem amount is multiplied by the actual LOS. If the patient is admitted and transferred on the same day, the actual LOS equals one (1). The receiving hospital shall receive the appropriate MS-DRG maximum value.

(g) To comply with Rule 16-6(B), the payer shall compare each billed charge type:

- The MS-DRG adjusted billed charges to the MS-DRG allowance (including any outlier allowance),

- "Supply et al." billed charges to the "Supply et al." allowance [cost + 20%], and

- The trauma center activation billed charge to the trauma center activation allowance.

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

(J) Scheduled Outpatient Surgery Facility Fees

(1) Provider Restrictions

(a) All non-emergency outpatient surgeries require prior authorization for payment (see Rule 16-9 and 16-10).

(b) A separate facility fee is only payable if the facility is licensed by the Colorado Department of Public Health and Environment (CDPHE) as:

(1) a hospital; or

(2) an Ambulatory Surgery Center (ASC).

(2) Bills for Services

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

(b) All professional charges are subject to the RVP© and Dental Fee Schedules as incorporated by Rule 18.

(c) ASCs and hospitals shall bill using the surgical RVP© code(s) as indicated by the surgeon's operative note up to a maximum of four surgery codes per surgical episode.

(3) Outpatient Surgery Facility Reimbursement:

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

(1) Children's hospital

(2) Veterans' Administration hospital

(3) State psychiatric hospital

(b) CAHs, listed in Exhibit 3 of Rule 18, are to be reimbursed at 80% of billed charges.

(c) All other outpatient surgery facilities are reimbursed based on Exhibit 4 of this Rule 18. Exhibit 4 lists Medicare's Outpatient Hospital Ambulatory Prospective Payment Codes (APC) with the Division's values for each APC code. Grouper

code 210, found in Exhibit 4, was DoWC created to reimburse RVP© spinal fusion codes not listed in Medicare's Revised January 2010 Update to reflect Affordable Care Act 05/18/2010- Addendum B [PDF, 961KB] (Revised Addendum B).

The surgical procedure codes are classified by APC code in Medicare's Revised Addendum B. This Addendum B should be used to determine the APC code payable under the Division's Exhibit 4. However, not every surgical code listed under Revised Addendum B warrants a separate facility fee.

The Revised Addendum B can be accessed at Medicare's Hospital Outpatient PPS website.

Total maximum facility value for an outpatient surgical episode of care includes the sum of:

(1) The highest valued APC code per Exhibit 4 plus 50% of any lesser-valued APC code values.

Multiple procedures and bilateral procedures are to be indicated by the use of modifiers –51 and –50, respectively. The 50% reduction applies to all lower valued procedures, even if they are identified in the RVP© as modifier -51 exempt. The reduction also applies to the second "primary" procedure of bilateral procedures.

The surgery discogram procedure (APC 388) value is for all levels and includes conscious sedation and the technical component of the radiological procedure.

Facility fee reimbursement is limited to a maximum of four surgical procedures per surgical episode with a maximum of only one procedure reimbursed at 100% of the allowed value.

If an arthroscopic procedure is converted to an open procedure on the same joint, only the open procedure is payable. If an arthroscopic procedure and open procedure are performed on different joints, the two procedures may be separately payable with anatomic modifiers.

When reported in conjunction with other knee arthroscopy codes, any combination of surgical knee arthroscopies for removal of loose body, foreign body, and/or debridement/shaving of articular cartilage shall be paid only if performed in a different compartment of the knee; and

(2) "Supply et al." is defined in Rule 16-2. Reimbursement shall be consistent with Rule 18-6(H). The billing provider is responsible for identifying and itemizing all "Supply et al." items; and

(3) Diagnostic testing and preoperative labs may be reimbursed by applying the appropriate CF to the unit values for the specific CPT® code as listed in the RVP.

However, diagnostic testing and preoperative labs shall be reimbursed according to Exhibit #4 when it lists a dollar value greater than zero. Other services with non-zero Exhibit #4 values, such as cardiac and dialysis procedures, shall also be reimbursed according to Exhibit #4.

Use Medicare's Revised Addendum B to link Exhibit #4 APC Grouper numbers to CPT® codes.

CPT® radiological procedure codes (not the injection codes) are to be used for all venograms, arthrograms and myelograms; and

(4) Observation room maximum allowance is limited to 6 hours without prior authorization for payment (see Rule 16-9 and 16-10). Documentation should support the medical necessity for observation or convalescent care. Observation time begins when the patient is placed in a bed for the purpose of initiating observation care in accordance with the physician's order. Observation or daily outpatient convalescence time ends when the patient is actually discharged from the hospital or ASC or admitted into a licensed facility for an inpatient stay. Observation time would not include the time patients remain in the observation area after treatment is finished for reasons such as waiting for transportation home. Hospital or convalescence licensure is required for billing observation or convalescence time beyond 23 hours.

Billing Codes:

G0378 Observation/Convalescence rate: $45.00 per hour rounded to the nearest hour.

(5) Additional reimbursement is payable for the following services not included in the values found in Exhibit 4 of Rule 18:

- ambulance services

- blood, blood plasma, platelets

(d) In rare cases, a reasonable facility fee may be paid when an outpatient surgical procedure poses a significant risk to the injured worker if performed in a lesser facility, even if the procedure:

- Has a zero dollar value in Exhibit 4, and/or

- Cannot be assigned to an APC Grouper based on Medicare's Revised Addendum B.

Once the risk to the injured worker has been provided in writing and the payer has agreed or it is ordered that this procedure may occur in the facility, a reasonable dollar value shall be determined by using a similar procedure code (if the exact code cannot be used) that can be assigned under Exhibit 4 or under Medicare's Revised Addendum B. If a value does not exist in Exhibit 4, then the APC dollar value from Medicare's Revised Addendum B with reductions for "Supply et al." is multiplied by 160%. The services normally included in Exhibit 4 values shall be included in this reimbursement value, and the services allowed as additional reimbursement under Rule 18-6 (J)(3)(c)(2)-(5) would be allowed.

(e) Discontinued surgeries require the use of modifier -73 (discontinued prior to administration of anesthesia) or modifier -74 (discontinued after administration of anesthesia). Modifier -73 results in a reimbursement of 50% of the APC value for the primary procedure only. Modifier -74 allows reimbursement of 100% of the primary procedure value only.

(f) All surgical procedures performed in one operating room, regardless of the number of surgeons, are considered one outpatient surgical episode of care for purposes of facility fee reimbursement.

(g) In compliance with Rule 16-6(B), the sum of Rule 18-6(J)(3)(c)(1-5) is compared to the total facility fee billed charges. The lesser of the two amounts shall be the maximum facility allowance for the surgical episode of care. A line by line comparison of billed charges to the calculated maximum fee schedule allowance of 18-6(J)(3)(c) is not appropriate.

(K) Outpatient Diagnostic Testing and Clinic Facility Fees

(1) Bills for Services

All providers shall indicate whether they are billing for the total, professional only or technical only component of a diagnostic test by listing the appropriate RVP© modifier on the UB-04 or CMS 1500 (08-05).

(2) Reimbursement

(a) The following types of outpatient diagnostic testing and clinic facilities are reimbursed at 100% of billed charges:

(1) Children's hospitals,

(2) Veterans' Administration hospitals

(3) State psychiatric hospitals

(b) Rural health facilities listed in Exhibit 5 are reimbursed at 80% of billed charges for clinic visits, diagnostic testing, and supplies and drugs that do not meet the "Supply et al." threshold.

"Supply et al." is defined in Rule 16-2 and reimbursement shall be consistent with Rule 18-6(H). The billing provider is responsible for identifying and itemizing all "Supply et al." items.

(c) All other facilities:

(1) No separate allowance for clinic visit fees. Supplies are reimbursed in accordance with Rule 18-6(H).

(2) No separate facility fee allowance for diagnostic testing. Facility fees for diagnostic testing are considered part of the procedure's technical component value except when there is a non-zero value listed in Exhibit 4 for the diagnostic test. Outpatient diagnostic testing is reimbursed using the RVP© code unit value, except when there is a non-zero value listed in Exhibit 4, in which case that value is used. Dyes and contrasts may be reimbursed according to Rule 18-6(H).

(3) "Supply et al." is defined in Rule 16-2 and reimbursement shall be consistent with Rule 18-6(H). The billing provider is responsible for identifying and itemizing all "Supply et al." items.

(d) Any prescription for a drug supply to be used longer than a 24 hour period, filled at

any clinic, shall fall under the requirements of and be reimbursed as, a pharmacy fee. See Rule 18-6(O).

(L) Outpatient Urgent Care Facility Fees

(1) Provider Restrictions:

(a) Prior agreement or authorization is recommended for all facilities billing a separate Urgent Care fee. Facilities must provide documentation of the required urgent care facility criteria if requested by the payer.

(b) Urgent care facility fees are only payable if the facility qualifies as an Urgent Care facility. Facilities licensed by the CDPHE as a Community Clinic (CC) or a Community Clinic and Emergency Center (CCEC) under 6 CCR 1011-1, Chapter IX, should still provide evidence of these qualifications to be reimbursed as an Urgent Care facility. The facility shall meet all of the following criteria to be eligible for a separate Urgent Care facility fee:

(1) Separate facility dedicated to providing initial walk-in urgent care;

(2) Access without appointment during all operating hours;

(3) State licensed physician on-site at all times exclusively to evaluate walk-in patients;

(4) Support staff dedicated to urgent walk-in visits with certifications in Basic Life Support (BLS);

(5) Advanced Cardiac Life Support (ACLS) certified life support capabilities to stabilize emergencies including, but not limited to, EKG, defibrillator, oxygen and respiratory support equipment (full crash cart), etc.;

(6) Ambulance access;

(7) Professional staff on-site at the facility certified in ACLS;

(8) Extended hours including evening and some weekend hours;

(9) Basic X-ray availability on-site during all operating hours;

(10) Clinical Laboratory Improvement Amendments (CLIA) certified laboratory on-site for basic diagnostic labs or ability to obtain basic laboratory results within 1 hour;

(11) Capabilities include, but are not limited to, suturing, minor procedures, splinting, IV medications and hydration;

(12) Written procedures exist for the facility's stabilization and transport processes.

(c) No separate facility fees are allowed for follow-up care. Subsequent care for an initial diagnosis does not qualify for a separate facility fee. To receive another facility fee any subsequent diagnosis shall be a new acute care situation entirely different from the initial diagnosis.

(d) 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.

(2) Bills for Services

(a) Urgent care facility fees may be billed on a CMS 1500 (08-05).

(b) Urgent care facility fees shall be billed using HCPCS Level II code: S9088 – "Services provided in an Urgent care facility."

(3) Urgent Care Reimbursement

The total maximum value for an urgent care episode of care includes the sum of:

(a) An Urgent Care Facility fee maximum allowance of $75.00; and

(b) "Supply et al." is defined in Rule 16-2 and reimbursement shall be consistent with Rule 18-6(H). The billing provider is responsible for identifying and itemizing all "Supply et al." items.

Supplies and drugs that do not meet the "Supply et al." threshold and treatment rooms are included in the Urgent Care facility maximum fees; and

(c) All diagnostic testing, laboratory services and therapeutic services (including, but not limited to, radiology, pathology, respiratory therapy, physical therapy or occupational therapy) shall be reimbursed by multiplying the appropriate CF by the unit value for the specific CPT® code as listed in the RVP© and Rule 18; and

(d) The Observation Room allowance shall not exceed a rate of $45.00 per hour and is limited to a maximum of 3 hours without prior authorization for payment (see Rule 16-9 and 16-10).

(e) In compliance with Rule 16-6 (B), the sum of all Urgent Care fees charged, less any amounts charged for professional fees or dispensed prescriptions per Rule 18-6(L)(4) found on the same bill, is to be compared to the maximum reimbursement allowed by the calculated value of Rule 18-6(L)(3)(a-d). The lesser of the two amounts shall be the maximum facility allowance for the episode of urgent care. A line by line comparison is not appropriate.

(4) Any prescription for a drug supply to be used longer than a 24 hour period, filled at any Urgent Care facility, shall fall under the requirements of, and be reimbursed as, a pharmacy fee. See Rule 18-6(O).

(M) Outpatient Emergency Room Department (ERD) Facility Fees

(1) Provider Restrictions

To be reimbursed under this section (M), all outpatient ERDs within Colorado must be physically located within a hospital licensed by the CDPHE as a general hospital, or if free-standing ERD, must have equivalent operations as a licensed ERD. To be paid as an ERD, out-of-state facilities shall meet that state's licensure requirements.

(2) Bills For Services

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

(b) Documentation should support the "Level of Care" being billed.

(3) ERD Reimbursement

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

(1) Children's hospitals

(2) Veterans' Administration hospitals

(3) State psychiatric hospitals

(b) Medicare certified Critical Access Hospitals (CAH) (listed in Exhibit 3 of Rule 18) are reimbursed at 80% of billed charges.

(c) The ERD "Level of Care" is identified based upon one of five levels of care. The level of care is defined by CPT® E&M definitions and internal level of care guidelines developed by the hospital in compliance with Medicare regulations. The hospital's guidelines should establish an appropriate graduation of hospital resources (ERD staff and other resources) as the level of service increases. Upon request the provider shall supply a copy of their level of care guidelines to the payer.

(d) Total maximum value for an ERD episode of care includes the sum of the following:

(1) ERD reimbursement amount for "Level of Care" points:

ERD Level	**Reimbursement**
1	$160.00
2	$360.00
3	$620.00
4	$870.00
5	$1,640.00
Critical Care	$1,640.00

(Only the higher one of any ERD Levels or critical care codes shall be paid)

and

(2) All diagnostic testing, laboratory services and therapeutic services not included in the hospital's point system (including, but not limited to, radiology, pathology, any respiratory therapy, PT or OT) shall be reimbursed by the appropriate CF multiplied by the unit value for the specific code as listed in the RVP© and Rule 18; and

(3) The observation room allowance shall not exceed a rate of $45.00 per hour and is limited to a maximum of 3 hours without prior authorization for payment (see Rule 16-9 and 16-10). The documentation should support the medical necessity for observation; and

(4) ERD level of care maximum fees include supplies and drugs that do not meet

the “Supply et al.” threshold and treatment rooms. “Supply et al.” is defined in Rule 16-2 and reimbursement shall be consistent with Rule 18-6(H). The billing provider is responsible for identifying and itemizing all “Supply et al.” items.

(e) For the purposes of Rule 16-6 (B), the sum of all outpatient ERD fees charged, less any amounts charged for professional fees found on the same bill, is to be compared to the maximum reimbursement allowed by the calculated value of Rule 18-6(M)(3)(d). The lesser of the two amounts shall be the maximum facility allowance for the ERD episode of care. A line by line comparison is not appropriate.

(f) If an injured worker is admitted to the hospital through that hospital’s ERD, the ERD reimbursement is included in the inpatient reimbursement under 18-6(I)(3).

(g) Trauma Center fees are not paid for alerts. Activation fees are as follows:

Level I $3,000.00

Level II $2,500.00

Level III $1,000.00

Level IV $00.00

(1) These fees are in addition to ERD and inpatient fees.

(2) Activation fees mean a trauma team has been activated, not just alerted.

(3) The level of trauma activation shall be determined by CDPHE’s assigned hospital trauma level designation.

(N) Home Therapy

Prior authorization for payment (see Rule 16-9 and 16-10) is required for all home therapy. The payer and the home health entity should agree in writing on the type of care, skill level of provider, frequency of care and duration of care at each visit, and any financial arrangements to prevent disputes.

(1) Home Infusion Therapy

The per diem rates for home infusion therapy shall include the initial patient evaluation, education, coordination of care, products, equipment, IV administration sets, supplies, supply management, and delivery services. Nursing fees should be billed as indicated in Rule 18-6(N)(2).

(a) Parenteral Nutrition:

0 -1 liter $140.00/day

1.1 - 2.0 liter $200.00/day

2.1 - 3.0 liter $260.00/day

(b) Antibiotic Therapy:

$105.00/day + Average Wholesale Price (AWP) (See Rule 18-6(O)(14))

(c) Chemotherapy:

$85.00/day + AWP (See Rule 18-6(O)(14))

(d) Enteral nutrition:

Category I $ 43.00/day

Category II $ 41.00/day

Category III $ 52.00/day

(e) Pain Management: $ 95.00/day + AWP (See Rule 18-6(O)(14))

(f) Fluid Replacement: $ 70.00/day + AWP (See Rule 18-6(O)(14))

(g) Multiple Therapies:

Rate per day for highest cost therapy only + AWP (See Rule 18-6(O)(14)) for all drugs

Medication/Drug Restrictions - the payment for drugs may be based upon the AWP (See Rule 18-6(O)(14)) of the drug as determined through the use of industry publications such as the monthly *Price Alert* , First Databank, Inc.

(2) Nursing Services

DoWC Z770 Skilled Nursing (LPN & RN)

$95.79 per hour

There is a limit of 2 hours without prior authorization for payment (see Rule 16-9 and 16-10).

DoWC Z771 Certified Nurse Assistant (CNA):

$31.67 per hour for the first hour per trip to injured worker;

$9.46 for each additional half hour. Service must be at least 15 minutes to bill an additional half hour charge.

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

(3) Physical Medicine

Physical medicine procedures are payable at the same rate as provided in the physical medicine and rehabilitation services section of Rule 18.

(4) Mileage

Travel allowances should be agreed upon with the payer and the mileage rate should not exceed $0.47 per mile, portal to portal.

DoWC code: Z772

(5) Travel Time

Travel is typically included in the fees listed. Travel time greater than 1 hr. one-way shall be reimbursed. The fee shall be agreed upon at the time of prior authorization for payment (see Rule 16-9 and 16-10) and shall not exceed $30.00 per hour.

DoWC code: Z773

(O) Pharmacy Fees

(1) AWP (See Rule 18-6(O)(14)) + $4.00

(2) All bills shall reflect the National Drug Code (NDC)

(3) All prescriptions shall be filled with bio-equivalent generic drugs unless the physician indicates "Dispense As Written" (DAW) on the prescription

(4) The above formula applies to both brand name and generic drugs

(5) The provider shall dispense no more than a 60-day supply per prescription

(6) A line-by-line itemization of each drug billed and the payment for that drug shall be made on the payment voucher by the payer

(7) AWP (See Rule 18-6(O)(14)) for brand name and generic pharmaceuticals may be determined through the use of such monthly publicationS as *Price Alert* , First Databank, Inc., *Red Book* , Medispan. In case of a dispute on AWP values, the parties should take the average of their referenced published values.

(8) Compounding Pharmacies

Reimbursement for compounding pharmacies shall be based on the cost of the materials plus 20%, $50.00 per hour for the pharmacist's documented time, and actual cost of any mailing & handling.

Bill Code:

DoWC Z790 Materials, mailing, handling

DoWC Z791 Pharmacist $50.00/hr

(9) Injured Worker Reimbursement

In the event the injured worker has directly paid for authorized prescriptions, the payer shall reimburse the injured worker for the amounts actually paid within thirty (30) days after receipt of the bill. See Rule 16-11(G).

(10) Dietary Supplements, Vitamins and Herbal Medicines

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

(11) Prescription Writing

Physicians shall indicate on the prescription form that the medication is related to a workers' compensation claim.

(12) Provider Reimbursement

Provider offices that prescribe and dispense medications from their office have a maximum allowance of AWP (See Rule 18-6(O)(14)) plus $4.00.

All medications administered in the course of the provider's care shall be reimbursed at actual cost incurred.

(13) Required Billing Forms

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

(1) CMS 1500 (08-05) (formerly CMS 1500) – the dispensing provider shall bill by using the RVP© supply code and shall include the metric quantity and NDC number of the drug being dispensed; or

(2) WC -M4 form or equivalent – each item on the form shall be completed, or

(3) With the agreement of the payer, the National Council for Prescription Drug Programs (NCPDP) or ANSI ASC 837 (American National Standards Institute Accredited Standards Committee) electronic billing transaction containing the same information as in (1) or (2) in this sub-section may be used for billing.

(b) Items prescribed for the work-related injury that do not have an NDC code shall be billed as a supply, using the RVP© supply code.

(c) The payer may return any prescription billing form if the information is incomplete.

(d) A signature shall be kept on file indicating that the patient or his/her authorized representative has received the prescription.

(14) If average wholesale price (AWP) ceases, substitute Wholesale Acquisition Cost (WAC) + 20% for AWP everywhere it is found in this rule.

(P) Complementary Alternative Medicine (CAM) (Requires prior authorization for payment (see Rule 16-9 and 16-10)

CAM is a term used to describe a broad range of treatment modalities, some of which are generally accepted in the medical community and others that remain outside the accepted practice of conventional western medicine. Providers of CAM may be both licensed and non-licensed health practitioners with training in one or more forms of therapy. Refer to Rule 17, Medical Treatment Guidelines for the specific types of CAM modalities.

(Q) Acupuncture

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

(1) Provider Restrictions

All providers must be Registered Acupuncturists (LAc) or certified by an existing licensing board as provided in Rule 16, Utilization Standards, and must provide evidence of training, registration and/or certification upon request of the payer.

(2) Billing Restrictions

(a). For treatment frequencies exceeding the maximum allowed in Rule 17 Medical Treatment Guidelines, the provider must obtain prior authorization for payment (see Rule 16-9 and 16-10).

(b) Unless the provider's medical records reflect medical necessity and the provider obtains prior authorization for payment (see Rule 16-9 and 16-10), the maximum amount of time allowed for acupuncture and procedures is one hour of procedures, per day, per discipline.

(3) Billing Codes:

(a) Reimburse acupuncture, including or not including electrical stimulation, as listed in the RVP©.

(b) Non-Physician evaluation services

(1) New or established patient services are reimbursable only if the medical record specifies the appropriate history, physical examination, treatment plan or evaluation of the treatment plan. Payers are only required to pay for evaluation services directly performed by an LAc. All evaluation notes or reports must be written and signed by the LAc. Without appropriate supporting documentation, the payer may deny payment. (See Rule 16-11)

(2) LAc new patient visit:

DoWC Z800 Maximum value $94.40

(3) LAc established patient visit:

DoWC Z801 Maximum value $63.72

(c) Herbs require prior authorization for payment (see Rule 16-9 and 16-10) and fee agreements as in this Rule 18-6(O)(10);

(d) See the appropriate physical medicine and rehabilitation section of the RVP© for other billing codes and limitations (see also Rule 18-5(H)).

(e) Acupuncture supplies are reimbursed in accordance with Rule 18-6(H).

(R) Use of an Interpreter

Rates and terms shall be negotiated. Prior authorization for payment (see Rule 16-9 and 16-10) is required except for emergency treatment. Use DoWC Z722 to bill.

18-7 DENTAL FEE SCHEDULE

The dental schedule is adopted using the American Dental Association's *Current Dental Terminology* , 2009-2010 (CDT-2009-2010). However, surgical treatment for dental trauma and subsequent, related procedures may be billed using medical codes from the RVP©. If billed using medical codes as listed in the RVP©, reimbursement shall be in accordance with the Surgery/Anesthesia section of the RVP© and its corresponding conversion factor. All dental billing and reimbursement shall be in accordance with the Division's Rule 16, Utilization Standards, and Rule 17, Medical Treatment Guidelines. See Exhibit 6 for the listing and maximum allowance for CDT-2009-2010 dental codes.

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

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 History link that appears above the text in 7 CCR 1101-3. To view versions effective after 01/01/2011, select the desired part of the rule, for example 7 CCR 1101-3 Rules 1-17, or 7 CCR 1101-3 Rule 18: Exhibit 1.

History

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