DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation

WORKERS' COMPENSATION RULES OF PROCEDURE WITH TREATMENT GUIDELINES

MEDICAL FEE SCHEDULE

7 CCR 1101-3 Rule 18 (no exhibits)

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

18-1 STATEMENT OF PURPOSE

Pursuant to § 8-42-101(3)(a)(I) C.R.S. and § 8-47-107, C.R.S., the Director promulgates this Medical Fee Schedule to review and establish maximum allowable fees for health care services falling within the purview of the Act. The Director adopts and hereby incorporates by reference as modified herein the 2014 edition of the Relative Values for Physicians (RVP©), developed by Relative Value Studies, Inc., published by OPTUMINSIGHT (Ingenix®), the Current Procedural Terminology CPT® 2014, Professional Edition, published by the American Medical Association (AMA) and Medicare Severity Diagnosis Related Groups (MS-DRGs) Definitions Manual, Version 32.0 developed and published by 3M Health Information Systems using MS-DRGs effective after October 1, 2014. The incorporation is limited to the specific editions named and does not include later revisions or additions. For information about inspecting or obtaining copies of the incorporated materials, contact the Medical Policy Unit Supervisor, 633 17th Street, Suite 400, Denver, Colorado 80202-3626. These materials may be examined at any state publications depository library. All guidelines and instructions are adopted as set forth in the RVP©, CPT® and MS-DRGs, and all CPT® modifiers, unless otherwise specified in this Rule.

This Rule applies to all services rendered on or after January 1, 2015. 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® 2014, copyrighted and distributed by the AMA and incorporated by reference in 18-1.

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

(C) MS-DRGs – version 31.0 incorporated by reference in 18-1.

(D) RVP© – the 2014 edition incorporated by reference in 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® OptumInsight, the Current Procedural Terminology, 2014 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	$ 53.73/RVU
Surgery	$ 99.83/RVU
Radiology	$ 18.41/RVU
Pathology	$ 13.72/RVU
Medicine	$ 8.33/RVU
Physical Medicine (Physical Medicine and Rehabilitation,Medical Nutrition Therapy and Acupuncture)	$ 6.23/RVU
Evaluation & Management (E&M)	$ 10.16/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.

(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. Division created codes (Zxxxx) and values supersede CPT® or RVP© codes and reimbursement levels. Those codes listed with RVUs of "BR" (by report) and "RNE" (relativity not established) require prior authorization as explained in Rule 16. The CPT® 2014 is adopted for codes, descriptions, parenthetical notes and coding guidelines, unless modified in this Rule.

Any billed CPT® code identified as a "separate procedure" in CPT® shall have an appropriate modifier appended to the code for the payer to allow separate payment (i.e., modifier -59).

No code listed in CPT® identified as an "add-on" code is payable unless an appropriate primary code is billed with the "add-on" code in the same episode of care.

(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, a Certified Registered Nurse Anesthetist (CRNA), or an anesthesiologist assistant (AA) who remains in constant attendance during the procedure for the sole purpose of rendering anesthesia.

When anesthesia is administered by a CRNA or AA:

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

(2) 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;

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

(a) Performs a pre-anesthesia examination and evaluation,

(b) Prescribes the anesthesia plan,

(c) Personally participates in the most demanding procedures in the anesthesia plan including induction and emergence,

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

(e) Monitors the course of anesthesia administration at frequent intervals,

(f) Remains physically present and available for immediate diagnosis and treatment of emergencies, and

(g) 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

AD – greater than four (4) concurrent (occurring at the same time) anesthesia service cases being supervised by an anesthesiologist

QK – anesthesiologist providing direction to qualified individuals of two (2) to four (4) concurrent anesthesia cases

QX – CRNA or AA service; with medical direction by a physician

QZ – CRNA service; without medical direction by a physician

QY – Medical direction of one CRNA or AA by an anesthesiologist

QS – Monitored anesthesia care service (MAC)

G8 – Monitored anesthesia care (MAC) for deep complex complicated, or markedly invasive surgical procedure

G9 – Monitored anesthesia care (MAC) of a patient who has a history of severe cardiopulmonary disease

(d) The supervision of AAs shall be limited in accordance with the Medical Practice Act.

(e) Physical status modifiers are reimbursed as follows, using the anesthesia conversion factor:

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	0 RVUs

(f) Qualifying circumstance codes are reimbursed using the medicine conversion factor:

Anesthesia complicated by extreme age; under 1 year old or > 70 years old	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

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

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

(i) Calculation of Maximum Fees for Anesthesia.

Base Anesthesia value from the RVP© Anesthesia Guidelines

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

"Qualifying circumstance" codes are reimbursed under section 18-5(D)(1)(f) of this Rule.

(j) Non-time based Anesthesia Procedures.

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

The relative value units are located in the RVP© Anesthesia Guidelines, Paragraph XIV

(2) Surgical Section

(a) The use of assistant surgeons shall be limited according to the American College Of Surgeons' Physicians as Assistants at Surgery: 2013 Study (January 2013), available from the American College of Surgeons, Chicago, IL, or from their web page. The incorporation is limited to the edition named and does not include later revisions or additions. Copies of the material incorporated by reference may be inspected at any State publications depository library. For information about inspecting or obtaining copies of the incorporated material, contact the Medical Policy Unit Supervisor, 633 17th Street, Suite 400, Denver, Colorado, 80202-3626.

Where the publication restricts use of such assistants to "almost never" or a procedure is not referenced in the publication, prior authorization for payment (see Rule 16-9) 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 (1) assistant surgeon or minimum assistant surgeon without prior authorization for payment (see Rule 16-9) 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) When an operation requires two primary surgeons performing two distinct portions of the operation, modifier -62 is used with the procedure in question and reimbursement is increased to 125% of the value, apportioned in relation to the responsibilities and work of each surgeon or 50% of the total increased maximum fee to each surgeon.

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

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

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

Minimum Assistant Surgeon, such as a physician's assistant, a nurse practitioner, or a clinical nurse specialist, is indicated by modifier -81 and reimbursed at 10% of the surgeon's fees.

(f) Global Period

1) All surgical procedures include the following:

a) Local infiltration, metacarpal/metatarsal/digital block or typical anesthesia;

b) One related E&M encounter on the date immediately prior to or on the date of the procedure (including history and physical);

c) Intraoperative services that are normally a usual and necessary part of a surgical procedure;

d) Immediate postoperative care, including dictating operative notes, talking with the family and other physicians;

e) Evaluating the patient in the post-anesthesia recovery room;

f) Post-surgical pain management by the surgeon;

g) Typical postoperative follow-up care during the global period of the surgery that is related to recovery from the surgery as identified in RVP© as global:

- 000 –are endoscopies or some minor surgical procedures, typically a 0 day postoperative period. Visits on the same day of procedures are generally included in the allowance for the procedure, unless a separately identifiable service is performed and billed with the appropriate modifier.

- 010 - are other minor procedures, 10 day postoperative period.

- 090 - are major surgeries, 90 day postoperative period.

- XXX – does not apply

- ZZZ – are covered under another procedure's global days

- MMM – global service day's concept does not apply. (See Medicare's Global Maternity Care reporting rule.)

- Global period, defined RVP©, begins the day after surgery and continues for the defined period.

h) Supplies – Except for those identified as exclusions;

i) Miscellaneous Services – Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts and splints; insertion, irrigation and removal of urinary catheters, routine peripheral IV lines, nasograstric and rectal tubes; changes and removal of tracheostomy tubes;

j) Applicable Surgical Modifiers:

- 24 - Unrelated E&M service by the same physician during a postoperative period.

- 25 - Significant and separately identifiable E&M service on the same day of the procedure within the global period of minor surgical procedures (0 or 10 days).

- 54 - Surgical Care only. Fee is 60% of the billed surgery code Maximum Fee Schedule value.

- 55 - Postoperative management only. Fee is 30% of the billed surgery code Maximum Fee Schedule value.

- 56 - Preoperative management only. Fee is 10% of the billed surgery code Maximum Fee Schedule value.

- 57 - Decision for surgery.

- 58 - Staged or related procedure or service by the same physician during the postoperative period.

- 76 - Repeat procedure or service by the same physician.

- 78 - Unplanned Return to the Operating/Procedure Room by the same physician following initial procedure for a related procedure during the postoperative period.

- 79 - Un-related procedure or service by the same physician during the postoperative period.

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

a) E&M services unrelated to the primary surgical procedure.

b) Services necessary to stabilize the patient for the primary surgical procedure.

c) Services not considered part of the surgical procedure, including an E&M visit by an authorized treating physician for disability management. The E&M service shall have an appropriate modifier appended to the E&M level of the service code when the surgeon is performing services during the global period. If at all possible, an appropriate identifying diagnosis code shall identify the E&M service as unrelated to the surgical global period. In addition, the reasonableness and necessity for an E&M service that is separate and identifiable from the surgical global period shall be clearly documented in the medical record.

d) Disability management of an injured worker for the same diagnosis requires the managing physician to clearly identify in the medical record the specific disability management detail that was performed during that visit. The definitions of what is considered disability counseling can be located under 18-5(I)(1) and in Exhibit #7 of this Rule.

e) Unusual circumstances, complications, exacerbations, or recurrences.

f) Unrelated diseases or injuries.

g) 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.

3) Separate identifiable services shall use an appropriate CPT®/RVP© modifier in conjunction with the billed service.

(g) Multiple Procedures (modifier -51) and Bilateral Procedures (modifier -50)

Multiple procedure guidelines do not apply to codes specifically identified as add-on procedures or to those specifically identified as exempt from modifier -51.

Bilateral procedures shall be billed on one line with one (1) unit and the modifier -50 appended to the CPT® code. The maximum fee is calculated at 150% of the Maximum Fee Schedule value.

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

(h) The "Services with Significant Direct Costs" section of the RVP© is not adopted. Supplies shall be reimbursed as set out in section 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 (2) 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 11.8 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.

(k) Relative value units listed in the 2014 RVP© Surgery Section listed below shall be replaced as follows:

1) Epidural for blood or clot patch injection = 1.9

2) Epidurals diagnostic or therapeutic injections substance(s) including anesthetic antispasmodic, opioid, steroid, other solutions (NOT neurolytic substances) for subarachnoid

a) Cervical or thoracic level = 2.0

b) Lumbar or sacral (caudal) = 1.65

3) Epidurals (including indwelling catheter placement), for continuous infusion or intermittent bolus of diagnostic or therapeutic substance(s) including anesthetic, antispasmodic, opioid, steroid, other solutions (NOT neurolytic substances) for subarachnoid

a) Cervical or thoracic level =1.85

b) Lumbar or sacral (caudal) = 1.77

4) Somatic nerve injections:

a) Greater occipital nerve= 1.5

b) Spinal accessory nerve = 1.5

c) Injection brachial plexus, continuous infusion by catheter (including catheter placement) = 1.0

d) Regional block (intercostal) = 1.7

e) Sciatic nerve, continuous infusion = 1.3

f) Femoral nerve, single = 1.5

g) Injection, femoral nerve, continuous infusion by catheter (including catheter placement) = 1.2

h) Lumbar plexus, posterior approach, continuous infusion = 2.0

i) Other peripheral nerve or branch = 1.25

5) Paravertebral facet joint injections:

a) Single level cervical/thoracic levels = 2.0

b) Second levels at cervical/thoracic = 1.25

c) Third and any additional levels at cervical/thoracic = 1.10

6) Paravertebral facet joint injections:

a) Single level lumbar/sacral levels = 1.75

b) Second levels at lumbar/sacral = 1.0

c) Third and any additional levels at lumbar/sacral = 1.0

7) Autonomic nerve injection

a) Anesthetic agent, superior hypogastric plexus = 1.3

b) Anesthetic agent, lumbar or thoracic (paravertebral sympathetic) = 2.0

8) Destruction of nerve by neurolytic agent:

a) Trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch, second and third division branches at foramen ovale = 5.5

b) Intercostal nerve = 3.0

c) Pudendal nerve = 3.0

d) Paravertebral facet joints at cervical and thoracic single level = 4.4

e) Paravertebral facet joints at cervical and thoracic each additional level = 2.0

f) Paravertebral facet joints at lumbar or sacral single level = 4.2

g) Paravertebral facet joints at lumbar or sacral single each additional level = 1.8

h) Other peripheral nerve or branch = 1.6

i) Celiac plexus = 2.9

9) Functional Assessments related to spinal or sacroiliac joint injections shall be reimbursed in accordance with 18-6(G)(6).

10) Tympanic Membrane surgery:

a) Tympanic membrane repair, with or without site preparation of perforation for closure, with or without patch = 11.7

(I) Venipuncture for clinical laboratory testing maximum fee allowance is covered under Exhibit #8 of this Rule.

(E) Radiology Section:

(1) General

(a) The cost of dyes and contrast shall be reimbursed in accordance with 18-6(K)(2)c)4).

(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 shall be billed using the appropriate modifier to bill either the professional component (26) or the technical component (TC). If a physician bills the total or professional component, a separate written interpretive report is required.

If a physician interprets the same radiological image more than once, or if multiple physicians interpret the same radiological image, only one (1) interpretation shall be reimbursed.

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

American Academy of Thermology;

American Chiropractic College of Infrared Imaging.

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

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

Sympathetically Maintained Pain (SMP);

Autonomic neuropathy;

(c) General Protocols for Stress Testing

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

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

(d) Thermography Billing Codes:

DoWC Z0200 Upper body w/ Autonomic Stress Testing	$865.37
DoWC Z0201 Lower body w/Autonomic Stress Testing	$865.37

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

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

(F) Pathology Section:

Laboratories with a CLIA certificate of waiver may perform only those tests cleared by the Food and Drug Administration (FDA) as waived tests. Laboratories with a CLIA certificate of waiver 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 do not append the QW modifier to claim lines.

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

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

- physician blood bank services,
- cytopathology and cell marker study interpretations,

- cytogenics or molecular cytogenics interpretation and report,
- surgical pathology gross and microscopic and special stain groups 1 and 2 and histochemical stain, blood or bone marrow interpretations, and
- Skin tests for "unlisted antigen each, coccidoidomycosis, histoplasmosis, TB intradermal.

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

(2) Drug Testing Codes and Values

(a) G0434 (Drug screen, other than chromatographic; any number of drug classes, by Clinical Laboratory Improvement Amendments (CLIA) waived test or moderate complexity test, per patient encounter) will be used to report very simple testing methods, such as dipsticks, cups, cassettes, and cards, that are interpreted visually, with the assistance of a scanner, or are read utilizing a moderately complex reader device outside the instrumented laboratory setting (i.e., non-instrumented devices). This code is also used to report any other type of drug screen testing using test(s) that are classified as CLIA moderate complexity test(s), keeping the following points in mind:

G0434 includes qualitative drug screen tests that are waived under CLIA as well as dipsticks, cups, cards, cassettes, etc. that are not CLIA waived.

(b) Only one (1) unit of service for code G0434 can be billed per patient encounter regardless of the number of drug classes tested and irrespective of the use or presence of the QW modifier on claim lines.

(c) G0431 (Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter) will be used to report more complex testing methods, such as multi-channel chemistry analyzers, where a more complex instrumented device is required to perform some or all of the screening tests for the patient. This code may only be reported if the drug screen test(s) is classified as CLIA high complexity test(s) with the following restrictions:

G0431 may only be reported when tests are performed using instrumented systems (i.e., durable systems capable of withstanding repeated use).

CLIA waived tests and comparable non-waived tests may not be reported under test code G0431; they must be reported under test code G0434.

CLIA moderate complexity tests should be reported under test code G0434 with one (1) Unit of Service (UOS).

G0431 may only be reported once per patient encounter.

Laboratories billing G0431 must not append the QW modifier to claim lines.

Maximum Fee Schedule values are listed under Exhibit #8 of this Rule.

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

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

(1) Concern regarding the functional status of the patient

(2) Abnormal results on previous testing

(3) Change in management of dosage or pain

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

(e) Qualitative testing must meet one of the following criteria before performing a quantitative review:

(1) The results of the qualitative screen are presumptively positive; or

(2) Results of the qualitative screen are negative and this negative finding is inconsistent with the patient's medical history.

(f) Codes G0431 and G0434 in section 18-5(F)(2) are to be billed and used to determine Maximum Fee Schedule values instead of the codes listed under the "Drug Testing" subsection in the "Pathology and Laboratory Section" of CPT® and RVP©. Specific quantitative drug testing codes listed under other sections of the "Pathology and Laboratory Section" of CPT® and RVP© are still recognized.

(G) Medicine Section:

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

(2) Anesthesia qualifying circumstance values are reimbursed in accordance with the section 18-5(D)(1).

(3) Biofeedback

Prior authorization for payment (see Rule 16-9) 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 Rule 17, Medical Treatment Guidelines. Persons providing biofeedback shall be certified by the Biofeedback Certification International Alliance (BCIA), or be a licensed physician or psychologist, as listed under Rule 16-5(A)(1)(a) and (b) with evidence of equivalent biofeedback training. Providers who are performing Individual Psychophysiological therapy that incorporates Biofeedback with psychotherapy must be appropriately licensed by DORA to perform psychotherapy.

Maximum Fee Schedule values for biofeedback services shall be consistent with the values published in the RVP Errata Quarter 2 2014 as follows:

Biofeedback training by any modality	0.3/min
Biofeedback peri/uro/rectal	0.3/min

(4) Appendix J of the 2014 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) shall be obtained before billing for more than four body regions in one (1) visit. Manipulative therapy is limited to the maximum allowed in Rule 17, Medical Treatment Guidelines. The provider's medical records shall reflect medical necessity and prior authorization for payment (see Rule 16-9) 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 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) is required any time the following limitations are exceeded on a single day:

Psychiatric diagnostic evaluation, with or without medical services, per episode limit: 2 hours (bill the appropriate CPT® code for each hour.)

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

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

(c) Psychotherapy services limit: 60 min. per visit

Prior authorization for payment (see Rule 16-9) is required any time the 60 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) except where specifically addressed in Rule 17, Medical Treatment Guidelines.

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

(1) Both services must be separately identifiable;

(2) The level of E&M is based on history, exam and medical decision making;

(3) Time may not be used as the basis for the E&M code selection; and

(4) Add-on psychotherapy codes are to be used by psychiatrists to indicate both services were provided.

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

(7) Hyperbaric Oxygen Therapy Services

The maximum unit value shall be 24 units per session, 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.

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

(a) Quantitative Sudomotor Axon Reflex Test (QSART) is a diagnostic test used to diagnose Complex Regional Pain Syndrome. This test is performed on a minimum of two (2) extremities, and encompasses the following components:

1) Resting Sweat Test

2) Stimulated Sweat Test

3) Resting Skin Temperature Test

4) Interpretation of clinical laboratory scores. Physician must evaluate the patient specific clinical information generated from the test and quantify it into a numerical scale. The data from the test and a separate report interpreting the results of the test must be documented.

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

QSART Billing Code

DoWC Z0401 QSART $1,007.00

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

(10) Intra-Operative Monitoring (IOM)

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

(a) Clinical Services for IOM: Technical and Professional

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

The American Society of Neurophysiologic Monitoring; or

The American Society of Electrodiagnostic Technologists

2) Professional/Supervisory /Interpretive

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

3) Technical Electronic Capacity for Real-time Communication requirements

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

(b) Procedures and Time Reporting

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

(11) 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.

(12) Vaccine and Toxoids

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

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

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

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

(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) is required for medical nutrition therapy.

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

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

The authorized treating provider shall obtain prior authorization for payment (see Rule 16-9) from the payer for any physical medicine or rehabilitation treatment not listed in or exceeding the frequency or duration recommendations in Rule 17, Medical Treatment Guidelines.

The injured worker shall be re-evaluated by the prescribing physician within 30 calendar days from the initiation of the prescribed treatment and at least once every month while that treatment continues to establish achievement of functional goals. Prior authorization for payment (see Rule 16-9) shall be required for treatment of a condition not covered under Rule 17, Medical Treatment Guidelines and exceeding 60 calendar days from the initiation of treatment.

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

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

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

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

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

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

The provider's medical records shall reflect the medical necessity and the provider shall obtain prior authorization for payment (see Rule 16-9) if the procedures are not recommended or the frequency and duration exceeds the recommendations of the Rule 17, Medical Treatment Guidelines. The maximum amount of time allowed is one (1) hour of procedures per day, per discipline; unless medical necessity is documented and prior authorization is obtained from the payer.

Aquatic Therapy Services

The maximum unit value shall be 5 units per 15-minutes instead of the 4.5 units as listed in the RVP©.

Dry Needling of Trigger Points, Single or multiple needles,

DoWC Z0501 - initial 15 minutes of dry needling	5.4 RVUs
DoWC Z0502 - each add'l 15 minutes of dry needling	4.5 RVUs

(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). For Maximum Fee Schedule value, see 18-6(H).

(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. All evaluation notes or reports must be written and signed by the PT, OT or ATC. 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 (1) health care professional on the same day. An evaluation service with appropriate documentation may be charged by 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 section18-5(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 Z0503)

- Work Tolerance Screening (DoWC Z0504)

(a) Billing Restrictions:

1) Job Site Evaluations require prior authorization for payment (see Rule 16-9) if exceeding two (2) hours. Computer-Enhanced Evaluations and Work Tolerance Screenings require prior authorization for payment for more than four (4) hours per test or more than three (3) tests per claim. Functional Capacity Evaluations require prior authorization for payment for more than four (4) hours per test or two (2) tests per claim.

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, PT, OT, speech language pathologist/therapist or audiologist. Final reports must be written and signed by the physician, PT, OT, speech language pathologist/therapist or audiologist.

(9) Supplies

Physical medicine supplies are reimbursed in accordance with section18-6(H).

(10) Unattended Treatment

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

DoWC Z0505 fixed fee per day 1.5 RVU

(11) 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 a written negotiated fee.

(12) Unlisted Service Physical Medicine

All unlisted services or procedures require a report.

(13) Work Conditioning, Work Hardening, Work Simulation

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

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

(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).

(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 is required (see Rule 16-9).

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) Evaluation and management codes may be billed by medical providers as defined in Rule 16-5(A)(1)(a) as well as nurse practitioners (NP) and physician assistants (PA). Medical record documentation shall encompass the "E&M Documentation Guidelines" criteria as adopted in Exhibit #7 of this Rule, to justify the billed level of E&M service. If 50% of the time spent for an E&M visit is shared decision making, 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 (1) day prior or seven (7) 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 (3) years. Any subsequent E&M visits are to be billed as an "established patient" and reflect the level of service indicated by the documentation when addressing all of the current injuries.

(3) Number of Office Visits

All providers are limited to one (1) office visit per patient, per day, per workers' compensation claim, unless prior authorization for payment is obtained (see Rule 16-9). 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 (1) day prior to a related E&M office visit, or

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

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

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 Z0601: $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 (see section 18-6(G)(4)).

(8) A consultation occurs when a treating physician seeks an opinion from another physician regarding a patient's diagnosis or treatment and meets the CPT® requirements for a consultation. An independent medical exam (IME) occurs when a physician is requested to evaluate a patient by any party or party's representative and is billed in accordance with section 18-6(G).

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

(J) Telehealth

(1) Closely associated with telemedicine is the term "telehealth", which is often used to encompass a broader definition of remote health care that does not always involve clinical services. Videoconferencing, transmission of still images, e-health including patient portals, remote monitoring of vital signs and continuing medical education are all considered part of telemedicine and telehealth.

Telemental Health is a broad term that refers to providing mental healthcare from a distance. Video conferencing, transmission of still images, e-health including patient portals, remote monitoring of vital signs and continuing medical education are all considered part of telemental health.

Services provided via telecommunications technologies are not covered if the client has access to a comparable service within 30 miles of his/her place of residence.

(2) Telehealth facilities can bill for the originating fee only if the patient's originating site is located in a:

(a) County outside of a Metropolitan Statistical Area (MSA), or

(b) A Health Professional Shortage Area, either located outside of an MSA or in a rural census tract, as determined by the office of Rural Health Policy within the Health Resources and Services Administration (HRSA).

Telehealth originating site facility fee:

Q3014 $35.00 /per 15 minutes

(3) HIPAA privacy and electronic security standards are required for both the originating site and the rendering providers.

(a) Protecting patient health information, and patient / client decision making and consent are vital.

(b) Policies and procedures need to be in place to protect the electronic security of data, and the physical security of telehealth equipment so that patient health information is protected.

(c) Compliance with accreditation requirements, regulations, and relevant legislation is necessary.

(d) Health professionals providing telehealth services shall be fully licensed, registered, and credentialed by the appropriate governing agency.

(4) All telehealth procedures are required to be at an originating site that is deemed appropriate with the appropriate HIPAA privacy and electronic security standards in place. Authorized originating sites are:

(a) The office of a physician or practitioner

(b) A hospital (inpatient or outpatient)

(c) A critical access hospital (CAH)

(d) A rural health clinic (RHC)

(e) A federally qualified health center (FQHC)

(f) A hospital based or critical access hospital based renal dialysis center (including satellites)

(g) A skilled nursing facility (SNF)

(h) A community mental health center (CMHC)

(5) The physician-patient / psychologist-patient relationship needs to be established.

(a) This relationship is established through assessment, diagnosis and treatment of the patient. Two way live audio / video services is acceptable to 'establish' a patient relationship.

(b) Physicians / psychologists need to meet standard of care.

(c) The patient is required to provide the appropriate consent for treatment.

(6) Communication Protocol

(a) Video conferencing is an advanced communication technology that may be used for telehealth.

(b) It is the originating site's required responsibility to establish provider and patient identity verification.

(7) Payment for telehealth services

(a) Telehealth consultations, emergency department or initial inpatient; 30 minutes communicating via telehealth

G0425 $187.95

(b) Telehealth consultations, emergency department or initial inpatient; 50 minutes communicating via telehealth

G0426 $256.69

(c) Telehealth consultations, emergency department or initial inpatient; 70 minutes communicating via telehealth

G0427 $375.88

(d) Follow up inpatient telehealth consultations;

G0406 Follow up inpatient, limited (typically 15 min.) $54.81

G0407 Follow up inpatient, intermediate (typically 25 min.) $97.45

G0408 Follow up inpatient, complex (typically 35 min.) $140.09

Subsequent inpatient hospital care services are limited to one telehealth visit every 3 days.

Subsequent nursing facility care services are limited to one telehealth visit every 30 days.

(e) For all other physician / psychologist telehealth services, the physician / psychologist shall bill the appropriate RVP© CPT® code with the GT modifier. Reimbursement is the RVU value for the CPT® code times the appropriate CF + $5.00 when modifier GT is appended to the appropriate CPT® code(s).

GT – Attached to the distance (rendering) physician / psychologist billed CPT® or HCPCS indicates the service was performed via interactive audio and video telecommunication systems. Using the modifier certifies that the patient was present at an eligible originating site when the telehealth service was furnished.

18-6 DIVISION ESTABLISHED CODES AND VALUES

(A) Face-to-face or telephonic 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).

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); and

(e) Billing code DoWC Z0701.

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

(B) Cancellation Fees for Payer Made Appointments

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

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

Cancellation Fee Billing Code: DoWC Z0720

(2) Missed Appointments:

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

(C) Copying Fees

The payer, payer's representative, injured worker and injured worker's representative shall pay a reasonable fee for the reproduction of the injured worker's medical record. Reasonable cost for paper copies shall not exceed $18.53 for the first 10 or fewer pages, $0.85 per page for pages 11-40, and $0.57 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 per page.

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

Copying Fee Billing Code: DoWC Z0721

(D) Deposition and Testimony Fees

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

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

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

Preparation Time:

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

(3) Deposition:

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

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

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

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

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

Deposition:

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

Billed in half-hour increments

(4) Testimony:

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

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

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

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

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

Testimony:

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

(E) Injured Worker Travel Expenses

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

Mileage Expense Billing Code: DoWC Z0723

Other Travel Expenses Billing Code: DoWC Z0724

(F) Permanent Impairment Rating

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

(2) Provider Restrictions

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

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

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

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

(b) Use the appropriate DoWC code:

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

Bill DoWC Z0759 $355.00.

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

Bill DoWC Z0760 $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 (1) Level II Accredited Physician:

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

(G) Report Preparation

(1) Routine Reports

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

- Diagnostic testing
- Procedure reports
- Progress notes
- Office notes
- Operative reports
- Supply invoices, if requested by the payer

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

(a) Initial Report

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

(b) Closing Report

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

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 section18-6(G)(2)(a), (b) or (c), and seeks reimbursement for completion of the form, the provider shall get prior approval from the payer.

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

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

DoWC Z0750 $47.00 Initial Report

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

DoWC Z0752 $47.00 Closing Report

DoWC Z0753 $47.00 Initial and Closing Reports are completed on the same form for the same date of service

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

(a) Billing Code Z0754

(b) Maximum fee is $47.00 per form completion

(4) Special Reports

Description: The term special reports includes reports not otherwise addressed under Rule 16, Utilization Standards, Rule 17, Medical Treatment Guidelines and Rule 18, including any form, questionnaire or letter with variable content. This includes, but is not limited to, independent medical evaluations (Z0756) or reviews when the physician is requested to review files and examine the patient to provide an opinion for the requesting party, performed outside C.R.S. §8-42-107.2 (the Division IME process) and treating or non-treating medical reviewers or evaluators producing written reports pertaining to injured workers not otherwise addressed. Special reports also include payment for meeting, reviewing another's written record, and amending or signing that record (see section 18-5(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 (2) hour deposit in advance in order to schedule any patient exam associated with a special report.

Cancellation:

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

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

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

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

Billing Codes:

Written Report Only	DoWC Code:	Z0755
IME/Report with patient exam	DoWC Code:	Z0756
Lengthy Form Completion	DoWC Code:	Z0757
18-5(I)(7) meeting and report with Non-treating Physician	DoWC Code:	Z0758
Special Report Maximum Fees: $325.00 per hour billed in 15- minute increments.		
CRS 8-43-404 IME Audio Recording	DoWC Code: $30.00 per exam	Z0766
CRS 8-43-404 IME Audio copying fee	DoWC Code: $20.00 per copy	Z0767

(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:

a) Concern regarding the functional status of the patient

b) Abnormal results on previous testing

c) Change in management of dosage or pain

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

4) The opioids prescribed for long-term treatment (opioids being prescribed for >30 days for non-surgical cases and >30 days post procedure for surgical cases) 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 (International Classification of Diseases (ICD))

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

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

(6) Functional Assessments

(a) Pre-and post-injection assessments by a trained physician, nurse, physician's assistant, occupational therapist, physical therapist, or a medical assistant may be billed with spinal or sacroiliac (SI) joint injection codes. The following 3 elements are required:

1) A brief commentary on the procedures, including the anesthesia used in the injection and verification of the needle placement by fluoroscopy, CT or MRI.

2) Pre-and post-injection procedure shall have at least 3 objective, diagnostically appropriate, functional measures identified, measured and documented. These may include spinal range of motion; tolerance and time limits for sitting, walking and lifting; straight leg raises for herniated discs; a variety of provocative SI joint maneuvers such as Patrick's sign, Gaeslen, distraction or gapping and compression tests. Objective descriptions, preferably with measurements, shall be provided initially and post procedure at the appropriate time for medication effect, usually 30 minutes post procedure.

3) There shall be a trained physician or trained non-physician health care professional detailed report with a pre- and post-procedure pain diagram, normally using a 0-10 point scale. The patient(s) should be instructed to keep a post injection pain diary that details the patient's pain level for all pertinent body parts, including any affected limbs. The patient pain diary should be kept for at least 8 hours post injection and preferably up to seven (7) days. The patient should be encouraged to also report any changes in activity level post injection.

(b) If all three elements are documented, the billing code and maximum fee is as follows:

DoWC Z0770	$91.44 per episode of care; pre-and post, functional assessment related to spinal or SI joint injections

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

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

(2) Unless other limitations exist in this Rule, medical professionals shall bill supplies, including "Supply et al.," orthotics, prostheses, DME or drugs, including injectables, using Medicare's HCPCS Level II codes, when one exists, as established in the January 2014 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) schedule or Medicare's Part B Drug Average Sale Price (ASP). Otherwise, the billing provider shall identify their cost by submitting a copy of their invoice with their bill. The DMEPOS schedule can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html (last checked 08/14/14). The Medicare Part B Drug Average Sale Price (ASP) fees can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html.

(3) Payers shall pay medical professionals using Medicare's January 2014 DMEPOS Colorado HCPCS Level II maximum fee values or Medicare's Part B Drug ASP values listed for the codes billed. If no code exists, the payer shall pay 120% of the cost for the item as indicated on the provider's invoice.

(4) Unless other limitations exist in this Rule, DMEPOS suppliers shall be reimbursed using Medicare's HCPCS Level II codes, when one exists, as established in the January 2014 DMEPOS schedule. Otherwise, the supplier shall be reimbursed at 100% of Colorado Medicaid's July 2014 fee schedule. The Colorado Medicaid Fee Schedule can be found at: https://www.colorado.gov/hcpf/provider-rates-fee-schedule. If no Medicare or Medicaid fee schedule value exists, payers shall reimburse Suppliers the published Manufactures Suggested Retail Price (MSRP), the item will be reimbursed at MSRP less 20%. If there is no established fee schedule value or MSRP, reimbursement shall be based on 120% of the cost of the item as indicated on the supplier's invoice.

(5) Reimbursement of supplies to facilities shall be in compliance with sections 18-6 (I) – (N).

(6) 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.

(7) Take home exercise supplies with a total cost of $50 or less may be billed without an invoice at a maximum fee of actual billed charges; however, payers reserve the right to request an invoice, at any time, to validate the provider's cost. Home exercise supplies can include, but are not limited to the following items: therabands, theratubes, band/tube straps, theraputty, bow-tie tubing, fitness cables/trainers, overhead pulleys, exercise balls, cuff weights, dumbbells, ankle weight bands, wrist weight bands, hand squeeze balls, flexbars, digiflex hand exercisers, power webs, plyoballs, spring hand grippers, hand helper rubber band units, ankle stretchers, rocker boards, balance paws, and aqua weights.

(8) Complex Rehabilitation Technology dispensed and billed by Non-Physician DMEPOS Suppliers

(a) Complex rehabilitation technology (CRT) items, including products such as complex rehabilitation power wheelchairs, highly configurable manual wheelchairs, adaptive seating and positioning systems, and other specialized equipment, such as standing frames and gait trainers, enable individuals to maximize their function and minimize the extent and costs of their medical care.

(b) Complex Rehabilitation Technology products must be provided by suppliers who are specifically accredited by a Center for Medicare and Medicaid Services (CMS) deemed accreditation organization as a supplier of CRT and licensed as a DMEPOS Supplier with the Colorado Secretary of State.

(c) The maximum fee schedule allowance for CRT is 100% of Medicare's January 2014 DMEPOS Colorado HCPCS Level II listed fee values. The DMEPOS schedule can be found at:http://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html

(d) If no Medicare fee schedule value exists for the billed CRT HCPCS code, the Maximum Fee Schedule value is the published Manufacturer's Suggested Retail Price (MSRP), less 20%.

(I) Inpatient Hospital Facility Fees

(1) Provider Restrictions

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

(2) Bills for Services

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

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

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

(c) Exhibit #1 of this Rule establishes the maximum length of stay (LOS) using the "arithmetic mean LOS". However, no additional allowance for exceeding this LOS, other than through the cost outlier criteria under section18-6(I)(3)(d) is allowed.

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

(3) Inpatient Facility Reimbursement:

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

1) Children's hospitals

2) Veterans' Administration hospitals

3) State psychiatric hospitals

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

1) Medicare certified Critical Access Hospitals (CAH) (listed in Exhibit #3 of this Rule)

2) Medicare certified long-term care hospitals

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

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 effect at the time of discharge in Exhibit #1 of this Rule and locate the hospital's base rate in Exhibit #2 of this Rule.

The "Maximum Fee Allowance" is determined by calculating:

1) (MS-DRG Relative Wt x Specific hospital base rate x 185%) + (trauma center activation allowance) + (organ acquisition, when appropriate).

2) For trauma center activation allowance, (revenue codes 680-685) see section18-6(J)(6)(b)5).

3) For organ acquisition allowance, (revenue codes 810-819) see section 18-6(I)(3)(h).

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

1) Determine the "Hospital's Cost":

Total billed charges (excluding any trauma center activation or organ acquisition billed charges) multiplied by the hospital's cost-to-charge ratio.

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

3) The "Difference" = "Hospital's Cost" – "Maximum Fee Allowance" excluding any trauma center activation or organ acquisition allowance (see (c) above).

4) If the "Difference" is greater than $25,799.00, additional reimbursement is warranted. The additional reimbursement is determined by the following equation:

"Difference" x .80 = additional fee allowance

(e) Inpatient combined with Emergency Room Department (ERD), Trauma Center or organ acquisition reimbursement

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

2) Trauma Center activation fees (see section 18-6(J)(6)(b)5)) and organ acquisition allowance (see section 18-6(I)(3)(h)) are paid in addition to inpatient fees (see sections 18-6(I)(3)(c-d)).

(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 of this Rule) divided by the MS-DRG geometric mean length of stay (Exhibit #1 of this Rule). This per diem amount is multiplied by the actual LOS. If the patient is admitted and transferred on the same day, the actual LOS equals one (1). The receiving hospital shall receive the appropriate MS-DRG maximum value.

(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);

- The trauma center activation billed charge to the trauma center activation allowance; and

- The organ acquisition charges to the organ acquisition maximum fees under section 18-6(I)(3)(h).

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

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

(J) Outpatient Hospital Facility Fees

(1) Provider Restrictions

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

(b) A separate facility fee is only payable if the facility is licensed as a hospital by the Colorado Department of Public Health and Environment (CDPHE) or applicable out of state governing agency and statute.

(2) Types of Bills for Service

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

(b) All professional charges (professional services include, but are not limited to, PT/OT, anesthesia, speech therapy, etc.) are subject to the RVP© and Dental Fee Schedules as incorporated by this Rule and applicable to all facilities regardless of whether the facility fees are based upon Exhibit #4 of this Rule or a percentage of billed charges.

(c) Outpatient hospital facility bills include all outpatient surgery, ERD, Clinics, Urgent Care (UC) and diagnostic testing in the Radiology, Pathology or Medicine section of CPT®/RVP©.

(3) Outpatient Facility Reimbursement:

(a) The following types of outpatient facilities are reimbursed at 100% of billed outpatient charges, except for any associated professional fees (see (J)(2)(b) above):

1) Children's hospitals

2) Veterans' Administration hospitals

3) State psychiatric hospitals

(b) The following types of outpatient facilities are reimbursed at 80% of billed outpatient clinic facility charges only, except for any associated professional fees:

1) CAH facilities listed in Exhibit #3 of this Rule.

(c) Exhibit #4 to this Rule

Hospital reimbursement is based upon Medicare's 2014 Outpatient Prospective Payment System (OPPS) as modified in Exhibit #4 of this Rule. Exhibit #4 lists Medicare's Outpatient Hospital Ambulatory Prospective Payment (APC) Codes and the Division's established rates for hospitals and other types of providers as follows:

- Column 1 lists the APC code number.
- Column 2 lists APC code description.
- Column 3 is used to determine maximum fees for all Outpatient Hospital Emergency Room Departments (ERDs).
- Column 4 is used to determine maximum fees for all hospital facilities not listed under sections18-6(J)(3)(a) and (b).
- Column 5 is used to determine maximum fees for all Ambulatory Surgery Centers (ASC) when outpatient surgery is performed in an ASC.

To identify which APC grouper is aligned with an Exhibit #4 APC code # and dollar value, use Medicare's 2014 Addendum B. Grouper code 210 in Exhibit #4 was created by the Division to reimburse RVP© spinal fusion codes not listed in Medicare's Hospital Outpatient Prospective Payment System, Addendum B.

(4) The APC Exhibit #4 values include the following packaged revenue codes inclusive of the following services and may not be billed separately (all surgically implanted items that remain in the body post-surgery are separately payable at cost to the facility):

(a) nursing, technician, and related services;

(b) use of the facility where the surgical procedure(s) was performed;

(c) drugs and biologicals for which separate payment is not allowed;

(d) medical and surgical supplies, durable medical equipment and orthotics not listed as a "pass through";

(e) surgical dressings;

(f) equipment;

(g) splints, casts and related devices;

(h) radiology services when not allowed under Exhibit #4;

(i) administrative, record keeping and housekeeping items and services;

(j) materials, including supplies and equipment for the administration and monitoring of anesthesia;

(k) supervision of the services of an anesthetist by the operating surgeon; and

(l) post-operative pain blocks.

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

Packaged Services	
Revenue Code	Description
0390	Administration, Processing and Storage for Blood and Blood Components; General Classification
0392	Administration, Processing and Storage for Blood and Blood Components; Processing and Storage
0399	Administration, Processing and Storage for Blood and Blood Components; Other Blood Handling
0621	Medical Surgical Supplies - Extension of 027X; Supplies Incident to Radiology
0622	Medical Surgical Supplies - Extension of 027X; Supplies Incident to Other DX Services
0623	Medical Supplies - Extension of 027X, Surgical Dressings
0624	Medical Surgical Supplies - Extension of 027X; FDA Investigational Devices
0630	Pharmacy - Extension of 025X; Reserved
0631	Pharmacy - Extension of 025X; Single Source Drug
0632	Pharmacy - Extension of 025X; Multiple Source Drug
0633	Pharmacy - Extension of 025X; Restrictive Prescription
0700	Cast Room; General Classification
0710	Recovery Room; General Classification
0720	Labor Room/Delivery; General Classification
0721	Labor Room/Delivery; Labor
0732	EKG/ECG (Electrocardiogram); Telemetry
0821	Hemodialysis-Outpatient or Home; Hemodialysis Composite or Other Rate
0824	Hemodialysis-Outpatient or Home; Maintenance - 100%
0825	Hemodialysis-Outpatient or Home; Support Services
0829	Hemodialysis-Outpatient or Home; Other OP Hemodialysis
0942	Other Therapeutic Services (also see 095X, an extension of 094x); Education/Training
0943	Other Therapeutic Services (also see 095X, an extension of 094X), Cardiac Rehabilitation
0948	Other Therapeutic Services (also see 095X, an extension of 094X), Pulmonary Rehabilitation

(5) Recognized Status Indicators from Medicare's Addendum B are applied as follows:

(a) "A" means use another fee schedule instead of Exhibit #4, i.e., 18-4 Conversion Factors or 18-6(Q) Ambulance Fee Schedule.

(b) "B" means it is not recognized by Medicare for Outpatient Hospital services Part B bill type (12x and 130x) and therefore is not separately payable unless separate fees are applicable under another section of this Rule, such as home health.

(c) "C" means recognized by Medicare as inpatient only procedures; however, the Division does recognize these procedures can be done outpatient if prior authorization is obtained per Rule 16-9.

(d) "F" means corneal tissue acquisition, certain CRNA services and Hepatitis A vaccines are allowed at a reasonable cost to the facility. The facility must provide a separate invoice identifying their cost.

(e) "G" means "Pass-Through Drugs and Biologicals" that are separately payable under Exhibit #4 as an APC.

(f) "H" means a "Pass-Through Device" that is separately payable under Exhibit #4 based upon cost to the facility. Any surgically implanted items are allowed at "cost" to the facility.

(g) "K" means a separately payable "Pass-Through Drug or Biological or Device," for therapeutic radiopharmaceuticals, brachytherapy sources, blood and blood products as listed under Exhibit #4.

(h) "L" represents Influenza Vaccine and therefore, is generally not considered workers' compensation related.

(i) Any "Packaged Codes" with Q1, Q2, Q3, or STVX combinations are not recognized unless the payer and provider make a prior agreement.

(j) "M" means not separately payable unless separate fees are applicable under another section of this Rule, such as home health.

(k) "N" means the service is bundled and is not separately payable.

(l) "P" means partial hospitalization and is paid based upon observation fees as outlined in section 18-6(J).

(m) "R" means separate payment for blood and blood products.

(n) "S" and "T" mean there are multiple procedures, the highest valued code allowed at 100% of the Exhibit #4 value and up to three (3) additional codes allowed at 50% of the Exhibit #4 value, per episode of care.

(o) "V" represents a clinic or ERD visit and is separately payable for hospitals as specified in section18-6(J).

(p) "X" represents Ancillary Services and is separately payable.

(q) "Y" represents non-implantable Durable Medical Equipment and is paid according to Medicare's Durable Medical Equipment Regional Carrier (DMERC) fee schedule for Colorado.

(6) Total maximum facility value for an outpatient hospital episode of care includes:

(a) The highest valued CPT® code aligned to APC code per Exhibit #4 plus 50% of any lesser-valued CPT® code aligned APC code values.

Facility fee reimbursement is limited to a maximum of four (4) CPT® procedure codes per episode, with a maximum of only one (1) procedure reimbursed at 100% of the allowed Exhibit #4 value for the type of facility:

- Hospital Outpatient ERD bills are reimbursed based upon Column 3;
- Hospitals are reimbursed based upon Column 4.
- ASCs are reimbursed based upon Column 5.

(b) Fees in addition to section 18-6(J)(6) and requirements necessary to be reimbursed under Column 3 from Exhibit #4 for an Outpatient Hospital ERD Column:

1) Outpatient ERDs within Colorado must be physically located within a hospital licensed by the CDPHE as a general hospital; or

2) Free-standing ERD, must have equivalent operations as a licensed ERD; or

3) Meets the out-of-state facility's state's licensure requirements.

4) The ERD "Level of Care" is identified based upon one (1) of five (5) 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. (Only the higher one (1) of any ERD levels or critical care codes shall be paid).

5) Trauma Center fees are not paid for alerts. Trauma activation fees are as follows:

- Revenue Code 681 $3,000.00
- Revenue Code 682 $2,500.00
- Revenue Code 683 $1,000.00
- Revenue Code 684 $0

a) These fees are in addition to ERD and inpatient fees.

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

c) The level of trauma activation shall be determined by CDPHE's assigned hospital trauma level designation.

6) The hospital shall be paid an outlier threshold payment if the hospital's cost is greater than its maximum fee per billed line by $500.00. The outlier calculation is as follows:

- "Cost" is calculated by taking the individual hospital's "CCR" rate listed in Exhibit #2 of this Rule and multiplying it by the hospital's line charge.
- "Difference" is equal to the Hospital's line cost subtracted from the line maximum fee.
- If the line "difference" is greater than $500.00, then the maximum outlier dollar is 80% of the difference. If the difference is equal to or less than $500.00 then no additional outlier dollars are warranted.

7) 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 seciton18-6(J)(6)(b). The lesser of the two (2) amounts shall be the maximum facility allowance for the ERD episode of care. A line by line comparison is not appropriate.

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

(c) Multiple APCs identified by multiple CPT® codes 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.

1) All surgical procedures performed in one (1) operating room, regardless of the number of surgeons, are considered one (1) outpatient surgical episode of care for purposes of facility fee reimbursement.

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

3) When reported in conjunction with other knee arthroscopy codes, any combination of surgical knee arthroscopies for removal of loose body, foreign body, and/or debridement/shaving of articular cartilage shall be paid only if performed in a different compartment of the knee using G0289.

4) 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.

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

(d) Any diagnostic testing clinical labs or therapies with a status indicator (SI) of "A" may be reimbursed using Exhibit #8 of this Rule or the appropriate CF to the unit values for the specific CPT® code as listed in the RVP©.

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

Billing Codes:

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

(f) Professional fees are reimbursed according to the fee schedule times the appropriate conversion factor regardless of the facility type. Additional reimbursement is payable for the following services not included in the values found in Exhibit #4 of this Rule:

- ambulance services (Revenue Code 540), see section18-6(Q)
- blood, blood plasma, platelets (Revenue Codes 380X)
- Physician or physician assistant services
- Nurse practitioner services
- Licensed clinical psychologist
- Licensed social workers
- Rehabilitation services (PT, OT, Respiratory or Speech/Language, Revenue Codes 420, 430,440) are paid based upon the RVP© unit value multiplied by the applicable conversion factor.

(g) Any prescription for a drug supply to be used longer than a 24 hour period, filled at any clinic, shall fall under the requirements of and be reimbursed as a pharmacy fee, see section 18-6(M).

(h) Outpatient Hospital Clinic and Urgent Care (Form Locator (FL) 4 are 07xx and revenue codes 51x-53x) Facility Fees

Clinic Visit fees are limited for all facilities in accordance with the following:

1) No separate facility fees are allowed for follow-up care visits. 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.

2) 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.

3) Any specialty care clinic (wound/infections) that require expensive drugs/supplies that are typically not provided by a physician's office may be allowed a separate clinic fee with prior approval from the payer as outlined in Exhibit #4.

4) Clinics designated as critical access hospitals (CAH) as listed in Exhibit #3 or rural health facilities as listed in Exhibit #5 (FL4 071x) of this Rule, may be reimbursed a separate clinic fee at 80% of billed charges regardless of whether the clinic is designated by the employer or the time of day or urgency of the episode of care.

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

(i) IV Infusions Performed in Outpatient Hospital Facilities

IV infusion therapy performed in an outpatient hospital facility is reimbursed per section18-6(J).

(K) Freestanding (Not Affiliated with a Hospital) Outpatient Diagnostic Testing or Treatment Facilities

(1) Types of facilities

(a) Ambulatory Surgery Centers licensed by the CDPHE

(b) Physician offices

(c) Freestanding Radiology Imaging Cardiovascular Testing and Procedure Centers

(d) Freestanding Clinical Laboratory Centers

(e) 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; and

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

(2) Billing and Maximum Fees

(a) ASCs are reimbursed in accordance with section18-6(J) and Column 5 from Exhibit #4 of this Rule.

(b) Maximum reimbursement for physicians performing diagnostic testing in their offices during the course of their care shall be based upon the appropriate RVP© unit value multiplied by the applicable 18-4 conversion factor.

(c) Maximum Fees for all Freestanding Diagnostic Testing Facilities:

1) All providers should indicate whether they are billing for the professional component only (26 modifier) or technical component only (TC modifier) for any diagnostic test or procedure by listing the appropriate RVP© modifier on the required billing form CMS-1500.

2) Shall be based upon the appropriate RVP© unit value multiplied by the applicable 18-4 conversion factor.

3) All radiology and cardiovascular codes are reimbursed at 90% of the modified or not modified RVP© unit value multiplied by the radiology 18-4 conversion factor. A maximum of four (4) radiology codes may be used in one (1) episode of outpatient diagnostic testing. The highest valued radiology code is allowed at 100% of the maximum value and the remaining three (3) lower valued codes are allowed at 50% of the maximum radiology value.

4) Diagnostic testing dyes, contrasts, supplies and drugs are not separately payable.

5) Fluoroscopy is generally considered incidental when used for guidance when performing higher valued radiology tests. Refer to CPT® for specific billing instructions.

6) The maximum fees for all clinical laboratory testing shall be reimbursed according the fees as outlined under Pathology, section 18-5(F).

7) All observation services must be prior approved by the payer if time is greater than three (3) hours.

G0378 Observation rate: $45.00 per hour

(d) Urgent Care Facility Reimbursement

1) The total maximum value for an urgent care episode of care includes:

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

b) 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 as listed in section 18-6(K) if requested by the payer.

c) All other services/procedures provided in an Urgent Care facility are reimbursed according the appropriate CPT® code relative weight from RVP© multiplied by the appropriate 18-4 conversion factor.

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

G0378 Observation rate: $45.00 per hour

e) All supplies are included in the facility fee for Urgent Care facilities.

g) 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 section18-6(M).

2) 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.

3) 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.

(L) Home Care Services

Prior authorization for payment (see Rule 16-9) is required for all home care-services. All skilled home care service providers shall be licensed by the Colorado Department of Public Health and Environment (CDPHE) as Type A providers. The payer and the home health entity should agree in writing on the type of care, the type and skill level of provider, frequency of care and duration of care at each visit, and any financial arrangements to prevent disputes.

(1) Home Infusion Therapy

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

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

(a) Parenteral Nutrition:

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

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

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

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

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

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

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

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

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

S9326 Continuous (24 hrs. or more)	$79.00/ day
S9327 Intermittent (less than 24 hrs.)	$103.00/ day
S9328 Implanted pump	$116.00/ refill

(No separate daily rate is applicable when the patient has an implanted pain pump.)

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

S9373 < 1 liter per day	$61.00/ day
S9374 1 liter per day	$85.00/ day
S9375 >1 but <2 liters per day	$85.00/ day
S9376 >2 liters but <3 liters	$85.00/ day
S9377 >3 liters per day	$85.00/ day

(g) Multiple Therapies:

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

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

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

(2) Nursing Services

(a) Skilled Nursing (LPN & RN)

S9123 RN	$111.00/hr.
S9124 LPN	$89.00/hr.

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

(b) Certified Nurse Assistant (CNA):

S9122 CNA $ 45.00/hr.

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

(3) Physical Medicine

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

(4) Mileage

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

DoWC code: Z0772

(5) Travel Time

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

DoWC code: Z0773

(M) Drugs and Medications

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

(2) Average Wholesale Price (AWP)

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

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

(3) Reimbursement for Drugs & Medications

(a) For prescriptions, except compounded topical prescriptions, written within 30 days from the date of injury, reimbursement shall be AWP + $4.00.

(b) For prescriptions, except compounded topical prescriptions, written after 30 days from the date of injury, 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.

(c) Drugs administered in the course of the provider's direct care (injectables) shall be reimbursed at the provider's actual cost incurred or Medicare's Part B Drug Average Sale Price (ASP).

(d) Over-the-counter medications, drugs that are safe and effective for use by the general public without a prescription, are reimbursed at NDC/AWP and are not eligible for dispensing fees.

(4) Compounded Drugs

All prescriptions shall be billed using the DoWC Z code corresponding with the applicable category for compounded topical products, including prepackaged compounded medications, as follows:

Category I Z0790 Fee $ 75.00 per 30 day supply

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

Category II Z0791 Fee $150.00 per 30 day supply

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

Category III Z0792 Fee $ 250.00 per 30 day supply

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

Category IV Z0793 Fee $ 350.00 per 30 day supply

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

All ingredient materials must be listed by quantity used per prescription. Category fees include materials, shipping and handling, and time. Regardless of how many ingredients or what type, compounded drugs cannot be reimbursed higher than the Category IV fee. The 30 day Maximum Fee Schedule value shall be fractioned down to the prescribed and dispensed amount given to the injured worker.

(5) Injured Worker Reimbursement

In the event the injured worker has directly paid for authorized prescriptions, the payer shall reimburse the injured worker for the amounts actually paid for authorized prescriptions or authorized over-the-counter drugs within 30 days after submission of the injured worker's receipt. See Rule 16-11(G).

(6) Dietary Supplements, Vitamins and Herbal Medicines

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

(7) Prescription Writing

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

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

(c) The provider shall prescribe no more than a 60-day supply per prescription.

(8) Required Billing Forms

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

1) CMS-1500 – the dispensing provider shall bill by using the metric quantity and NDC number of the drug being dispensed; or, if one does not exist, the RVP© supply code; 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.

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

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

(b) Items prescribed for the work-related injury that do not have an NDC code shall be billed as a supply, using the RVP© supply code (see section18-6(H)).

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

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

(9) 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.

(N) Complementary Alternative Medicine (CAM)

CAM is a term used to describe a broad range of treatment modalities, some of which are generally accepted in the medical community and others that remain outside the accepted practice of conventional western medicine. Non-physician providers of CAM may be both licensed and non-licensed health practitioners with training in one (1) or more forms of therapy and certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in acupuncture and/or Chinese herbology. CAM requires prior authorization for payment (see Rule 16-9). Refer to Rule 17, Medical Treatment Guidelines for the specific types of CAM modalities.

(O) Acupuncture

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

(1) Provider Restrictions

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

(2) Billing Restrictions

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

(b) Unless the provider's medical records reflect medical necessity and the provider obtains prior authorization for payment (see Rule 16-9), the maximum amount of time allowed for acupuncture and procedures is one (1) hour of procedures, per day, per discipline.

(3) Billing Codes:

(a) Reimburse acupuncture, including or not including electrical stimulation, as listed in the 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 Z0800
Maximum value $99.68

3) LAc established patient visit: DOWC Z0801
Maximum value $67.28

(c) Herbs require prior authorization for payment (see Rule 16-9) and fee agreements as per section18-6(M)(6).

(d) See the appropriate Physical Medicine and Rehabilitation section of the RVP© for other billing codes and limitations (see also section18-5(H)).

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

(P) Use of an Interpreter

Rates and terms shall be negotiated. Prior authorization for payment (see Rule 16-9) is required except for emergency treatment. Use DoWC Z0722 to bill.

(Q) Ambulance Fee Schedule

(1) Billing Requirements:

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

(2) General Claims Submission:

(a) All hospitals billing for ground or air ambulance services shall bill on the UB-04 and all other ambulance providers shall bill on the CMS-1500.

(b) Use the appropriate HCPCS code plus the HCPCS origin/destination modifier.

(c) The transporting supplier's name, complete address and provider number should be listed in Item 33 (CMS-1500).

(d) The zip code for the origin (point of pickup) must be in Item 23 (CMS-1500). If billing on the UB-04 use FL 39-41 with an "AO" and the point of pick up zip code. If billing for multiple trips and the zip code for each origin is the same, services can be submitted on the same claim. If the zip codes are different, a separate claim must be submitted for each trip.

(3) Ground and Air Ambulance Vehicle and Crew Requirements

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

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

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

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

		Urban	Rural (R = Zip Code) First 17 miles or > if not a Super Rural	Super Rural (B =Zip code)
Ground Ambulance	HCPCS Code Description	Medicare Rate *250%	Medicare Rate *250%	Medicare Rate *250%
A0425	Ground mileage, per statue mile	$17.90	$18.08	$18.08
A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1-Non-Emergency)	$671.89	$ 678.48	$831.82
A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS1-Emergency)	$1,063.83	$1,074.26	$1,317.04
A0428	Ambulance service, basic life support, non-emergency transport (BLS)	$559.91	$565.40	$693.18
A0429	Ambulance service, basic life support, emergency transport (BLS-Emergency)	$895.86	$904.64	$1,109.09
A0433	Advanced life support, level 2 (ALS2)	$1,539.75	$1,554.85	$1,906.25
A0434	Specialty care transport (SCT)	$1,819.71	$1,837.55	$2,252.84
A0432	Paramedic intercept (PI), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers.	$979.84	$989.45	$989.45

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

(5) Modifiers

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

Code	Description
D	Diagnostic or therapeutic site other than "P" or "H"
E	Residential, domiciliary, custodial facility, nursing home other than SNF (other than 1819 facility)
G	Hospital-based dialysis facility (hospital or hospital-related) which includes: - Hospital administered/Hospital located - Non-Hospital administered/Hospital located
H	Hospital
I	Site of transfer (e.g., airport, ferry, or helicopter pad) between modes of ambulance transport
J	Non-hospital-based dialysis facility - Non-Hospital administered/Non-Hospital located - Hospital administered/Non-Hospital located
N	Skilled Nursing Facility (SNF) (1819 Facility)
P	Physician's Office (includes HMO non-hospital facility, clinic, etc.)
R	Residence
S	Scene of Accident or Acute Event
X	Destination Code Only (Intermediate stop at physician's office enroute to the hospital, includes HMO non-hospital facility, clinic, etc.)

(6) Mileage

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

18-7 DENTAL FEE SCHEDULE

The dental fee schedule is adopted using the American Dental Association's Current Dental Terminology, 2014 (CDT-2014). 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 of this Rule for the listing and Maximum Fee Schedule value for CDT-2014 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]