Colorado Register

40 CR 13

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Introduction

The *Colorado Register* is published pursuant to C.R.S. 24-4-103(11) and is the sole official publication for state agency notices of rule-making, proposed rules, attorney general's opinions relating to such rules, and adopted rules. The register may also include other public notices including annual departmental regulatory agendas submitted by principal departments to the secretary of state.

"Rule" means the whole or any part of every agency statement of general applicability and future effect implementing, interpreting, or declaring law or policy or setting forth the procedure or practice requirements of any agency. "Rule" includes "regulation". C.R.S. 24-4-102(15). Adopted rules are effective twenty days after the publication date of this issue unless otherwise specified.

The *Colorado Register* is published by the office of the Colorado Secretary of State twice monthly on the tenth and the twenty-fifth. Notices of rule-making and adopted rules that are filed from the first through the fifteenth are published on the twenty-fifth of the same month, and those that are filed from the sixteenth through the last day of the month are published on the tenth of the following month. All filings are submitted through the secretary of state's electronic filing system.

For questions regarding the content and application of a particular rule, please contact the state agency responsible for promulgating the rule. For questions about this publication, please contact the Administrative Rules Program at rules@sos.state.co.us.

Notice of Proposed Rulemaking

Tracking number

2017-00259

Department

200 - Department of Revenue

Agency

203 - Division of Liquor Enforcement

CCR number

1 CCR 203-2

Rule title

LIQUOR CODE

Rulemaking Hearing

Date

08/10/2017

Time

01:00 PM

Location

1881 Pierce Street, Room 110, Lakewood, CO 80214

Subjects and issues involved

Setting fees under regulation 47-506, 1 CCR 203-2 relating to liquor application fees established by the State Licensing Authority pursuant to section 12.47-501(2), C.R.S.

Statutory authority

Subsections 12-47-202(1)(b) and 12-47-501(2)-(3), C.R.S.

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COLORADO DEPARTMENT OF REVENUE
LIQUOR ENFORCEMENT DIVISION
CHANGES TO EXISTING RULES

1 C.C.R. 203-2
Filed June 28, 2017

Regulation 47-506. Fees.

Basis and Purpose. The statutory authority for this regulation is located at subsections 12-47-202(1)(b) and 12-47-501(2)-(3), C.R.S. The purpose of this regulation is to establish fees for certain applications, notices, reports, and services.

Below are the fees set by the State Licensing Authority pursuant to sections 12-47-501(2) and 12-47-501(3), C.R.S.

Alternating Proprietor Licensed Premises	~~$150.00~~ 300.00
Application for New License	~~$1,950.00~~ 1,550.00
~~Application for New License with Concurrent Review~~	~~$2,050.00~~
Application for Transfer License	~~$1,950.00~~ 1,550.00
Application for Transfer & Conversion for an Additional Liquor-Licensed Drugstore	~~$2,230.00~~ 1,830.00
~~Art Gallery Permit~~	~~$71.25~~
~~Bed & Breakfast Permit~~	~~$50.00~~
Branch Warehouse or Warehouse Storage Permit	~~$100.00~~ 200.00
Change of Corporate or Trade Name	~~$50.00~~ 100.00
Change of Location	~~$150.00~~ 300.00
CONCURRENT REVIEW	$200.00
Corporate/LLC Change (Per Person)	~~$100.00~~ 200.00
Duplicate Liquor License	$50.00
Limited Liability Change	$100.00
Manager Permit Registration (Liquor-Licensed Drugstore)	~~$100.00~~ 200.00
~~Manager Registration (Hotel/Restaurant or Tavern)~~	~~$75.00~~
Master File Background	~~$250.00~~ 500.00
Master File Location Fee (Per Location)	~~$25.00~~ 50.00
Modification of License Premises (City or County)	~~$150.00~~ 300.00
New Product Registration (Per Unit)	$0.00
Optional Premises Added to H&R License (Per Unit)	~~$100.00~~ 200.00
Retail Warehouse Storage Permit	~~$100.00~~ 200.00
SOLE SOURCE REGISTRATION	$200.00
~~Wine Festival Permit Wine~~	~~$25.00~~
Winery Direct Shipment Permit	~~$50.00~~ 100.00
Subpoena Testimony (Per Hour)	$50.00

Minimum of four (4) hours of appearance or on-call or travel time to court and mileage, meals, and lodging at state employee per-diem rate. Actual hourly rate for all hours in excess of four (4) hours.

NOTICE OF RULEMAKING HEARING

The State Licensing Authority of the Colorado Department of Revenue, Liquor Enforcement Division, will consider the promulgation of amendments to its Rules and Regulations as authorized by the Colorado Liquor Code, sections 12-47-101 *et seq.*, C.R.S. For specific information and language concerning the proposed changes, please refer to the contents of this Notice and to the proposed rules that are set forth following this notice and are also at the Colorado Department of Revenue, Liquor Enforcement Division's website at www.colorado.gov/enforcement/liquor.

STATUTORY AUTHORITY FOR RULEMAKING

The State Licensing Authority promulgates these rules pursuant to the authority granted in sections 12-47-202 and 12-47-501, C.R.S., of the Colorado Liquor Code and section 24-4-103, C.R.S., of the Administrative Procedure Act.

SUBJECT OF RULEMAKING

The proposed rules and relevant information are posted on the Colorado Department of Revenue, Liquor Enforcement Division's website at www.colorado.gov/enforcement/liquor. In addition, the proposed rules attached to this Notice are fully incorporated herein.

The State Licensing Authority will consider the promulgation of the following list of new rules and/or existing rules with changes proposed. For specific information and language concerning the proposed changes, please refer to the proposed rules that are set forth with this notice, at the Colorado Department of Revenue, Liquor Enforcement Division's website, and on the Colorado Secretary of State website.

RULES TO BE CONSIDERED FOR AMENDMENT OR ADOPTION

Certain fees under Regulation 47-506, 1 C.C.R. 203-2 relating to liquor application fees established by the state licensing authority pursuant to Section 12-47-501(2), C.R.S. are described as follows:

Regulation 47-506 - Fees, 1 C.C.R. 203-2:

Alternating Proprietor Licensed Premises	~~$150.00~~ 300.00
Application for New License	~~$1,950.00~~ 1,550.00
~~Application for New License with Concurrent Review~~	~~$2,050.00~~
Application for Transfer License	~~$1,950.00~~ 1,550.00
Application for Transfer & Conversion for an Additional Liquor-Licensed Drugstore	~~$2,230.00~~ 1,830.00
~~Art Gallery Permit~~	~~$71.25~~
~~Bed & Breakfast Permit~~	~~$50.00~~
Branch Warehouse or Warehouse Storage Permit	~~$100.00~~ 200.00
Change of Corporate or Trade Name	~~$50.00~~ 100.00
Change of Location	~~$150.00~~ 300.00
CONCURRENT REVIEW	$200.00
Corporate/LLC Change (Per Person)	~~$100.00~~ 200.00

Duplicate Liquor License $50.00
Limited Liability Change..... $100.00
Manager Permit Registration (Liquor-Licensed Drugstore)..... ~~$100.00~~ 200.00
~~Manager Registration (Hotel/Restaurant or Tavern)~~ ..... ~~$75.00~~
Master File Background ..... ~~$250.00~~ 500.00
Master File Location Fee (Per Location) ..... ~~$25.00~~ 50.00
Modification of License Premises (City or County) ..... ~~$150.00~~ 300.00
New Product Registration (Per Unit) $0.00
Optional Premises Added to H&R License (Per Unit) ..... ~~$100.00~~ 200.00
Retail Warehouse Storage Permit ..... ~~$100.00~~ 200.00
SOLE SOURCE REGISTRATION..... $200.00
~~Wine Festival Permit Wine~~ ..... ~~$25.00~~
Winery Direct Shipment Permit ..... ~~$50.00~~ 100.00
Subpoena Testimony (Per Hour) $50.00

These fees are effective July 1, 2017 by emergency rule adopted on June 28, 2017 and are proposed to be increased on a permanent basis.

RULEMAKING RECORD AND PUBLIC PARTICIPATION

1. Official Rulemaking Record. The official record for purposes of the rulemaking hearing to be held on August 10, 2017, will include any written comments or oral testimony submitted or presented.

2. Written Comments. The State Licensing Authority encourages interested parties to submit written comments on the proposed rules, including alternate proposals, by August 4, 2017 so that the State Licensing Authority can review comments prior to the rulemaking hearing. Written comments will also be accepted after that date. The deadline to submit written comments is 5:00 P.M. on August 14, 2017.

   The State Licensing Authority will accept all written comments but strongly encourages written comments to be submitted on the Liquor Enforcement Division Suggested Revision to Rules Form (Rule Form). The form may be found at: https://www.colorado.gov/pacific/sites/default/files/DR%202477.pdf.

   Please print, complete, and save the Rule Form as a separate document and then submit the Rule Form via e-mail. Written comments and completed Rule Forms may be emailed to: dor_led@state.co.us. In addition, you may submit completed Rule Forms to:

   Liquor Enforcement Division – Room 108
   Ref: Rules
   P.O. Box 173350
   Denver, CO 80217-3350

   Written comments will be accepted at the rulemaking hearing.

3. Oral Comments. At his/her discretion, the State Licensing Authority may afford interested parties an opportunity to make brief oral presentations at the rulemaking hearing.

If allowed, oral presentations will likely be limited to two minutes or less per person. Individuals will not be allowed to cede their time to another person (for instance, one person speaking on behalf of five people will not be given ten minutes to speak). Organized groups of individuals are urged to identify one spokesperson and to be concise. The State Licensing Authority encourages interested parties to avoid duplicating previously-submitted material and testimony.

HEARING SCHEDULE

Date: August 10, 2017
Time: 1 p.m.
Location: 1881 Pierce Street, Entrance B, Conference Room 110

Location of the rulemaking hearing will also be posted on the Liquor Enforcement Division's website and the Secretary of State's website.

The hearing may be continued at such place and time as the State Licensing Authority may announce.

The State Licensing Authority shall deliberate upon testimony and written submissions presented at this hearing, as well as applicable legal provisions and any related matters properly submitted before the hearing record is closed. Pursuant to said hearing, in the above-entitled matter at the time and place aforesaid, or at any adjourned meeting, the State Licensing Authority will adopt such rules as in its judgment are justified by the rulemaking record and applicable legal provisions.

If you are an individual with a disability who needs a reasonable accommodation in order to participate in this rulemaking hearing, please contact Sandra Lowman at Sandra.Lowman@state.co.us no later than August 7, 2017.

Dated this 28th day of June, 2017.

THE COLORADO DEPARTMENT OF REVENUE,
STATE LICENSING AUTHORITY,
LIQUOR ENFORCEMENT DIVISION

for Barbara J. Brohl
State Licensing Authority
Colorado Department of Revenue

Notice of Proposed Rulemaking

Tracking number

2017-00255

Department

200 - Department of Revenue

Agency

204 - Division of Motor Vehicles

CCR number

1 CCR 204-10

Rule title

TITLE AND REGISTRATION SECTION

Rulemaking Hearing

Date

08/07/2017

Time

10:00 AM

Location

1881 Pierce Street, Lakewood CO 80214: Rm 110 (Board/Commission Meeting Room)

Subjects and issues involved

Rule 36. The rule is promulgated to establish requirements for reserving registration numbers requested by the License Plate Auction Group (LPAG), for placing auctioned registration number on license plates, and registering license plates with auctioned registration numbers to vehicles.

Statutory authority

The statutory bases for this regulation are 42-1-204 title 42, article 1, part 4, 42-3-201, 42-3-202, 42-3-203 and 42-3-211, C.R.S

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DEPARTMENT OF REVENUE

Division of Motor Vehicles – Title and Registration Section

1 CCR 204-10

RULE 36. AUCTIONED REGISTRATION NUMBERS

Basis: The statutory bases for this regulation are 42-1-204 title 42, article 1, part 4, 42-3-201, 42-3-202, 42-3-203 and 42-3-211, C.R.S.

Purpose: The following rules and regulations are promulgated to establish requirements for reserving registration numbers requested by the License Plate Auction Group (LPAG), for placing auctioned registration numbers on license plates, and registering license plates with auctioned registration numbers to vehicles.

1.0 Definitions

1.1 "Alternative Materials" means a material that is not currently used in the manufacture of license plates, but that was previously used. Alternative materials may include, but are not limited to, porcelain, steel, or a grade of aluminum other than a grade currently being used. Alternative materials must be pre-approved by the Department.

1.2 "Design Standards" or "Security Features" means the standards established in 42-3-201, 42-3-202 and 42-3-203, C.R.S.

1.3 "Non-Standard Numbering" means any registration number that is not consistent with the Colorado standard issued numbering system, including single character registration numbers.

1.4 "Reserved for Auction" means a registration number to be reserved for the License Plate Auction Group in motor vehicle and manufacturing systems to prevent the manufacturing, issuance, registration, renewal or any other transaction from being performed on the registration number unless and until the registration number is released by the License Plate Auction Group.

1.5 "Standard Numbering" means three numbers and three alphas (###AAA) or three alphas and three numbers (AAA###), that may or may not be separated by a dash " ".

2.0 Requirements

2.1 The Department shall reserve a registration number for auction upon receipt of a request from the License Plate Auction Group unless:

a. The registration number has been approved for issuance, and payment has been pending, for less than 13 months; or

b. Payment has been made, the personalized plate has been manufactured, but the owner has not registered it to his/her vehicle for 13 months; or

c. The registration number is currently issued.

2.2 When an owner of a currently registered registration number relinquishes ownership to the License Plate Auction Group for auction pursuant to 42-1-403(5)(k), C.R.S., the owner must provide the license plate containing the relinquished registration number to the Department. Upon receipt of the license plate containing the relinquished registration number, the Department will destroy, recycle, or otherwise permanently dispose of the license plate and reserve the registration number for future auction.

2.3 The Department will not issue a license plate with a registration number purchased at auction until the buyer of that registration number completes all title and registration requirements to register a vehicle, including payment of all taxes and fees.

2.4 The right to use auctioned registration numbers shall be solely held by the buyer of the auctioned registration number, and not by all owners listed on the vehicle record to which the auctioned registration number is registered.

2.5 All auctioned registration numbers with non-standard numbering will result in the license plate logo being removed regardless of the number of digits.

Comment [IDT1]: Rule repealed with HB16-1362 and fully executed IGA with Colorado Disability Funding Committee

Notice of Proposed Rulemaking

Tracking number

2017-00257

Department

200 - Department of Revenue

Agency

204 - Division of Motor Vehicles

CCR number

1 CCR 204-25

Rule title

VENDOR CONTRACTS FOR THE BULK ELECTRONIC TRANSFER OF DEPARTMENT RECORDS

Rulemaking Hearing

Date

08/18/2017

Time

09:00 AM

Location

1881 Pierce Street, Lakewood CO 80214: Rm 110 (Board/Commission Meeting Room)

Subjects and issues involved

This rule governs annual contracts between the department and vendors and primary users for the purpose of establishing, regulating, and maintaining the bulk electronic transfer of information.

Rule being recodified to 1 CCR 204-30 Rule 14

Statutory authority

This rule is promulgated in accordance with the State Administrative Procedures Act, section 24-4-101 et seq., C.R.S. and adopted pursuant to the authority in sections 42-1-204 C.R.S. and 42-1-206(3.7).

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1 CCR 204-25 (RECODIFIED AS 1 CCR 204-30, RULE 14)

CONTRACTS FOR THE BULK ELECTRONIC TRANSFER OF DEPARTMENT INFORMATION

Authority

This rule is promulgated in accordance with the State Administrative Procedures Act, section 24-4-101 et seq., C.R.S. and adopted pursuant to the authority in sections 42-1-204 C.R.S. and 42-1-206(3.7).

Scope and Purpose

A. This rule governs annual contracts between the department and vendors and primary users for the purpose of establishing, regulating, and maintaining the bulk electronic transfer of information.

B. This rule does not apply to any federal, state, or local governmental agency that receives Data directly from the department.

1.0 Definitions

"Data" means a subset of Information.

"Information" means the total of all files, updated files, or portions thereof, that the department is permitted by law to release through a bulk electronic transfer.

"Sub-Vendor" means any person who enters into an agreement with a vendor to receive Data. A primary user of Data may also be a Sub-Vendor.

2.0 Contract Requirements

A. The department will not transfer Information to a vendor or primary user unless the vendor or primary user has executed a contract with the department in accordance with section 42-1-206(3.7), C.R.S.

B. A contract between the department and a vendor shall include provisions that ensure that no Data will be transferred to a Sub-Vendor unless the Sub-Vendor has provided the vendor, and the vendor has approved, a form, DR 2489, Requestor Release and Affidavit of Intended Use, and has agreed that it will not use the Data in a manner prohibited by law.

Editor's Notes

History

DEPARTMENT OF REVENUE

Division of Motor Vehicles

VENDOR CONTRACTS FOR THE BULK ELECTRONIC TRANSFER OF DEPARTMENT RECORDS

1 CCR 204-25

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

Section 1. Authority

This rule is promulgated under the authority of § § 42-1-206(3.7)(b) and 42-1-206(f), C.R.S.

Section 2. Definitions

"Affidavit of Intended Use" : A document indicating the requestor's intended use of Department records. An Affidavit of Intended Use states that the requestor shall not obtain, use, resell, or transfer the information for any purpose prohibited by law (per § § 24-72-204 and 42-1-206, C.R.S.).

"Bulk Record System" : The Department's process to allow bulk electronic transfer of records to vendors who are permitted to receive such information.

"Certification" : Prior to being allowed to serve as a Vendor pursuant to contract, the Vendor is required to have its internal processes and records systems certified by the Department.

"Contract" : The written agreement to be entered into between certified Vendors and the Department.

"Department" : The Colorado Department of Revenue, Motor Vehicle Business Group

"Master File Baseline" : Complete transfer of all records maintained by the Department and transferable pursuant to law.

"Nightly Update" The process in which the Department provides additions, deletions, and other changes to records (Master File). Updates are provided each night after the Department's close of business, excluding weekends and holidays.

"Primary User" Entity that uses Department records for its own purposes as permitted under § 24-72-204(7), C.R.S.

"Records" : The driver history, motor vehicle records, or any portion of the history and records maintained by the Department as defined under § § 42-2-121 and 42-1-206(3.7)(a), (d), C.R.S.

"Statement of Confidentiality" : Statement from employee, officer, staff member, temporary employee, or subcontractor of Vendor or Sub-vendor that the confidentiality of the information contained within Department records shall be maintained at all times and that records shall not be distributed, sold or shared with any third party or used in any way except as expressly authorized by law.

"Subcontractor" : An entity that provides goods and/or services to the Vendor who may have direct or indirect contact with records while providing such goods and/or services.

"Sub-vendor" : A business entity that obtains records from a Vendor for purposes of distributing the records to Primary Users.

"Vendor" : Certified entity selected that serves as the Department's representative for the distribution of records to Sub-vendors and Primary Users.

Section 3. Certification of Vendor(s)

Prior to being allowed to manage and distribute Department records, the Vendor must successfully complete a certification process. The process for the Certification shall include the following:

1. Completed Affidavit(s) of Intended Use forms received from Vendor for each intended use.

2. Statement of Confidentiality forms received from all employees, officers, staff members, temporary employees or Sub-contractors of the Vendor that may have access to Department records.

3. Verification of minimum security measures – may include onsite inspection of equipment and procedures.

4. Master File Baseline to Vendor to be verified as to the count of records received and verify the detail of the first and last record.

5. Verification that Master File Baseline and Nightly Updates from the Department can be received, organized, updated nightly, and stored by Vendor with 100% accuracy.

6. Verification of documented record sales.

Section 4. Scope of Vendor Contract

Minimum requirements for contract:

1. Provision for annual fee that encompasses all direct costs of the department related to the bulk electronic transfer of records to the Vendor. This fee is due upon execution of contract.

2. The Department retains exclusive ownership of all records provided to vendor.

3. Contract to include time allowed after contract execution for vendor to complete certification process.

4. Vendor must review each request for records and approve or deny in accordance with state and federal rules and statutes.

5. All forms used by the vendor in connection with the release of Department records shall be approved by the Department prior to their use.

6. Contracts between Vendor and Sub-vendor must be approved by the Department prior to the distribution of records to a Sub-vendor. Copy of fully executed contract between the Vendor and Sub-vendor shall be provided to the Department.

7. Provision for Vendor to maintain security over all records provided by the Department and no confidential information shall be distributed, sold to any third party, or used in any way except as authorized by law and/or contract.

8. The Vendor shall deny access to records to any Sub-vendor or Primary User who has not returned to the Vendor a completed Affidavit of Intended Use form.

9. Provision for Vendor to maintain all records for five years including tracking what record was obtained, by whom obtained, when obtained, and for what purpose. the information will be used.

10. Provision prohibiting the Vendor from providing the entire Department database to a Sub-vendor. Vendor may only supply records that are individually identified and requested by a Sub-vendor or Primary User.

11. Vendor shall be responsible for auditing costs.

12. Provision for termination of contract for the convenience of the Department.

13. Reporting requirements to the Department from the Vendor shall include but are not limited to the following:

    a. The Vendor shall provide a copy of all "Statement of Confidentiality" forms to the Department as new employees, staff members, officers, temporary employees, or subcontractors are given access to Department records.

    b. The Vendor shall file annually with the Department an Affidavit of Intended Use form executed by the Vendor, to be kept on file by the Department. A separate Affidavit of Intended Use is required for each intended use.

    c. The Vendor shall provide a copy of executed contract between the Vendor and a Sub-vendor to the Department before providing records to a Sub-vendor.

    d. The Vendor shall quarterly provide to the Department a complete list of all the Sub-vendors and Primary Users for which the Vendor has an Affidavit of Intended Use on file. Upon the request of the Department, these affidavits shall immediately be provided.

    e. The Vendor shall notify the Department by telephone within 24 hours when the Vendor has reason to believe a Sub-vendor, Primary User, or subcontractor may be in violation of the terms and conditions set forth in Vendor contract.

    f. The Vendor will notify the Department within 5 days after being served with a summons, complaint, or other pleading in a case which involves services provided under this contract and which has been filed in any federal or state court or administrative agency.

14. Contract shall be a no cost contract. The Department shall have no liability for payment of any Vendor costs associated with this contract.

Section 5. Requestor Release and Affidavit of Intended Use

Vendors may release records to Primary Users and Sub-vendors in accordance with § 24-72-204(7), C.R.S.

~~A "Requestor Release and Affidavit of Intended Use" form shall indicate the requestor's intended use of records and contains an affidavit that the requestor shall not obtain, use, resell, or transfer the records or any part of them for any purpose prohibited by law or contract.~~

~~Prior to release of records to Primary Users and Sub-vendors, an Affidavit of Intended Use must be obtained from the requestor.~~

~~Neither the Vendor, Sub-vendor, nor Primary User of records shall commingle in any database any of the Department's records with any other information, data, or records.~~

~~All employees, officers, staff members, temporary employees, or subcontractors of Vendor or Sub-vendor shall complete a Statement of Confidentiality stating that the confidentiality of the information within Department records shall be maintained at all times and that records shall not be distributed, sold, or shared with any third party or used in any way except as expressly authorized by the Department.~~

~~Section 6. Quarterly Download of Department Records~~

~~The Department shall, at a minimum, transfer a "Master File Baseline" to all vendors on a quarterly basis within a calendar year.~~

~~Editor's Notes~~

~~History~~

Notice of Proposed Rulemaking

Tracking number

2017-00247

Department

300 - Department of Education

Agency

301 - Colorado State Board of Education

CCR number

1 CCR 301-26

Rule title

COLORADO RULES FOR THE OPERATION, MAINTENANCE AND INSPECTION OF SCHOOL TRANSPORTATION VEHICLES

Rulemaking Hearing

Date

08/16/2017

Time

02:00 PM

Location

201 E. Colfax Ave, Room 101 - State Board Room

Subjects and issues involved

Pursuant to Sections 22-51-108 and 42-4-1904, C.R.S., the State Board of Education has the authority to promulgate rules related to school transportation including reasonable and adequate standards of safety in the maintenance and operations of buses and pupil transportation that promote the welfare of the students and afford reasonable protection to the public.

This notice of rulemaking is a follow-up to the emergency rules the board adopted on May 10, 2017. The rulemaking is to adopt the emergency rules on a permanent basis.

The emergency rulemaking was necessary following Senate Bill 17-083 which removed several rules in 1 CCR 301-26 due to technical issues identified during the rule review conducted by the Committee on Legal Services. In addition to the changes included in the emergency rulemaking, the department recommends additional changes to clarify various items within the rules.

Statutory authority

22-51-108 and 42-4-1904, C.R.S.

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DEPARTMENT OF EDUCATION
Colorado State Board of Education

COLORADO RULES FOR THE OPERATION, MAINTENANCE AND INSPECTION OF SCHOOL TRANSPORTATION VEHICLES

1 CCR 301-26

4204-R-1.00 Statement of Basis and Purpose

1.01 Colorado law provides for the State Board of Education to adopt and enforce regulations governing the safe operation of school buses used for the transportation of students pursuant to Sections 22-51-108 and 42-4-1904, C.R.S.

1.02 The purpose of these rules is to adopt and enforce regulations governing the reasonable and adequate standards of safety for the operation, maintenance and inspection of school transportation vehicles that promote the welfare of the students and afford reasonable protection to the public. These rules are designed to align with federal standards, reflect current industry practices, and incorporate recommendations from school district and service provider transportation professionals.

1.03 The Commissioner, or designee, may provide an exemption to the Rules for the Operation, Maintenance and Inspection of School Transportation Vehicles to the extent the Commissioner finds an exemption to be appropriate.

1.04 These rules shall become effective January 1, 2017 for all student transportation.

4204-R-2.00 Applicability of Rules

2.01 These rules and regulations apply to the operation, maintenance and inspection of all public school transportation conducted by:

2.01(a) A school district or charter school for routes (home to school, school to school, and school to home);

2.01(b) A school district or charter school for activity trips (school related events);

2.01 (c) A company or individual hired by a district or charter school (service provider) for routes (home to school, school to school, and school to home).

~~vehicles (School Bus, Multifunction Bus, Motor Coach Bus and Small Vehicle as defined in 1 CCR 301-25 R-5.00) transporting students to and from school, from school to school, and/or to and from school related events in vehicles owned, leased or rented by the district or under agreement with the district.~~

2.02 These rules are not intended to include:

2.02(a) Private motor vehicles used exclusively to carry members of the owner's household; or

2.02(b) Transportation arrangements not authorized by the district including but not limited to~~;~~ sharing of actual gasoline expense or participation in a car pool; or

2.02(c) The operations of vehicles in bona fide emergency situations consistent with policies of the local board of education; or

2.02(d) Transportation conducted by a company or individual for activity trips (school related events), including service providers, parent volunteers, and coaches or teachers using a private motor vehicle; or ~~Student transportation under public transportation programs subject to the Federal Motor Carrier Safety Regulations, 49 CFR sections 390 to 399, available at https://www.ecfr.gov/.~~

2.02(e) Route transportation provided by a company or individual as part of their operation as a common carrier under the jurisdiction of the US Department of Transportation or Public Utilities Commission, including RTD, taxi cab services, Uber services, and Lyft services.

2.03 These rules shall not preclude a school district or service provider from establishing a more rigid standard or policy when deemed necessary by the local board of education or service provider.

4204-R-3.00 Non-Compliance

3.01 CDE will perform periodic School Transportation Advisory Reviews (STAR) of school districts, charter schools and service providers to evaluate and assist with compliance of these rules.

3.01(a) CDE will provide school districts, charter schools and service providers written notification of the STAR findings.

3.01(b) Upon receipt of the written notification of STAR findings, school districts, charter schools or service providers shall respond in writing to outline corrective actions if necessary.

3.02 CDE shall revoke or suspend the certificate for a school transportation annual inspector, school transportation annual inspector hands-on tester or inspection site under the following circumstances:

3.02(a) A school transportation annual inspector, school transportation annual inspector hands-on tester or inspection site does not meet the requirements outlined in these rules.

3.02(b) School transportation annual inspections or hands-on tests have not been properly conducted.

4204-R-4.00 School District, Charter School and Service Provider Employment Responsibilities

4.01 School districts, charter schools and service providers shall outline job responsibilities and develop job qualification standards for each school transportation vehicle operator and school transportation paraprofessionals, consistent with federal and state regulations. A copy of these requirements shall be provided to each school transportation vehicle operator and paraprofessional upon employment.

4.02 School districts, charter schools and service providers shall maintain separate files for each school transportation vehicle operator, school transportation paraprofessional, and school transportation annual inspector with written documentation evidencing all listed requirements indicated in Rule 5.00, Rule 6.00 and Rule 7.00, as applicable. Training documentation shall include the trainer name, date of the training, description of the training, duration of each topic covered and the signature of all attendees.

4.02(a) If a school transportation vehicle operator, school transportation paraprofessional, or school transportation annual inspector works for more than one school district, charter school, service provider, or operator of an inspection site, each ~~district~~ shall maintain a file with documentation in accordance with this rule.

4.03 School districts, charter schools and service providers shall ensure all employees required to possess a commercial driver's license (CDL) shall be in a US DOT approved substance abuse testing program.

4.04 School districts, charter schools and service providers shall not permit a school transportation vehicle operator to transport students, while the operator's ability or alertness is so impaired, through fatigue, illness or any other cause, as to make it unsafe for the operator to transport students.

4.05 School districts, charter schools and service providers shall have written emergency procedures and/or contingency plans to be followed in the event of a traffic accident, vehicle breakdown, unexpected school closing, unforeseen route change or relocation of a student stop in an emergency.

4.06 School district, charter schools and service providers shall ensure that documentation outlining transportation related services and requirements, including required use of Child Safety Restraint Systems and medical and behavioral information as it relates to student transportation, is available to applicable school transportation vehicle operators and paraprofessionals prior to providing transportation services.

4204-R-5.00 School Transportation Vehicle Operator Requirements

5.01 School transportation vehicle route operators (transporting students to and from school or from school to school) driving a School Bus with the capacity of 16 or greater passengers (counting the driver) and school transportation vehicle operators, other than route operators, driving

vehicles with the capacity of 16 or greater passengers (counting the driver), including a School Bus, Multifunction Bus and Motor Coach Bus, shall meet or exceed the following requirements:

5.01(a) The operator shall possess a valid commercial driver's license (CDL) with the proper class and endorsements for size and type of vehicle(s) to be driven and the associated Medical Examination Report required pursuant to the Federal Motor Carrier Safety Regulations, 49 CFR section 391.43 (2015). Only the Federal Motor Carrier Safety Regulations adopted as of October 1, 2015 apply to this rule; later amendments do not apply. The federal regulations incorporated by reference in this rule are available for public inspection during regular business hours from the Colorado Department of Education, 201 E. Colfax Ave., Denver, Colorado 80209. In addition, these regulations are available at https://www.ecfr.gov/.

5.01(b) The operator shall be a minimum of 18 years of age.

5.01(c) The district or service provider shall obtain a motor vehicle record of each operator prior to transporting students and annually thereafter.

5.01(d) The operator shall be given and/or have access to the CDE School Bus/Multifunction Bus/Motor Coach Bus Operator Guide prior to transporting students.

5.01(e) The operator shall receive a minimum of six hours of in-service training annually which may include required training in 1 CCR 301-26-R-5.00. A portion of this annual in-service requirement may occur during the school year.

5.01(f) The operator shall successfully pass a CDE School Bus/Multifunction Bus/Motor Coach Bus Operator written test for the current school year prior to transporting students and annually thereafter.

5.01(g) The operator shall successfully pass a driving performance test including a pre-trip inspection prior to transporting students and annually thereafter. This test shall be conducted in a vehicle, which is similar in type and size to the vehicle the applicant is assigned to operate. Districts have the option to re-test at their discretion.

5.01(h) The operator shall receive pre-service training on the type of vehicle(s) to be driven, the type of duties they may be required to perform and in student confidentiality requirements prior to transporting students.

5.01(i) The operator shall have written documentation evidencing that they have received first aid training, including cardiopulmonary resuscitation and universal precautions within 90 calendar days after initial employment. If the operator holds a current first aid, cardiopulmonary resuscitation certificate it will meet the requirements of this section. Operators shall receive first aid training and/or re-certification every two (2) years thereafter.

5.01(j) The operator shall receive training regarding the proper use and maintenance of Child Safety Restraint Systems (CSRS) and proper wheelchair securement, when the operator is engaged in transportation involving these systems and devices prior to transporting

students.

5.02 School transportation vehicle route operators (transporting students to and from school or from school to school) driving vehicles with the capacity of 15 or fewer passengers (counting the driver), including Type A Multifunction Bus and Small Vehicle, shall meet or exceed the following requirements:

5.02(a) The operator shall possess a valid driver's license.

5.02(b) The operator shall be a minimum of 18 years of age.

5.02(c) The operator shall have a current physical examination (not to exceed two years) consistent with the requirements of the Federal Motor Carrier Safety Regulations, 49 CFR section 391.43 (2015). Only the Federal Motor Carrier Safety Regulations adopted as of October 1, 2015 apply to this rule; later amendments do not apply. The federal regulations incorporated by reference in this rule are available for public inspection during regular business hours from the Colorado Department of Education, 201 E. Colfax Ave., Denver, Colorado 80209. In addition, these regulations are available at https://www.ecfr.gov/.

5.02(d) The district or service provider shall obtain a motor vehicle record of each operator prior to transporting students and annually thereafter.

5.02(e) The operator shall be given and/or have access to the CDE Type A Multifunction Bus /Small Vehicle Route Driver Guide prior to transporting students.

5.02(f) The operator shall receive a minimum of six hours of in-service training annually which may include required training in 1 CCR 301-26-R-5.00. A portion of this annual in-service requirement may occur during the school year.

5.02(g) The operator shall successfully pass a CDE Type A Multifunction Bus/Small Vehicle Route Operator written test for the current school year prior to transporting students and annually thereafter.

5.02(h) The operator shall successfully pass a driving performance test including a pre-trip inspection prior to transporting students and annually thereafter. This test shall be conducted in a vehicle, which is similar in type and size to the vehicle the applicant is assigned to operate. Districts have the option to re-test at their discretion.

5.02(i) The operator shall receive pre-service training on the type of vehicle(s) to be driven, the type of duties they may be required to perform and in student confidentiality requirements prior to transporting students.

5.02(j) The operator shall have written documentation evidencing that they have received first aid training, including cardiopulmonary resuscitation and universal precautions within 90 calendar days after initial employment. If the operator holds a current first aid, cardiopulmonary resuscitation certificate it will meet the requirements of this section.

Operators shall receive first aid training and/or re-certification every two (2) years thereafter.

5.02(k) The operator shall receive training regarding the proper use and maintenance of Child Safety Restraint Systems (CSRS) and proper wheelchair securement, when the operator is engaged in transportation involving these systems and devices prior to transporting students.

5.03 School transportation vehicle operators, other than route operators, driving vehicles with the capacity of 15 or fewer passengers (counting the driver), including Type A Multifunction Bus and Small Vehicle, shall meet or exceed the following requirements:

5.03(a) The operator shall possess a valid driver's license.

5.03(b) The operator shall be a minimum of 18 years of age.

5.03(c) The district or service provider shall obtain a motor vehicle record of each operator prior to transporting students and annually thereafter.

5.03(d) The operator shall be given and/or have access to the CDE Type A Multifunction Bus /Small Vehicle Operator Guide prior to transporting students.

5.03(e) The operator shall successfully pass a Type A CDE Multifunction Bus/Small Vehicle Operator written test for the current school year prior to transporting students and annually thereafter.

5.03(f) The operator shall annually complete the CDE Multifunction/Small Vehicle Operators Medical Information Form (STU-17). Any yes annotations shall require a doctor's release.

5.03(g) The operator shall receive pre-service training on the type of vehicle(s) to be driven, the type of duties they may be required to perform and in student confidentiality requirements prior to transporting students.

5.03(h) The operator shall be given and/or have access to first aid information, including cardiopulmonary resuscitation and universal precautions.

5.03(i) The operator shall successfully pass a driving performance test including a pre-trip inspection prior to transporting students. This test shall be conducted in a vehicle, which is similar in type and size to the vehicle the applicant is assigned to operate. Districts have the option to re-test in subsequent years at their discretion.

5.03(j) Prior to driving a school transportation vehicle pursuant to 1 CCR 301-26-R-12.11, operators shall receive training on towing a trailer.

5.04 School transportation paraprofessional is a person assigned to assist a school transportation vehicle operator control behavior of students in the bus and/or ensure the safety of students getting on and off the school transportation vehicle.

5.04(a) The school transportation paraprofessional shall receive pre-service training for the type of duties they may be required to perform prior to assisting with transporting students.

5.05 School transportation vehicle operators and school transportation paraprofessionals are required to be able to perform all essential functions including emergency evacuations when transporting students as determined by the school district or service provider job qualification standards.

5.05(a) The employing school district or service provider has the authority to require at any time a medical evaluation of a school transportation vehicle operator or school transportation paraprofessional for any condition that could impair the employee's ability to operate a vehicle safely, assist student(s) as required by their position, and/or perform other required job duties, and may take appropriate action on the outcome of such evaluation.

5.05(b) School transportation vehicle operators and school transportation paraprofessionals that have medical conditions which result in temporary loss of performance abilities shall provide return to work documentation from their physician, and any other requirements per district policy to the employing school district/service provide prior to returning to their assigned duties.

4204-R-6.00 School Transportation Annual Inspector Requirements

6.01 School transportation annual inspector is a person qualified to perform annual inspections on a school transportation vehicle to confirm the vehicle complies with CDE regulations.

6.02 School transportation annual inspectors shall meet or exceed the following requirements:

6.02(a) The school transportation annual inspector shall be in possession of a valid driver's license with the proper class and endorsements for the size and type of vehicle(s) to be inspected.

6.02(b) The school transportation annual inspector shall provide to the school district or service provider a Brake Inspector Qualification Certificate meeting the requirements of the Federal Motor Carrier Safety Regulations, 49 CFR section 396.25 (2015). Only the Federal Motor Carrier Safety Regulations adopted as of October 1, 2015 apply to this rule; later amendments do not apply. The federal regulations incorporated by reference in this rule are available for public inspection during regular business hours from the Colorado Department of Education, 201 E. Colfax Ave., Denver, Colorado 80209. In addition, these regulations are available at https://www.ecfr.gov/.

6.02(c) The school transportation annual inspector shall have at least two years verifiable experience in the maintenance of light, medium or heavy duty vehicles.

6.02(d) The school transportation annual inspector shall successfully pass the CDE initial hands-on performance test.

6.02(d)(1) A certified school transportation annual inspector hands-on tester must proctor the hands-on performance test.

6.02(e) The school transportation annual inspector shall successfully pass the CDE annual inspector qualification written test initially, and every three years thereafter pass the CDE annual inspector recertification written test.

6.02(e)(1) A representative of the district or service provider, other than a school transportation annual inspector candidate, shall grade the written test.

6.03 A school district, charter school, ~~or~~ service provider or operator of an inspection site ~~with an Inspection Site Certificate shall~~ may submit a CDE Application for CDE Annual Inspector Qualification or Recertification Form (STU-20) to CDE verifying that the above requirements have been satisfied. CDE will issue an Annual Inspector Certificate.

6.04 If any of the above requirements become invalid, the annual inspector certificate is invalid until the requirement(s) is made valid.

6.05 If a school transportation annual inspector has an expired certificate, the certificate can be recertified as follows:

6.05(a) If the certificate has been expired less than six months, then the CDE Annual Inspector Recertification Written Test is required.

6.05(b) If the certificate has been expired between six and 12 months, then the CDE Annual Inspector Qualification Written Test is required.

6.05(c) If the certificate has been expired for more than one year, then both the CDE Annual Inspector Qualification Written Test and the CDE hands-on performance test are required.

4204-R-7.00 Annual Inspector Hands-On Tester

7.01 School transportation annual inspector hands-on tester is a person qualified to proctor hands-on tests to annual inspector candidates.

7.02 School transportation annual inspector hands-on testers shall meet or exceed the following requirements:

7.02(a) The school transportation annual inspector hands-on tester shall have maintained a CDE Annual Inspector certificate for a minimum of two years.

7.02(b) The school transportation annual inspector hands-on tester shall have satisfactorily completed a four hour CDE school transportation annual inspector hands-on tester training.

7.02 (c) The school transportation annual inspector hands-on testers shall have completed a four hour brake training in the last three years or have maintained an ASE School Bus or

Medium/Heavy Duty Truck or Transit Bus Brake Certification.

7.02(d) The school transportation annual inspector hands-on tester candidate shall submit a CDE Application for Certification or Recertification of CDE Annual Inspector Hands-On Tester Form (STU-30) verifying that the above criteria have been satisfied. CDE will issue an Annual Inspector Hands-On Tester Certificate.

7.02(e) The school transportation annual inspector hands-on tester shall conduct at least two hands-on tests every three years or attend a CDE school transportation annual inspector hands-on recertification training to recertify as a school transportation annual inspector hands-on tester.

7.03 If any of the above requirements become invalid, the hands-on tester certificate is invalid until the requirement(s) is made valid.

4204-R-8.00 Pre-trip/Post-trip Vehicle Inspections

8.01 Each school transportation vehicle shall have a daily pre-trip and post-trip inspection performed and documented by the school transportation vehicle operator or a district, charter school or service provider authorized transportation employee. A daily pre-trip inspection shall be completed prior to a vehicle being placed in service. A daily post-trip inspection shall be completed at the end of daily operation of each vehicle.

8.02 The pre-trip and post-trip inspection requirements for school transportation vehicles, other than small vehicles, shall include at a minimum all items listed on the CDE School Transportation Vehicle (School Bus/Multifunction Bus/Motor Coach Bus) – Pre-Trip and Post Trip Requirements Form (STU-9).

8.03 The pre-trip and post-trip inspection requirements for school transportation small vehicles shall include at a minimum all items listed on the CDE School Transportation Vehicle (Small Vehicle) – Pre-Trip and Post Trip Requirements Form (STU-8).

8.04 School districts and service providers shall have a procedure in place to verify that students are not left on an unattended school transportation vehicle.

4204-R-9.00 Inspection Site Certification

9.01 A CDE Inspection Site Certificate is required at each facility/location where annual inspections for school transportation vehicles are performed.

9.02 The inspection site shall meet or exceed the following criteria to acquire and maintain an inspection site certificate.

9.02(a) The inspection site shall be large enough to accommodate the vehicle, equipment and tools necessary to perform the inspection.

9.02(b) The inspection site shall have a floor surface or pad adequate to safely support the maximum weight of the largest vehicle to be inspected.

9.02(c) The inspection site shall have adequate lighting and ventilation.

9.02(d) The inspection site or inspector shall, at the time of inspection, have the equipment and tools necessary to properly complete the annual inspection.

9.02(e) The inspection site or inspector shall have tools designed and calibrated to take accurate readings of appropriate measurements, such as brakes and tires.

9.03 The operator of an inspection site ~~district or service provider~~ shall submit a request for an inspection site certificate on the CDE Application for Inspecting Site Certification Form (STU-22) that the above criteria have been satisfied.

9.04 The operator of an inspection site ~~district or service provider~~ shall post the CDE Inspection Site Certificate at the inspection site.

4204-R-10.00 Annual Inspection

10.01 School districts, charter schools and service providers shall ensure all school transportation vehicles and trailers pursuant to 1 CCR 301-26-R-12.11 have a CDE annual inspection conducted by a CDE certified annual inspector.

10.01(a) Recently purchased school transportation vehicles shall successfully pass a CDE annual inspection prior to transporting students.

10.02 Annual inspection results shall be documented on the CDE Affidavit of Annual Inspection for School Transportation Vehicles Form (STU-25).

10.02(a) A copy of the current Affidavit is maintained inside the vehicle and a copy is placed in the vehicle file.

10.03 All annual inspection criteria of school transportation vehicles must meet or exceed manufacturer's specifications. The annual inspection shall be documented and shall include at a minimum all fields listed on the CDE Annual Inspection and Preventive Maintenance Requirements Form (STU-26).

10.04 All annual inspection criteria of trailers must meet or exceed manufacturer's specifications and shall include at a minimum all fields listed on the CDE Trailer Annual Inspection and Preventive Maintenance Requirements Form (STU-27).

10.05 During the annual inspection, all four wheels shall be pulled for full inspection of the foundation brake system. The three exceptions are:

10.05(a) School transportation vehicles with less than 4,000 miles since the previous annual inspection shall have two wheels (one front and one rear) pulled different than those pulled for the previous inspection.

10.05(b) School transportation vehicles equipped with a retarder meeting the specifications outlined in 1 CCR 301-25-R-33.00, shall have two wheels (one front and one rear) pulled which are different than those pulled for the previous inspection.

10.05(c) Trailers pursuant to 1 CCR 301-26-R-12.11 shall have 50 percent of the wheels pulled different than those pulled for the previous inspection.

4204-R-11.00 Maintenance and Repair

11.01 School districts, charter schools and service providers must ensure all school transportation vehicles are systematically inspected, maintained and repaired to ensure that school transportation vehicles are in safe and proper operating condition.

11.02 School districts, charter schools and service providers shall have a system to document preventative maintenance, reported defects and repairs made to school transportation vehicles.

11.03 School districts, charter schools and service providers shall maintain separate files for each school transportation vehicle with documentation of all annual inspections, all preventative maintenance and all reported damage, defects or deficiencies and the corresponding repair and maintenance performed.

11.04 Any identified damage, defect or deficiency of a school transportation vehicle must be reported to the school district, charter schools or service provider which:

11.04(a) Could affect the safety of operation of the school transportation vehicle, or

11.04(b) Could result in a mechanical breakdown of the school transportation vehicle, or

11.04(c) Results in noncompliance with Colorado Minimum Standards Governing School Transportation Vehicles (1 CCR 301-25) and/or manufacturer's specifications.

11.05 Documentation for reported defects must include all of the following:

11.05(a) The name of the school district, charter school or service provider.

11.05(b) Date and time the report was submitted.

11.05(c) All damage, defects or deficiencies of the school transportation vehicle.

11.05(d) The name of the individual who prepared the report.

11.06 Following a reported damage, defect or deficiency of a school transportation vehicle, school districts, charter schools and service providers or a representative agent must repair the reported damage, defects or deficiencies, or document that no repair is necessary, ensuring that the vehicle is in safe and proper operating condition prior to transporting students.

11.07 School districts, charter schools and service providers shall not transport students in a school transportation vehicle which is not in safe and proper operating condition. A school

transportation vehicle shall be designated as "out-of-service" by a school district, charter schools or service provider, a school transportation annual inspector or the CDE School Transportation Unit.

11.07(a) Exemption - Any school transportation vehicle discovered to be in an unsafe condition while being operated on the highway, roadway or private road may be continued in operation only to the nearest place where repairs can safely be affected. Such operation shall be conducted only if it is less hazardous to the public than to permit the vehicle to remain on the highway, roadway or private road.

11.08 Following a school transportation vehicle being placed "out-of-service", a school district, charter school, service provider or a representative agent must make required repairs, ensuring that the vehicle is in safe and proper operating condition prior to transporting students. In the event of being placed "out-of-service" during an annual inspection, the school transportation vehicle must successfully pass a CDE annual inspection prior to transporting students.

11.09 The preventative maintenance inspection on air drum brake systems shall include, at a minimum, that the brake rod travel has been measured and documented. The applied pressure method shall be used.

11.09(a) The inspection-interval shall not exceed 4,000 miles for buses equipped with a manual slack adjuster air brake system.

11.09(b) The inspection-interval shall not exceed 6,000 miles for buses equipped with an automatic slack adjuster air brake system.

11.10 The preventive maintenance inspection interval on air disc brake systems shall not exceed 6,000 miles and shall include, at a minimum; inspection and documentation of:

11.10(a) Inspect the pad thickness by checking the mechanical wear indicators.

11.10(b) Inspect the visible part of the rotors for cracks, excessive wear, damage, etc.

11.10(c) Inspect running clearance. If the caliper has no movement or appears to move greater than the distances indicated by the manufacturer, then a full wheel removal inspection will be necessary.

11.11 The preventive maintenance inspection interval for hydraulic brake systems shall not exceed 6,000 miles and shall include, at a minimum, inspection and documentation of:

11.11(a) Proper parking brake operation.

11.11(b) Proper brake fluid level and clarity.

11.11(c) Adequate pedal reserve.

11.11(d) Proper hydraulic/vacuum assist operation.

11.11(e) Visual inspection for brake fluid leakage.

11.12 If brake adjustment or repair is needed, the work shall be completed by or supervised by a DOT or equivalent qualified brake inspector meeting the requirements of the Federal Motor Carrier Safety Regulations, 49 CFR section 396.25 (2015). Only the Federal Motor Carrier Safety Regulations adopted as of October 1, 2015 apply to this rule; later amendments do not apply. The federal regulations incorporated by reference in this rule are available for public inspection during regular business hours from the Colorado Department of Education, 201 E. Colfax Ave., Denver, Colorado 80209. In addition, these regulations are available at https://www.ecfr.gov/.

4204-R-12.00 Operation of a School Transportation Vehicle

12.01 A school transportation vehicle shall not be operated in a manner which is unsafe or likely to cause an accident or damage of the vehicle.

12.02 A school transportation vehicle shall not be placed in motion on a roadway, highway or private road with the passenger entry door/service door open.

12.03 A school transportation vehicle's headlights or daytime running headlights shall be activated while the vehicle is in operation.

12.04 A school transportation vehicle shall not be fueled while students are on board, except in instances when unloading the students would present a greater hazard or peril to their safety.

12.05 Use of tobacco products as defined in Section 18-13-121(5), C.R.S., use or possession of illegal controlled substances, use or possession of alcohol and use or possession of marijuana or cannabinoid product, except as otherwise allowed by law, aboard any school transportation vehicle shall be prohibited at all times**.**

12.06 A school transportation vehicle operator shall not consume food unless the vehicle is stopped at a safe location with the park/emergency brake set.

12.07 When a school transportation vehicle is equipped with a roof mounted strobe lamp, the use of the strobe lamp is permitted only when the vehicle presents a hazard to other motorists, such as loading or unloading students in inclement weather or to enhance visibility of the vehicle when barriers inhibit such visibility.

12.08 A school transportation vehicle operator may use the strobe, in addition to the four-way hazard lamps, to warn other motorists that the vehicle is not in motion or is being operated at a speed of twenty-five miles per hour or less.

12.09 The school transportation vehicle operator shall use extreme caution when backing. Before backing on a roadway, highway or private property, the horn or audible warning device shall be sounded and four-way hazard lamps actuated or there shall be a person outside the vehicle giving direction.

12.09(a) Backing a school transportation vehicle when students are outside of the vehicle at a student stop is prohibited.

12.10 School transportation vehicles including Type A, B, C and D School Bus, Multifunction Bus and Motor Coach Bus shall not be operated with a trailer or other vehicle attached while students are being transported.

12.11 School transportation small vehicles, with the capacity of 15 or fewer passengers (counting the driver), may tow trailers while students are being transported to the extent that trailering is a necessary component of a district sponsored program**.**

4204-R-13.00 Authorized Passengers

13.01 Only district or charter school personnel, students enrolled in a district or charter school, or law enforcement officials or individuals that have received prior authorization from the school district, charter schools or service provider may be passengers on any school transportation vehicle.

13.02 The number of passengers transported on any school transportation vehicle shall not exceed the maximum seating capacity of the vehicle. Small vehicle capacity shall not exceed the number of safety belts as designed by the vehicle manufacturer.

13.03 Passengers shall not be permitted to stand in any school transportation vehicle while the vehicle is in motion. This does not preclude authorized persons (such as school transportation paraprofessionals) from completing their duties as required.

13.04 School districts and service providers shall consider the size of the passengers when determining the number of passengers that can safely occupy a school transportation vehicle seat.

4204-R-14.00 Safety Restraints

14.01 A school transportation vehicle operator shall have the safety belt fastened, worn correctly and properly adjusted prior to the school transportation vehicle being placed in motion.

14.02 All passengers in a school transportation vehicle under 10,000 lbs. GVWR shall have their safety belts fastened, worn correctly and properly adjusted prior to the school transportation vehicle being placed in motion.

4204-R-15.00 Transportation of Miscellaneous Items

15.01 A school transportation vehicle operator shall make a reasonable and prudent determination that all carry-on items are properly handled in order to minimize the danger to all others.

15.02 All baggage, articles, equipment or medical supplies not held by individual passengers shall be secured in a manner which assures unrestricted access to all exits by occupants, does not restrict the driver's ability to operate the bus and protects all occupants against injury resulting from falling or displacement of any baggage, article or equipment. Oxygen cylinders secured to a wheelchair shall be considered to be in compliance with this subsection, provided they do not impede access to any exit.

15.03 All chemicals and cleaning supplies carried on a school transportation vehicle must meet the following precautions:
15.03(a) Container is non-breakable.

15.03(b) Container is labeled with contents.

15.03(c) Pressurized aerosols are prohibited.

15.03(d) Container is secured in a bracket, or in a closed compartment in the driver's area or a compartment on the exterior of the bus.

15.03(e) Containers and quantities of products must be no more than 32 ounces in size.

15.04 Interior-decorations shall not be located within the driver's area (which includes the space in front of the front barriers including the step-well, dash, walls and ceiling, the windshield, the entry door, the driver's side window, and all windows in front of the front barrier), the first two passenger windows on both sides of the vehicle and all windows on the rear of the vehicle. Other decorations within the passenger compartment shall not:

15.04(a) Cover any required lettering.

15.04(b) Impede the aisle or any emergency exit.

15.04(c) Hang from the walls and/or ceiling.

4204-R-16.00 Maximum Driving Time for School Transportation Vehicle Operators

16.01 The school transportation vehicle operator, including small vehicle operators, shall not drive nor shall the school district or service provider permit or require an operator to drive:

16.01(a) In excess of 10 hours or after being on-duty 14 hours until completing 10 hours off-duty. This would include on-duty time for all employers. Ten hours off-duty may be consecutive or accumulated in two or more periods of off-duty time with one period having a minimum of 6 consecutive hours off-duty.

16.01(b) After being on-duty for more than 70 hours in any seven consecutive days.

16.02 In place of section 16.00 of these rules, the school district or service provider may comply with the Federal Motor Carrier Safety Regulations, 49 CFR section 391.43 (2015). Only the Federal Motor Carrier Safety Regulations adopted as of October 1, 2015 apply to this rule; later amendments do not apply. The federal regulations incorporated by reference in this rule are available for public inspection during regular business hours from the Colorado Department of Education, 201 E. Colfax Ave., Denver, Colorado 80209. In addition, these regulations are available at https://www.ecfr.gov/.

16.03 Definitions:

16.03(a) Adverse driving conditions - In case of emergency, an operator may complete the trip

without being in violation if such trip reasonably could have been completed absent the emergency.

16.03(b) Day - Means any 24-consecutive hour period beginning at the time designated by the school district or service provider.

16.03(c) On-duty time - Includes all time worked for any and all employers, including all driving and non-driving duties.

16.03(d) Off-duty time - School transportation vehicle operators may consider waiting time at special events, meal stops and school related events as off-duty if the following criteria are met: (Compensated waiting time does not necessitate on-duty time.)

16.03(d)(1) The operator shall be relieved of all duty and responsibility for the care and custody of the vehicle, its accessories and students, and

16.03(d)(2) The operator shall be at liberty to pursue activities of his/her choice including leaving the premises on which the bus is located.

16.04 All school transportation vehicle operators shall document that they are in compliance with this section, hours of service.

16.04(a) An operator's daily log, or equivalent, shall be completed for the trip in the operator's own handwriting, when the trip requires a scheduled or unscheduled overnight stay away from the work reporting location.

4204-R-17.00 Route Planning – Student Loading and Discharge

17.01 School transportation small vehicles, Type A Multifunction Buses with 15 or fewer passenger capacity (counting the driver) and School Buses (Types A, B, C, and D) may be used to transport students to and from school. Multifunction Buses Type B, C and D and Motor Coach Buses shall not be used to transport students to and from school.

17.02 The location of student stops shall consider factors including:

17.02(a) Ages of the students.

17.02(b) Visibility.

17.02(c) Lateral clearance.

17.02(d) Student access.

17.02(e) Control of other motorists.

17.02(e)(1) Student stops for Type A Multifunction Buses with 15 or fewer passenger capacity (counting the driver) and school transportation small vehicles should be located off of the roadway whenever possible.

17.03 School transportation vehicle operators shall stop at least 10 feet away from students at each designated stop. The school transportation vehicle operator shall apply the parking brake and shift the vehicle into neutral or park prior to opening the service door of a bus or passenger door(s) of a small vehicle.

17.04 The school transportation vehicle operator shall stop as far to the right of the roadway, highway or private road as possible before discharging or loading passengers, allowing sufficient area to the right and front of the vehicle but close enough to the right to prevent traffic from passing on the right so students may clear the vehicle safely while in sight of the operator.

17.04(a) Exception: The school transportation vehicle operator may block the lane of traffic when passengers being received or discharged are required to cross the roadway.

17.05 Student stops shall not be located on the side of any major thoroughfare whenever access to the destination of the passenger is possible by the use of a road or street which is adjacent to the major thoroughfare.

17.06 If students are required to cross a roadway, highway or private road on which a student stop is being performed, they are prohibited from crossing a roadway, highway or private road constructed or designed to permit three or more separate lanes of vehicular traffic in either direction or with a median separating multiple lanes of traffic. This does not include crossing the roadway, highway or private road with the assistance of a traffic controls signal or with the assistance of a crossing guard.

17.07 Four-way hazard lamps shall be used on private property such as parking lots.

17.08 Alternating flashing red warning signal lamps shall not be activated within ~~50~~ 200 feet of an intersection if the intersection is controlled by a traffic control signal.

17.09 Routes shall be planned as to:

17.09(a) Eliminate, when practical, railroad crossings.

17.09(b) Have stops be a minimum of 200 feet apart since alternating flashing amber warning signal lamps must be activated a minimum of 200 feet in advance of the stop on the roadway on which the bus stop will be performed.

17.09(b)(1) Exception: Student stops located in areas where wildlife may create a high risk of threat to students' safety while they are waiting and/or walking to a student stop, may designate student stops less than 200 feet apart upon detailed written approval by the school district board of education or governing body of a charter school and/or their designee. A copy of the written approval shall be kept in the school transportation office and route operators shall be given written notice of the exception and have it indicated on route sheets.

17.10 In determining the length of routes, districts, charter schools and service providers must make an effort to minimize student ride times while considering student educational needs and the geographic boundaries, terrain, traffic congestion, and financial resources within the district. ~~L~~A local board~~s~~ of education or the governing body of a charter school may establish a maximum student ride time.

17.11 Pursuant to Section 42-4-1903(2), C.R.S., school transportation vehicle operators are not required to actuate the alternating flashing red warning signal lamps on a school bus when the student stop is at a location where the local traffic regulatory authority has by prior written designation declared such actuation unnecessary and when discharging or loading passengers who require the assistance of a lift device and no passenger is required to cross the roadway. Further, Type A Multifunction Buses with 15 or fewer passenger capacity (counting the driver) and school transportation small vehicles do not have the functionality to control traffic. In these instances, the school transportation vehicle operator shall stop as far to the right off the roadway as possible to reduce obstruction to traffic, activate the four-way hazard warning lamps a minimum of 200 feet prior to the student stop, continue to display the four-way hazard warning lamps until the process of discharging or loading passengers has been completed, and deactivate the four-way hazard lamps before resuming motion. Students are prohibited from crossing any lanes of traffic to access the student stop or after disembarking.

17.12 School transportation vehicle operators shall not relocate a student stop without approval of the school district or service provider.

17.13 School transportation vehicle operators of School Buses, Multifunction Buses and Motor Coach Buses, whether transporting students or not, shall apply the following procedures during the process of approaching, stopping and crossing railroad tracks:

17.13(a) Activate the four-way hazard lamps not less than 200 feet from the railroad crossing to alert other motorists of the pending stop for the crossing.

17.13(b) Stop the bus within 50 feet but not less than 15 feet from the nearest rail.

17.13(c) When stopped, the bus should be as far to the right of the roadway as possible and should not form two lanes of traffic unless the highway is marked for four or more lanes of traffic.

17.13(d) Use a prearranged signal to alert students to the need for quiet aboard the bus when approaching railroad tracks. Turn off all noise making equipment (fans, heater, radio, etc.)

17.14 After quietness aboard the stopped bus has been achieved, bus operators shall open the service door and operator window. The bus operator shall listen and look in both directions along the track(s) for any approaching train(s) and for signals indicating the approach of a train.

17.14(a) If the tracks are clear, the bus operator shall close the service door and may then proceed in a gear low enough to permit crossing the tracks without having to manually

shift gears. The bus operator shall cancel the four-way hazard lamps after the bus has cleared the tracks.

17.14(b) When two or more tracks are to be crossed, the bus operator shall not stop a second time unless the bus is completely clear of the first crossing and has at least 15 feet clearance in front and at least 15 feet clearance to the rear.

17.14(c) Before crossing the tracks, the bus operator shall verify that there is enough space after the tracks for the bus plus 15 feet if it is necessary to stop after crossing the tracks.

17.15 School transportation vehicle operators of School Buses, Multifunction Buses and Motor Coach Buses are not required to stop at crossings only controlled by a red, amber, green traffic control signal when it is in the green position or when the crossing is controlled by a police officer or human flag person, or when the crossing is marked with an official "exempt" sign placed on the railroad crossing light post or cross bucks post.

4204-R-18.00 Emergency Evacuation Drills

18.01 Emergency evacuation drills shall be conducted with students by all school transportation vehicle operators and school transportation paraprofessionals at least twice during each school year.

18.01(a) One drill shall be conducted in the fall and the second drill conducted in the spring.

18.01(b) Substitute and Multifunction operators of 16 or greater capacity (counting the driver) vehicles shall be trained how to conduct the emergency evacuation drills.

18.02 Students on school related events shall receive emergency evacuation instruction prior to departure.

18.03 School district, charter schools and service providers shall maintain records documenting that the required evacuation drills were conducted and/or evacuation instruction was given.

Notice of Proposed Rulemaking

Tracking number

2017-00263

Department

700 - Department of Regulatory Agencies

Agency

702 - Division of Insurance

CCR number

3 CCR 702-2

Rule title

CORPORATE ISSUES

Rulemaking Hearing

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1560 Broadway, Ste 110 D, Denver CO 80202

Subjects and issues involved

2-1-8 CONCERNING RISK RETENTION GROUPS AND PURCHASING GROUPS
The purpose of this regulation is to regulate the formation and/or operation of risk retention groups or purchasing groups in this state formed pursuant to the provisions of the federal Liability Risk Retention Act of 1986, 15 U.S.C. § 3901 et seq ("RRA 1986"), to the extent permitted by such law.

Statutory authority

10-1-109 and 10-3-1403

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COLORADO DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-2

CORPORATE ISSUES

Proposed Amended Regulation 2-1-8

CONCERNING RISK RETENTION GROUPS AND PURCHASING GROUPS

Section 1 Authority

This regulation is promulgated under the authority of §§ 10-1-109 and 10-3-1403, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to regulate the formation and/or operation of risk retention groups or purchasing groups in this state formed pursuant to the provisions of the federal Liability Risk Retention Act of 1986, 15 U.S.C. § 3901 et seq ("RRA 1986"), to the extent permitted by such law.

Section 3 Applicability

This regulation shall apply to any insurance company or purchasing group eligible or seeking to become eligible to operate under the RRA 1986 in Colorado.

Section 4 Definitions

As used in this regulation

A. “Board of directors” or “board” means, for the purposes of this regulation, the governing body of the risk retention group elected by the shareholders or members to establish policy, elect or appoint officers and committees, and make other governing decisions.

B. "Completed operations liability" means, for the purposes of this regulation, liability arising out of the installation, maintenance, or repair of any product at a site which is not owned or controlled by

1. Any person who performs that work; or

2. Any person who hires an independent contractor to perform that work; but shall include liability for activities which are completed or abandoned before the date of the occurrence giving rise to the liability.

C. “Director” means, for the purposes of this regulation, a natural person designated in the articles of the risk retention group, or designated, elected or appointed by any other manner, name or title to act as a director.

BD. "Domicile", , for the purposes of this regulation, and for the purposes of determining the state in which a purchasing group is domiciled, means for a corporation, the state in which the purchasing group is incorporated; and for an unincorporated entity, the state of its principal place of business.

CE. "Hazardous financial condition" means, for the purposes of this regulation, that, based on its present or reasonably anticipated financial condition, a risk retention group, although not yet financially impaired or insolvent, is unlikely to be able to meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or to pay other obligations in the normal course of business.

DF. "Insurance" means, for the purposes of this regulation, primary insurance, excess insurance, reinsurance, surplus lines insurance, and any other arrangement for shifting and distributing risk which is determined to be insurance under the laws of this state.

EG. "Liability" means, for the purposes of this regulation, legal liability for damages (including costs of defense, legal costs and fees, and other claims expenses) because of injuries to other persons, damage to their property, or other damage or loss to such other persons resulting from or arising out of any business (whether profit or nonprofit), trade, product, services (including professional services), premises, or operations; or any activity of any state or local government, or any agency or political subdivision thereof; but does not include personal risk liability and an employer's liability with respect to its employees other than legal liability under the Federal Employers' Liability Act (45 U.S.C. 51 et seq.).

FH. "Personal risk liability" means, for the purposes of this regulation, liability for damages because of injury to any person, damage to property, or other loss or damage resulting from any personal, familial, or household responsibilities or activities, rather than from responsibilities or activities referred to in Section 4.EG.

GI. "Plan of operation or a feasibility study" means, for the purposes of this regulation, an analysis which presents the expected activities and results of a risk retention group including, at a minimum:

1. Information sufficient to verify that its members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business, trade, product, services, premises operations;

2. For each state in which it intends to operate, the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer;

3. Historical and expected loss experience of the proposed members and national experience of similar exposures to the extent that this experience is reasonably available;

4. Pro forma financial statements and projections;

5. Appropriate opinions by a qualified, independent casualty actuary, including a determination of minimum premium or participation levels required to commence operations and to prevent a hazardous financial condition;

6. Identification of management, underwriting and claims procedures, marketing methods, managerial oversight methods, investment policies and reinsurance agreements;

7. Identification of each state in which the risk retention group has obtained, or sought to obtain, a charter and license, and a description of its status in each such state; and

8. Such other matters as may be prescribed by the commissioner of the state in which the risk retention group is chartered for liability insurance companies authorized by the insurance laws of that state.

~~H~~J. "Product liability" means, for the purposes of this regulation, liability for damages because of any personal injury, death, emotional harm, consequential economic damage, or property damage (including damages resulting from the loss of use of property) arising out of the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product, but does not include the liability of any person for those damages if the product involved was in the possession of such a person when the incident giving rise to the claim occurred.

~~I~~K. "Purchasing group" means, for the purposes of this regulation, any group which

1. Has as one of its purposes the purchase of liability insurance on a group basis;

2. Purchases such insurance only for its group members and only to cover their similar or related liability exposure, as described in Section 4.~~(I~~K.~~)(~~3.~~)~~;

3. Is composed of members whose businesses or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations; and

4. Is domiciled in any state.

~~J~~L. "Risk retention group" means, for the purposes of this regulation, any corporation or other limited liability association:

1. Whose primary activity consists of assuming and spreading all, or any portion, of the liability exposure of its group members;

2. Which is organized for the primary purpose of conducting the activity described in Section 4~~(.J~~L.~~)(~~1~~).~~;

3. Which

a. Is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or

b. Before January 1, 1985 was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before such date, had certified to the insurance commissioner of at least one state that it satisfied the capitalization requirements of such state, except that any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since that date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability (as such terms were defined in the Product Liability Risk Retention Act of 1981 before the date of the enactment of RRA of 1986);

4. Which does not exclude any person from membership in the group solely to provide for members of such a group a competitive advantage over such a person;

5. Which

a. Has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group; or

b. Has as its sole owner an organization which has as:

i(1). Its members only persons who comprise the membership of the risk retention group; and

ii(2). Its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group;

6. Whose members are engaged in businesses or activities similar or related with respect to the liability of which such members are exposed by virtue of any related, similar or common business trade, product, services, premises or operations;

7. Whose activities do not include the provision of insurance other than

a. Liability insurance for assuming and spreading all or any portion of the liability of its group members; and

b. Reinsurance with respect to the liability of any other risk retention group (or any members of such other group) which is engaged in businesses or activities so that such group or member meets the requirement described in Section IV 4(.JL.)(6).for membership in the risk retention group which provides such reinsurance; and

8. The name of which includes the phrase "Risk Retention Group".

KM. "State" means, for the purposes of this regulation, any state of the United States or the District of Columbia.

LN. "NAIC" means, for the purposes of this regulation, National Association of Insurance Commissioners.

Section 5 Risk Retention Groups Chartered in this State

A. A risk retention group shall be chartered and licensed to write only liability insurance as limited by RRA 1986 and, except as provided elsewhere in this regulation, must comply with all of the

laws, rules, regulations and requirements applicable to insurers chartered and licensed in this state and with Section 6. of this regulation to the extent such requirements are not a limitation on laws, rules, regulations or requirements of this state.

B. Notwithstanding any other provision to the contrary, all risk retention groups chartered in this state shall file with the Division of Insurance and the NAIC, an annual statement in a form prescribed by the Commissioner and in diskette form, if required by the Commissioner and completed in accordance with its instructions.

C. Before it may offer insurance in any state, each risk retention group shall also submit for approval to the Commissioner a plan of operation or feasibility study. The risk retention group shall submit an appropriate revision in the event of any subsequent material change in any item of the plan of operation or feasibility study, within ten (10) days of any such change. The group shall not offer any additional kinds of liability insurance, in this state or in any other state, until a revision of such plan or study is approved by the Commissioner.

D. At the time of filing its application for license, and in addition to the filing requirements of Colorado Insurance Regulation 2-1-7 the risk retention group shall provide to the Commissioner in summary form the following information: the identity of the initial members of the group, the identity of those individuals who organized the group or who will provide administrative services or otherwise influence or control the activities of the group, the amount and nature of initial capitalization, the coverages to be afforded, and the states in which the group intends to operate. An additional copy of this information shall be filed and upon receipt of this information, the Commissioner shall forward the information to the NAIC. Providing notification to the NAIC is in addition to and shall not be sufficient to satisfy the requirements of Section 6. or any other requirements of this regulation.

E. Governance Standards for Risk Retention Groups

1. The board of directors of the risk retention group shall have a majority of independent directors. If the risk retention group is a reciprocal, then the attorney-in-fact would be required to adherer to the same standards regarding independence of operation and governance as imposed on the risk retention group's board of directors/subscribers advisory committee under these standards; and, to the extent permissible under state law, service providers of a reciprocal risk retention group should contract with the risk retention group and not the attorney-in-fact.

2. No director qualifies as "independent" unless the board of directors affirmatively determines that the director has no "material relationship" with the risk retention group. Each risk retention group shall disclose these determinations to its domestic regulator, at least annually. For this purpose, any person that is a direct or indirect owner of or subscriber in the risk retention group (or is an officer, director and/or employee of such owner and insured, unless some other position of such officer, director and/or employee constitutes a "material relationship"), as contemplated by 15 U.S.C. § 3901(a)(4)(E)(ii) of the Liability Risk Retention Act, is considered to be "independent".

3. "Material relationship" of a person with the risk retention group includes, but is not limited to:

a. The receipt in any 12-month period of compensation or payment of any other item of value by such person, a member of such person's immediate family or any business with which such person is affiliated from the risk retention group or a consultant or service provider to the risk retention group is greater than or equal to five percent (5%) of the risk retention group's gross written premium for such 12-month period or two percent (2%) of its surplus, whichever is greater, as measured at the end of any fiscal quarter falling in the 12-month period. Such

person or immediate family member of such person is not independent until one year after his/her compensation from the risk retention group falls below the threshold.

b. A relationship with an auditor as follows: a director or an immediate family member of a director who is affiliated with or employed in a professional capacity by a present or former internal or external auditor until one year after the end of the affiliation, employment or auditing relationship.

c. A relationship with a related entity as follows: a director or immediate family member of a director who is employed as an executive officer of another company where any of the risk retention group's present executives serve on that other company's board of directors is not independent until one year after the end of such service or the employment relationship.

4. The term of any material service provider contract with the risk retention group shall not exceed five years. Any such contract, or its renewal, shall require the approval of the majority of the risk retention group's independent directors. The risk retention group's board of directors shall have the right to terminate any service provider, audit or actuarial contracts at any time for cause after providing adequate notice as defined in the contract. The service provider contract is deemed material if the amount to be paid for such contract is greater than or equal to five percent (5%) of the risk retention group's annual gross premium or two percent (2%) of its surplus, whichever is greater.

a. For the purposes of this standard, "service providers" shall include captive managers, auditors, accountants, actuaries, investment advisors, lawyers, managing general underwriters or other party responsible for underwriting, determination of rates, collection of premium, adjusting and settling claims and/or the preparation of financial statements. Any reference to 'lawyers' in the prior sentences does not include defense counsel retained by the risk retention group to defend claims, unless the amount of fees paid to such lawyers are 'material' as referenced in Section 5.1.b. of this regulation.

b. No service provider contract meeting the definition of "material relationship" contained in Section 5.1.b. of this regulation shall be entered into unless the risk retention group has notified the Commissioner in writing of its intention to enter into such transaction at least 30 days prior thereto and the Commissioner has not disapproved it within such time.

5. The risk retention group's board of directors shall adopt a written policy in the plan of operation as approved by the board that requires the board to:

a. Assure that all owners/insureds of the risk retention group receive evidence of ownership interest;

b. Develop a set of governance standards applicable to the risk retention group;

c. Oversee the evaluation of the risk retention group's management including but not limited to the performance of the captive manager, managing general underwriter or other party or parties responsible for underwriting, determination of rates, collection of premium, adjusting or settling claims or the preparation of financial statements;

d. Review and approve the amount to be paid for all material service providers; and

e. Review and approve, at least annually:

(1) Risk retention group's goals and objectives relevant to the compensation of officers and service providers;

(2) The officers' and service providers' performance in light of these goals and objectives; and,

(3) The continued engagement of the officers and material service providers.

6. Audit Committee – The risk retention group shall have an audit committee composed of at least three independent board members. A non-independent board member may participate in the activities of the audit committee, if invited by the members, but cannot be a member of such committee.

a. The audit committee shall have a written charter that defines the committee's purpose, which at a minimum, must be to:

(1) Assist board oversight of the integrity of the financial statements, the compliance with legal and regulatory requirements, and the qualifications, independence and performance of the independent auditor and actuary;

(2) Discuss the annual audited financial statements and quarterly financial statements with management;

(3) Discuss the annual audited financial statements with its independent auditor and if advisable, discuss its quarterly financial statements with its independent auditor;

(4) Discuss policies with respect to risk assessment and risk management;

(5) Meet separately and periodically, either directly or through a designated representative of the committee, with management and independent auditors;

(6) Review with the independent any audit problems or difficulties and management's response;

(7) Set clear hiring policies of the risk retention group as to the hiring of employees or former employees of the independent auditor;

(8) Require the external auditor to rotate the lead (or coordinating) audit partner having primary responsibility for the risk retention group's audit as well as the audit partner responsible for reviewing that audit so that neither individual performs audit services for more than five consecutive fiscal years; and

(9) Reports regularly to the board of directors.

b. If an audit committee is not designated by the risk retention group, the entire board of directors of the risk retention group shall constitute the audit committee.

7. Governance Standards – The board of directors shall adopt and disclose governance standards, where "disclose" means making such information available through electronic

(e.g., posting such information on the risk retention group's website) or other means, and providing such information to members/insureds upon request, which shall include:

a. A process by which the directors are elected by the owners/insureds;

b. Director qualification standards;

c. Director responsibilities;

d. Director access to management and, as necessary and appropriate, independent advisors

e. Director compensation;

f. Director orientation and continuing education;

g. The policies and procedures that are followed for management succession; and

h. The policies and procedures that are followed for annual performance evaluation of the board.

8. Business Conduct and Ethics – The board of directors shall adopt and disclose a code of business conduct and ethics for directors, officers and employees and promptly disclose to the board of directors any waivers of the code for directors or executive officers, which should include the following topics:

a. Conflicts of interest;

b. Matters covered under the corporate opportunities doctrine under the state of domicile;

c. Confidentiality;

d. Fair dealing;

e. Protection and proper use of risk retention group assets;

f. Compliance with all applicable laws, rules and regulations; and

g. Requiring the reporting of any illegal or unethical behavior which affects the operation of the risk retention group.

9. Reporting Non-Compliance – The captive manager, president or chief executive officer of the risk retention group shall promptly notify the domestic regulator in writing if either becomes aware of any material non-compliance with any of these governance standards.

10. Compliance dates

a. Existing risk retention groups shall be in compliance with the standards of Section 5.E. of this regulation no later than October 1, 2018.

b. New risk retention groups shall be in compliance with the standards of Section 5.E. of this regulation at the time of licensure.

Section 6 Risk Retention Groups Not Chartered in this State

Risk retention groups chartered and licensed in states other than this state and seeking to do business as a risk retention group in this state shall comply with the laws of this state as follows:

A. Notice of Operations and Designation of Commissioner as Agent.

1. Before offering insurance in this state, a risk retention group shall submit to the Commissioner on a form prescribed by the Commissioner:

a. A statement identifying the state or states in which the risk retention group is chartered and licensed as a liability insurance company, charter date, its principal place of business, and such other information, including information on its membership, as the Commissioner may require to verify that the risk retention group is qualified under Section 4.~~(JL).~~;

b. A copy of its plan of operations or feasibility study and revisions of such plan or study submitted to the state in which the risk retention group is chartered and licensed; provided, however, that the provision relating to the submission of a plan of operation or feasibility study shall not apply with respect to any line or classification of liability insurance which:

(1). Was defined in the Product Liability Risk Retention Act of 1981 before October 27, 1986; and

(2). Was offered before such date by any risk retention group which had been chartered and operating for not less than three years before such date; and

2. The risk retention group shall submit a copy of any revision to its plan of operation or feasibility study required by Section 6.~~(~~A.~~)(~~1.~~)(~~b.~~)~~ at the same time that such revision is submitted to the commissioner of its chartering state.

3. The risk retention group shall submit a statement of registration, which designates the Commissioner as its agent for the purpose of receiving service of legal documents or process.

4. The risk retention group shall submit a resolution of the board of directors, certified by the corporate secretary or equivalent officer, which designates the Commissioner as agent for the purpose of receiving service of legal documents or process.

B. Financial Condition.

Any risk retention group doing business in this state shall submit to the Commissioner:

1. A copy of the group's financial statement submitted to the state in which the risk retention group is chartered and licensed which shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a qualified actuary;

2. A copy of each examination of the risk retention group as certified by the commissioner or public official conducting the examination;

3. Upon request by the Commissioner, a copy of any information or document pertaining to any outside audit performed with respect to the risk retention group; and

4. Such information as may be required to verify its continuing qualification as a risk retention group under Section 4.~~(JL)~~.

C. Taxation.

1. Each risk retention group shall be liable for the payment of premium taxes on business for risks resident or located within this state, and shall report to the Commissioner the gross premiums written for risks resident or located within this state. The risk retention group shall be subject to taxation, and any applicable fines and penalties related thereto, on the same basis as a foreign admitted insurer.

2. To the extent licensed agents or brokers are utilized, they shall report to the Commissioner the premiums for direct business for risks resident or located within this state which the licensees have placed with or on behalf of a risk retention group not chartered in this state.

3. To the extent that insurance agents or brokers are utilized, the agent or broker shall keep a complete and separate record of all policies procured from each risk retention group, which record shall be open to examination by the Commissioner, as provided in § 10-1-201, C.R.S. These records shall, for each policy and each kind of insurance provided thereunder, include the following:

a. The limit of liability;

b. The time period covered;

c. The effective date;

d. The name of the risk retention group which issued the policy;

e. The gross premium charged; and

f. The amount of return premiums, if any.

D. Any risk retention group shall comply with the laws of this state, specifically § 10-3-1104, C.R.S., regarding unfair, deceptive, false or fraudulent acts or practices. However, if the Commissioner seeks an injunction regarding such conduct, the injunction must be obtained from a court of competent jurisdiction.

E. Any risk retention group must submit to an examination by the Commissioner to determine its financial condition if the commissioner of the jurisdiction in which the group is chartered and licensed has not initiated an examination or does not initiate an examination within sixty (60) days after a request by the Commissioner of this state. Any such examination shall be coordinated to avoid unjustified repetition and conducted in an expeditious manner and in accordance with the policies and procedures for examinations by the Colorado Division of Insurance.

F. Every application form for insurance from a risk retention group, and every policy (on its front and declaration pages) issued by a risk retention group, shall contain in ten point type the following notice:

NOTICE THIS POLICY IS ISSUED BY YOUR RISK RETENTION GROUP. YOUR RISK RETENTION GROUP MAY NOT BE SUBJECT TO ALL OF THE INSURANCE LAWS AND REGULATIONS OF YOUR STATE. STATE INSURANCE INSOLVENCY GUARANTY FUNDS ARE NOT AVAILABLE FOR YOUR RISK RETENTION GROUP.

G. The following acts by a risk retention group are hereby prohibited:

1. The solicitation or sale of insurance by a risk retention group to any person who is not eligible for membership in such group; and

2. The solicitation or sale of insurance by, or operation of, a risk retention group that is in hazardous financial condition or financially impaired.

H. No risk retention group shall be allowed to do business in this state if an insurance company is directly or indirectly a member or owner of such risk retention group, other than in the case of a risk retention group all of whose members are insurance companies.

I. The terms of any insurance policy issued by any risk retention group shall not provide, or be construed to provide, coverage prohibited generally by statute of this state or declared unlawful by the highest court of this state whose law applies to such policy.

J. A risk retention group not chartered in this state and doing business in this state shall comply with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by a state insurance commissioner if there has been a finding of financial impairment after an examination under Section 6{E}.

K. A risk retention group that violates any provision of this regulation will be subject to fines and penalties including revocation of its right to do business in this state, applicable to licensed insurers generally.

Section 7 Compulsory Associations

A. No risk retention group shall be required or permitted to join or contribute financially to any insurance insolvency guaranty fund, or similar mechanism, in this state, nor shall any risk retention group, or its insureds or claimants against its insureds, receive any benefit from any such fund for claims arising under the insurance policies issued by such risk retention group.

B. When a purchasing group obtains insurance covering its members' risks from an authorized insurer, only risks resident or located in this state shall be covered by the state guaranty fund subject to § 10-4-501 et seq, C.R.S..

C. When a purchasing group obtains insurance covering its members' risks from an insurer not authorized in this state or a risk retention group, no such risks, wherever resident or located, shall be covered by any insurance guaranty fund or similar mechanism in this state.

Section 8 Purchasing Groups - Exemption from Certain Laws

A purchasing group and its insurer or insurers shall be subject to all applicable laws of this state, except that a purchasing group and its insurer or insurers shall be exempt, in regard to liability insurance for the purchasing group, from any law that would:

A. Prohibit the establishment of a purchasing group;

B. Make it unlawful for an insurer to provide or offer to provide insurance on a basis providing, to a purchasing group or its members, advantages based on their loss and expense experience not afforded to other persons with respect to rates, policy forms, coverages or other matters;

C. Prohibit a purchasing group or its members from purchasing insurance on a group basis described in Section 8{B};

D. Prohibit a purchasing group from obtaining insurance on a group basis because the group has not been in existence for a minimum period of time or because any member has not belonged to the group for a minimum period of time;

E. Require that a purchasing group must have a minimum number of members, common ownership or affiliation, or certain legal form;

F. Require that a certain percentage of a purchasing group must obtain insurance on a group basis;

G. Otherwise discriminate against a purchasing group or any of its members; or

H. Require that any insurance policy issued to a purchasing group or any of its members be countersigned by an insurance agent or broker residing in this state.

Section 9 Notice and Registration Requirements of Purchasing Groups

A. A purchasing group which intends to do business in this state shall, prior to doing business, furnish notice to the Commissioner which shall, on forms prescribed by the Commissioner:

1. Identify the state in which the group is domiciled;

2. Specify the lines and classifications of liability insurance which the purchasing group intends to purchase;

3. Identify the insurance company or companies from which the group intends to purchase its insurance and the domicile of such company;

4. Specify the method by which, and the person or persons, if any, through whom insurance will be offered to its members whose risks are resident or located in this state;

5. Identify the principal place of business of the group; and

6. Provide such other information as may be required by the Commissioner to verify that the purchasing group is qualified under Section 4.~~(~~H K~~)~~.

B. A purchasing group shall, within ten (10) days, notify the Commissioner of any changes in any of the items set forth in Section 9.~~(~~A~~)~~.

C. The purchasing group shall register and designate the Commissioner as its agent solely for the purpose of receiving service of legal documents or process, accompanied by a Board of Directors resolution authorizing the power of attorney, except that such requirements shall not apply in the case of a purchasing group which only purchases insurance that was authorized under the federal Products Liability Risk Retention Act of 1981, and:

1. Which in any state of the United States was domiciled before April 1, 1986; and is domiciled on and after October 27, 1986;

2. Which before October 27, 1986 purchased insurance from an insurance carrier licensed in any state; and since October 27, 1986 purchased its insurance from an insurance carrier licensed in any state; or

3. Which was a purchasing group under the requirements of the Product Liability Risk Retention Act of 1981 before October 27, 1986.

D. Each purchasing group that is required to give notice pursuant to subsection A of this section shall also furnish such information as may be required by the Commissioner to:

1. Verify that the entity qualifies as a purchasing group;

2. Determine where the purchasing group is located; and

3. Determine appropriate tax treatment.

Section 10 Restrictions on Insurance Purchased by Purchasing Groups

A. A purchasing group may not purchase insurance from a risk retention group that is not chartered in a state or from an insurer not admitted in the state in which the purchasing group is located, unless the purchase is effected through a licensed agent or broker acting pursuant to the surplus lines laws and regulations of such state.

B. A purchasing group which obtains liability insurance from an approved surplus lines carrier or a risk retention group shall inform each of the members of such group which have a risk resident or located in this state that such risk is not protected by an insurance insolvency guaranty fund in this state, and that such risk retention group or such insurer may not be subject to all insurance laws and regulations of this state.

C. No purchasing group may purchase insurance providing for a deductible or self-insured retention applicable to the group as a whole; however, coverage may provide for a deductible or self-insured retention applicable to individual members.

D. Purchases of insurance by purchasing groups are subject to the same standards regarding aggregate limits which are applicable to all purchases of group insurance.

Section 11 Purchasing Group Taxation

Premium taxes and taxes on premiums paid for coverage of risks resident or located in this state by a purchasing group or any members of the purchasing groups shall be:

A. Imposed at the same rate and subject to the same interest, fines and penalties as that applicable to premium taxes and taxes on premiums paid for similar coverage from a similar insurance source by other insureds; and

B. Paid first by such insurance source, and if not by such source by the agent or broker for the purchasing group, and if not by such agent or broker then by the purchasing group, and if not by such purchasing group then by each of its members.

Section 12 Administrative and Procedural Authority Regarding Risk Retention Groups and Purchasing Groups

The Commissioner may make use of any of the provisions of Title 10 of the Colorado Revised Statutes to enforce the laws of this state not specifically preempted by the RRA 1986 including the Commissioner's administrative authority to investigate, issue subpoena, conduct depositions and hearings, issue orders, impose penalties and seek injunctive relief. With regard to any investigation, administrative proceedings or litigation, the Commissioner will rely on the procedural laws of this state.

Section 13 Incorporated Materials

15 U.S.C. § 3901(a)(4)(E)(ii), the Liability Risk Retention Act, published by the Government Publishing Office shall mean 15 U.S.C. § 3901(a)(4)(E)(ii) 3901(a)(4)(E)(ii), as published on the effective date of this

regulation and does not include later amendments to or editions of 15 U.S.C. § 3901(a)(4)(E)(ii). A copy of 15 U.S.C. § 3901(a)(4)(E)(ii) may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A certified copy of 15 U.S.C. § 3901(a)(4)(E)(ii) may be requested from the Colorado Division of Insurance for a fee. A copy may also be obtained online at www.uscode.house.gov

Section 1~~3~~4 Severability

~~If any clause, sentence, paragraph, section or part of this regulation or the application thereof to any person or circumstances, shall, for any reason, be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair or invalidate the remainder of this regulation, and the application thereof to other persons or circumstance, but shall be confined in its operation to the clause, sentence, paragraph, section or part thereof directly involved in the controversy in which such judgment shall have been rendered and to the person or circumstances involved.~~ If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 1~~4~~5 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 1~~5~~6 Effective Date

This amended regulation shall become effective on ~~July~~ October 1, 201~~2~~7.

Section 1~~6~~7 History

Regulation amended and restated effective December 1, 1992
Amended regulation effective April 1, 2004
Amended regulation effective July 1, 2012
Amended regulation effective October 1, 2017

Notice of Proposed Rulemaking

Tracking number

2017-00264

Department

700 - Department of Regulatory Agencies

Agency

702 - Division of Insurance

CCR number

3 CCR 702-3

Rule title

FINANCIAL ISSUES

Rulemaking Hearing

Date

08/01/2017

Time

02:00 PM

Location

1560 Broadway, Ste 110 D, Denver CO 80202

Subjects and issues involved

3-1-8 CONCERNING ACTUARIAL OPINIONS AND MEMORANDUMS FOR LIFE COMPANIES AND FRATERNAL BENEFIT SOCIETIES.
The purpose of this regulation is to prescribe:
A.Guidelines and standards for statements of actuarial opinion, which are to be submitted in accordance with §§10-7-114 and 10-14-602, C.R.S. and for memorandums submitted in support thereof;
B.Rules applicable to the appointment of an appointed actuary; and
C.Guidance as to the meaning of adequacy of reserves.

Statutory authority

10-1-108(7), 10-1-109, 10-7-114, and 10-14-505

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DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Proposed Amended Regulation 3-1-8

CONCERNING ACTUARIAL OPINIONS AND MEMORANDUMS FOR LIFE COMPANIES AND FRATERNAL BENEFIT SOCIETIES

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§10-1-108(7), 10-1-109, 10-7-114, and 10-14-505, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to prescribe:

A. Guidelines and standards for statements of actuarial opinion, which are to be submitted in accordance with §§10-7-114 and 10-14-602, C.R.S. and for memorandums submitted in support thereof;

B. Rules applicable to the appointment of an appointed actuary; and

C. Guidance as to the meaning of “adequacy of reserves.”

Section 3 Applicability

This regulation shall apply to all life insurance companies and fraternal benefit societies doing business in this State and to all life insurance companies and fraternal benefit societies that are authorized to reinsure life insurance, annuities or accident and health insurance business in this State. This regulation shall be applied in a manner that allows the appointed actuary to utilize his or her professional judgment in performing the asset adequacy analysis and developing the actuarial opinion and supporting memoranda, consistent with relevant actuarial standards of practice. However, the Commissioner shall have the authority to specify specific methods of actuarial analysis and actuarial assumptions when, in the Commissioner’s judgment, these specifications are necessary for an acceptable opinion to be rendered

relative to the adequacy of reserves and related items; see Section 7.D. of this regulation for requirements specific to companies domiciled in the State of Colorado.

This regulation shall be applicable to all annual statements filed with the office of the Commissioner after the effective date of this regulation. A statement of opinion on the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with Section 6. of this regulation, and a memorandum in support thereof in accordance with Section 7. of this regulation, shall be required each year.

Section 4 Definitions

A. "Actuarial Opinion" means the opinion of an appointed actuary regarding the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with Section 6. of this regulation and with applicable Actuarial Standards of Practice.

B. "Actuarial Standards Board" means the board established by the American Academy of Actuaries to develop and promulgate actuarial standards of practice.

C. "Actuarial Standards of Practice" means the Actuarial Standards of Practice and Compliance Guidelines as promulgated by the Actuarial Standards Board.

D. "Annual statement" means that statement required by §§10-3-208 and 10-14-602, C.R.S. to be filed annually, by the company, with the Commissioner.

E. "Appointed actuary" means an individual who is appointed or retained in accordance with the requirements set forth in Section 5.B. of this regulation to provide the actuarial opinion and supporting memorandum as required by this regulation and §10-7-114, C.R.S.

F. "Asset adequacy analysis" means an analysis that meets the standards and other requirements referred to in Section 5.C. of this regulation. It may take many forms, including, but not limited to, cash flow testing, sensitivity testing or applications of risk theory.

G. "Commissioner" means the Insurance Commissioner of the State of Colorado.

H. "Company" means a life insurance company, fraternal benefit society or reinsurer subject to the provisions of this regulation.

I. "Qualified actuary" means an individual who meets the requirements set forth in §10-7-114 (1.1) ~~(e)~~, C.R.S.

Section 5 General Requirements

A. Submission of Statement of Actuarial Opinion

1. There is to be included on or attached to Page 1 of the annual statement for each year beginning with the year in which this regulation becomes effective the statement of an appointed actuary, entitled "Statement of Actuarial Opinion," setting forth an opinion relating to reserves and related actuarial items held in support of policies and contracts, in accordance with Section 6. of this regulation.

2. Upon written request and showing adequate justification by the company, the Commissioner may grant an extension of the date for submission of the Statement of Actuarial Opinion. Actuarial Opinions not received by the required filing date, or approved extended date, shall be subject to a penalty of up to $100.00 per day.

B. Appointed Actuary. An “appointed actuary” is a qualified actuary who is appointed or retained to prepare the Statement of Actuarial Opinion required by this regulation, either directly by or by the authority of the board of directors through an executive officer of the company other than the qualified actuary. The company shall give the Commissioner timely written notice of the name, title (and, in the case of a consulting actuary, the name of the firm) and manner of appointment or retention of each person appointed or retained by the company as an appointed actuary and shall state in the notice that the person meets the requirements set forth in §10-7-114(1.1)~~(e)~~, C.R.S. Once notice is furnished, no further notice is required with respect to this person, provided that the company shall give the Commissioner timely written notice in the event the actuary ceases to be appointed or retained as an appointed actuary or to meet the requirements set forth in §10-7-114(1.1)~~(e)~~, C.R.S. If any person appointed or retained as an appointed actuary replaces a previously appointed actuary, the notice shall so state and give the reasons for replacement.

C. Standards for Asset Adequacy Analysis. The asset adequacy analysis required by this regulation:

1. Shall conform to the Standards of Practice as promulgated from time to time by the Actuarial Standards Board, and on any additional standards under this regulation, which standards are to form the basis of the Statement of Actuarial Opinion in accordance with this regulation; and

2. Shall be based on methods of analysis as are deemed appropriate for such purposes by the Actuarial Standards Board.

D. Liabilities to be Covered.

1. Under authority of §10-7-114(1)(b), C.R.S., the Statement of Actuarial Opinion shall apply to all in force business on the statement date, whether directly issued or assumed, regardless of when or where issued, e.g., reserves of Exhibits 5, 6 and 7, and claim liabilities in Exhibit 8, Part 1 of the Annual Statement and equivalent items in the separate account statement or statements.

2. If the appointed actuary determines, as the result of asset adequacy analysis, that a reserve should be held in addition to the aggregate reserve held by the company, and calculated in accordance with methods set forth in Article 7 of Title 10, C.R.S., the company shall establish the additional reserve.

3. Additional reserves established under Paragraph (2) above and deemed not necessary in subsequent years may be released. Any amounts released shall be disclosed in the actuarial opinion for the applicable year. The release of such reserves would not be deemed an adoption of a lower standard of valuation.

Section 6 Statement of Actuarial Opinion Based On Asset Adequacy Analysis

A. General Description. The Statement of Actuarial Opinion submitted in accordance with this section shall consist of:

1. A paragraph identifying the appointed actuary and his or her qualifications (see Subsection B.1. of this regulation);

2. A scope paragraph identifying the subjects on which an opinion is to be expressed, and describing the scope of the appointed actuary’s work, including a tabulation delineating the reserves and related actuarial items that have been analyzed for asset adequacy and the method of analysis, (see Subsection B.2. of this regulation) and identifying the reserves and related actuarial items covered by the opinion that have not been so analyzed;

3. A reliance paragraph describing those areas, if any, where the appointed actuary has deferred to other experts in developing data, procedures or assumptions, (e.g., anticipated cash flows from currently owned assets, including variation in cash flows according to economic scenarios (see Subsection B.3.), supported by a statement of each such expert in the form prescribed by Subsection E.; and

4. An opinion paragraph expressing the appointed actuary's opinion with respect to the adequacy of the supporting assets to mature the liabilities (see Subsection B.4.) of this regulation).

5. One or more additional paragraphs will be needed in individual company cases as follows:

   a. If the appointed actuary considers it necessary to state a qualification of his or her opinion;

   b. If the appointed actuary must disclose an inconsistency in the method of analysis or basis of asset allocation used at the prior opinion date with that used for this opinion;

   c. If the appointed actuary must disclose whether additional reserves as of the prior opinion date are released as of this opinion date, and the extent of the release; and/or

   d. If the appointed actuary chooses to add a paragraph briefly describing the assumptions that form the basis for the actuarial opinion.

B. Recommended Language. The following paragraphs are to be included in the Statement of Actuarial Opinion in accordance with this section. Language is that which in typical circumstances should be included in a Statement of Actuarial Opinion. The language may be modified as needed to meet the circumstances of a particular case, but the appointed actuary should use language that clearly expresses his or her professional judgment. However, in any event the opinion shall retain all pertinent aspects of the language provided in this section.

1. The opening paragraph should generally indicate the appointed actuary's relationship to the company and his or her qualifications to sign the opinion. For a company actuary, the opening paragraph of the actuarial opinion should include a statement such as:

   "I, [name], am [title] of [insurance company name] and a member of the American Academy of Actuaries. I was appointed by, or by the authority of, the Board of Directors of said insurer to render this opinion as stated in the letter to the Commissioner dated [insert date]. I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and health insurance companies."

   For a consulting actuary, the opening paragraph should include a statement such as:

   "I, [name], a member of the American Academy of Actuaries, am associated with the firm of [name of consulting firm]. I have been appointed by, or by the authority of, the Board of Directors of [name of company] to render this opinion as stated in the letter to the Commissioner dated [insert date]. I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and health insurance companies."

2. The scope paragraph should include a statement such as:

"I have examined the actuarial assumptions and actuarial methods used in determining reserves and related actuarial items listed below, as shown in the annual statement of the company, as prepared for filing with state regulatory officials, as of December 31, 20[ ]. Tabulated below are those reserves and related actuarial items which have been subjected to asset adequacy analysis.

3. If the appointed actuary has relied on other experts to develop certain portions of the analysis, the reliance paragraph should include a statement such as:

"I have relied on [name], [title] for [e.g., "anticipated cash flows from currently owned assets, including variations in cash flows according to economic scenarios" or "certain critical aspects of the analysis performed in conjunction with forming my opinion"], as certified in the attached statement. I have reviewed the information relied upon for reasonableness."

A statement of reliance on other experts should be accompanied by a statement by each of the experts in the form prescribed by Section 6.E.

4. If the appointed actuary has examined the underlying asset and liability records, the reliance paragraph should include a statement such as:

"My examination included such review of the actuarial assumptions and actuarial methods and of the underlying basic asset and liability records and such tests of the actuarial calculations as I considered necessary. I also reconciled the underlying basic asset and liability records to [exhibits and schedules listed as applicable] of the company's current annual statement."

5. If the appointed actuary has not examined the underlying records, but has relied upon data (e.g., listings and summaries of policies in force or asset records) prepared by the company, the reliance paragraph should include a statement such as:

"In forming my opinion on [specify types of reserves], I relied upon data prepared by [name and title of company officer certifying in force records or other data] as certified in the attached statements. I evaluated that data for reasonableness and consistency. I also reconciled that data to [exhibits and schedules to be listed as applicable] of the company's current annual statement. In other respects, my examination included review of the actuarial assumptions and actuarial methods used and tests of the calculations I considered necessary."

The section shall be accompanied by a statement by each person relied upon in the form prescribed by Subsection 6.E. of this regulation.

6. The opinion paragraph should include a statement such as:

"In my opinion the reserves and related actuarial values concerning the statement items identified above:

a. Are computed in accordance with presently accepted actuarial standards consistently applied and are fairly stated, in accordance with sound actuarial principles;

b. Are based on actuarial assumptions that produce reserves at least as great as those called for in any contract provision as to reserve basis and method, and are in accordance with all other contract provisions;

c. Meet the requirements of the Insurance Law and Regulation of the State of [state of domicile]; and are at least as great as the minimum aggregate amounts required by the state in which this statement is filed;

d. Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the annual statement of the preceding year-end (with any exceptions noted below); and

e. Include provision for all actuarial reserves and related statement items which ought to be established.

The reserves and related items, when considered in light of the assets held by the company with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on the assets, and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the company.

The actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Actuarial Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis of this statement of opinion.

This opinion is updated annually as required by statute. To the best of my knowledge, there have been no material changes from the applicable date of the annual statement to the date of the rendering of this opinion which should be considered in reviewing this opinion."

or

"The following material change(s) which occurred between the date of the statement for which this opinion is applicable and the date of this opinion should be considered in reviewing this opinion: (Describe the change or changes.)"

Note: Choose one of the above two paragraphs, whichever is applicable.

"The impact of unanticipated events subsequent to the date of this opinion is beyond the scope of this opinion. The analysis of asset adequacy portion of this opinion should be viewed recognizing that the company's future experience may not follow all the assumptions used in the analysis."

_____
Signature of Appointed Actuary

_____
Address of Appointed Actuary

_____
Telephone Number of Appointed Actuary

_____

Date

Note: This table must be included in the actuarial opinion filed.

Asset Adequacy Tested Amounts—Reserves and Liabilities					
Statement Item	**Formula Reserves (1)**	**(a) Additional Actuarial Reserves (2)**	**(b) Analysis Method**	**Other Amount (3)**	**Total Amount (1)+(2)+(3) (4)**
Exhibit 5 A Life Insurance					
B Annuities					
C Supplementary Contracts Involving Life Contingencies					
D Accidental Death Benefit					
E Disability – Active					
F Disability – Disabled					
G Miscellaneous					
Total (Exhibit 5, Item 1, Page 3)					
Exhibit 6 A Active Life Reserve					
B Claim Reserve					
Total (Exhibit 6, Item 2, Page 3)					
Exhibit 7 Premium and Other Deposit Funds (Column 5, Line 14)					
Guaranteed Interest Contracts (Column 2, Line 14)					
Other (Column 6, Line 14)					
Supplemental Contracts and Annuities Certain (Column 3, Line 14)					
Dividend Accumulations or Refunds (Column 4, Line 14)					
Total (Exhibit 7, Column 1, Line 14)					
Exhibit 8, Part 1 Life (Page 3, Line 4.1)					
Health (Page 3, Line 4.2)					
Total (Exhibit 11, Part 1)					
Separate Accounts (Page 3 of the Annual Statement, Line 27)					
TOTAL RESERVES					

IMR (General Account, Page 3, Line 9.4)	
Separate Accounts, (Page 3, Line 27)	
AVR (Page 3, Line 24.1)	(c)
Net Deferred and Uncollected Premium, (Page 2, Lines 13.1 and 13.2)	

Notes:

(a) The additional actuarial reserves are the reserves established under Paragraph (3) of Section 5.D.

(b) The appointed actuary should indicate the method of analysis, determined in accordance with the standards for asset adequacy analysis referred to in Section 5.C. of this regulation, by means of symbols that should be defined in footnotes to the table.

(c) Allocated amount of Asset Valuation Reserve (AVR).

C. Assumptions for New Issues

The adoption for new issues or new claims or other new liabilities of an actuarial assumption that differs from a corresponding assumption used for prior new issues or new claims or other new liabilities is not a change in actuarial assumptions within the meaning of this Section 6.

D. Adverse Opinions

If the appointed actuary is unable to form an opinion, then he or she shall refuse to issue a Statement of Actuarial Opinion. If the appointed actuary's opinion is adverse or qualified, then he or she shall issue an adverse or qualified actuarial opinion explicitly stating the reasons for the opinion. This statement should follow the scope paragraph and precede the opinion paragraph.

E. Reliance on Information Furnished by Other Persons

If the appointed actuary relies on the certification of others on matters concerning the accuracy or completeness of any data underlying the actuarial opinion, or the appropriateness of any other information used by the appointed actuary in forming the actuarial opinion, the actuarial opinion should so indicate the persons the actuary is relying upon and a precise identification of the items subject to such reliance. In addition, the persons on whom the appointed actuary relies shall provide a certification that precisely identifies the items on which the person is providing information and a statement as to the accuracy, completeness or reasonableness, as applicable, of the items. This certification shall include the signature, title, company, address and telephone number of the person rendering the certification, as well as the date on which it is signed.

F. Alternate Option

1. The Standard Valuation Law gives the Commissioner broad authority to accept the valuation of a foreign insurer when that valuation meets the requirements applicable to a company domiciled in this state in the aggregate. As an alternative to the requirements of Subsection 6.B.6.c. of this regulation, the opining actuary may state that the reserves "meet the requirements of the insurance laws and regulations of the State of [state of domicile] and I have verified that the company's request to file an opinion based on the laws of the state of domicile has been approved and that any conditions required by the Commissioner for approval of that request have been met."

   The foreign insurer should request a written statement from the Commissioner seeking this approval, prior to March 31 of the year it is to be effective. The statement should be issued no later than March 31 of this year. It shall remain valid until rescinded or modified by the Commissioner. The rescission or modifications shall be issued no later than March 31 of the year they are first effective. Subsequent to that statement being issued, if a company chooses to use this alternative, the company shall file a request to do so, along with justification for its use, no later than April 30 of the year of the opinion to be filed. The

request shall be deemed approved on October 1 of that year if the Commissioner has not denied the request by that date.

2. Notwithstanding the above, the Commissioner may reject an opinion based on the laws and regulations of the state of domicile and require an opinion based on the laws of this state. If a company is unable to provide the opinion within sixty (60) days of the request or such other period of time determined by the Commissioner after consultation with the company, the Commissioner may contract an independent actuary at the company's expense to prepare and file the opinion.

G. Confidentiality. The Statement of Actuarial Opinion is not considered to be a confidential document; however, all related supporting materials and memoranda are confidential pursuant to § 10-7-114, C.R.S. and the Colorado Open Records Act (§ 24-72-201 et seq, C.R.S).

Section 7 Description of Actuarial Memorandum Including an Asset Adequacy Analysis and Regulatory Asset Adequacy Issues Summary

A. General

1. In accordance with §§10-7-114 and 10-14-602, C.R.S., the appointed actuary shall prepare a memorandum to the company describing the analysis done in support of his or her opinion regarding the reserves. The memorandum shall be made available for examination by the Commissioner upon his or her request, but shall be destroyed by the Division of Insurance, or returned to the company, if a written request accompanies the filing of the memorandum, after such examination and shall not be considered a record of the Division of Insurance or subject to automatic filing with the Commissioner.

2. In preparing the memorandum, the appointed actuary may rely on, and include as a part of his or her own memorandum, memoranda prepared and signed by other actuaries who are qualified within the meaning of §10-7-114(1.1)~~(e)~~, C.R.S., with respect to the areas covered in such memoranda, and so state in the appointed actuary's memorandum.

3. If the Commissioner requests a memorandum and no such memorandum exists or if the Commissioner finds that the analysis described in the memorandum fails to meet the standards of the Actuarial Standards Board or the standards and requirements of this regulation, the Commissioner may designate a qualified actuary to review the opinion and prepare such supporting memorandum as is required for review. The reasonable and necessary expense of the independent review shall be paid by the company but shall be directed and controlled by the Commissioner.

4. The reviewing actuary shall have the same status as the Commissioner for purposes of obtaining data from the company and the work papers and documentation of the reviewing actuary shall be retained by the Commissioner; provided, however, that any information provided by the company to the reviewing actuary and included in the work papers shall be considered as material provided by the company to the Commissioner and shall be kept confidential to the same extent as is prescribed by law with respect to other material provided by the company to the Commissioner pursuant to the statute governing this regulation. The reviewing actuary shall not be an employee of a consulting firm involved with the preparation of any prior memorandum or opinion for the insurer pursuant to this regulation for any one of the current year or the preceding three (3) years.

5. In accordance with §10-7-114(~~2~~1)(g), C.R.S, the appointed actuary shall prepare a regulatory asset adequacy issues summary, the contents of which are specified in Section 7.C. of this regulation. The regulatory asset adequacy issues summary will be

submitted no later than March 15 of the year following the year for which a Statement of Actuarial Opinion based on asset adequacy is required. The regulatory asset adequacy issues summary is to be kept confidential to the same extent and under the same conditions as the actuarial memorandum.

B. Details of the Memorandum Section Documenting Asset Adequacy Analysis

When an actuarial opinion is provided, the memorandum shall demonstrate that the analysis has been done in accordance with the standards for asset adequacy referred to in Section 5.C. of this regulation and any additional standards under this regulation. It shall specify:

1. For reserves:

a. Product descriptions including market description, underwriting and other aspects of a risk profile and the specific risks the appointed actuary deems significant;

b. Source of liability in force;

c. Reserve method and basis;

d. Investment reserves;

e. Reinsurance arrangements;

f. Identification of any explicit or implied guarantees made by the general account in support of benefits provided through a separate account or under a separate account policy or contract and the methods used by the appointed actuary to provide for the guarantees in the asset adequacy analysis; and

g. Documentation of assumptions to test reserves for the following:

(1) Lapse rates (both base and excess);

(2) Interest crediting rate strategy;

(3) Mortality;

(4) Policyholder dividend strategy;

(5) Competitor or market interest rate;

(6) Annuitization rates;

(7) Commissions and expenses; and

(8) Morbidity.

The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions;

2. For assets:

a. Portfolio descriptions, including a risk profile disclosing the quality, distribution and types of assets;

b. Investment and disinvestment assumptions;

c. Source of asset data;

d. Asset valuation bases; and

e. Documentation of assumptions made for:

(1) Default costs;

(2) Bond call function;

(3) Mortgage prepayment function;

(4) Determining market value for assets sold due to disinvestment strategy; and

(5) Determining yield on assets acquired through the investment strategy.

The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions;

3. For the analysis basis:

a. Methodology;

b. Rationale for inclusion or exclusion of different blocks of business and how pertinent risks were analyzed;

c. Rationale for degree of rigor in analyzing different blocks of business (include in the rationale the level of "materiality" that was used in determining how rigorously to analyze different blocks of business);

d. Criteria for determining asset adequacy (include in the criteria the precise basis for determining if assets are adequate to cover reserves under "moderately adverse conditions" or other conditions as specified in relevant actuarial standards of practice); and

e. Whether the impact of federal income taxes was considered and the method of treating reinsurance in the asset adequacy analysis;

4. Summary of material changes in methods, procedures, or assumptions from prior year's asset adequacy analysis;

5. Summary of results; and

6. Conclusions.

C. Details of the Regulatory Asset Adequacy Issues Summary

1. The regulatory asset adequacy issues summary shall include:

a. Descriptions of the scenarios tested (Section 7.D. of this regulation) and the sensitivity testing done relative to those scenarios. If negative ending surplus

results under certain tests in the aggregate, the actuary should describe those tests and the amount of additional reserve as of the valuation date which, if held, would eliminate the negative aggregate surplus values. Ending surplus values shall be determined by either extending the projection period until the in-force and associated assets and liabilities at the end of the projection period are immaterial or by adjusting the surplus amount at the end of the projection period by an amount that appropriately estimates the value that can reasonably be expected to arise from the assets and liabilities remaining in-force;

b. The extent to which the appointed actuary uses assumptions in the asset adequacy analysis that are materially different than the assumptions used in the previous asset adequacy analysis;

c. The amount of reserves and the identity of the product lines that had been subjected to asset adequacy analysis in the prior opinion but were not subject to analysis for the current opinion;

d. Comments on any interim results that may be of significant concern to the appointed actuary. For example, the impact of the insufficiency of assets to support the payment of benefits and expenses and the establishment of statutory reserves during one or more interim periods;

e. The methods used by the actuary to recognize the impact of reinsurance on the company's cash flows, including both assets and liabilities, under each of the scenarios tested; and

f. Whether the actuary has been satisfied that all options whether explicit or embedded, in any asset or liability (including but not limited to those affecting cash flows embedded in fixed income securities) and equity-like features in any investments have been appropriately considered in the asset adequacy analysis.

2. The regulatory asset adequacy issues summary shall contain the name of the company for which the regulatory asset adequacy issues summary is being supplied and shall be signed and dated by the appointed actuary rendering the actuarial opinion.

D. Required Interest Scenarios

For the purpose of performing the asset adequacy analysis required by this regulation, the qualified actuary is expected to follow all appropriate Actuarial Standards of Practice. In addition, the appointed actuary, for each Colorado domestic insurer, must consider, in any analysis incorporating cash flow testing as the basis for the asset adequacy analysis, the effect of at least the following interest rate scenarios:

1. Level with no deviation;

2. Uniformly increasing over ten (10) years at a half percent per year and then level;

3. Uniformly increasing at one percent per year over five (5) years and then uniformly decreasing at one percent per year to the original level at the end of ten (10) years and then level;

4. An immediate increase of three percent (3%) and then level;

5. Uniformly decreasing over ten (10) years at a half percent per year and then level;

6. Uniformly decreasing at one percent per year over five (5) years and then uniformly increasing at one percent per year to the original level at the end of ten (10) years and then level; and

7. An immediate decrease of three percent (3%) and then level.

For these and other scenarios that may be used, projected interest rates for a five (5) year Treasury Note need not be reduced beyond the point where such five (5) year Treasury Note yield would be at fifty percent (50%) of its initial level.

The beginning interest rates may be based on interest rates for new investments as of the valuation date similar to recent investments allocated to support the product being tested or be based on an outside index, such as Treasury yields, of assets of the appropriate length on a date close to the valuation date. Whatever method is used to determine the beginning yield curve and associated interest rates should be specifically defined. The beginning yield curve and associated interest rates should be consistent for all interest rate scenarios.

E. Conformity to Standards of Practice.

The memorandum shall include this statement:

"Actuarial methods, considerations and analyses used in the preparation of this memorandum conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis for this memorandum."

F. Use of Assets Supporting the Interest Maintenance Reserve and the Asset Valuation Reserve.

An appropriate allocation of assets in the amount of the interest maintenance reserve (IMR), whether positive or negative, shall be used in any asset adequacy analysis. Analysis of risks regarding asset default may include an appropriate allocation of assets supporting the asset valuation reserve (AVR); these AVR assets may not be applied for any other risks with respect to reserve adequacy. Analysis of these and other risks may include assets supporting other mandatory or voluntary reserves available to the extent not used for risk analysis and reserve support.

The amount of the assets used for the AVR shall be disclosed in the Table of Reserves and Liabilities of the opinion and in the memorandum. The method used for selecting particular assets or allocated portions of assets shall be disclosed in the memorandum.

G. Documentation.

The appointed actuary shall retain on file, for at least seven (7) years, sufficient documentation so that it will be possible to determine the procedures followed, the analyses performed, the bases for assumptions and the results obtained.

Section 8 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 9 Enforcement

Noncompliance with this regulation may result~~, after proper notice and hearing,~~ in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of ~~fines~~ civil penalties, issuance of cease and desist orders, and/or

suspensions or revocation of license subject to the requirements of due process. ~~Among others, the penalties provided for in §10-3-1108, C.R.S. may be applied.~~

Section 10 Effective Date

This ~~amended~~ regulation ~~is~~ shall become effective on November 1, 201~~0~~7

Section 11 History

New regulation effective September 1, 1992.
Amended regulation effective September 1, 1994.
Amended regulation effective January 1, 2004.
Amended regulation effective November 1, 2010.
Amended Regulation effective November 1, 2017.

Notice of Proposed Rulemaking

Tracking number

2017-00265

Department

700 - Department of Regulatory Agencies

Agency

702 - Division of Insurance

CCR number

3 CCR 702-4 Series 4-7

Rule title

LIFE, ACCIDENT AND HEALTH, Series 4-7

Rulemaking Hearing

Date

08/01/2017

Time

02:00 PM

Location

1560 Broadway, Ste 110 D, Denver CO 80202

Subjects and issues involved

4-7-1 HEALTH MAINTENANCE ORGANIZATIONS

The purposes of this regulation are to provide the requirements for licensure as a health maintenance organization (HMO) and establish standards for HMO organization and operations.

Statutory authority

10-1-109, 10-16-109, 10-16-111, and 10-16-403(2)(b)

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DEPARTMENT OF REGULATORY AGENCIES

DIVISION OF INSURANCE

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Proposed Amended Regulation 4-7-1

HEALTH MAINTENANCE ORGANIZATIONS

Section 1 Authority

This regulation is promulgated under the authority of §§ 10-1-109, 10-16-109, 10-16-111, and 10-16-403(2)(b), C.R.S.

Section 2 Scope and Purpose

The purposes of this regulation are to provide the requirements for licensure as a health maintenance organization (HMO) and establish standards for HMO organization and operations.

Section 3 Applicability

This regulation applies to licensed HMOs or persons seeking to become licensed to operate an HMO in Colorado.

Section 4 Definitions

A. "NAIC" means, for the purposes of this regulation, the National Association of Insurance Commissioners.

B. "Material modification of the plan of operations" means and includes, for the purposes of this regulation, a change in service area, or the initial entrance or withdrawal from the Medicare, Medicaid or commercial market, or any other transaction or series of related transactions which the HMO could reasonably predict would involve a net increase or decrease of 20% or more in the number of HMO enrollees or result in a 20% increase or decrease in the HMO's net worth over a 12 month period based upon projected financial statements.

Section 5 Authorization of Insurers and Nonprofit Hospital, Medical-Surgical and Health Service Corporation

A. Any licensed health carrier may apply to the Division of Insurance to become licensed as an HMO, as defined in part 1 of article 16 of title 10, C.R.S. If a licensed health carrier is authorized to hold a certificate of authority to operate as an HMO, the requirements of part 4, article 16, title 10, C.R.S., will apply in addition to the other requirements for its health carrier certificate of authority.

B. Nothing herein shall be deemed to amend the intent or provisions of article 20 of title 10, C.R.S. Any HMO product offered by a licensed health carrier is not provided coverage and protection by the Colorado Life and Health Insurance Protection Association Act (§ 10-20-103(8), C.R.S.).

Section 6 Application for Licensure

Any person seeking licensure as an HMO shall submit two copies of an application to the Corporate Affairs Section of the Division of Insurance (Division). Applications shall include all items as required under § 10-16-401(4), C.R.S., and the following:

A. A list of all persons who will ultimately control the proposed HMO. If the proposed HMO is organized as a stock company, the application must identify all persons who directly or indirectly will own or control ten percent or more of the outstanding stock.

B. Biographical sketches of all the official persons of the organization, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association, officers, directors, organizers and controlling individuals. Biographical information shall be submitted on the NAIC Biographical Affidavit (form available upon request). A complete fingerprint set, as may be obtained from local law enforcement sources may be requested at the discretion of the Commissioner. Any person who has been involved with any adverse administrative action within the prior five years shall disclose such activity in the biographical affidavit.

C. The addresses of company offices and the HMO functions to be performed by each office, including sufficient information to verify compliance with the provisions of § 10-3-128, C.R.S.

D. A statement as to whether the HMO will be seeking Federal qualification.

E. Current financial information and three (3) year financial projections, including balance sheets and income statements, conforming to the format of the NAIC convention blank. The projections shall also contain projected member-month enrollment at calendar year end and a detailed summary of all assumptions used to generate the projections.

F. A description of the method of marketing including, at a minimum, proposed advertisements, solicitation material, use of brokers and agents, use of HMO staff, and marketing research that will indicate the ability to meet the enrollment projections.

G. Proposed enrollment and/or application forms.

H. An actuarial opinion supporting the proposed premiums or rates to be charged and the underlying actuarial report reflecting the methodology and assumptions used in arriving at the rates used within the projections. The opinion and report must be prepared using generally accepted actuarial standards and principles.

I. A description of the geographic service area by county. Where the service area will be a part of a county, appropriate zip codes may be used to describe the service area.

J. A list of contracting providers, by specific geographic area and by specialty within each geographic area along with a map clearly indicating the service area. If there are no providers or specialty providers within a specific geographic service area, a separate description of the method of providing covered services in said service area, or part thereof, shall be provided.

K. An access plan for each separate network.

L. A description of the provider network arrangements, including copies of specimen contracts. This description should include the due diligence procedures to be performed by the HMO to ensure performance of the services by the participating providers.

M. A detailed description of the sources of funding of the HMO.

N. The filing fees as required by § 10-3-207, C.R.S.

O. Evidence that the applicant meets the minimum surplus requirements found at § 10-16-411, C.R.S.

P. Evidence that the applicant meets the statutory deposit requirements found at § 10-16-412, C.R.S.

Q. Evidence that the applicant meets the requirements for the maintenance of a complaint system as found at § 10-16-409, C.R.S.

R. Evidence that the applicant meets the requirements for establishing and maintaining an ongoing quality assurance program as found at § 10-16-402(1)(b)(II), C.R.S.

~~O~~S. An application for licensure as a foreign HMO must also include the following:

1. The most recent financial examination report conducted by the state of domicile.

2. The most recent market conduct report ~~conducted by the state of domicile~~ issued concerning the applicant.

3. An original certificate of compliance or a certified copy of the certificate of authority from the state of domicile referencing the approved lines of authority.

4. An explanation of any limitations imposed by the state of domicile.

5. Disclosure of any administrative action currently pending or taken against the company within the last five (5) years.

Section 7 Organizational Changes

A. An HMO requesting a material modification in the plan of operations on file with the Division, shall provide two copies of the following:

1. The financial statement for the HMO prepared within 90 days prior to the date of request for a modification in the plan of operations.

2. To the extent applicable with regard to the modification, a list of providers under contract or who have committed to contracting with the HMO and a description of the provider network arrangements, including specimen copies of provider contracts. This description shall provide due diligence procedures to be performed by the HMO to ensure performance of the services by the participating providers.

3. Three year financial projections disclosing the impact of the modification in the HMO operations. Include balance sheets and income statements which conforms to the format of the NAIC convention blank. The projections shall also contain projected member-month enrollment at calendar year end and a detailed summary of all assumptions used to generate the projections.

4. To the extent applicable with regard to the modification, a Memorandum and certification by a qualified actuary, supporting the proposed premiums or rates to be charged in the new service area(s) or for the new market.

    a. The certification shall include a statement that the rates are not excessive, inadequate or unfairly discriminatory.

    b. In the Memorandum, the actuary shall discuss the differences in provider agreements to the extent that the agreements affect the underlying premium or rate requirements.

    c. The Memorandum shall include justification and support for the difference, or lack of difference, between the rates to be charged for the new market or service area(s) and the existing rate(s).

    d. If the new operations include Medicaid business or other business in which the premium is set by the contract holder and not the HMO, the Memorandum shall provide justification that the premium received will be at least equal to the company's medical and administrative costs. If the actuary cannot provide such a justification the HMO shall provide an adequate explanation as to why the HMO would accept a premium which is not at least equal to the company's medical and administrative costs.

B. An HMO requesting to modify its approved plan of operations on file with the Division by withdrawing from the geographic service area or a market, shall provide two copies of the following:

1. A statement as to why the HMO is withdrawing from a service area or market.

2. Evidence that there will no longer be any enrollment in the portion of the service area at the time of the proposed withdrawal. Such elimination of enrollment in the affected area may be accomplished by nonrenewal according to Colorado statutes and regulations or by any other means acceptable to the Commissioner.

3. An affidavit that the HMO will honor existing coverage for any enrollee hospitalized on the date of such withdrawal from the portion of the geographic service until the date of discharge or arrangements are made for alternative coverage.

C. Changes to the basic organizational documents, such as articles of incorporation and related documents, shall be filed with the Corporate Affairs Section and approved by the Commissioner before filing appropriate documents with the Colorado Secretary of State.

Section 8 Fidelity Bond

Pursuant to § 10-16-405, C.R.S., the funds received from enrollees must be treated in a fiduciary capacity. In order to protect the HMO enrollees from misuse of enrollee funds, an HMO licensed in Colorado shall have fidelity coverage, meeting the requirements of Regulation 3-1-1 (3 CCR 702-3), for all officers, directors and employees who have access to the HMO funds.

Section 9 Reinsurance

A. An HMO may enter into reinsurance agreements under which its risks are indemnified by an insurer. Such agreements must conform to the provisions of §10-3-~~118~~701 et seq., C.R.S., and Colorado Insurance Regulations 3-3-3 and 3-3-4 (3 CCR 702-3).

B. Section 10-3-~~118~~701 et seq, C.R.S., provides that an HMO may assume risks from another HMO provided it is licensed or authorized to write the type of coverage assumed.

C. An HMO may only assume contract obligations from another HMO with the Commissioner's prior written approval. Any assumption transaction shall follow the provisions of § 10-3-701, et seq., C.R.S., and Colorado Insurance Regulation 3-3-1 (3 CCR 702-3). ~~In all transactions subject to the provisions of § 10-3-701, et seq.,~~ Tthe assuming HMO must be licensed in the ceding HMO's service area and must demonstrate the ability to service the proposed acquisition and continue to meet compliance with the availability, accessibility and quality of care requirements.

Section 10 Subordinated Debentures

A. An HMO may enter into loans or similar obligations, for cash or liquid securities received, which may be treated as surplus, pursuant to § 10-16-411(1), C.R.S. These arrangements shall be in a form acceptable to the Commissioner and must comply with the following:

1. Any such obligation must be approved by the Commissioner prior to entering into the final contract.

2. The contract must contain language that it shall not be paid in whole or in part, whether as to principal or interest, or converted, without the Commissioner's prior written approval.

3. The contract must contain language that repayment may only be made from available funds in excess of the net worth required by the Division of Insurance.

B. No loan or advance made under the provisions of this section or interest accruing thereon shall form a part of the legal liabilities of the HMO until authorized for payment by the Commissioner, but, until such authorization, all statements published by the HMO or filed with the Commissioner shall show the amount thereof then remaining as a special surplus account.

Section 11 Guarantees for Uncovered Expenditures

An HMO may have financial arrangements under which uncovered expenditures are guaranteed by a third party in the event of insolvency or nonpayment by the HMO. Such arrangements require prior written approval by the Commissioner. At a minimum, the following criteria must be met:

A. The guarantor must demonstrate a net gain from operations or positive income for each of the five years prior to entering into the guarantee.

B. The guarantee must contain a provision that if the Commissioner determines that the HMO cannot meet its obligations as they become due and payable, the Commissioner may, without notice, call on the guarantor to immediately meet the HMO's applicable net worth requirements.

C. A guarantee may not provide for fees or interest charges for placing the guarantee, keeping the guarantee in place or terminating the guarantee. Agreements with such provisions will be considered subordinated debentures or loans.

D. The guarantor must maintain a minimum net worth equal to the greater of $5,000,000 (five million dollars) or 6 months of the operating expenses of the HMO in excess of the guaranteed amount. For the purposes of this Subsection, net worth shall be limited to tangible assets less liabilities.

E. The guarantor must demonstrate that it has the experience, financial strength and access to capital to serve as a guarantor.

F. The guarantor must agree to file audited financial statements with the Division of Insurance for each year the guarantee is in place. Upon initial filing for approval for the guarantee, the most recent audit report must be submitted.

Section 12 Provider Agreements

A. An HMO must establish that executed agreements between the HMO and the providers exist prior to licensure or granting of approval for an increase in geographic service area. Provider agreements must be maintained in Colorado in the HMO's administrative office or other designated office for examination and shall be made available to the Commissioner upon request.

B. In order to qualify as a covered expenditure, a provider, intermediary, IPA or other provider group contract or provider subcontract must have a "hold harmless" provision which substantially complies with the following:

1. Provider agrees that in no event, including but not limited to nonpayment by the HMO, insolvency of the HMO or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a subscriber, an enrollee or persons (other than the HMO) acting on his/their behalf for services provided pursuant to this agreement. This provision does not prohibit the provider from collecting supplemental charges or copayments or fees for uncovered services delivered on a 'fee-for-service' basis to HMO subscribers/enrollees.

2. Provider agrees that this provision shall survive the termination of this agreement, for authorized services rendered prior to the termination of this agreement, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the HMO subscriber/enrollees. This provision is not intended to apply to services provided after this agreement has been terminated.

3. Provider agrees that this provision supersedes any oral or written contrary agreement now or existing hereafter entered into between the provider and the subscriber, enrollee, or persons acting on their behalf insofar as such contrary agreement relates to liability for payment of services provided under the terms and conditions of this agreement.

4. Any modification, addition, or deletion to this provision shall become effective on a date no earlier than thirty (30) days after the Commissioner has received written notification of proposed changes.

C. Every contract between an HMO and a provider shall contain a provision clearly setting forth the HMO's reimbursement arrangements with the participating provider, including any financial risk assumed by the participating provider. An HMO shall maintain evidence that it took reasonable steps to ascertain that the provider understands such arrangements and that the HMO has determined that the provider is capable of undertaking the financial risk assumed.

D. HMOs may only transfer financial risk to providers for services which the provider performs, or services which such provider controls, directs or influences. Out of network emergency services are not controlled, directed or influenced by the provider and financial risk for such services may not be transferred. Any individual arrangement may be submitted to the Commissioner to be reviewed on a case by case basis to determine its acceptability.

E. An HMO shall have available a continuous program and procedure for review of providers ensuring their ability to provide contracted services. At a minimum this program must include the following:

1. Financial review of intermediaries and providers accepting risk for services which they do not control, direct or influence directly from the HMO.

2. Review all provider subcontract specimen forms for compliance with applicable insurance statutes and regulations, availability of services and evaluation of risk transfers.

3. Procedures for review of the timely and accurate compensation of providers pursuant to contract.

4. Review of quality management, utilization review, credentialing and other health care management services, if being conducted by the intermediary, provider or subcontracting provider. The procedures and practices used must be the same as those approved for the HMO by the Executive Director of the Colorado Department of Public Health and Environment.

5. Procedures for assuring continuity of care and for making payments to subcontracting providers in the event of the insolvency of an intermediary or provider

6. The reviews in subsections 1. through 5., above, shall occur upon initial contracting with the intermediary, provider or subcontracting provider. Subsequent reviews shall be undertaken at least annually. Additional reviews should be undertaken as necessary based upon: (1) the results of previous reviews of the intermediary, provider or subcontracting provider; or (2) complaints from enrollees or providers or (3) other information which may impact the intermediary's ability to provide services or pay subcontractors.

Section 13 Administrative and Other Service Agreements

A. An HMO may contract for the performance of administrative functions. Any contract for administrative functions shall contain the following:

1. Ninety (90) days written notice of cancellation to the Commissioner;

2. A provision that the contract may not restrict the HMO's Board of Directors from appointing, removing or changing officers or employees of the HMO;

3. A statement of the administrator's compensation, duties and responsibilities;

4. State that all books, records, assets, and liabilities of the HMO shall, at all times, remain the property of the HMO; and

5. If the HMO contracts for Electronic Data Processing (EDP) and/or Management Information Systems (MIS), a provision providing appropriate access to the system upon examination by the Commissioner, and a mechanism under which the system is available to the HMO or its successor upon insolvency of the HMO, or termination or cancellation of the contract.

B. All management agreements and any material amendments thereto shall be filed with the Division of Insurance for review 30 days prior to the effective date. Agreements filed in compliance with §10-3-805(14)(~~a~~b)(IV), C.R.S., need not be filed under this regulation. For purposes of this regulation, management agreements mean any agreements between the HMO and any entity or person not employed by the HMO for the purpose of managing the day to day operations of the HMO.

C. An HMO may offer administrative or other services to another person to the extent not inconsistent with the provisions of article 16 of title 10, C.R.S., provided that:

1. The provider network is sufficient to absorb any enrollment from such action and the availability, accessibility and quality of the services to the HMO's enrollees are not impaired;

2. The arrangement entered into may be terminated by the HMO if such obligation substantially interferes with the HMO's operations or its ability to maintain compliance with law; and

3. The contract shall constitute the HMO's entire service obligation and shall be filed with the Commissioner.

Section 14 Administrative Reports

An HMO shall provide the following reports to the Commissioner no less frequently than annually:

A. A report that compiles, evaluates, and provides statistics relating to the cost of the HMO's operations, including the pattern of utilization of its serves, and the availability and accessibility of services, as required by § 10-16-402(1)(b)(II), C.R.S.; and

B. A report containing the information on the HMO's complaint system as required by by § 10-16-409(1)(b), C.R.S.

Section 15 Financial Reports

A licensed health carrier also licensed as an HMO shall include the following exhibits of the HMO convention blank detailing their HMO activities as appendices to its NAIC convention blank filing:

A. The income and loss statement for total business and Colorado business;

B. The enrollment report for total business and for Colorado business;

C. The schedule reflecting health care receivables for total business and Colorado business;

D. The claims payable analysis for total business and Colorado business;

E. The summary of transactions with providers for total business and Colorado business; and

F. Any other form of the NAIC blank the Commissioner requires to analyze the business of the HMO including, but not limited to, electronic filing.

Section 156 Property Acquisitions

Section 10-16-403(1), C.R.S., provides that an HMO may acquire property which may reasonably be required for its administrative offices or for such other purposes as may be necessary to accomplish the business of the organization. The following rules apply in order to meet the requirements of § 10-16-403(2), C.R.S., regarding the prior approval of property purchases. Any property acquired without filing a notification, other than as outlined herein, shall be nonadmitted for statutory accounting purposes.

A. For acquiring real property, e.g. hospitals, medical facilities, nursing care and intermediate care facilities, an HMO must file, at least 30 days prior to acquisition, notice of its intent to acquire property. The filing shall include a description of:

1. The nature of the real property;

2. The location of the real property;

3. Method of acquisition (build new facility, remodel existing facility, etc.);

4. How the property contributes to the accomplishment of the nature of the HMO's business; and

5. An estimate of the amount to be expended and source of funding (i.e. loans, operating funds, etc.).

B. Electronic data processing equipment and software shall be admitted and valued in accordance with the statements of statutory accounting principles contained in the National Association of Insurance Commissioners Accounting Practices and Procedures Manual.

C. The HMO may acquire property which is other than real property and which is used in the direct delivery of health care services, such as pharmaceuticals and surgical supplies, durable medical equipment, furniture, medical equipment and fixtures, and leasehold improvements in health care facilities.

1. Furniture, medical equipment and fixtures and leasehold improvements in health care facilities must meet the following conditions in order to qualify as an admitted asset

a. useful life of at least two (2) years; and

b. cost of more than $500.00.

2. The aggregate admitted value of all property other than real property is limited to the lesser of 5% of assets or 25% of surplus.

3. The Commissioner may waive the aggregate limitations of subsection 2. above. A request for waiver must include:

a. A detailed list and cost of each item;

b. An explanation of why the property is necessary for the conduct of the business of the HMO;

c. A statement as to why the request would not result in a deterioration of the liquidity or solvency of the HMO; and

4. Property other than real property shall be carried at the lesser of cost at the time of request less accumulated depreciation or the market value at the time of valuation, unless it is an asset whose method of valuation is specified in the insurance laws, regulations, or nationally recognized insurance statutory accounting principles.

5. The admissibility of property other than real property is subject to review and restriction of admissibility when the net worth of an HMO, less the admitted value of property subject to this section, is below the statutory minimum net worth as required by § 10-16-411, C.R.S., or if such property will cause a hazardous financial condition as determined by Colorado Insurance Regulation 3-1-7 (3 CCR 702-3).

6. A licensed health carrier, also authorized to hold a certificate of authority directly to operate an HMO, is restricted to the property which is admitted under rules applicable for the certificate of authority of the licensed health carrier.

D. The admitted value of property, other than real property acquired and admitted prior to January 1, 2001, which is not used in the direct delivery of health care services, may be phased out over a period not to exceed three years. The rate for phasing out the admitted value of such property shall be documented in the HMO's records, available for examination by the Division.

Section 167 Confidentiality

A. Except as set forth in statute or regulation, documents filed with the Division of Insurance shall generally be considered public records under the Public Records Act, § 24-72-201, et. seq., C.R.S.

B. If an HMO considers a document to be confidential, it must submit the document under separate cover or in a file clearly labeled "CONFIDENTIAL" and a completed ~~Vaughn~~ Confidentiality Index explaining why the document is considered confidential.

C. Documents found to be confidential by the Division of Insurance, will be maintained in a separate, confidential file and will not be released to the general public for inspection or copying.

Section 17 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 18 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 19 Effective Date

This amended regulation shall become effective on October 1, 2012~~2~~7

Section 20 History

Originally issued as regulation 74-21 effective 1974

Re-codified as Regulation 4-7-1 effective December 1, 1993
Amended regulation effective September 1, 1999
Amended regulation effective July 1, 2001
Amended regulation effective January 31, 2003
Amended regulation effective October 1, 2012
Amended regulation effective October 1, 2017

Notice of Proposed Rulemaking

Tracking number

2017-00256

Department

1000 - Department of Public Health and Environment

Agency

1014 - Colorado State Board of Health

CCR number

6 CCR 1014-4

Rule title

COLORADO HEALTH CARE PROFESSIONAL CREDENTIALS APPLICATION

Rulemaking Hearing

Date

08/16/2017

Time

09:00 AM

Location

Northeast Colorado Health Department, 700 Columbine Street, Auditorium, Sterling CO 80751

Subjects and issues involved

This rulemaking concerns a series of technical edits to existing Credential Appplication questions to clarify and improve the application process.

Statutory authority

Section 25-1-108.7, C.R.S.

Contact information

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To: Members of the State Board of Health

From: George Dikeou, Chairman Health Care Credentialing Application Review Committee

Date: June 21, 2017

Subject: **Request for Rulemaking Hearing**
Proposed Amendments to the Colorado Health Care Professional Credentials Application, 6 CCR 1014-4, with a request for a rulemaking hearing in August of 2017

The Applications Review Committee (Committee) is mandated by statute to meet once a calendar year to receive input from the public as well as consider changes to the Professional Credentials Application (Application). The committee met on February 28, 2017 and recommended the noted changes to the Board of Health and requests that these adopted changes be made to the application.

Al Schwindt and I are happy to address any questions and concerns you may have about the Application and the proposed Amendments.

Thank you for your consideration and cooperation.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to
Colorado Health Care Professional Credentials Application
6 CCR 1014-4
June 21, 2017

Basis and Purpose.
The Health Care Credentials Application Review Committee, per § 25-1-108.7, C.R.S., recommends the Colorado Health Care Professional Credentials Application be amended as indicated on the revised document. Some changes relate to formatting, correcting typographical errors and clarifying the application form. The substantive proposed changes are:

- General Instructions, Statement #10., is amended to state "Any gaps of time greater than thirty (30) days during the last ten years to the present date must be accounted for before your Application will be considered complete." The recommendation came from the representative of CAMSS, the Colorado Association of Medical Staff Support and the committee agreed with the change. The revision clarifies the time frame for including affiliations and work history and maintains consistency with similar requests in the application.

- Section V, Education Since High School, Section E, Faculty Positions, is amended to include the word "compensated" after the words "List all" and before the word "academic". The recommendation came from a representative of Centura Health Physician Group, a guest from the credentialing community, and was validated by the representative of CAMSS and the committee agreed with the change. The revision identifies whether a Faculty position was paid or unpaid because some institutions only do verification if the practitioner was compensated.

- Section XII, Attestation Questions, Question C 1 and C 2, are amended regarding an involuntary resignation, termination or surrender of medical staff privileges or employment from a hospital, group practice or other health care facility or medical staff, and if so was it to avoid disciplinary action or investigation or while under investigation or pending investigation. The revision was suggested by the representative of CAMSS to provide clarity and the Committee agreed to revise the questions accordingly on the application to:

  C. 1. Have you ever involuntarily resigned, terminated or surrendered medical staff privileges or employment form a hospital, group practice or other health care facility or medical staff?
  Yes Date
  No
  C.2. Have you ever voluntarily resigned, terminated, or surrendered medical staff privileges or employment from a hospital, group practice or other healthcare facility or medical staff to avoid disciplinary action or investigation or while under investigation, or is such an investigation pending?
  Yes Date
  No

Given the nature of the application form, the form has been provided in its entirety. The proposed changes are noted in red text and yellow highlight.

The committee requests a December 15, 2017 effective date.

Specific Statutory Authority.
These rules are promulgated pursuant to the following statutes: § 25-1-108.7, C.R.S.

Is this rulemaking due to a change in state statute?

_____ Yes, the bill number is _____. Rules are ___ authorized ___ required.
___X__ No

Is this rulemaking due to a federal statutory or regulatory change?

_____ Yes
__X___ No

Does this rulemaking incorporate materials by reference?

_____ Yes
___X__ No

If "Yes," the rule needs to provide the URL of where the material is available on the internet (CDPHE website recommended) or the Division needs to provide one print or electronic copy of the incorporated material to the State Publications Library. § 24-4-103(12.5)(c), C.R.S.

Does this rulemaking create or modify fines or fees?

_____ Yes
__X___ No

REGULATORY ANALYSIS
for Amendments to
Colorado Health Care Professional Credentials Application
6 CCR 1014-4
June 21, 2017

1. A description of the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Health care professionals who are registered, certified or licensed by the state of Colorado, who are practicing or intend to practice and subject to credentialing are affected and will benefit by the proposed changes. There are no anticipated costs associated with these changes.

2. To the extent practicable, a description of the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   All changes are intended to provide clarification of information and data requested on the application and to provide consistent formatting of the document for easier understanding and use.

3. The probable costs to the agency and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   None.

4. A comparison of the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The effort required to update the application is minimal. The benefits of the proposed rule will make for a more user friendly and efficient document for credentialing purposes.

5. A determination of whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no costs. The changes do not make the rule any more or less intrusive.

6. Alternative Rules or Alternatives to Rulemaking Considered and Why Rejected.

   Because of how the statute is written, the application is in rule and thus, any changes to the application must occur with rulemaking.

7. To the extent practicable, a quantification of the data used in the analysis; the analysis must take into account both short-term and long-term consequences.

   These recommended changes address the feedback received from health care providers, various credentialing entities and health care professionals. Because professional credentialing is essential to the careers of each professional required to do so, clarity of questions asked, clarity of expected and anticipated answers and understanding of the process governs the Committee in making its recommendations to the Board.

STAKEHOLDER COMMENTS
for Amendments to
Colorado Health Care Professional Credentials Application
6 CCR 1014-4
June 21, 2017

State law requires agencies to establish a representative group of participants when considering to adopt or modify new and existing rules. This is commonly referred to as a stakeholder group.

Early Stakeholder Engagement:
The following individuals and/or entities were invited to provide input and included in the development of these proposed rules:

The Application Review Committee is comprised of individuals that represent a statewide association or society of physicians, a statewide association or society of Colorado hospitals, a statewide association or society of health plans, a professional liability insurance carrier that provides professional liability insurance to health care professionals in Colorado, a statewide association or society of Colorado health care medical staff service specialists, and advanced practice nurses. The Committee making these recommendations is representative of most, if not all, of the stakeholders who have an interest in the process or credentialing health care providers in Colorado. The committee is acting on feedback from credentialing entities and applicants.

Including committee members who represent the Colorado Medical Society, the Colorado Hospital Association, the Colorado Association of Health Plans, COPIC Insurance Company, the Colorado Association of Medical Staff Services and Advanced Practice Nurses, also represented and informed of the proposed rules are: Denise Ross and Tommy Lee of Centura Health Physician Group, Alexis Comrack and Randi Chapman of Council of Affordable Quality Healthcare, Inc. (CAQH), Fabiola Medina and Jody Leonnig of Banner Health, Kathryn Wessler and Bonnie Gutierrez of Centura Health, Danielle Roper of ICON Eyecare, Gail Lewis of Orion Health, Renee Holmes of CU Medicine, Al Schwindt and Rhiannon Tryon of COPIC.

Stakeholder Group Notification
The stakeholder group was provided notice of the rulemaking hearing and provided a copy of the proposed rules or the internet location where the rules may be viewed. Notice was provided prior to the date the notice of rulemaking was published in the Colorado Register.

__X__ Not applicable. This is a Request for Rulemaking Packet. Notification will occur if the Board of Health sets this matter for rulemaking.

____ Yes.

Summarize Major Factual and Policy Issues Encountered and the Stakeholder Feedback Received. If there is a lack of consensus regarding the proposed rule, please also identify the Department's efforts to address stakeholder feedback or why the Department was unable to accommodate the request.

These changes are proposed by the review committee. To date, no major factual or policy issues were encountered. The changes streamline the application and protect the privacy of applicants.

Please identify health equity and environmental justice (HEEJ) impacts. Does this proposal impact Coloradoans equally or equitably? Does this proposal provide an opportunity to advance HEEJ? Are there other factors that influenced these rules?

There are no health equity or environmental justice concerns. The application treats all healthcare professionals similarly and the benefit of uniform credentialing impacts Coloradoans similarly.

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Adopted by the State Board of Health effective proposed date 12/15/17

State Board of Health

6 CCR 1014-4

COLORADO HEALTH CARE PROFESSIONAL CREDENTIALS APPLICATION

This is the Colorado healthcare professional credentials application. The Colorado legislature has mandated that all health care entities and all health care plans engaged in the collection of information to be used in the process of credentialing of health care professionals use this form (C.R.S. § 25-1-108.7).

This uniform application has been designed to allow each credentialing entity to receive from you core credentialing information needed in common by all of them, without duplication.

THIS UNIFORM APPLICATION HAS BEEN DESIGNED TO ALLOW EACH PRACTITIONER TO COMPLETE A SINGLE FORM WITH CORE INFORMATION FOR SUBMISSION TO EACH CREDENTIALING ENTITY TO WHICH THE PRACTITIONER IS APPLYING. This application need not be used for case specific temporary privileges.

Each credentialing entity may require additional, non – duplicative credentials information, if it is deemed by them to be essential to the completion of their credentialing process.

A healthcare professional by law, means any physician, dentist, dental hygienist, chiropractor, podiatrist, psychologist, advanced practice nurse, optometrist, physician assistant, licensed clinical social worker, child health associate, marriage and family therapist, or any other health care professional who is registered, certified or licensed by the state of Colorado, who practices, or intends to practice, in Colorado, and who is subject to credentialing.

Those credentialing entities that are required to use this uniform application are:

1) A health care facility or other health care organization licensed or certified to provide medical or health services in Colorado;
2) A health care professional partnership, corporation, limited liability company, professional services corporation or group practice;
3) An independent practice association or physician-hospital organization;
4) A professional liability insurance carrier; or
5) An insurance company, health maintenance organization, or other entity that contracts for the provision of health benefits.

No State of Colorado licensing or certification board is required to use this uniform application.

The reason Colorado has mandated the use of this uniform application is to reduce health care costs and duplication.

COLORADO HEALTH CARE PROFESSIONAL CREDENTIALS APPLICATION

This application form should be used for both initial credentialing and re-credentialing purposes. PRIOR TO COMPLETING THIS APPLICATION FORM, PLEASE READ AND OBSERVE THE FOLLOWING:

GENERAL INSTRUCTIONS

1. Please type or print your responses legibly.
2. Please note that modification to the wording or format of this Application will invalidate it. Use of any form of correctional fluid or tape is not acceptable.
3. All information requested must be FULLY and TRUTHFULLY provided.
4. Any changes to your responses must be lined through, initialed and dated. Use of any form of correctional fluid or tape is not acceptable.
5. If an entire section does not apply to you, then please check the box provided at the top of that section to indicate that the section does not apply to you.
6. If a particular question does not apply to you, then write "N/A" in the answer blank. If there are multiple, repetitive answer blanks in a particular section (as, for example, in the section entitled "Residencies and Fellowships"), it is not necessary to mark "N/A" in each unneeded answer blank.
7. Unless *specifically permitted* by a particular question, please understand that a reference to "See CV" for an answer is not appropriate.
8. **If you need more space to answer a question completely, please attach additional paper. Include the section and page number of the question being answered as well as your name (printed) on each additional sheet. Attach all additional sheets to this application.**
9. After the Application has been completed in its entirety but *before* you sign and date it, MAKE A COPY OF THE APPLICATION TO RETAIN IN YOUR FILES AND/OR COMPUTER FOR FUTURE USE. In so doing, at the time of a submission to all Credentialing Entities as identified on Page 1, all you will need to do is to check to ensure that all the information remains complete, current and accurate before signing and forwarding the Application as needed.
10. Any gaps of time greater than thirty (30) days deletefrom completion of health care professional school addduring the last ten years to the present date must be accounted for before your Application will be considered complete.
11. Please sign and date the Application prior to mailing.
12. Please sign and date Schedule A.
13. Mail the Application, Schedule A, any attached sheets prepared in order to answer any question(s) completely as well as a copy of all applicable enclosures listed on pages 3 and 26 to the Healthcare Entity to which you are submitting this application.
14. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law and that they will conform to both HIPAA, ADA and other applicable laws and regulations.
15. All signatures *must be* original or electronic equivalent. Stamp signatures are not acceptable.

GENERAL INSTRUCTION – continued

If requested by your credentialing entity for purposes of credentialing or re-credentialing, please include a current copy of the following documents:

A. State Professional License(s).
B. Federal Narcotics License (DEA Registration).
C. All applicants must submit a resume or curriculum vitae, whichever is appropriate, with complete professional history in chronological order (month and year).
D. Diplomas and/or certificates of completion (e.g., medical school, internship, residency, fellowship, nursing, dental or other healthcare professional school).
E. Diplomat of National Board of Medical Examiners or Educational Commission for Foreign Medical Graduates (ECFMG) Certificate (if applicable).
F. Specialty/Subspecialty Board Certification or letter from Board(s) stating your status (if applicable).
G. Certificate of Insurance.
H. Military Discharge Record (Form DD-214) (if applicable).
I. Certificates for Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), Advanced Trauma Life Support (ATLS), Pediatric Advanced Life Support (PALS) and Neonatal Resuscitation Program (NRP).
J. CME transcripts/certificates

COLORADO HEALTH CARE PROFESSIONAL CREDENTIALS APPLICATION FORM

I. Identifying Information *Please provide your full legal name.*

A. Last Name(include suffix, Jr., Sr., III): First: Middle: Title:

B. Other name used (e.g., maiden name, nickname)? ☐Yes ☐ No
Name: Dates used (mm/dd/yyyy): From: To:
Name: Dates used (mm/dd/yyyy): From: To:
Name: Dates used (mm/dd/yyyy): From: To:

C. Home Address:

City: State: Zip:

D. Home Telephone Number: Cell Phone: Email Address:

E. Social Security Number: Place of birth: National Provider Identifier Number:

II. Current Practice Setting(s) *Use additional copies of this Part II to list any additional practice sites*

A. Primary Practice Location

Name of Clinical Practice: _____

Clinical Practice Street Address: _____

_____

City: _____ County: _____ State: __ Zip: _____

Type of Practice Setting:
☐ Solo ☐ Group/Single Specialty ☐ Group/Multi-Specialty ☐ Hospital Based ☐ Other

Start Date at Location (mm//yy): _____

Office Telephone Number: _____ Office Fax Number: _____ Patient Appointment Telephone Number: _____

Mailing Address (if different from above): _____

City: _____ St: __ Zip: _____

Office Manager/Administrative Contact: _____
Office Manager's Telephone Number: _____
Office Manager's Fax Number: _____
Email Address: _____

Credentialing Contact: _____
Telephone Number: _____
Fax Number: _____
Email Address: _____

Answering Service Number: _____ Pager Number: _____

Office Email Address: _____ Practice Website: _____

Federal Tax ID Number for this Practice Address: _____

Name Affiliated with Tax ID Number: _____

Practice National Provider Identifier Number: _____

Applicant's Medicare Provider Number: _____

Applicant's Colorado Medicaid Provider Number: _____

Office Hours (enter time as Hour:Minute and indicate am or pm for each):

Monday _____ am pm . . . to _____ am pm
Tuesday _____ am pm . . . to _____ am pm
Wednesday _____ am pm . . . to _____ am pm
Thursday _____ am pm . . . to _____ am pm
Friday _____ am pm . . . to _____ am pm
Saturday _____ am pm . . . to _____ am pm
Sunday _____ am pm . . . to _____ am pm

Languages:
Please list all languages other than English (including sign language and type) available in this office.
_____

Billing Address – *if different from your primary practice site address*:
_____
City: _____ St: __ Zip**:** _____

B. Other Practice Location ☐Not Applicable
Name of Clinical Practice:
_____
Clinical Practice Street Address:
_____
_____
City:
_____
Type of Practice Setting: ☐Group/Multi-Specialty ☐ Solo ☐ Hospital Based ☐ Group/Single Specialty ☐Other
Start Date at Location (mm/yy): _____
County: _____ State: __ Zip: _____
Office Telephone Number: _____
Office Fax Number: _____
Patient Appointment Telephone Number: _____

Mailing Address (if different from above):
_____
City: _____ St: __ Zip: _____

Name of Office Manager/Administrative Contact: _____
Office Manager's Telephone Number: _____
Office Manager's Fax Number: _____

Answering Service Number: _____ Pager Number: _____
Office Email Address**:** _____

Federal Tax ID Number for this Practice Address: _____

Name Affiliated with Tax ID Number: _____

Practice National Provider Identifier Number: _____
Add Applicant's Medicare Provider Number: _____
Add Applicant's Colorado Medicaid Provider Number: _____

Office Hours (enter time as Hour:Minute and indicate am or pm for each):

Monday _____am pm . . . to _____ am pm
Tuesday _____ am pm. . . to _____ am pm
Wednesday _____ am pm . . . to _____ am pm
Thursday _____ am pm . . . to _____ am pm
Friday _____ am pm . . . to _____ am pm
Saturday _____ am pm . . . to _____ am pm
Sunday _____ am pm. . . .to _____ am pm

Languages: *Please list all languages other than English (including sign language & type) available in this office.*

Billing Address – *if different from your primary practice site address*:

City: _____ St: __ Zip: _____

III. Call Coverage ***Please list all persons with whom you have made arrangement for call coverage.***

☐ Not Applicable If not applicable, please explain why:

Name/Address:	Specialty:

IV. Licenses/Registrations/Certificates ***List all state health care licenses, registrations, certificates and advanced practice registry as well as other relevant numbers, including pending, expired and inactive.***

Practice Type–MD, DO, RN, APN etc: _____ Specialty: _____

List all sub specialties or areas of interest/emphasis: _____

Type of License, Certificate or Registration: _____
Number: _____
State/Institution: _____
Expiration Date (mm/yy): _____ Year Obtained: ____
☐ Active ☐ Inactive/Expired ☐ Pending
Year Relinquished: ____

Type of License, Certificate or Registration: _____
Number: _____
State/Institution: _____
Expiration Date (mm/yy): _____ Year Obtained: ____
☐ Active ☐ Inactive/Expired ☐ Pending
Year Relinquished: ____

Type of License, Certificate or Registration: _____
Number: _____
State/Institution: _____
Expiration Date (mm/yy): _____ Year Obtained: ____
☐ Active ☐ Inactive/Expired ☐ Pending
Year Relinquished: ____

DEA Registration Number: _____ Expiration Date (mm/yy): _____

Prescriptive Authority Number: _____ (APN, NP, CNM, CNS, CRNA only) Date Issued(mm/yy): _____

V. Education Since High School. Check the appropriate box (i.e., undergraduate, graduate, medical/professional) for each school attended.

A. Foreign Medical Graduate ☐Not Applicable

Educational Commission for Foreign Medical Graduates (ECFMG) Number: _____ Date Issued (mm/yy): _____

Other:
Fifth Pathway ☐Yes ☐No If Yes, please provide name and address of institution:

_____

Date of Attendance: From (mm/yy): _____ To: _____

B. Education *List in chronological order beginning with the earliest. Use additional copies of this Part V B. to list additional education other than post graduate, CME or clinical training courses.*

☐Undergraduate ☐Graduate ☐Medical /Professional

Complete School Name: _____

Degrees/Certification Received: _____ Graduation Date(mm/yy): _____

Course of Study or Major: _____

Address: _____

Email: _____ Telephone Number: _____ Fax Number: _____

Dates Attended: From (mm/yy): _____ To: _____ Program Completed? ☐Yes ☐ No
If no, please attach Explanation Form(s).

☐Undergraduate ☐ Graduate ☐Medical /Professional

Complete School Name: _____

Degrees/Certification Received: _____ Graduation Date(mm/yy): _____

Course of Study or Major: _____

Address: _____

Email: _____ Telephone Number: _____ Fax Number: _____

Dates Attended: From (mm/yy): _____ To: _____ Program Completed? ☐Yes ☐ No
If no, please attach Explanation Form(s).

☐ Undergraduate ☐ Graduate ☐Medical /Professional

Complete School Name: _____

Degrees/Certification Received: _____ Graduation Date(mm/yy): _____

Course of Study or Major: _____

Address: _____

Email: _____ Telephone Number: _____ Fax Number: _____

Dates Attended: From (mm/yy): _____ To: _____ Program Completed? ☐Yes ☐ No
If no, please attach Explanation Form(s).

☐ Undergraduate ☐ Graduate ☐Medical /Professional

C. Post Graduate Training *Check the appropriate box (i.e., internship, residency, fellowship) for each type of training. Use additional copies of this Part V C. to list additional post graduate training.* ☐ Not Applicable

☐ Internship ☐ Residency ☐ Fellowship

Institution Name: _____

Address: _____ City: _____

State/Country: _____ Zip: _____

Dates Attended (mm/yy): From: _____ To: _____ Program Completed? ☐Yes ☐ No

If no, please attach Explanation Form(s).

Specialty: _____ Date of Completion (mm/yy): _____

Name of Program Director: _____ Fax Number: _____

Telephone Number: _____ Email: _____

☐ Internship ☐ Residency ☐ Fellowship

Institution Name: _____

Address: _____ City: _____

State/Country: _____ Zip: _____

Dates Attended (mm/yy): From: _____ To: _____ Program Completed? ☐Yes ☐ No

If no, please attach Explanation Form(s).

Specialty: _____ Date of Completion (mm/yy): _____

Name of Program Director: _____ Fax Number: _____

Telephone Number: _____ Email: _____

☐ Internship ☐ Residency ☐ Fellowship

Institution Name: _____

Address: _____ City: _____

State/Country: _____ Zip: _____

Dates Attended (mm/yy): From: _____ To: _____ Program Completed? ☐Yes ☐ No

If no, please attach Explanation Form(s).

Specialty: _____ Date of Completion (mm/yy): _____

Name of Program Director: _____ Fax Number: _____

Telephone Number: _____ Email: _____

D. Other Clinical Training Programs *List those that are pertinent to your required privileges/practice (For example, preceptorship, procedural certificate course, etc.). Use additional copies of this part V. D to list additional clinical training.* ☐ Not Applicable

Institution Name: _____

Address: _____ City: _____

State/Country: _____ Zip: _____

Dates Attended (mm/yy): From: _____ To: _____ Date of Completion(mm/yy): _____

Specialty: _____ Certificate Awarded: _____

Did you complete the program? ☐Yes ☐No If no, please attach Explanation Form(s).

Name of Program Director: _____ Fax Number: _____

Telephone Number: _____ Email: _____

Institution Name: _____

Address: _____ City: _____

State/Country: _____ Zip: _____

Dates Attended (mm/yy): From: _____ To: _____ Date of Completion(mm/yy): _____

Specialty: _____ Certificate Awarded: _____

Did you complete the program? ☐Yes ☐No If no, please attach Explanation Form(s).

Name of Program Director: _____ Fax Number: _____

Telephone Number: _____ Email: _____

List Certifications (*provide copies – see page 3*)

☐ BLS (Basic Life Support)	Expiration Date (mm/yy): _____
☐ ACLS (Advanced Cardiac Life Support)	Expiration Date (mm/yy): _____
☐ ATLS (Advanced Trauma Life Support)	Expiration Date (mm/yy): _____
☐ PALS (Pediatric Advanced Life Support)	Expiration Date (mm/yy): _____
☐ NRP (Neonatal Resuscitation Program)	Expiration Date (mm/yy): _____
☐ Other _____	Expiration Date (mm/yy): _____
_____	Expiration Date (mm/yy): _____
_____	Expiration Date (mm/yy): _____
_____	Expiration Date (mm/yy): _____

E. Faculty Positions *List all addcompensated academic, faculty, research, assistantships or teaching positions you have held and the dates of those appointments. Use additional copies of part V. E and/or F to list additional faculty positions or CME.* ☐ Not Applicable

Institution Name: _____ Academic Rank/Title: _____

Address: _____ City: _____

State/Country: _____ Zip: _____

Dates Attended(mm/yy): From :_____ To: _____ Specialty: _____

Contact: _____ Email: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Institution Name: _____ Academic Rank/Title: _____

Address: _____ City: _____

State/Country: _____ Zip: _____

Dates Attended(mm/yy): From :_____ To: _____ Specialty: _____

Contact: _____ Email: _____

Address: _____

Telephone Number: _____ Fax Number: _____

F. Continuing Medical Education *State the number of relevant CME or CEU credit hours you have received in the last 36 months.* ☐None

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

VI. Board and Professional Certification/Recertification *List all current and past Board certifications.*

Physicians: Please enter all Board Certifications and answer the questions below regarding such Board Certifications

Allied Health Professionals: Please enter all Professional and National Certifications and answer the questions below regarding such Certifications

Are you Board certified? ☐ Yes ☐ No ☐ Not Applicable

Name of Issuing Board	Specialty	Dt Certified	Dt Recertified	Expiration

Please answer the following questions. Attach explanation form(s) if necessary.

A. 1. If you are not currently certified, have you applied for the certification examination? ☐ Yes ☐ No

2. If you have not applied for the certification examination, do you intend to apply for the certification examination? If yes, when? ☐ Yes Date: ____ ☐ No

3. If you have applied for the certification examination, have you been accepted to take the certification examination? ☐ Yes ☐ No

4. If you have been accepted, when do you intend to take the examination? Date: ____

5. If you do not intend to apply for the certification examination, please attach reason on Explanation Form(s).

6. If you are not currently certified, please provide the expiration date of admissibility. Date: ____

B. Have you ever had certification denied, revoked, limited, restricted, suspended, involuntarily relinquished, subject to stipulated or probationary conditions, received a letter of reprimand from a specialty Board, or is any such action currently pending or under review? If yes, please attach Explanation Form(s). ☐ Yes Date: ____ ☐ No

C. Have you ever voluntarily relinquished a certification, including any voluntary non-renewal of a time limited certification? If yes, please attach an Explanation Form(s). ☐ Yes Date: ____ ☐ No

D. Have you ever failed a certification exam? ☐ Yes ☐ No
If yes, explain: ____
____
____

VII. Current Hospital and Other Facility Affiliations

Please list in reverse chronological order the past ten years of all hospital and other facility affiliations beginning with all hospital applications in process: current hospital affiliation(s) second, previous hospital affiliations third and other current facility affiliations (which includes surgery centers, dialysis centers, nursing homes and other health care related facilities) fourth. Do not list residencies, internships, fellowships, or employment. A resume is not sufficient for a complete answer to these questions. Submission date only required if pending.

Facility Name: _____

Department: ____ Staff Status: _____ (e.g., active, courtesy, provisional, pending)

Appointment Date: From (mm/yy): _____ To (mm/yy): _____

Address: _____

AddMedical Office Contact: _____ Phone Number: _____

Email: ____ Fax Number: _____

Facility Name: _____

Department: ____ Staff Status: _____ (e.g., active, courtesy, provisional, pending)

Appointment Date: From (mm/yy): _____ To (mm/yy): _____

Address: _____

AddMedical Office Contact: _____ Phone Number: _____

Email: ____ Fax Number: _____

Facility Name: _____

Department: ____ Staff Status: _____ (e.g., active, courtesy, provisional, pending)

Appointment Date: From (mm/yy): _____ To (mm/yy): _____

Address: _____

AddMedical Office Contact: _____ Phone Number: _____

Email: ____ Fax Number: _____

Facility Name: _____

Department: ____ Staff Status: _____ (e.g., active, courtesy, provisional, pending)

Appointment Date: From (mm/yy): _____ To (mm/yy): _____

Address: _____

AddMedical Office Contact: _____ Phone Number: _____

Email: ____ Fax Number: _____

VII. Current Hospital and Other Facility Affiliations - continued

Facility Name: _____

Department: ____ Staff Status: _____
(e.g., active, courtesy, provisional, pending)

Appointment Date: From (mm/yy): _____ To (mm/yy): _____

Address: _____
AddMedical Office Contact: _____ Phone Number: _____

Email: __________ Fax Number: _____

Facility Name: _____

Department: ____ Staff Status: _____
(e.g., active, courtesy, provisional, pending)

Appointment Date: From (mm/yy): _____ To (mm/yy): _____

Address: _____
AddMedical Office Contact: _____ Phone Number: _____

Email: ____ Fax Number: _____

Facility Name: _____

Department: ____ Staff Status: _____
(e.g., active, courtesy, provisional, pending)

Appointment Date: From (mm/yy): _____ To (mm/yy): _____

Address: _____
AddMedical Office Contact: _____ Phone Number: _____

Email: ____ Fax Number: _____

VIII. Professional Work History

Please list in reverse chronological order all professional work history during the past ten years not listed previously. Include any previous office addresses and any military experience and public health service. Explain below any gaps greater than thirty (30) days. Use additional copies of this part VIII to list additional professional work history. A curriculum vitae is not sufficient for a complete answer to these questions.

☐ Not Applicable

Name of Practice/Employer: _____
Title/Position held: _____
From (mm/yy):_____ To (mm/yy): _____ Reason for leaving? _____

_____

_____

Eligible for rehire? ☐Yes ☐ No If No why, please attach Explanation Form.

Address: _____ City: _____
State/Country: _____ Zip:_____
Contact: _____ Fax Number: _____
Email: _____ Telephone Number: _____

VIII. Professional Work History - continued

Name of Prior Practice/Employer: _____
Title/Position held: _____
From (mm/yy):_____ To (mm/yy): _____ Reason for leaving? _____

_____
_____
_____

Eligible for rehire? ☐Yes ☐ No If No why, please attach Explanation Form.

Address: _____ City: _____
State/Country: _____ Zip:_____
Contact: _____ Fax Number: _____
Email: _____ Telephone Number: _____

Name of Prior Practice/Employer: _____
Title/Position held: _____
From (mm/yy):_____ To (mm/yy): _____ Reason for leaving? _____

_____
_____
_____

Eligible for rehire? ☐Yes ☐ No If No why, please attach Explanation Form.

Address: _____ City: _____
State/Country: _____ Zip:_____
Contact: _____ Fax Number: _____
Email: _____ Telephone Number: _____

IX. Peer References

Please list three (3) references, from professional peers (preferably no more than 1 partner) who through recent (last two years) observations have personal knowledge of and are directly familiar with your professional competence, conduct and work. Do not include relatives. Prefer references be practitioners in your same professional discipline. Allied Health Professionals must list at least one physician reference.

Name of Reference: _____ Relationship: _____

Specialty: _____ Dates of Association: From (mm/yy): _____ To (mm/yy): _____

Address: _____ City: _____

State/Country: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

Email:_____

IX. Peer References - continued

Name of Reference: _____ Relationship: _____

Specialty: _____ Dates of Association: From (mm/yy): _____ To (mm/yy): _____

Address: _____ City: _____

State/Country: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

Email:_____

Name of Reference: _____ Relationship: _____

Specialty: _____ Dates of Association: From (mm/yy): _____ To (mm/yy): _____

Address: _____ City: _____

State/Country: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

Email:_____

X. Professional Liability Insurance (*yours or your supervising agent*)

Insurance Carrier / Provider of Professional Liability Coverage:

_____

Policy Number: _____ Type of Coverage (check one): ☐ Claims-Made ☐ Occurrence

Per claim limit of liability: $_____ Aggregate amount: $ _____

Dates (mm/dd/yyyy): Effective: _____ Expiration: _____ Retroactive: _____

If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage? ☐ Yes ☐ No

If yes, please provide details/supporting data. If no, please explain why not.

_____

Name of Local Contact : _____

(e.g., insurance agent or broker)

Mailing Address: _____

Telephone Number: _____ Ext: _____

AddClaims History Contact: _____ Fax Number: _____ Email: _____

X. Professional Liability Insurance - continued

Please list all previous professional liability carriers within the past ten (10) years including any carriers during professional training if within the ten year period. Use additional copies of this Part X to list additional professional liability insurance. ☐ Not Applicable

Insurance Carrier / Provider of Professional Liability Coverage:

_____

Policy Number: _____ Type of Coverage (check one): ☐ Claims-Made ☐ Occurrence

Per claim limit of liability: $_____ Aggregate amount: $ _____

Dates (mm/dd/yyyy): Effective: _____ Expiration: _____ Retroactive: _____

If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage? ☐ Yes ☐ No

If yes, please provide details/supporting data. If no, please explain why not.

_____

Name of Local Contact : _____
(e.g., insurance agent or broker)

Mailing Address: _____

Telephone Number: _____ Ext: _____

Professional Insurance History: ***Please answer each of the following questions in full. If the answer to any question is "YES", or requires further information, please give a full explanation of the specific details and attach to the Application.***

1. Has your professional liability insurance coverage ever been terminated, not renewed, cancelled, limited, restricted, modified, or altered by action of the insurance company? ☐ Yes Date:_____ ☐ No

   If yes, please provide date, name of company(s), and basis for coverage change.

2. Have you ever been denied coverage? ☐ Yes Date:_____ If yes, please provide details. ☐ No

3. Has your present professional liability insurance carrier excluded any specific procedures from your insurance coverage? ☐ Yes Date:_____ If yes, please identify procedures and provide details. ☐ No

Professional Claims History: ***If the answer to any of these questions is "Yes", please give a full explanation and attach to the Application.***

1. Have there *ever* been any professional liability (i.e., malpractice) claims, suits, judgments, settlements or arbitration proceeding involving you? ☐ Yes Date:_____ ☐ No

2. Are any professional liability (i.e., malpractice) claims, suits, judgments, settlements or arbitration proceedings involving you *currently pending?* ☐ Yes Date:_____ ☐ No

3. Are you aware of any formal demand for payment or similar claim submitted to your insurer that did not result in a lawsuit or other proceeding alleging professional liability? ☐ Yes Date:_____ ☐ No

XI. QUESTIONS FOR HEALTH PLANS ONLY *Answer these questions only if you are applying to a Health Plan.*

1. Do you wish to be listed in the Health Plan Directory as a primary care practitioner? ☐ Yes ☐ No

2. Do you wish to be listed in the Health Plan Directory as a specialist? ☐ Yes ☐ No

3. List which specialty: _____

4. Please furnish a copy of your W-9 Federal Tax Form.

5. Does this site offer handicapped access for the following:

Building?	☐ Yes	☐ No
Parking?	☐ Yes	☐ No
Restroom?	☐ Yes	☐ No

Does this site offer other services for the disabled? ☐ Yes ☐ No

Text Telephone (TTY)?	☐ Yes	☐ No
American Sign Language?	☐ Yes	☐ No
Mental/Physical Impairment Services?	☐ Yes	☐ No

Accessible by public transportation? ☐ Yes ☐ No

Bus?	☐ Yes	☐ No
Light rail?	☐ Yes	☐ No
Regional train?	☐ Yes	☐ No

XII. Attestation Questions

This section to be completed by the Practitioner. Modification to the wording or format of these Attestation Questions will invalidate the Application..

Please answer the following questions "yes" or "no". If your answer to any of the following questions is "yes", please provide details and reasons including dates, as specified in each question, on an Explanation Form and attach to the Application.

For the purpose of the following questions, the term "adverse action" means a voluntary or involuntary termination, loss of, reduction, withdrawal, limitation, restriction, suspension, revocation, denial, surrender, resignation, relinquishment, reprimand, censure, sanction, subject to probation, placed under special or intensified review, withdrawn or failed to proceed with an application, denied or recommended for denial, any such action pending or in progress, or non-renewal of membership, clinical privileges, academic affiliation or appointment or employment. "Adverse action" also means, with respect to professional licensure registration or certification, any previously successful or currently pending challenges to such licensure, registration or certification including any voluntary or involuntary restriction, suspension, revocation, denial, surrender, non-renewal, admonishment, public or private reprimand, probation, consent order, reduction, withdrawal, limitation, relinquishment, or failure to proceed with an application for such licensure, registration or certification.

A. To your knowledge, have you ever been the subject of an **adverse action** (or is an investigation or **adverse action** currently pending) by:

1. a hospital or other healthcare facility (e.g., surgical center, nursing home, renal dialysis facility, etc.)? ☐ Yes Date: ____ ☐ No

2. an education facility or program (e.g., dental or other health care professional school, residency, internship, etc.)? ☐ Yes Date: ____ ☐ No

3. a professional organization or society? ☐ Yes Date:____ ☐ No

4. a professional licensing body (in any jurisdiction for any profession)? ☐ Yes Date:____ ☐ No

5. a private, federal, or state agency regarding your participation in a third party payment program (Medicare, Medicaid, Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Preferred Hospital Organization (PHO), Provider-Sponsored Health Care Corporations (PSHCC), network, system, managed care organization, etc.)? ☐ Yes Date:____ ☐ No

6. a state or federal agency (DEA, etc.) regarding your prescription of controlled substances? ☐ Yes Date:____ ☐ No

B. To your knowledge, have you ever been the subject of any report(s) to a state or federal data bank or state licensing or disciplining entity? ☐ Yes Date:____ ☐ No

XII. Attestation Questions - continued

C. 1.Have you ever deletevoluntarily or involuntarily resigned, terminated or surrendered medical staff privileges or employment from a hospital, group practice or other health care facility or medical staff?
☐ Yes Date: _____
☐ No

C. 2. deleteIf your answer to the above Question is Yes, was it AddHave you ever voluntarily resigned, terminated, or surrendered medical staff privileges or employment from a hospital, group practice or other healthcare facility or medical staff to avoid disciplinary action or investigation or while under investigation, or is such an investigation pending? ☐ Yes Add Date/Box ☐ No

D. Have you ever been suspended, fined, disciplined, investigated, expelled, sanctioned or otherwise restricted or excluded from participating in any private, federal or state health insurance program (for example, Medicare or Medicaid) or are any such proceedings in progress? ☐ Yes Date: _____
☐ No

E. Has any professional review organization under contract with Medicare or Medicaid ever made an adverse quality determination concerning your treatment rendered to any patient or are any such proceedings in progress? ☐ Yes Date:_____
☐ No

F. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony or misdemeanor that is reasonably related to your qualifications, competence, functions, or duties as a health care professional or are you currently under indictment or currently have pending against you any such charges? ☐ Yes Date: _____
☐ No

G. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony or misdemeanor that alleged fraud, an act of violence, child abuse, or a sexual offense or sexual misconduct or are you currently under indictment or currently have pending against you any such charges?
☐ Yes Date: _____
☐ No

H. In the last ten years, have you been found liable or responsible for or named in any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a health care professional or that alleged fraud, an act of violence, child abuse, or a sexual offense or sexual misconduct? ☐ Yes Date: _____
☐ No

I. Have you ever been court-martialed for actions related to your duties as a health care professional?
☐ Yes Date: _____
☐ No

XIII. ATTESTATION AND SIGNATURE

By signing this Application, I certify, agree, understand and acknowledge the following:

1. The information in this entire Application, including all subparts and attachments, is complete, current, correct, and not misleading.
2. Any misstatements or omissions (whether intentional or unintentional) on this Application may constitute cause for denial of my Application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement without right of hearing.
3. A photocopy of this Application, including this attestation, the authorization and release of information form and any or all attachments has the same force and effect as the original.
4. I have reviewed the information in this Application on the most recent date indicated below and it continues to be true and complete.
5. While this Application is being processed, I agree to update the information originally provided should there be any change in the information.
6. No action will be taken on this Application until it is complete and all outstanding questions with respect to the Application have been resolved.
7. I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not per se an application for employment with the Entity and that acceptance of my application by the Entity may not result in my employment by the Entity.
8. I understand and agree that I will notify all credentialing entities to which I have submitted this Uniform Application of any and all changes to the information contained in this Application

This attestation statement and Application must be signed no more than 180 days prior to the credentialing decision date.

Please print your name: _____

_____
Signature

_____
Date

REMEMBER TO SAVE THE COMPLETED APPLICATION

Schedule A

COLORADO HEALTH CARE PROFESSIONAL CREDENTIALS APPLICATION
AUTHORIZATION AND RELEASE OF INFORMATION FORM
Modified Releases Will Not Be Accepted

By submitting this Application, including all subparts and attachments, I acknowledge, understand, consent and agree to the following:

1. As an applicant for medical staff membership at the designated hospital(*s*) and/or participation status with the health care related organization(*s*) (e.g., *hospital, medical staff, medical group independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), managed care organization network, medical society, professional association, medical school faculty position, professional liability insurance carrier, other healthcare delivery entity or system, hereinafter referred to as a "Healthcare Entity")* indicated on this Application, I have the burden of producing adequate information for proper evaluation of this Application.
2. I also understand that I have the continuing responsibilities to resolve any questions, concerns or doubts regarding any and all information in this Application. If I fail to produce this information, then I understand that the Healthcare Entity will not be required to evaluate or act upon this Application. I also agree to provide updated information as may be required or requested by the Healthcare Entity or its authorized representatives or designated agents.
3. The Healthcare Entity and its authorized representatives or designated agents will investigate the information in this Application. I consent and agree to such investigation and to the disciplinary reporting and information exchange activities of the Healthcare Entity as a part of the verification and credentialing process.
4. I specifically authorize the Healthcare Entity and its authorized representatives and designated agents to obtain and act upon information regarding my competence, qualifications, education, training, professional and clinical ability, character, conduct, ethics, judgment, mental and physical health status, emotional stability, utilization practices, professional licensure or certification, and any other matter related to my qualification or matters addressed in this Application (my "Qualifications")
5. I authorize all individuals, institutions, schools, programs, entities, facilities, hospitals, societies, associations, companies, agencies, licensing authorities, boards, plans, organizations, Healthcare Entities or others with which I have been associated as well as all professional liability insures with which I have had or currently have professional liability insurance, who may have information bearing on my Qualifications to consult with the Healthcare Entity and its authorized representatives and designated agents and to report, release, exchange and share information and documents with the Healthcare Entity, for the purpose of evaluating this application and my Qualifications.
6. I consent to and authorize the inspection of appropriate records and documents that may be material to an evaluation of this Application and my Qualifications and my ability to carry out the clinical privileges/services/participation I have requested. I authorize each and every individual and organization with custody of such records and documents to permit such inspection and copying as may be necessary for the evaluation of this Application. I also agree to appear for interviews, if required or requested by the Healthcare Entity, in regard to this Application.

7. I further consent to and authorize the release by the Healthcare Entity to other Healthcare Entities and interested persons on request of information the Healthcare Entity may have concerning me (including but not limited to peer review information which is provided to another Healthcare Entity for peer review purposes). I hereby release from all liability the Healthcare Entity and its authorized representatives or designated agents from any claim for damages of whatever nature for any release of information made in good faith by the Healthcare Entity or its representatives or agents.
8. I release from any liability, to the fullest extent permitted by law, all persons and entities (individuals and organizations) for their acts performed in a reasonable manner in conjunction with investigating and evaluating my Application and Qualifications, and I waive all legal claims of whatever nature against the Healthcare Entity and its representatives and designated agents acting in good faith and without malice in connection with the investigation of this Application and my Qualifications.
9. For Healthcare Entity membership and privileges, I acknowledge that I have been informed of or have been given the opportunity to review the medical staff bylaws, rules, regulations and policies of the entity and I hereby agree to abide by them. I agree to conduct my practice in accordance with applicable laws and ethical principles of my profession.
10. I acknowledge that any investigations, actions or recommendations of any committee or the governing body of the Healthcare Entity with respect to the evaluation of this Application and any periodic reappraisals or evaluations will be undertaken as a medical review and/or peer review committee and in fulfillment of the Healthcare Entity's obligations under Colorado law to conduct a review of professional practices in the facility, and are therefore entitled to any protections provided by law.
11. I have read and understand this Authorization and Release of Information Form. A photocopy of this Authorization and Release of Information Form shall be as effective as the original and shall constitute my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this Application. This Authorization and Release shall apply in connection with the evaluation and processing of this Application as well as in connection with any periodic reappraisals and evaluation undertaken. I agree to execute such additional releases as may be required from time to time in connection with such periodic reappraisals and evaluations.
12. I understand that I have an opportunity to review the information submitted in support of this application pursuant to each entity's policy regarding review. If during the process of credentialing, an entity receives information that varies substantially from information I have provided, I will be notified of this and will have an opportunity to correct erroneous information. I have the right, upon request, to be informed of the status of my application

COLORADO HEALTH CARE PROFESSIONAL CREDENTIALS APPLICATION
AUTHORIZATION AND RELEASE OF INFORMATION FORM

Please print your name: _____

Signature: _____ **Date:** _____

REMEMBER TO SAVE THE COMPLETED APPLICATION

CAUTION
READ THIS INSTRUCTION CAREFULLY

Complete Supplemental A, page 25, and Supplemental B, page 26 & 27, unless instructed otherwise by credentialing entity.

Supplemental A

Please answer these questions in full. DO NOT ANSWER THESE QUESTIONS if you are seeking to be employed by the credentialing entity.

1. Citizenship: Are you a citizen of the United States? ☐ Yes ☐ No If no, please provide appropriate documentation.

2. Date of Birth: Month ___ Day __ Year ____ Gender: ☐ Male ☐ Female

3. Are you currently engaged in the illegal use of drugs? (Currently means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice your profession. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances and alcohol).

   ☐ Yes ☐ No

4. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?

   ☐ Yes ☐ No

5. Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?

   ☐ Yes ☐ No

6. You must provide the following documents unless you are seeking to be employed by the credentialing entity.

   A. One recent passport size photograph of yourself or a copy of your current driver's license.

   B. Permanent Resident Card or Visa Status (if applicable).

Please print your name: _____

_____
Signature

_____
Date

REMEMBER TO SAVE THE COMPLETED APPLICATION

Supplemental B

Health Status. ***Please answer each of the following questions in full. DO NOT ANSWER THESE QUESTIONS if you are seeking to be employed by the credentialing entity.***

1. Do you currently have any physical or mental condition(s) that may affect your ability to practice or exercise the clinical privileges or responsibilities typically associated with the specialty and position for which you are submitting this Application? *If the answer to this question is "YES", please give full explanation of the specific details on an Explanation Form and attach to the Application.*

   ☐ Yes ☐ No

   (*Note: Physical or mental condition(s) include, but are not limited to, current alcohol or drug dependency, current treatment or monitoring programs for alcohol or drug dependency, medical limitation of activity, workload, etc., and prescribed medications that may affect your clinical judgment or motor skills.)*

2. Are you currently in a treatment or monitoring program(s) for a physical or mental condition that may affect your ability to practice or exercise the clinical privileges or responsibilities typically associated with the specialty and position for which you are submitting this application?
   If the answer to this question is "YES", please give a full explanation of the specific details, including dates of treatment or monitoring, on an Explanation Form and attach to the Application.

   ☐ Yes ☐ No

   (*Note: Physical or mental condition(s) include, but are not limited to, current alcohol or drug dependency, current treatment or monitoring programs for alcohol or drug dependency, medical limitation of activity, workload, etc., and prescribed medications that may affect your clinical judgment or motor skills.)*

3. Are you able to perform all the essential functions of the position for which you are applying, safely and according to accepted standards of performance, with or without reasonable accommodation? *If reasonable accommodation is required, please specify such on an attached Explanation Form.*

   ☐ Yes ☐ No

4. Please document your current TB status by checking the applicable boxes below:

   ☐ I have had a TB test within the last 12 months and the test was negative. Documentation attached. I have not experienced new risk factors for TB nor am I experiencing symptoms of active TB since my last TB test.

   ☐ I have had a history of previous infection with Mycobacterium Tuberculosis or a positive TB test but I since have had a chest x-ray which was read as normal. Documentation attached. I currently have no symptoms of active disease and have not experienced new risk factors for TB in the past year.

   ☐ I currently have active TB disease which is being adequately treated. Applicable documentation is attached.

   ☐ Other _____

5. The Colorado Board of Health requires licensed health care facilities to annually report their health care worker influenza vaccination rate and achieve a vaccination rate of at least 90%. To facilitate compliance with this rule, some health care facilities may require annual influenza vaccination of employees and staff.

☐ If this facility must comply with the Colorado Board of Health requirements, I agree to provide proof of influenza vaccination or a medical exemption before practicing at this facility.

Please print your name: _____

_____ _____

Signature Date

REMEMBER TO SAVE THE COMPLETED APPLICATION

COLORADO
Board of Health
Department of Public Health & Environment

Notice of Public Rule-Making Hearing

August 16, 2017

ID #: 102

NOTICE is hereby given pursuant to the provisions of §24-4-103, C.R.S.; that the Colorado Board of Health will conduct a public rule-making hearing on:

Date: August 16, 2017

Time: 9:00 AM

Place: Northeast Colorado Health Department; 700 Columbine Street, Auditorium; Sterling, CO 80751

To consider the promulgation/amendments or repeal of:

CCR Number(s)
6 CCR 1014-4, Colorado Health Care Professional Credentials Application

The proposed rules have been developed by the following division or office of the Colorado Department of Public Health and Environment:

Not Applicable- Health Care Credentials Application Review Committee

Statute(s) that requires or authorizes the Board of Health to promulgate, amend, or repeal this rule:

Statute(s)
§25-1-108.7, C.R.S.

Agenda and Hearing Documents

The Board of Health agenda and the proposed rules, together with the proposed statement of basis and purpose, specific statutory authority and regulatory analysis will be available, at least seven (7) days prior to the meeting, on the Board's website, https://colorado.gov/cdphe/boh .

For specific questions regarding the proposed rules, contact the division below:

State Board of Health Office, EDO A-5, 4300 Cherry Creek Drive S., Denver, CO 80246, (303) 692-3466

Participation

The Board encourages all interested persons to participate in the hearing by providing written data, views, or comments, or by making oral comments at the hearing. At the discretion of the Chair, oral testimony at the hearing may be limited to three minutes or less depending on the number of persons wishing to comment.

Written Testimony

Pursuant to 6 CCR 1014-8, §3.02.1, written testimony must be submitted no later than five (5) calendar days prior to the rule-making hearing.

Persons wishing to submit written comments should submit them to: Colorado Board of Health, ATTN: Jamie L. Thornton, Program Assistant, Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South, EDO-A5, Denver, Colorado 80246-1530 or by e-mail at: cdphe.bohrequests@state.co.us

Written testimony is due by 5:00 p.m., Thursday, August 10, 2017.

Deborah Nelson, Board of Health Administrator

Date: 2017-06-23T11:05:49

Notice of Proposed Rulemaking

Tracking number

2017-00252

Department

1100 - Department of Labor and Employment

Agency

1101 - Division of Workers' Compensation

CCR number

7 CCR 1101-3

Rule title

WORKERS' COMPENSATION RULES OF PROCEDURE WITH TREATMENT GUIDELINES

Rulemaking Hearing

Date

08/01/2017

Time

09:30 AM

Location

633 17th St. Denver CO 80202

Subjects and issues involved

Rules 16 and 18: Utilization standards and medical fee schedule

Statutory authority

8-47-107

Contact information

Name

David Gallivan

Title

Regulatory Analyst

Telephone

3033188723

Email

david.gallivan@state.co.us

DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation
7 CCR 1101-3
WORKERS' COMPENSATION RULES OF PROCEDURE

Rule 16 UTILIZATION STANDARDS

16-1 STATEMENT OF PURPOSE

In an effort to comply with its legislative charge to assure appropriate and timely medical care at a reasonable cost, the Director (Director) of the Division of Workers' Compensation (Division) has promulgated these utilization standards, effective January 1, ~~2017~~2018. This Rule defines the standard terminology, administrative procedures and dispute resolution procedures required to implement the Division's Medical Treatment Guidelines and Medical Fee Schedule. With respect to any matter arising under the Colorado Workers' Compensation Act and/or the Workers' Compensation Rules of Procedure and to the extent not otherwise precluded by the laws of this state, all providers and payers shall use and comply with the provisions of the "Medical Treatment Guidelines," Rule 17, and the "Medical Fee Schedule," Rule 18, as incorporated and defined in the Workers' Compensation Rules of Procedure, 7 CCR 1101-3.

16-2 STANDARD TERMINOLOGY FOR RULES 16 AND 18

(A) Ambulatory Surgical Center (ASC) – licensed as an ambulatory surgery center by the Colorado Department of Public Health and Environment.

(B) Authorized Treating Provider (ATP) – may be any of the following:

(1) The treating physician designated by the employer and selected by the injured worker;

(2) A health care provider to whom an authorized treating physician refers the injured worker for treatment, consultation, or impairment rating;

(3) A physician selected by the injured worker when the injured worker has the right to select a provider;

(4) A physician authorized by the employer when the employer has the right or obligation to make such an authorization;

(5) A health care provider determined by the Director or an administrative law judge to be an ATP;

(6) A provider who is designated by the agreement of the injured worker and the payer.

(C) Billed Service(s) – any billed service, procedure, equipment or supply provided to an injured worker by a provider.

(D) Billing Party – a service provider or an injured worker who has incurred authorized medical costs.

Style Definition: Normal
Style Definition: Heading 1
Style Definition: Department
Style Definition: Agency
Style Definition: upar5
Style Definition: CCR Number
Style Definition: CCR Title
Style Definition: par1
Style Definition: par2
Style Definition: upar3
Style Definition: upar4
Style Definition: par3
Style Definition: par4
Style Definition: par5
Style Definition: title1
Style Definition: Style par2 + Bold
Style Definition: Header
Style Definition: Footer
Style Definition: Balloon Text
Style Definition: List Paragraph
Style Definition: Comment Text
Style Definition: Comment Subject
Formatted: Indent: Left: 1", Hanging: 0.5"

(E) Certificate of Mailing – a signed and dated statement containing the names and mailing addresses of all persons receiving copies of attached or referenced document(s), certifying the documents were placed in the U.S. Mail, postage pre-paid, to those persons.

(F) Children's Hospital – identified and Medicare-certified by the Colorado Department of Public Health and Environment.

(G) Convalescent Center – licensed by the Colorado Department of Public Health and Environment.

(H) Critical Access Hospital (CAH) – Medicare-certified by the Colorado Department of Public Health and Environment.

(I) Day – defined as a calendar day unless otherwise noted. In computing any period of time prescribed or allowed by Rules 16 or 18, the parties shall refer to Rule 1-2.

(J) Free-Standing Facility – an entity that furnishes healthcare services and is not integrated with any other entity as a main provider, a department of a provider, remote location of a hospital, satellite facility, or provider –based entity.

(K) Hospital – licensed by the Colorado Department of Public Health and Environment.

(L) Long-Term Care Facility –licensed and Medicare-certified by the Colorado Department of Public Health and Environment.

(M) Medical Fee Schedule – Division's Rule 18, its exhibits, and the documents incorporated by reference in that Rule.

(N) Medical Treatment Guidelines – the medical treatment guidelines as incorporated into Rule 17, "Medical Treatment Guidelines."

(O) Over-the-Counter Drugs – Drugs that are safe and effective for use by the general public without a prescription.

(P) Payer – an insurer, employer, or their designated agent(s) who is responsible for payment of medical expenses.

(Q) Prior Authorization – assurance that appropriate reimbursement for a specific treatment will be paid in accordance with Rule 18, its exhibits, and the documents incorporated by reference in that Rule.

(R) Provider – a person or entity providing authorized health care service, whether involving treatment or not, to a worker in connection with work-related injury or occupational disease.

(S) Psychiatric Hospital – licensed by the Colorado Department of Public Health and Environment.

(T) Rehabilitation Hospital Facility – licensed as a rehabilitation hospital by the Colorado Department of Public Health and Environment.

(U) Rural Health Clinic Facility – Medicare-certified by the Colorado Department of Public Health and Environment.

(V) Skilled Nursing Facility (SNF) – licensed as a skilled nursing facility by the Colorado Department of Public Health and Environment.

(W) "Supply et al." – any single supply, durable medical equipment (DME), orthotic, prosthesis, biologic item, or single drug dose, for which the billed amount exceeds $500.00 and all implants.

(X) Telehealth – a broad term describing a mode of delivery of health care services through telecommunications systems, including information, electronic, and communication technologies, to facilitate the assessment, diagnosis, consultation, treatment, education, care management, and/or self-management of an injured worker's health care while the injured worker is located at an originating site and the provider is located at a distant site. The term includes synchronous interactions and store-and-forward transfers. The term does not include the delivery of health care services via telephone with audio only function, facsimile machine, or electronic mail systems. .

(Y) Telemedicine – two-way, real time interactive communication between the injured worker, and the provider at the distant site. This electronic communication involves, at minimum, audio and video telecommunications equipment. Telemedicine enables the remote diagnoses and evaluation of injured workers in addition to the ability to detect fluctuations in their medical condition(s) at a remote site in such a way as to confirm or alter treatment plan, including medications and/or specialized therapy.

~~(Y)~~(Z) Veterans' Administration Medical Facilities – all medical facilities overseen by the United States Department of Veterans' Affairs.

16-3 REQUIRED USE OF THE MEDICAL TREATMENT GUIDELINES AND PAYMENT FOR SERVICE

When an injury or occupational disease falls within the purview of Rule 17, Medical Treatment Guidelines and the date of injury occurs on or after July 1, 1991, providers and payers shall use the medical treatment guidelines, in effect at the time of service, to prepare or review their treatment plan(s) for the injured worker. A payer may not dictate the type or duration of medical treatment or rely on its' own internal guidelines or other standards for medical determination. When treatment exceeds or is outside of the Medical Treatment Guidelines, prior authorization is required. Requesters and reviewers should consider how their decision will affect the overall treatment plan for the individual patient. In all instances of contest appropriate processes to deny are required. Refer to applicable sections of 16-10, 16-11 and/or 16-12.

16-4 REQUIRED USE OF THE MEDICAL FEE SCHEDULE

(A) When services provided to an injured worker fall within the purview of the Medical Fee Schedule, all payers shall use the fee schedule to determine maximum allowable fees~~.~~, except as permitted by Rule 16-5(B)(3).

(B) Providers must accurately report their services using codes and modifiers listed in the National Relative Value File, as published by Medicare in ~~January 2016~~the February 2017 Resource Based Relative Value Scale (RBRVS). Providers also must use codes, modifiers, instructions, and parenthetical notes listed in the American Medical Association's Current Procedural Terminology (CPT®) ~~2016~~2017 edition. Finally, providers must use codes, modifiers, and billing instructions listed in Rule 18, Medical Fee Schedule. The Medical Fee Schedule sets the maximum allowable payment but the fee schedule does not limit the billing charges.

(C) The provider may be subject to penalties under the Workers' Compensation Act for inaccurate billing when the provider knew or should have known that the services billed were inaccurate, as determined by the Director or an administrative law judge.

16-5 RECOGNIZED HEALTH CARE PROVIDERS

(A) Physician and Non-Physician Providers

(1) For the purpose of this Rule, recognized health care providers are divided into the major categories of "physician" and "non-physician". Recognized providers are defined as follows:

(a) "Physician providers" are those individuals who are licensed by the State of Colorado through one of the following state boards:

~~1)~~ (i) Colorado Medical Board;

(ii) ~~2)~~ Colorado Board of Chiropractic Examiners;

(iii) ~~3)~~ Colorado Podiatry Board; or

(iv) ~~4)~~ Colorado Dental Board.

Only physicians licensed by the Colorado Medical Board may be included as individual physicians on the employer's or insurer's designated provider list required under § 8-43-404(5)(a)(I), C.R.S.

(b) "Non-physician providers" are those individuals who are registered, certified, or licensed by the Colorado Department of Regulatory Agencies (DORA), the Colorado Secretary of State, or a national entity recognized by the State of Colorado as follows:

~~1)~~(i) Acupuncturist (LAc) – licensed by the Office of Acupuncture Licensure, Colorado Department of Regulatory Agencies;

~~2)~~(ii) Advanced Practice Nurse (APN) – licensed by the Colorado Board of Nursing; Advanced Practice Nurse Registry;

~~3)~~(iii) Anesthesiologist Assistant (AA) – licensed by the Colorado Medical Board, Colorado Department of Regulatory Agencies;

~~4)~~(iv) Athletic Trainers (ATC) –registered by the Office of Athletic Trainer Registration, Colorado Department of Regulatory Agencies;

~~5)~~(v) Audiologist (AU.D. CCC-A) – licensed by the Office of Audiology and Hearing Aid Provider Licensure, Colorado Department of Regulatory Agencies;

~~6)~~(vi) Certified Registered Nurse Anesthetist (CRNA) – licensed by the Colorado Board of Nursing;

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~~7)~~(vii) Clinical Social Worker (LCSW) – licensed by the Board of Social Work Examiners, Colorado Department of Regulatory Agencies;

~~8)~~(viii) Durable Medical Equipment, Prosthetic, Orthotics and Supplies (DMEPOS) Supplier – licensed by the Colorado Secretary of State;

~~9)~~(ix) Marriage and Family Therapist (LMFT) – licensed by the Board of Marriage and Family Therapist Examiners, Colorado Department of Regulatory Agencies;

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~~10)~~(x) Massage Therapist (MT) –licensed as a massage therapist by the Office of Massage Therapy Licensure, Colorado Department of Regulatory Agencies;

~~11)~~(xi) Nurse Practitioner (NP) – licensed as an APN and authorized by the Colorado Board of Nursing;

~~12)~~(xii) Occupational Therapist (OTR) – licensed by the Office of Occupational Therapy, Colorado Department of Regulatory Agencies,;

~~13)~~(xiii) Optometrist (OD) – licensed by the Board of Optometry, Colorado Department of Regulatory Agencies;

~~14)~~(xiv) Orthopedic Technologist (OTC) – certified by the National Board for Certification of Orthopedic Technologists;

~~15)~~(xv) Pharmacist – licensed by the Board of Pharmacy, Colorado Department of Regulatory Agencies;

~~16)~~(xvi) Physical Therapist (PT) – licensed by the Physical Therapy Board, Colorado Department of Regulatory Agencies;

~~17)~~(xvii) Physical Therapist Assistant (PTA) – licensed by the Physical Therapy Board, Colorado Department of Regulatory Agencies;

~~18)~~(xviii) Physician Assistant (PA) – licensed by the Colorado Medical Board;

~~19)~~(xix) Practical Nurse (LPN) – licensed by the Colorado Board of Nursing;

~~20)~~(xx) Professional Counselor (LPC) – licensed by the Board of Professional Counselor Examiners, Colorado Department of Regulatory Agencies;

~~21)~~(xxi) Psychologist (PsyD, PhD, EdD) – licensed by the Board of Psychologist Examiners, Colorado Department of Regulatory Agencies;

~~22)~~(xxii) Registered Nurse (RN) – licensed by the Colorado Board of Nursing;

~~23)~~(xxiii) Respiratory Therapist (RTL) – certified by the National Board of Respiratory Care and licensed by the Office of Respiratory Therapy Licensure, Colorado Department of Regulatory Agencies;

~~24)~~(xxiv) Speech Language Pathologist (CCC-SLP) – certified by the Office of Speech-Language Pathology Certification, Colorado Department of Regulatory Agencies; and

~~25)~~(xxv) Surgical Technologist (CST) – registered by the Office of Surgical Assistant and Surgical Technologist Registration, Colorado Department of Regulatory Agencies.

(2) Upon request, health care providers must provide copies of license, registration, certification or evidence of health care training for billed services.

(3) Any provider not listed in section 16-5(A)(1)(a) or (b) must comply with section 16-10, Prior Authorization when providing all services.

(4) Referrals:

(a) A payer or employer shall not redirect or alter the scope of an authorized treating provider's referral to another provider for treatment or evaluation of a compensable injury. Any party who has concerns regarding a referral or its scope shall advise the other parties and providers involved.

(b) All non-physician providers must have a referral from an authorized treating physician. An authorized treating physician making the referral to any listed or unlisted non-physician provider is required to clarify any questions concerning the scope of the referral, prescription, or the reasonableness or necessity of the care.

(c) Any listed or non-listed non-physician provider is required to clarify any questions concerning the scope of the referral, prescription, or the reasonableness or necessity of the care with the referring authorized treating physician.

(5) Rule 18, Medical Fee Schedule applies to authorized services provided in relation to a specific workers' compensation claim.

(6) Use of PAs and NPs in Colorado Workers' Compensation Claims:

(a) All Colorado Workers' Compensation claims (medical only or lost time claims) shall have an "authorized treating physician" responsible for all services rendered to an injured worker by any PA or NP.

(b) The authorized treating physician provider must be immediately available in person or by telephone to furnish assistance and/or direction to the PA or NP while services are being provided to an injured worker.

(c) The service is within the scope of the PA's or NP's practice and complies with all applicable provisions of the Colorado Medical Practice Act or the Colorado Nurse Practice Act, and all applicable rules promulgated by the Colorado Medical Board or the Colorado Board of Nursing.

(d) For services performed by an NP or a PA, the authorized treating physician must counter sign patient records related to the injured worker's inability to work resulting from the claimed work injury or disease, and the injured worker's ability to return to regular or modified employment, as required by §§ 8-42-105(2)(b) and (3), C.R.S. The authorized treating physician also must counter sign Form WC 164. The signature of the physician provider shall serve as a certification that all requirements of this rule have been met.

(e) The authorized treating physician must evaluate the injured worker within the first three visits to the physician's office.

(B) Out-of-State Provider

(1) Injured Worker Relocated

(a) Upon receipt of the "Employer's First Report of Injury" or the "Worker's Claim for Compensation" form, the payer shall notify the injured worker that the procedures for change-of-provider, should s/he relocate out-of-state, can be obtained from the payer.

(b) A change of provider must be made:

(i) ~~1)~~ Through referral by the injured worker's authorized treating physician; or

(ii) ~~2)~~ In accordance with § 8-43-404 (5)(a), C.R.S.

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(2) Injured Worker Referred

In the event an injured worker has not relocated out-of-state but is referred to an out-of-state provider for treatment or services not available within Colorado, the referring provider shall obtain prior authorization from the payer as set forth in section 16-10, Prior Authorization. The referring provider's written request for out-of-state treatment shall include the following information:

(a) Medical justification prepared by the referring provider;

(b) Written explanation as to why the requested treatment/services cannot be obtained within Colorado;

(c) Name, complete mailing address and telephone number of the out-of-state provider;

(d) Description of the treatment/services requested, including the estimated length of time and frequency of the treatment/service, and all associated medical expenses; and

(e) Out-of-state provider's qualifications to provide the requested treatment or services.

(3) The Colorado fee schedule should govern reimbursement for out-of-state providers~~.~~, but the payer and provider may negotiate reimbursement in excess of

this fee schedule when necessary to obtain reasonable and necessary care for an injured worker.

16-6 HANDLING, PROCESSING AND PAYMENT OF MEDICAL BILLS

(A) Use of agents, including but not limited to Preferred Provider Organizations (PPO) networks, bill review companies, third party administrators (TPAs) and case management companies, shall not relieve the employer or insurer from their legal responsibilities for compliance with these Rules.

(B) Payment for billed services identified in the Medical Fee Schedule shall not exceed those scheduled rates and fees, or the provider's actual billed charges, whichever is less. except as permitted by Rule 16-5(B)(3).

(C) Payment for billed services not identified or identified but without established value in the Medical Fee Schedule shall require prior authorization from the payer as set forth in section 16-10, Prior Authorization, except when the billed non-established valued service or procedure is an emergency or a payment mechanism under Rule 18 is identifiable, but not explicit. Examples of the prior authorization request exception(s) include ambulance bills or supply bills that are covered under Rule18-6(H) with an identified payment mechanism.

Similar established code values from the Medical Fee Schedule, recommended by the requesting physician, shall govern the maximum fee value payment.

(D) Any payer contesting a provider's treatment shall follow the procedures as outlined under section 16-11, Contest of a Request for Prior Authorization, or section 16-12, Payment of Medical Benefits.

~~(E) International Classification of Diseases (ICD) codes shall not be used to establish the work relatedness of an injury or treatment.~~

16-7 REQUIRED BILLING FORMS AND ACCOMPANYING DOCUMENTATION

(A) Providers may use electronic reproductions of any required form(s) referenced in this section; however, any such reproduction shall be an exact duplication of such form(s) in content and appearance. With the agreement of the payer, identifying information may be placed in the margin of the form.

(B) Required Billing Forms

All health care providers shall use only the following billing forms or electronically produced formats when billing for services:

(1) CMS (Centers for Medicare & Medicaid Services) -1500 shall be used by all providers billing for professional services, durable medical equipment (DME) and ambulance services, with the exception of those providers billing for dental services or procedures. Health care providers shall provide their name and credentials in the appropriate box of the CMS-1500.

(a) Non-hospital based ASCs may bill on the CMS-1500, however an SG modifier must be appended to the technical component of services to indicate a facility charge and to qualify for reimbursement as a facility claim.

(2) UB-04 - shall be used by all hospitals, hospital-based ambulance/air services, Children's Hospitals, CAHs, Veterans' Administration Medical Facilities, home health and facilities meeting the definitions found in section 16-2, when billing for hospital services or any facility fees billed by any other provider, such as hospital-based ASCs.

(a) Some outpatient hospital therapy services (Physical, Occupational, or Speech) may also be billed on UB-04. For these services, the UB-04 must have Form Locator Type 013x, 074x, 075x, or 085x, and one of the following revenue code(s):

- Revenue Code 042X Physical Therapy
- Revenue Code 043X Occupational Therapy
- Revenue Code 044X Speech/Language Therapy

(b) CAHs designated by Medicare or Exhibit # 3 to Rule 18 may use UB-04 to bill professional services if the professional has reassigned his or her billing rights to the CAH using Medicare's Method II. The CAH shall list bill type 851-854, as well as one of the following revenue code(s) and Health Care Common Procedure Coding System (HCPCS) codes in the HCPCS Rates field number 44:

- 0960 - Professional Fee General
- 0961 - Psychiatric
- 0962 - Ophthalmology
- 0963 - Anesthesiologist (MD)
- 0964 - Anesthetist (CRNA)
- 0971 - Professional Fee For Laboratory
- 0972 - Professional Fee For Radiology Diagnostic
- 0973 – Professional Fee - Radiology - Therapeutic
- 0974 - Professional Fee - Radiology - Nuclear
- 0975 - Professional Fee - Operating Room
- 0981 - Emergency Room Physicians
- 0982 - Outpatient Services
- 0983 - Clinic
- 0985 - EKG Professional
- 0986 - EEG Professional
- 0987 - Hospital Visit professional (MD/DO)
- 0988 - Consultation (Professional (MD/DO)

All professional services billed by a CAH are subject to the same coding and payment rules as professional services billed independently. The

following modifiers shall be appended to HCPCS codes to identify the type of provider rendering the professional service:

GF Services rendered in a CAH by a NP, clinical nurse specialist, certified registered nurse, or PA

SB Services rendered in a CAH by a nurse midwife

AH Services rendered in a CAH by a clinical psychologist

AE Services rendered in a CAH by a nutrition professional/registered dietitian

AQ Physician services in a physician-scarcity area

(c) No provider except those listed above shall bill for the professional fees using UB-04.

(3) American Dental Association's Dental Claim Form, Version 2012 shall be used by all providers billing for dental services or procedures.

(4) With the agreement of the payer, the ANSI ASC X12 (American National Standards Institute Accredited Standards Committee) or NCPDP (National Council For Prescription Drug Programs) electronic billing transaction containing the same information as in (1), (2) or (3) in this subsection may be used.

NCPDP Workers' Compensation/Property and Casualty (P&C) universal claim form, version 1.1, for prescription drug billed on paper shall be used by dispensing pharmacies and pharmacy benefit managers (PBM). Physicians may use the CMS-1500 billing form as described in section 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.

(C) International Classification of Diseases (ICD) Codes

All provider bills~~, including outpatient hospital bills,~~ shall list the ~~appropriate diagnosis codes using the~~ current ICD-10~~-~~ Clinical Modification (CM) diagnosis code(s~~).~~) and preferably include the Chapter 20 External Causes of Morbidity code(s). If ICD-10-CM requires a seventh character ~~is required by ICD-10-CM, it~~, the provider must ~~be applied~~apply it in accordance with the ICD-10-CM Chapter Guidelines provided by the Centers for Medicare and Medicaid Services (CMS). The ICD-10-CM diagnosis code(s) shall not be used as a sole factor to establish work-relatedness of an injury or treatment.

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(D) Required Billing Codes

All billed services shall be itemized on the appropriate billing form as set forth in sections 16-7(A) and (B), and shall include applicable billing codes and modifiers from the Medical Fee Schedule. National provider identification (NPI) numbers are required for workers' compensation bills; providers who cannot obtain NPI numbers are exempt from this requirement. When billing on a CMS-1500, the NPI should be that of the rendering provider and should include the correct place of service codes at the line level.

(E) Inaccurate Billing Forms or Codes

Payment for any services not billed on the forms identified in this Rule, and/or not itemized as instructed in sections 16-7(B) and (C), may be contested until the provider complies. However, when payment is contested, the payer shall comply with the applicable provisions set forth in section 16-12, Payment of Medical Benefits.

(F) Accompanying Documentation

(1) Authorized treating physicians sign (or countersign) and submit to the payer, with their initial and final visit billings, a completed "Physician's Report of Workers' Compensation Injury" (Form WC 164) specifying:

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

(b) The report type as "closing" when the authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient determines the injured worker has reached maximum medical improvement (MMI) 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 also be completed and the following additional information shall be attached to the bill at the time MMI is determined:

(i) ~~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

(ii) ~~2)~~ Referral to a 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.

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(c) At no charge, the physician shall supply the injured worker with one legible copy of all completed "Physician's Report of Workers' Compensation Injury" (WC 164) forms at the time the form is completed.

(d) The provider shall submit to the payer the completed WC 164 form as specified in section 16-7(F), no later than 14 days from the date of service.

(2) Providers, other than hospitals, shall provide the payer with all supporting documentation at the time of submission of the bill unless other agreements have been made between the payer and provider. This shall include copies of the examination, surgical, and/or treatment records.

(3) Hospital documentation shall be available to the payer upon request. Payers shall specify what portion of a hospital record is being requested. (For example, only the emergency room (ER) chart notes, in-patient physician orders and chart notes, x-rays, pathology reports, etc.)

(4) In accordance with section 16-12, the payer may contest payment for billed services until the provider completes and submits the relevant required accompanying documentation as specified by section16-7(F).

(G) Providers shall submit their bills for services rendered within 120 days of the date of service or the bill may be denied unless extenuating circumstances exist. Extenuating circumstances may include, but are not limited to, delays in compensability being decided or the provider has not been informed where to send the bill.

(H) All services provided to patients are expected to be documented in the medical record at the time they are rendered. Occasionally, certain entries related to services provided are not properly documented. In this event, the documentation will need to be amended, corrected, or entered after rendering the service. Amendments, corrections and delayed entries must comply with Medicare's widely accepted recordkeeping principles as outlined in the July 2016 Medicare Program Integrity Manual Chapter 3, section 3.3.2.5. (This section does not apply to patients' requests to amend records as permitted by the Health Insurance Portability and Accountability Act (HIPAA)).

16-8 REQUIRED MEDICAL RECORD DOCUMENTATION

(A) A treating provider shall maintain medical records for each injured worker when the provider intends to bill for the provided services.

(B) All medical records shall contain legible documentation substantiating the services billed. The documentation shall itemize each contact with the injured worker and shall detail at least the following information per contact or, at a minimum for cases where contact occurs more than once a week, be summarized once per week:

(1) Patient's name;

(2) Date of contact, office visit or treatment;

(3) Name and professional designation of person providing the billed service;

(4) Assessment or diagnosis of current condition with appropriate objective findings;

(5) Treatment status or patient's functional response to current treatment;

(6) Treatment plan including specific therapy with time limits and measurable goals and detail of referrals;

(7) Pain diagrams, where applicable;

(8) If being completed by an authorized treating physician, all pertinent changes to work and/or activity restrictions which reflect lifting, standing, stooping, kneeling, hot or cold environment, repetitive motion or other appropriate physical considerations; and

(9) All prior authorization(s) for payment received from the payer (i.e., who approved the prior authorization for payment, services authorized, dollar amount, length of time, etc.).

16-9 NOTIFICATION

(A) The Notification process is for treatment consistent with the Medical Treatment Guidelines that has an established value under the Medical Fee Schedule. Providers may, but are not required to, utilize the Notification process to ensure payment for medical treatment that falls within the purview of the Medical Treatment Guidelines. Therefore, lack of response from the payer within the time requirement set forth in section 16-9 (D) shall deem the proposed treatment/service authorized for payment.

(B) Notification may be made by phone, during regular business hours.

(1) Providers can accept verbal confirmation; or

(2) Providers may request written confirmation of an approval, which the payer should provide upon request.

(C) Notification may be submitted using the "Authorized Treating Provider's Notification to Treat" (Form WC 195).

(1) The completed form shall include:

(a) Provider's certification that the proposed treatment/service is medically necessary and consistent with the Medical Treatment Guidelines.

(b) Documentation of the specific Medical Treatment Guideline(s) applicable to the proposed treatment/service.

(c) Provider's email address or fax number to which the payer can respond.

(D) Payers shall respond to a Notification submission within five (5) business days from receipt of the request with an approval or contest of the proposed treatment. Initially, payer may limit its approval to the number of treatments or treatment duration listed in the "time to produce effect" section(s) of the relevant Medical Treatment Guideline(s), without a medical review. If subsequent medical records document functional progress, payer shall pay for the additional number of treatments/treatment duration listed in the relevant Guideline(s). If payer proposes to discontinue treatment before the maximum number of treatments/treatment duration has been reached due to lack of functional progress, payer shall support that decision with a medical review compliant with section 16-11(B).

~~(D)~~(E) Payers may contest the proposed treatment only for the following reasons:

(1) For claims which have been reported to the Division, no admission of liability or final order finding the injury compensable has been issued:

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(2) Proposed treatment is not related to the admitted injury;

(3) Provider submitting Notification is not an Authorized Treating Provider (ATP), or is proposing for treatment to be performed by a provider who is not eligible to be an ATP;

(4) Injured worker is not entitled to proposed treatment pursuant to statute or settlement;

(5) Medical records contain conflicting opinions among the ATPs regarding proposed treatment;

(6) Proposed treatment falls outside the Medical Treatment Guidelines (see section 16-9(E~~)~~)).

~~(E)~~(F) If the payer contests Notification under sections (16-9(D)(2), (5) or (6) above, the payer shall notify the provider, allow the submission of relevant supporting medical documentation as defined in section 16-10 (F), and review the submission as a prior authorization request, allowing an additional seven (7) business days for review.

~~(F)~~(G) Contests for denied Notification by a provider shall be made in accordance with the prior authorization dispute process outlined in 16-11(C).

~~(G)~~(H) Any provider or payer who incorrectly applies the Medical Treatment Guidelines in the Notification/prior authorization process may be subject to penalties under the Workers' Compensation Act.

16-10 PRIOR AUTHORIZATION

(A) Granting of prior authorization is a guarantee of payment when in accordance with Rule 18, RBRVS and CPT® for those services/procedures requested by the provider per section16-10 (F).

(B) Prior authorization for payment shall only be requested by the provider when:

(1) A prescribed service exceeds the recommended limitations set forth in the Medical Treatment Guidelines;

(2) The Medical Treatment Guidelines otherwise require prior authorization for that specific service;

(3) A prescribed service is identified within the Medical Fee Schedule as requiring prior authorization for payment; or

(4) A prescribed service is not identified in the Medical Fee Schedule as referenced in section 16-6(C).

(C) Prior authorization for a prescribed service or procedure may be granted immediately and without medical review. However, the payer shall respond to all providers requesting prior authorization within seven (7) business days from receipt of the provider's completed request, as defined in section16-10(F). The duty to respond to a provider's written request applies without regard for who transmitted the request.

(D) The payer, ~~upon receipt of the "Employer's First Report of Injury" or a "Worker's Claim for Compensation," shall give written notice to the injured worker stating that the requirements for obtaining prior authorization for payment are available from the payer.~~

~~(E) The payer,~~ unless ~~they have~~it has previously notified said provider, shall give notice to the provider of these procedures for obtaining prior authorization for payment upon receipt of the initial bill from that provider.

(~~F~~E) To complete a prior authorization request, the provider shall concurrently explain the reasonableness and the medical necessity of the services requested, and shall provide relevant supporting medical documentation. Supporting medical documentation is defined as documents used in the provider's decision-making process to substantiate the need for the requested service or procedure.

(1) When the indications of the Medical Treatment Guidelines are met, no prior authorization is required. When prior authorization for payment is indicated, the following documentation is required:

(a) An adequate definition or description of the nature, extent, and necessity for the procedure;

(b) Identification of the appropriate Medical Treatment Guideline application to the requested service, if applicable; and

(c) Final diagnosis.

(2) When the service/procedure does not fall within the Medical Treatment Guidelines and/or past treatment failed functional goals; or if the requested procedure is not identified in the Medical Fee Schedule or does not have an established value under the Medical Fee Schedule, such as any unlisted procedure/service with a BR value or an RNE value listed in the RBRVS, authorization requests may be made using the "Authorized Treating Provider's Request for Prior Authorization" (Form WC 188).

(~~G~~F) To contest a request for prior authorization, the payer is required to comply with the provisions outlined in section 16-11.

(~~H~~G) The Division recommends payers confirm in writing, to providers and all parties, when a request for prior authorization is approved.

(~~I~~H) If, after the service was provided, the payer agrees the service provided was reasonable and necessary, lack of prior authorization for payment does not warrant denial of payment. However, the provider is still required to provide, with the bill, the documentation required by section 16-10(F) for any unlisted valued service or procedure for payment.

(~~J~~I) All medical records should be signed by the rendering provider. Electronic signatures are accepted.

16-11 CONTEST OF A REQUEST FOR PRIOR AUTHORIZATION

(A) If the payer contests a request for prior authorization for non-medical reasons as defined under section 16-12(B)(1), the payer shall notify the provider and parties, in writing, of the basis for the contest within seven (7) business days from receipt of the provider's

completed request as defined in section 16-10(F). A certificate of mailing of the written contest must be sent to the provider and parties.

If an ATP requests prior authorization and indicates in writing, including ~~their~~ reasoning and relevant documentation, that ~~they believe~~he or she believes the requested treatment is related to the admitted workers' compensation claim, the insurer cannot deny ~~based~~ solely ~~on~~for relatedness without a medical ~~review~~opinion as required by section 16-11(B). The medical review, IME report, or report from an ATP that addresses the relatedness of the requested treatment to the admitted claim may precede the prior authorization request.

(B) If the payer is contesting a request for prior authorization for medical reasons, the payer shall, within seven (7) business days of the completed request:

(1) Have all the submitted documentation under section 16-10(F) reviewed by a physician or other health care professional, as defined in section 16-5(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. The physicians or chiropractors performing this review shall be Level I or Level II accredited.

(2) After reviewing all the submitted documentation and other documentation referenced in the prior authorization request and available to the payer, the reviewing provider may call the requesting provider to expedite communication and processing of prior authorization requests. However, the written contest or approval still needs to be completed within the specified seven (7) business days under section 16-11(B).

(3) Furnish the provider and the parties with a written contest that sets forth the following information:

(a) An explanation of the specific medical reasons for the contest, including the name and professional credentials of the person performing the medical review and a copy of the medical reviewer's opinion;

(b) The specific cite from the Medical Treatment Guidelines exhibits to Rule 17, when applicable;

(c) Identification of the information deemed most likely to influence the reconsideration of the contest when applicable; and

(d) A certificate of mailing to the provider and parties.

(C) Prior Authorization Disputes

(1) The requesting party or provider shall have seven (7) business days from the date of the certificate of mailing on the written contest to provide a written response to the payer, including a certificate of mailing. The response is not considered a "special report" when prepared by the provider of the requested service.

(2) The payer shall have seven (7) business days from the date of the certificate of mailing of the response to issue a final decision, including a certificate of mailing to the provider and parties.

(3) In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts.

(D) An urgent need for prior authorization of health care services, as recommended in writing by an authorized treating provider, shall be deemed good cause for an expedited hearing.

(E) Failure of the payer to timely comply in full with ~~the requirements of~~ section 16-11(A) or (B~~),~~) shall be deemed authorization for payment of the requested treatment unless~~:~~

~~(1)~~ ~~A hearing is requested~~ the payer has scheduled an independent medical examination (IME) and notified the requesting provider of the IME within the time prescribed for responding ~~as~~ set forth in section 16-11(~~A)~~B). The IME must occur within 30 days, or ~~(B) and the requesting provider is notified accordingly. A~~upon first available appointment, of the prior authorization request ~~for hearing~~, not to exceed 60 days absent an order extending the deadline. The IME physician must issue his or her report within 20 days of the IME and the insurer shall ~~not relieve the payer from conducting a medical review of the requested treatment, as set forth in section 16-11(B); or~~

~~(2)~~ ~~The~~ respond to the prior authorization request within five business days of the receipt of the IME report. If the injured worker does not attend or reschedules the IME, the payer ~~has scheduled an independent medical examination (IME) within the time prescribed for responding as set forth in section 16-11(B).~~may deny the prior authorization request pending completion of the IME. The IME shall comply with Rules 8-8 to 8-13 as applicable.

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(F) Unreasonable delay or denial of prior authorization, as determined by the Director or an administrative law judge, may subject the payer to penalties under the Workers' Compensation Act.

16-12 PAYMENT OF MEDICAL BENEFITS

(A) Payer Requirements for Processing Medical Service Bills

(1) For every medical service bill submitted by a provider, the payer shall reply with a written notice or explanation of benefits. In those instances where the payer reimburses the exact billed amount, identification of the patient's name, the payer, the paid bill, the amount paid and the dates of service are required. If any adjustments are made then the payer's written notice shall include:

(a) Name of the injured worker or patient;

(b) Specific identifying information coordinating the notice with any payment instrument associated with the bill;

(c) Date(s) of service(s), if date(s) was (were) submitted on the bill;

(d) Payer's claim number and/or Division's workers' compensation claim number, if one has been created;

(e) Reference to the bill and each item of the bill;

(f) Notice that the billing party may submit corrected bill or appeal within 60 days;

(g) For compensable services for a work-related injury or occupational disease the payer shall notify the billing provider that the injured worker shall not be balance-billed for services related to the work-related injury or occupational disease;

(h) Name of insurer with admitted, ordered or contested liability for the workers' compensation claim, when known;

(i) Name, address, e-mail (if any), phone number and fax of a person who has responsibility and authority to discuss and resolve disputes on the bill;

(j) Name and address of the employer, when known; and

(k) Name and address of the Third Party Administrator (TPA) and name and address of the bill reviewer if separate company when known; and

(l) If applicable, a statement that the payment is being held in abeyance because a relevant issue is being brought to hearing.

(2) The payer shall send the billing party written notice that complies with sections 16-12(A)(1) and (B) or (C) if contesting payment for non-medical or medical reasons within 30 days of receipt of the bill. Any notice that fails to include the required information set forth in sections 16-12(A)(1) and (B) or (C) if contesting payment for non-medical or medical reasons is defective and does not satisfy the payer's 30-day notice requirements set forth in this section.

(3) Unless the payer provides timely and proper reasons as set forth by the provisions outlined in sections 16-12(B) - (D), all bills submitted by a provider are due and payable in accordance with the Medical Fee Schedule within 30 days after receipt of the bill by the payer.

(4) If the payer discounts a bill and the provider requests clarification in writing, the payer shall furnish to the requester the specifics of the discount within 30 days including a copy of any contract relied on for the discount. If no response is forthcoming within 30 days, the payer must pay the maximum Medical Fee Schedule allowance or the billed charges, whichever is less.

(5) Date of receipt of the bill may be established by the payer's date stamp or electronic acknowledgement date; otherwise, receipt is presumed to occur three (3) business days after the date the bill was mailed to the payer's correct address.

(6) Unreasonable delay in processing payment or denial of payment of medical service bills, as determined by the Director or an administrative law judge, may subject the payer to penalties under the Workers' Compensation Act.

(7) If the payer fails to make timely payment of uncontested billed services, the billing party may report the incident to the Division's Carrier Practices Unit who may use it during an audit.

(B) Process for Contesting Payment of Billed Services Based on Non-Medical Reasons

(1) Non-medical reasons are administrative issues. Examples of non-medical reasons for contesting payment include the following: no claim has been filed with the payer; compensability has not been established; the billed services are not related to the admitted injury; the provider is not authorized to treat; the insurance coverage is at issue; typographic, gender or date errors are in the bill; failure to submit medical documentation; unrecognized CPT® code.

(2) If an ATP bills for medical services and indicates in writing, including ~~their~~ reasoning and relevant documentation that ~~they believe~~he or she believes the medical services are related to the admitted WC claim, the payer cannot deny ~~based~~ solely ~~on~~for relatedness without a medical review as required by section 16-12(C). A medical review that only addresses the relatedness of the requested treatment to the admitted claim may precede the prior authorization request.

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(3) In all cases where a billed service is contested for non-medical reasons, the payer shall send the billing party written notice of the contest within 30 days of receipt of the bill. The written notice shall include all of the notice requirements set forth in section 16-12(A)(1) and shall also include:

(a) Date(s) of service(s) being contested, if date(s) was(were) submitted on the bill;

(b) If applicable, acknowledgement of specific uncontested and paid items submitted on the same bill as contested services;

(c) Reference to the bill and each item of the bill being contested; and

(d) Clear and persuasive reasons for contesting the payment of any item specific to that bill including the citing of appropriate statutes, rules and/or documents supporting the payer's reasons for contesting payment.

Any notice that fails to include the required information set forth in this section is defective. Such defective notice shall not satisfy the payer's 30 day notice requirement set forth in this section.

(4) Prior to modifying or down-coding a billed code, the payer must contact the billing provider and determine if the ~~modified~~ code is accurate or, in the case of down-coding, explain why the billed code does not meet the level of care criteria.

(a) If the billing provider agrees with the payer, then the payer shall process the service with the agreed upon code and shall document on ~~their~~the explanation of benefits (EOB) the agreement with the provider. The EOB shall include the name of the person at the provider's office who made the agreement.

(b) If the provider is in disagreement, then the payer shall proceed according to section 16-12(B) or 16-12(C), as appropriate.

(5) Lack of prior authorization for payment does not warrant denial of liability for payment.

(6) When no established fee is given in the Medical Fee Schedule and the payer agrees the service or procedure is reasonable and necessary, the payer shall list on ~~their~~the written notice of contest (see section 16-12(A)(1)) one of the following payment options:

(a) A reasonable value based upon the similar established code value recommended by the requesting provider~~;~~, or

(b) The provider's requested payment based on an established similar code value as required by section 16-10(F~~); or~~).

~~(c) The billed charges.~~

If the payer disagrees with the provider's recommended code value, the payer's notice of contest shall include an explanation of why the requested fee is not reasonable, the code(s) used by the payer, and ~~what their~~how the payer calculated/derived its maximum fee recommendation ~~is, based on the payment options.~~

. If the payer is contesting the medical necessity of any non-valued procedure after a prior authorization was requested, the payer shall follow section 16-12(C).

(C) Process for Contesting Payment of Billed Services Based on Medical Reasons

When contesting payment of billed services based on medical reasons, the payer shall:

(1) Have the bill and all supporting medical documentation under section 16-7(F) reviewed by a physician or other health care professional as defined in section 16-5(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. The physicians or chiropractors performing this review shall be Level I or Level II accredited. After reviewing the supporting medical documentation, the reviewing provider may call the billing provider to expedite communication and timely processing of the contested or paid medical bill.

(2) In all cases where a billed service is contested for medical reasons, the payer shall send the provider and the parties written notice of the contest within 30 days of receipt of the bill. The written notice shall include all of the notice requirements set forth in section 16-12(A)(1) and shall also include:

(a) Date(s) of service(s) being contested, if date(s) was (were) submitted on the bill;

(b) If applicable, acknowledgement of specific uncontested and paid items submitted on the same bill as contested services;

(c) Reference to the bill and each item of the bill being contested;

(d) An explanation of the clear and persuasive medical reasons for the decision, including the name and professional credentials of the person performing the medical review and a copy of the medical reviewer's opinion;

(e) The specific cite from the Medical Treatment Guidelines exhibits to Rule 17, when applicable; and

(f) Identification of the information deemed most likely to influence the reconsideration of the contest, when applicable.

(3) Any notice that fails to include the required information set forth in this section is defective. Such defective notice shall not satisfy the payer's 30-day notice requirement set forth in this section.

(4) If the payer is contesting the medical necessity of any non-valued procedure provided without prior authorization, the payer shall follow the procedures given in sections 16-12(C)(1)and (2).

(D) Process for Ongoing Contest of Billed Services

(1) The billing party shall have 60 days to respond to the payer's written notice under section 16-12(A) – (C). The billing party's timely response must include:

(a) A copy of the original or corrected bill;

(b) A copy of the written notice or EOB received;

(c) A statement of the specific item(s) contested;

(d) Clear and persuasive supporting documentation or clear and persuasive reasons for the appeal; and

(e) Any available additional information requested in the payer's written notice.

(2) If the billing party responds timely and in compliance with section 16-12(D)(1), the payer shall:

(a) When contesting for medical reasons, have the bill and all supporting medical documentation and reasoning under section16-7(F) and, if applicable, section 16-12(D)(1) reviewed by a physician or other health care professional as defined in section 16-5(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. After reviewing the provider's documentation and response, the reviewing provider may call the billing provider to expedite communication and timely processing of the contested or paid medical bill.

(b) When contesting for non-medical reasons, have the bill and all supporting medical documentation and reasoning under section 16-7(F) and, if applicable, section 16-12(D)(1) reviewed by a person who has knowledge of the bill. After reviewing the provider's documentation and response, the reviewing person may call the billing provider to expedite communication and timely processing of the contested or paid medical bill.

(3) If before or after conducting a review pursuant to section 16-12(D)(2), the payer agrees with the billing party's response, the billed service is due and payable in

accordance with the Medical Fee Schedule within 30 days after receipt of the billing party's response. Date of receipt may be established by the payer's date stamp or electronic acknowledgement date; otherwise, receipt is presumed to occur three (3) business days after the date the response was mailed to the payer's correct address.

(4) After conducting a review pursuant to section 16-12(D)(2), if there is still a dispute regarding the billed services, the payer shall send the billing party written notice of contest within 30 days of receipt of the response. The written notice shall include all of the notice requirements set forth in section 16-12(A)(1) and shall also include:

(a) Date(s) of service(s) being contested, if date(s) was(were) submitted by the provider;

(b) If applicable, acknowledgement of specific uncontested and paid items submitted on the same bill as contested services;

(c) Reference to the bill and each item of the bill being contested;

(d) An explanation of the clear and persuasive medical or non-medical reasons for the decision, including the name and professional credentials of the person performing the medical or non-medical review and a copy of the medical reviewer's opinion when the contest is over a medical reason; and

(e) The explanation shall include the citing of appropriate statutes, rules and/or documents supporting the payer's reasons for contesting payment.

(5) Any notice that fails to include the required information set forth in this section is defective. Such defective notice shall not satisfy the payer's 30-day notice requirement set forth in this section.

(6) In the event of continued disagreement, and within 12 months of the date the original bill should have been processed in compliance with section 16-12, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts.

(E) Retroactive review of Medical Bills

(1) All medical bills paid by a payer shall be considered final at 12 months after the date of the original explanation of benefits unless the provider is notified that:

(a) A hearing is requested within the 12 month period, or

(b) A request for utilization review has been filed pursuant to § 8-43-501, C.R.S.

(2) If the payer conducts a retroactive review to recover overpayments from a provider based on medical reasons, the payer shall have the bill and all supporting documentation reviewed by a physician or other health care professional as defined in section 16-5(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition,

procedures, or treatment under review. The payer shall send the billing party written notice that shall include all of the notice requirements set forth in section 16-12(A)(1) and shall also include:

(a) Reference to each item of the bill where payer seeks to recover overpayments;

(b) Clear and persuasive medical reason(s) for seeking recovery of overpayment(s). The explanation shall include the citing of appropriate statutes, rules, and/or other documents supporting the payer's reason for seeking to recover overpayment; and

(c) Evidence that these payments were in fact made to the provider.

(3) If the payer conducts a retroactive review to recover overpayments from a provider based on non-medical reasons, the payer shall send the billing party written notice that shall include all of the notice requirements set forth in section 16-12(A)(1) and shall also include:

(a) Reference to each item of the bill where payer seeks to recover overpayments;

(b) Clear and persuasive reason(s) for seeking recovery of overpayment(s). The explanation shall include the citing of appropriate statutes, rules, and/or other documents supporting the payer's reason for seeking to recover overpayment; and

(c) Evidence that these payments were in fact made to the provider.

(4) In the event of continued disagreement, the parties may follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts.

(F) An injured worker shall never be required to directly pay for admitted or ordered medical benefits covered under the Workers' Compensation Act. In the event the injured worker has directly paid for medical services that are then admitted or ordered as covered under the Workers' Compensation Act, the payer shall reimburse the injured worker for the amounts actually paid for authorized services within 30 days after receipt of the bill. If the actual costs exceed the maximum fee allowed by the Medical Fee Schedule, the payer may seek a refund from the medical provider for the difference between the amount charged to the injured worker and the maximum fee. Each request for a refund shall indicate the service provided and the date of service(s) involved.

(G) To the extent not otherwise precluded by the laws of this state, contracts between providers, payers and any agents acting on behalf of providers or payers shall comply with section 16-12.

16-13 DISPUTE RESOLUTION PROCESS

When seeking dispute resolution from the Division's Medical Policy Unit (MPU), the requesting party must complete the Division's "Medical ~~Billing~~ Dispute Resolution Intake Form" (Form WC 181) found on the Division's web page. The items listed on the bottom of the form must be provided at the time of submission. If necessary items are missing or if more information is

required, the Division will forward a request for additional information and initiation of the process may be delayed.

When the request is properly made and the supporting documentation submitted, the Division will issue a confirmation of receipt. If after reviewing the materials the Division believes the dispute criteria have not been met, the Division will issue an explanation of those reasons. If the Division determines there is cause for facilitating the disputed items, the other party will be sent a request for a written response, allowing the other party ten (10) business days to respond.

The MPU will facilitate the dispute by reviewing the parties' compliance with Rules 11, 16, 17, and 18 within 30 days of receipt of the complete supporting documentation; or as soon thereafter as possible. In addition, the payer shall pay interest at the rate of eight percent per annum in accordance with § 8-43-410(2), C.R.S., upon all sums not paid timely and in accordance with the Division Rules.

Upon review of all submitted documentation, disputes resulting from violation of Rules 11, 16, 17 and ~~/or~~ 18, as determined by the Director, may result in a Director's Order that cites the specific violation.

Evidence of compliance with the order shall be provided to the Director. If the party does not agree with the findings, it shall state with particularity and in writing its reasons for all disagreements by providing a response with all relevant legal authority, and/or other relevant proof upon which it relies in support of its position(s) concerning disagreements with the order.

Failure to respond or cure violations may result in penalties in accordance with § 8-43-304, C.R.S. Daily fines up to $~~1000~~1,000/day for each such offence will be assessed until the party complies with the Director's Order.

Resolution of disputes not pertaining to Rule violations will be facilitated by the MPU to the extent possible. In the event both parties cannot reach an agreement, the parties will be provided additional information on pursuing resolution and adjudication procedures available through the Office of Administrative Courts. Use of the dispute resolution process does not extend the 12 month application period for hearing.

16-14 ONSITE REVIEW OF HOSPITAL OR OTHER MEDICAL CHARGES

(A) The payer may conduct a review of billed and non-billed hospital or medical facility charges related to a specific workers' compensation claim.

(B) The payer shall comply with the following procedures:

Within 30 days of receipt of the bill, notify the hospital or other medical facility of its intent to conduct a review. Notification shall be in writing and shall set forth the following information:

(1) Name of the injured worker;

(2) Claim and/or hospital or other medical facility I.D. number associated with the injured worker's bill;

(3) An outline of the items to be reviewed; and

(4) If applicable, the name, address and telephone number of any person who has been designated by the payer to conduct the review (reviewer).

(C) The hospital or other medical facility shall comply with the following procedures:

(1) Allow the review to begin within 30 days of the payer's notification;

(2) Upon receipt of the patient's signed release of information form, allow the reviewer access to all items identified on the injured worker's signed release of information form;

(3) Designate an individual(s) to serve as the primary liaison(s) between the hospital or other medical facility and the reviewer who will acquaint the reviewer with the documentation and charging practices of the hospital or other medical facility;

(4) Provide a written response to each of the preliminary review findings within ten (10) business days of receipt of those findings; and

(5) Participate in the exit conference in an effort to resolve discrepancies.

(D) The reviewer shall comply with the following procedures:

(1) Obtain from the injured worker a signed information release form;

(2) Negotiate the starting date for the review;

(3) Assign staff members who are familiar with medical terminology, general hospital or other medical facility charging and medical records documentation procedures or have a level of knowledge equivalent at least to that of an LPN;

(4) Establish the schedule for the review which shall include, at a minimum, the dates for the delivery of preliminary findings to the hospital or other medical facility, a ten (10) business day response period for the hospital or other medical facility, and the delivery of an itemized listing of discrepancies at an exit conference upon the completion of the review; and

(5) Provide the payer and hospital or other medical facility with a written summary of the review within 20 business days of the exit conference.

Style Definition ...

DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation
7 CCR 1101-3
WORKERS' COMPENSATION RULES OF PROCEDURE

Rule 18 MEDICAL FEE SCHEDULE

Table of Contents

18-1 STATEMENT OF PURPOSE

Pursuant to § 8-42-101(3)(a)(I), C.R.S., and § 8-47-107, C.R.S., the Director promulgates this Medical Fee Schedule to review and establish maximum allowable fees for health care services falling within the purview of the Act. The Director adopts and hereby incorporates by reference, as modified and published by Medicare in ~~January 2016~~February 2017, National Physician Fee Schedule Relative Value file (RBRVS-Resource Based Relative Value Scale); the Current Procedural Terminology CPT® ~~2016~~2017, Professional Edition, published by the American Medical Association (AMA); and Medicare Severity Diagnosis Related Groups (MS-DRGs) Definitions Manual, Version 34 using MS-DRGs effective after October 1, ~~2016~~2017. The incorporation is limited to the specific editions named and does not include later revisions or additions. For information about inspecting or obtaining copies of the incorporated materials, contact the Medical Policy Unit Supervisor, 633 17th Street, Suite 400, Denver, Colorado 80202-3626. These materials may be examined at any state publications depository library. All guidelines and instructions are adopted as set forth in the RBRVS, CPT® and MS-DRGs, and all CPT® modifiers, unless otherwise specified in this Rule.

This Rule applies to all services rendered on or after January 1, ~~2017~~2018. All other bills shall be reimbursed in accordance with the fee schedule in effect at the time service was rendered.

18-2 STANDARD TERMINOLOGY FOR THIS RULE

(A) CPT® - Current Procedural Terminology CPT® ~~2016~~2017, copyrighted and distributed by the AMA and incorporated by reference in 18-1.

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

(C) MS-DRGs – version 34.0 incorporated by reference in 18-1.

(D) Medicare's ~~January 2016~~February 2017 National Physician Fee Schedule Relative Value file (RBRVS)

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

18-3 HOW TO OBTAIN COPIES

All users are responsible for the timely purchase and use of Rule 18 and its supporting documentation as referenced herein. The Division shall make available for public review and inspection the copies of all materials incorporated by reference in Rule 18. Copies of the RBRVS may be obtained from Medicare's website, ~~www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/PhysicianFeeSched/Index.html~~ www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/PhysicianFeeSched/Index.html. The Current Procedural Terminology, ~~2016~~2017 Edition, may be purchased from the AMA. The MS-DRGs Definitions Manual may be purchased from 3M Health Information Systems. The Colorado Workers' Compensation Rules of Procedures with Treatment Guidelines, 7 CCR 1101-3, may be purchased from LexisNexis Matthew Bender & Co., Inc., Albany, NY. Interpretive Bulletins and unofficial copies of all rules, including Rule 18, are available on the Colorado Department of Labor and Employment web site. An official copy of the rules is available on the Secretary of State's webpage.

18-4 CONVERSION FACTORS (CF)

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

RBRVS SECTION	CF
Anesthesia	$~~55.61~~50.00/RVU
Surgery	$~~68.01~~71.17/RVU
Radiology	$71.~~99~~17/RVU
Pathology	$68.~~31~~40/RVU
Medicine	$~~67.00~~68.34/RVU
Physical Medicine and Rehabilitation (Includes Medical Nutrition Therapy and Acupuncture)	$~~41.14~~42.38/RVU
Evaluation & Management (E&M)	$~~50.20~~53.53/RVU

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

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

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

(A) MAXIMUM ALLOWANCE

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

(1) The service is provided in a rural area. Rural area means:

(a) a county outside a Metropolitan Statistical Area (MSA) or

(b) a Health Professional Shortage Area, either located outside of an MSA or in a rural census tract, as determined by the Office of Rural Health Policy, Health Resources and Services Administration, United States Department of Health and Human Services.

(2) The ~~"incident to" criteria found in 42 CFR §§ 410.26(a) and (b), 410.27, and 410.32(b)(3) have been met.~~PA or NP has received Level I accreditation.

(B) RBRVS, CPT AND Z CODES

(1) Unless modified herein, the RBRVS is adopted for RVUs. Division-created codes (Zxxxx) and values supersede the CPT® or RBRVS codes. Those codes listed with RVUs of "BR" (by report), not listed, or listed with a zero value and not included by Medicare in another procedure(s), require prior authorization

pursuant to Rule 16. The CPT® ~~2016~~2017 is adopted for codes, descriptions, parenthetical notes and coding guidelines, unless modified in this Rule.

(2) When billing for services reported with time-based codes, practitioners are required to document in the medical record the duration of the encounter. The time considered is time spent face-to-face with the patient, performing the billed service (e.g., 60 minutes of psychotherapy) and/or the time spent performing non-face-to-face services/procedures (e.g., prolonged record review).

(3) Any billed CPT® code identified as a "separate procedure" in CPT® shall have an appropriate modifier appended to the code for the payer to allow separate payment (i.e., modifier 59 or one of the below applicable X modifiers).

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

(a) XE - Separate Encounter: a service that is distinct because it occurred during a separate encounter.

(b) XS – Separate Structure: a service that is distinct because it was performed on a separate organ/structure.

(c) XP – Separate Practitioner: a service that is distinct because it was performed by a different practitioner.

(d) XU – Unusual Non-Overlapping Service: the use of a service that is distinct because it does not overlap usual components of the main service.

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

(5) The National Physician Fee Schedule Relative Value file, as modified, are the only fields recognized in the Colorado Workers' Compensation Medical Fee Schedule:

(a) HCPCS (Healthcare Common Procedure Coding System) –including any non-listed CPT® codes;

(b) Level I (CPT®) and Level II (HCPCS) Modifiers (listed and unlisted);

(c) Description – short description as listed in the file and long description as specified in CPT®;

(d) Total Non-Facility RVU;

(e) Total Facility RVU;

(f) PC/TC (Professional Component/Technical Component) Indicators:

(i) "0" – Physician Services Only – PC/TC distinction does not apply to these service codes;

(ii) "1" – Diagnostic Radiology Tests/Services - diagnostic test codes for radiology service may be billed with or without modifiers 26 or TC;

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(iii) "2" – Professional Component Only Codes – stand-alone professional service codes only (no modifier is appropriate because the code description dictates the service is professional only, e.g., CPT® 93010 Electrocardiogram represents "interpretation and report only");

(iv) "3" - Technical Component Only Codes - stand-alone technical service codes only (no modifier is appropriate because the code description dictates the service is technical only, e.g., CPT® 93005 Electrocardiogram represents "tracing only");

(v) "4" – Global Test Only Codes - modifiers 26 and TC cannot be used with these codes because the values equal to the sum of the total RVUs (work, practice expense and malpractice);

(vi) "5" - Incident To Codes - do not apply to workers' compensation;

(vii) "6" - Laboratory Physician Interpretation Codes – clinical laboratory codes for which separate payments for interpretations by laboratory physicians may be made (these codes represent the professional component of a clinical laboratory service and cannot be billed with a modifier TC);

(viii) "7" - Physical Therapy Services – these codes are not recognized by DoWC;

(ix) "8" - Physician Interpretation Codes –clinical laboratory codes for which separate payments may be made only when a physician interprets an abnormal smear for a hospital in-patient. This indicator applies to CPT® codes 88411, 85060, and HCPCS code P3001-26. No TC component is recognized;

(x) "9" - Not Applicable – PC/TC component does not apply to this indicator;

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(g) Global Days;

(h) Conversion factors as specified in Rule 18-4.

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

(C) ANESTHESIA

(1) All anesthesia base values shall be established by the use of the codes as set forth in Medicare's ~~2016~~2017 Anesthesia Base Values. Anesthesia services are only reimbursable if the anesthesia is administered by a physician, a Certified Registered Nurse Anesthetist (CRNA), or an anesthesiologist assistant (AA) who remains in constant attendance during the procedure for the sole purpose of rendering anesthesia.

When anesthesia is administered by a CRNA or AA:

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

(b) If billed separately, CRNAs and AAs, under the medical direction of an anesthesiologist, shall be reimbursed 50% of the maximum anesthesia value. The other 50% is payable to the anesthesiologist providing the medical direction to the CRNA or AA;

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

(i) Performs a pre-anesthesia examination and evaluation,
(ii) Prescribes the anesthesia plan,
(iii) Personally participates in the most demanding procedures in the anesthesia plan including induction and emergence,
(iv) Ensures that any procedure in the anesthesia plan that s/he does not perform is performed by a qualified anesthetist,
(v) Monitors the course of anesthesia administration at frequent intervals,
(vi) Remains physically present and available for immediate diagnosis and treatment of emergencies, and
(vii) Provides indicated post-anesthesia care.

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

(a) AA – anesthesia services performed personally and billed by the anesthesiologist. Maximum allowance is 100% of maximum anesthesia calculated fees.

(b) AD – greater than four (4) concurrent (occurring at the same time) anesthesia service cases being supervised by an anesthesiologist. Maximum allowance for supervising multiple cases is calculated using three (3) base anesthesia units to each case, regardless of the number of base anesthesia units assigned to each specific anesthesia episode of care.

(c) QK – anesthesiologist providing direction to qualified individuals of two (2) to four (4) concurrent anesthesia cases. Maximum allowance is 50% of maximum anesthesia calculated fees for the billing anesthesiologist providing direction.

(d) QX – CRNA or AA service; with medical direction by a physician. Maximum allowance is 50% of the maximum anesthesia calculated fees for the CRNA or AA administering the anesthesia.

(e) QZ – CRNA service; without medical direction by a physician. Maximum allowance is 90% of maximum anesthesia calculated fees for the CRNA.

(f) QY – Medical direction of one CRNA or AA by an anesthesiologist. Maximum allowance is 50% of maximum anesthesia calculated fees for the anesthesiologist providing direction.

(g) QS – Monitored anesthesia care service (MAC).

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

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

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

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

(a)	P-1	Healthy patient	0 RVUs
(b)	P-2	Patient with mild systemic disease	0 RVUs
(c)	P-3	Patient with severe systemic disease	1 RVU
(d)	P-4	Patient with severe systemic disease that is a constant threat to life	2 RVUs
(e)	P-5	A moribund patient who is not expected to survive without the operation	3 RVUs
(f)	P-6	A declared brain-dead patient	0 RVUs

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

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

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

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

(8) Calculation of Maximum Fees for Anesthesia

Base Anesthesia value from the Medicare's ~~2016~~2017 Anesthesia Base Values

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

(9) Non-time based Anesthesia Procedures

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

(D) SURGERY

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

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

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

(3) No payment shall be made for more than one (1) assistant surgeon or minimum assistant surgeon without prior authorization for payment (see Rule 16-10).

(4) The payer may use available billing information such as provider credential(s) and clinical record(s) to determine if an appropriate modifier should be used on the bill. To modify a billed code refer to Rule 16-12(B)(4).

(5) When an operation requires two primary surgeons performing two distinct portions of the operation, modifier -62 is used with the procedure in question and reimbursement is increased to 125% of the value, apportioned in relation to the responsibilities and work of each surgeon or 50% of the total increased maximum fee to each surgeon.

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

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

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

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

(a) –AS for services performed by NPs or PAs (the 85% adjustment in section 18-5(A) does not apply);

(b) –81 for services performed by clinical nurse specialists, surgical technicians, or any other non-physician providers~~;~~.

(6) Global Period

(a) All surgical procedures include the following:

(i) Local infiltration, metacarpal/metatarsal/digital block or typical anesthesia;
(ii) One related E&M encounter on the date immediately prior to or on the date of the procedure (including history and physical);
(iii) Intraoperative services that are normally a usual and necessary part of a surgical procedure;
(iv) Immediate postoperative care, including dictating operative notes, talking with the family and other physicians;
(v) Evaluating the patient in the post-anesthesia recovery room;
(vi) Post-surgical pain management by the surgeon;
(vii) Typical postoperative follow-up care during the global period of the surgery that is related to recovery from the surgery as identified in RBRVS as global:

- 000 –are endoscopies or some minor surgical procedures, typically a 0 day postoperative period. Visits on the same day of procedures are generally included in the allowance for the procedure, unless a separately identifiable service is performed and billed with the appropriate modifier.
- 010 - are other minor procedures, 10 day postoperative period.
- 090 - are major surgeries, 90 day postoperative period.
- XXX – does not apply
- ZZZ – are covered under another procedure's global days
- MMM – global service day's concept does not apply. (See Medicare's Global Maternity Care reporting rule.)
- Global period, defined RBRVS, begins the day after surgery and continues for the defined period.

(viii) Supplies – Except for those identified as exclusions;
(ix) Miscellaneous Services – Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts and splints; insertion, irrigation and removal of urinary catheters, routine peripheral IV lines, ~~nasogastric~~nasogastric and rectal tubes; changes and removal of tracheostomy tubes;
(x) Applicable Surgical Modifiers:

- 22 – Increased procedural service. The payer and provider shall negotiate the value based on the fee schedule and the amount of additional work.

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- 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.

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

(i) E&M services unrelated to the primary surgical procedure.
(ii) Services necessary to stabilize the patient for the primary surgical procedure.
(iii) Services not considered part of the surgical procedure, including an E&M visit by an authorized treating physician for disability management. The E&M service shall have an appropriate modifier appended to the E&M level of the service code when the surgeon is performing services during the global period. If at all possible, an appropriate identifying diagnosis code shall identify the E&M service as unrelated to the surgical global period. In addition, the reasonableness and necessity for an E&M service that is separate and identifiable from the surgical global period shall be clearly documented in the medical record.
(iv) Disability management of an injured worker for the same diagnosis requires the managing physician to clearly identify in the medical record the specific disability management detail that was performed during that visit. The definitions of what is considered disability counseling can be located under 18-5(l)(1) and in Exhibit #7 of this Rule.
(v) Unusual circumstances, complications, exacerbations, or recurrences.
(vi) Unrelated diseases or injuries.
(vii) If a patient is seen for the first time or an established patient is seen for a new problem and the "decision for surgery" is made the day of the procedure or the day before the procedure is performed, then the

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surgeon can bill both the procedure code and an E&M code, using a -57 modifier or -25 modifier on the E&M code.

(c) Separately identifiable services shall use an appropriate CPT®/ modifier in conjunction with the billed service.

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

Multiple procedure guidelines (modifier -51) do not apply to codes specifically identified in CPT® as add-on procedures "+" or to those specifically identified as exempt from modifier -51.

Bilateral procedures not identified by CPT® as bilateral shall be billed on one line with one (1) unit and modifier -50 shall be appended to the CPT® code. The maximum fee is calculated at 150% of the Maximum Fee Schedule value.

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

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

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

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

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

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

(11) Platelet Rich Plasma (PRP) Injections

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

The provider performing PRP injections in an office setting shall bill DoWC Z0813, maximum total ~~all-inclusive~~ allowance of $~~735~~744.00, for ~~PRP injections~~ professional fees.

The provider performing PRP injections in a facility setting shall bill CPT® 0232T, maximum total allowance of $269.50, for professional fees.

The above allowances include and apply to ~~any~~all body ~~part. This includes~~parts, imaging guidance, harvesting ~~and~~, preparation ~~(if performed),~~ the injection itself, ~~as well as~~and kits and supplies.

(E) RADIOLOGY

(1) General Policies

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

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

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

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

(2) Payments

(a) The Division recognizes the value of accreditation for quality and safe radiological imaging. Only offices/facilities that have attained accreditation from American College of Radiology (ACR), Intersocietal Accreditation Commission (IAC), RadSite, or The Joint Commission (TJC) may bill the technical component for ~~advanced diagnostic imaging~~Advanced Diagnostic Imaging (ADI) procedures (magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine scan). Providers separately reporting Z9999 certify accreditation status. The payer may also request proof of accreditation.

(b) The professional component for MRIs, CTs, and nuclear medicine scans performed in an accredited facility is reimbursable at 130% of the fee schedule.

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

(d) Copying charges for x-rays and MRIs shall be $15.00/film regardless of the size of the film.

(e) The payer may use available billing information such as provider credential(s) and clinical record(s) to determine if an appropriate CPT®/RBRVS modifier should have been used on the bill. To modify a billed code, refer to Rule 16-12(B)(4).

(f) In billing radiology services, the applicable radiology procedure code shall be billed using the appropriate modifier to bill either the professional component (26) or the technical component (TC). If a physician bills the total or professional component, a separate written interpretive report is required.

(g) Providers using film instead of digital X-rays shall append "FX" modifier. The fee is 80% of the maximum fee schedule.

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

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

(3) Thermography

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

(i) American Academy of Thermology~~;~~. or
(ii) American Chiropractic College of Infrared Imaging.

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

(i) Complex Regional Pain Syndrome/Reflex Sympathetic Dystrophy (CRPS/RSD);
(ii) Sympathetically Maintained Pain (SMP);or
(iii) 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:

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DoWC Z0200 Upper body w/ Autonomic Stress Testing
$~~865.37~~980.00

DoWC Z0201 Lower body w/Autonomic Stress Testing
$~~865.37~~980.00

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

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

(F) PATHOLOGY

(1) General Policies

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

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

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

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

(2) Clinical Laboratory Improvement Amendments (CLIA)

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

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

(3) Payments

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

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

(a) physician blood bank services,

(b) cytopathology and cell marker study interpretations,

(c) cytogenics or molecular cytogenics interpretation and report,

(d) surgical pathology gross and microscopic and special stain groups 1 and 2 and histochemical stain, blood or bone marrow interpretations, and

(e) Skin tests for "unlisted antigen each, 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 RBRVS, not DoWC Z0755.

(4) Clinical Drug Screening/Testing Codes and Values

(a) Clinical drug screening/testing evaluates whether:

(i) Prescribed medications are at or below therapeutic or toxic levels (Therapeutic Drug Monitoring); or
(ii) The patient is taking prescribed controlled substance ~~medication(s);~~medications; or
(iii) The patient is taking any illicit or non-prescribed drugs.

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(b) Billing requirements for Clinical Drug Testing:

(i) The ordering physician shall document the medical necessity of the clinical drug test.
(ii) The ordering physician shall specify which drugs require definitive testing to meet the patient's medical needs.
(iii) Quantification of illicit or non-prescribed drugs or drug classes requires a physician order.

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(iv) Medicare codes used in the ~~2016~~2017 Medicare Fee Schedule shall be billed for presumptive and definitive urine drug tests.

(v) All recognized codes and maximum fee values are listed in Exhibit #8 to this rule.

(c) Presumptive Tests

Presumptive drug class assays identify possible use or non-use of drug(s) or drug class(es), but may not identify the specific drug or metabolite. All drug class immunoassays or enzymatic methods are considered to be presumptive. Providers may ONLY bill for one (1) of the three presumptive codes per date of service, regardless of the number of drug classes tested~~:~~. Presumptive drug class screening shall be billed using one of three codes – 80305, 80306, or 80307.

~~(i) Drug test(s), presumptive, any number of drug classes; any number of devices or procedures (e.g. immunoassay) capable of being read by a direct optical observation only (e.g. dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service (G0477).~~

~~(ii) Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g, immunoassay) read by instrument-assisted direct optical observation (e.g. dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service (G0478).~~

~~(iii) Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers (e.g, immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service (G0479).~~

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

(d) Definitive Tests – Gas Chromatography/Mass Spectrometry (GC/MS) or Liquid Chromatography/Mass Spectrometry (LC/MS) – no immunoassays or enzymatic methods.

(i) Definitive qualitative or quantitative tests identify specific drug(s) and any associated metabolites, providing sensitive and specific results expressed as a concentration in ng/mL or as the identity of a specific drug. Definitive quantitative tests must be ordered by a physician. The reasons for ordering a definitive quantification drug test may include:

- Unexpected positive presumptive or qualitative test results inadequately explained by the injured worker~~;~~.
- Unexpected negative presumptive or qualitative test results and suspected medication diversion~~;~~.
- Differentiate drug compliance:
  - Buprenorphine vs. norbuprenorphine
  - Oxycodone vs. oxymorphone, noroxycodone and oxycodone

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- Need for quantitative levels to compare with established benchmarks for clinical decision-making, such as tetrahydrocannabinol (THC) quantitation to document discontinuation of a drug.
- Chronic Opioid Management
  - Drug testing shall be done prior to the implementation of the initial long-term drug prescription and randomly repeated at least annually.
  - While the injured worker is receiving chronic opioid management, additional drug screens with documented justification may be conducted. Examples of documented justification include the following:
    - Concern regarding the functional status of the patient
    - Abnormal results on previous testing
    - Change in management of dosage or pain
    - Chronic daily opioid dosage above 150 mg of morphine or equivalent
- ~~The following four definitive drug testing codes replace the G6030 - G6058 HCPCS codes.~~ Providers may ONLY bill for one ~~(1)~~ of the ~~four~~five definitive codes per day:

  - G0480- Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to ~~GC/MS~~gc/ms (any type, single or tandem) and ~~LC/MS~~lc/ms (any type, single or tandem and excluding immunoassays (~~eg, IA, EIA, ELISA, EMIT, FPIA~~e.g., Ia, eia, elisa, emit, fpia) and enzymatic methods ~~(eg,~~[e.g., alcohol dehydrogenase~~));~~]), (2) Stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day~~,~~; 1-7 drug class(es), including metabolite(s) if performed.
  - G0481- Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to ~~GC/MS~~gc/ms (any type, single or tandem) and ~~LC/MS~~lc/ms (any type, single or tandem and excluding immunoassays (e.g~~, IA, EIA, ELISA, EMIT, FPIA~~., Ia, eia, elisa, emit, fpia) and enzymatic methods ~~(~~[e.g~~.~~., alcohol dehydrogenase~~));~~]), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day~~,~~; 8-14 drug class(es), including metabolite(s) if performed.
  - G0482- Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish

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between structural isomers (but not necessarily stereoisomers), including, but not limited to ~~GC/MS~~gc/ms (any type, single or tandem) and ~~LC/MS~~lc/ms (any type, single or tandem and excluding immunoassays (e.g~~. IA, EIA, ELISA, EMIT, FPIA~~., Ia, eia, elisa, emit, fpia) and enzymatic methods (e.g~~.~~., alcohol dehydrogenase~~));~~)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day~~,~~; 15-21 drug class(es), including metabolite(s) if performed~~.~~),

- G0483- Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to ~~GC/MS~~gc/ms (any type, single or tandem) and ~~LC/MS~~lc/ms (any type, single or tandem and excluding immunoassays (~~eg, IA, EIA, ELISA, EMIT, FPIA~~e.g., Ia, eia, elisa, emit, fpia) and enzymatic methods (~~eg, alcohol~~e.g., Alcohol dehydrogenase~~));~~)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., To control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., To control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day~~,~~; 22 or more drug class(es), including metabolite(s) if performed.
- ~~(ii)~~ G0659 - Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to gc/ms (any type, single or tandem) and lc/ms (any type, single or tandem), excluding immunoassays (e.g., Ia, eia, elisa, emit, fpia) and enzymatic methods (e.g., alcohol dehydrogenase), performed without method or drug-specific calibration, without matrix-matched quality control material, or without use of stable isotope or other universally recognized internal standard(s) for each drug, drug metabolite or drug class per specimen; qualitative or quantitative, all sources, includes specimen validity testing, per day, any number of drug classes.

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

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

Anabolic steroids	Buprenorphine	hetamines	Relaxants
Analgesics, non-opioids	Cannabinoids, natural	Methylphenidate	Stereoisomer (enantiomer) analysis
Antidepressants, serotonergic class	Cannabinoids, synthetic	Opiates	Stimulants, synthetic
Antidepressants, Tricyclic and other cyclicals	Cocaine	Opioids and Opiate analogs	Tapentadol
Antidepressants, not otherwise specified	Fentanyls	Oxycodone	Tramadol
Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified			

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(G) MEDICINE

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(1) Medicine home therapy services in the RBRVS are not adopted. For appropriate codes see section 18-6(M) Home Care Services.

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

(3) Biofeedback

Licensed medical and mental health professionals who provide biofeedback must practice within the scope of their training. Non-licensed biofeedback providers must hold Clinical Certification from the BCIA, practice within the scope of their

training, and receive a prior approval of their biofeedback treatment plan from the patient's authorized treating physician, psychologist, or psychiatrist. Professionals integrating biofeedback with any form of psychotherapy must be licensed as a psychologist, a social worker, a marriage or a family therapist, or a licensed professional counselor. For purposes of this rule, "licensed" means holding a license issued by the Colorado Medical Board, the Colorado Board of Chiropractic Examiners, the Colorado Podiatry Board, the Colorado Dental Board, or a board of the Colorado Department of Regulatory Agencies (DORA).

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

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

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

CPT® Code 90901, Biofeedback training by any modality:

Non-facility RVU is 2.14, Facility RVU is 1.14

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

Non-facility RVU is 4.76, Facility RVU is 2.48

(4) Appendix J of the ~~2016~~2017 CPT® identifies mixed, motor, and sensory nerve conduction studies and ~~their appropriate~~applicable billing~~.~~ requirements. EMG and NCV values generally include an evaluation and management (E&M) service. However, an E&M service may be separately payable if the requirements listed in Appendix A of the 2017 CPT® for billing modifier 25 have been met.

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

(a) Prior authorization for payment (see Rule 16-10) shall be obtained before billing for more than four body regions in one (1) visit. Manipulative therapy is limited to the maximum allowed in Rule 17, Medical Treatment Guidelines. The provider's medical records shall reflect medical necessity and prior authorization for payment (see Rule 16-10) if treatment exceeds these limitations.

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

(c) Facility RVU is 0.79 and non-facility RVU is 1.00 for CPT® code 98940.

(6) Psychiatric/Psychological Services:

(a) A licensed psychologist (PsyD, PhD, EdD) is reimbursed a maximum of 100% of the medical fee listed in the RBRVS. Other non-physician

providers performing psychological/psychiatric services shall be paid at 85% of the fee allowed for physicians.

(b) Prior authorization for payment (see Rule 16-10) is required any time the limitations discussed in this rule are exceeded on a single day.

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

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

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

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

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

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

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

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

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

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

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

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

(1) Both services must be separately identifiable;

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

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

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

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

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

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

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

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

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

(i) Resting Sweat Test;
(ii) Stimulated Sweat Test;

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(iii) Resting Skin Temperature Test; and

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

(b) 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~~066.00

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

(9) Intra-Operative Monitoring (IOM)

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

(a) Clinical Services for IOM: Technical and Professional

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

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

(ii) Professional/Supervisory /Interpretive

A ~~specifically neurophysiology trained~~ Colorado licensed physician trained in neurophysiology shall monitor the patient's nervous system throughout the surgical procedure. The monitoring physician's time is billed based upon the actual time the physician devotes to the individual patient, even if the 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

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neuromonitoring physician, unless he/she is utilized in a specific case.

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

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

(b) Procedures and Time Reporting

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

(c) Billing Restrictions

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

CPT® 95940 and 95941 do not have separate professional and technical components. However, certain tests performed in conjunction with CPT® 95940 and 95941 throughout the surgical procedure do have separate professional and technical components, which may be separately payable if documented and otherwise allowed under Rule 18.

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

(10) Speech Therapy/Evaluation and Treatment

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

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

(11) Vaccine and Toxoids

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

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

IV infusion therapy performed in a physician's office shall be billed under the "Therapeutic, Prophylactic, and Diagnostic Injections and Infusions" and the "Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration" in the Medicine Section of CPT®. The appropriate CPT®/RBRVS code units multiplied by the Medicine conversion factor is the

Maximum Fee Schedule value for the infusion service. The infused therapeutic drugs are payable at cost to the provider's office.

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

~~(13~~ (13) Moderate (conscious) sedation

Providers billing for moderate sedation services shall comply with all applicable 2017 CPT® billing instructions. The maximum fee schedule value is determined using the Medicine Conversion Factor.

~~(14~~) Special Services, Procedures and Reports in the Medicine Section of CPT®

(a) Handling and conveyance of specimens in connection with a transfer from an office to a laboratory is a flat rate of $25.00 (CPT® codes 99000 and/or 99001). Any other handling and conveyance in connection with implementation of an order involving devices (such as orthotics) is a flat rate of $13.00 (CPT® code 99002).

(b) Postoperative follow-up visit, CPT® code 99024, is included in the global package and is not separately payable.

(c) Educational supplies are considered "at cost" to the provider and may be billed based upon an agreement between the payer and provider (CPT® codes 99070, 99071 or 99078).

(d) Any stored clinical or physiological data analysis is not recognized unless the provider shows the reasonableness and necessity of these services and obtains prior authorization from the payer (CPT® codes 99090 and 99091).

(e) The charges for services performed after regular business hours, during holidays, or during scheduled disruptions of regular office services are not separately payable unless the provider shows the reasonableness and necessity of these services and obtains prior authorization (CPT® codes 99026, 99027, 99050, 99051, 99053, 99056, 99058, and 99060).

(f) Unusual travel expenses require prior authorization by the payer. The payer and billing provider shall agree upon maximum fees (CPT® code 99082).

(g) Medical testimony is covered under Rule 18-6(D) and special reports are covered under Rule 18-6(G)(3)&(4) (CPT® codes 99075 and 99080).

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

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

(1) Billing and documentation requirements:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Dry Needling of Trigger Points, Single or multiple needles,

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

(7) Modalities

RBRVS Timed and Non-timed Modalities

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

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

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

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

(a) All evaluation services must be supported by the appropriate history, physical examination documentation, treatment goals and treatment plan or re-evaluation of the treatment plan~~.~~, as outlined in the 2017 CPT®. The provider shall clearly state the reason for the evaluation, the nature and results of the physical examination of the patient, and the reasoning for recommending the continuation or adjustment of the treatment protocol. Without appropriate supporting documentation, the payer may deny payment. The re-evaluation codes shall not be billed for routine pre-treatment patient assessment.

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

A reexamination, reevaluation, or ~~reassessment (CPT® codes 97002, 97004, or 97006) are~~re-assessment is different from a progress note. Therapists should not bill these codes for a progress note. Therapists may bill CPT® codes ~~97002, 9700497164, 97168~~, or ~~9700697172~~ for a reevaluation only in the following cases:

(i) Professional assessment indicates a significant improvement or decline or change in the patient's condition or a functional status that was not anticipated in the Plan of Care (POC) for that time interval.
(ii) New clinical findings come to light.
(iii) The patient fails to respond to the treatment outlined in the current POC.

(b) PT and OT and Athletic Trainer Evaluation and Re-Evaluation RVU changes are as follows:

~~CPT® code 9700197161 –~~ PT ~~and 97003 OT Initial Evaluation =~~initial evaluation, low complexity, 1.66 RVUs

~~(i)~~ 97162 – PT initial evaluation, moderate complexity, 2.48 RVUs~~, facility and non-facility;~~

~~CPT® code 97005 Athletic Trainer Initial Evaluation is 85% of the PT/~~97163 – PT initial evaluation, high complexity, 3.71 RVUs

97164 – PT re-evaluation, 1.60 RVUs

97165 – OT initial evaluation, low complexity, 1.66 RVUs

~~(ii)~~ 97166 – OT initial evaluation ~~service value;~~, moderate complexity, 2.48 RVUs

~~CPT® code 97002 PT and 9700497167 –~~ OT ~~Re-Evaluation = 1.68~~initial evaluation, high complexity, 3.71 RVUs~~,~~

97168 – OT re-evaluation, 1.60 RVUs

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97169 – ATC initial evaluation, low complexity, 1.41 RVUs

97170 – ATC initial evaluation, moderate complexity, 2.10 RVUs

97171 – ATC initial evaluation, high complexity, 3.10 RVUs

97172 – ATC re-evaluation, 1.36 RVUs

~~(iii)~~ The above RVUs are for both facility and non-facility~~,~~ providers.

~~(iv) CPT® code 97006 Athletic Trainer re-evaluation is 85% of the PT/OT reevaluation value.~~

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

Billing code DoWC Z0817 - $15.00

(d) Payers are only required to pay for evaluation services directly performed by a PT, OT, or ATC. All evaluation notes or reports must be written and signed by the PT, OT or ATC.

(e) A patient may be seen by more than one (1) health care professional on the same day. An evaluation service with appropriate documentation may be charged by each professional per patient, per day.

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

(g) All interdisciplinary team conferences shall be billed in compliance with section18-5(H)(5).

(9) Special Tests

(a) The following ~~respective tests~~ are considered special tests:

(i) Job Site Evaluation
(ii) Functional Capacity Evaluation
(iii) Assistive Technology Assessment
(iv) Speech
(v) Computer Enhanced Evaluation (DoWC Z0503)
(vi) Work Tolerance Screening (DoWC Z0504)

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

(b) Billing Restrictions:

(i) Job Site Evaluations require prior authorization for payment (see Rule 16-10) if exceeding two (2) hours. Computer-Enhanced Evaluations and Work Tolerance Screenings require prior authorization for payment for more than four (4) hours per test or more than three (3) tests per claim. Functional Capacity Evaluations require prior authorization for payment for more than four (4) hours per test or two (2) tests per claim.

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

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

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

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

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

(10) Supplies

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

(11) Unattended Treatment

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

DoWC Z0505	fixed fee per day	0.232 RVU

(12) Non-Medical Facility

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

(13) Unlisted Service Physical Medicine

All unlisted services or procedures require a report.

(14) Work Conditioning, Work Hardening, Work Simulation

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

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

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

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

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

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

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

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

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

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(15) Wound Care

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

(I) EVALUATION AND MANAGEMENT (E&M)

(1) Evaluation and management codes may be billed by medical providers as defined in Rule 16-5(A)(1)(a~~) as well as~~), nurse practitioners (NP~~)~~), and physician

assistants (PA). ~~Medical~~To justify the billed level of E&M service, medical record documentation shall ~~encompass~~utilize the 2017 CPT® E&M Services Guidelines and either the "E&M Documentation Guidelines" criteria ~~as~~ adopted in Exhibit #7 of this Rule, or Medicare's 1997 Evaluation and Management Documentation Guidelines~~, to justify the billed level of E&M service.~~ .

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

(2) New or Established Patients

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

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

(3) Number of Office Visits

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

(4) Treating Physician Telephone or On-line Services (CPT® 99441-99444):

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~~ the medical records/documentation specifies all the following:

~~(i~~
(a) The amount of time and date;
(~~ii~~b) The patient, family member, or healthcare provider talked to; and
(~~iii~~c) The specifics of the discussion and/or decision made during the communication.

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

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

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

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

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

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

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

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

(a) Identification of the requesting physician for the opinion.

(b) Documentation in the report supports the need for a consultant's opinion.

(c) Identification the report was submitted to the requesting provider (either carbon copied or written directly to the requesting provider).

Outpatient Consultation RVUs:

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

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

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

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

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

Inpatient Consultation facility RVUs:

CPT® 99251 = 2.79

CPT® 99252 = 3.83

CPT® 99253 = 4.95

CPT® 99254 = 6.39

CPT® 99255 = 8.47

Subsequent Hospital RVU changes are as follows:

CPT® 99231 = 2.21 RVUs

CPT® 99232 = 3.15 RVUs

CPT® 99233 = 4.22 RVUs

(7) ~~When~~Prolonged Services:

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

(a) Physicians or other qualified health care professionals (MDs, DOs, DCs, DMPs, NPs, and PAs) with or without direct patient contact:

(i) An E&M code shall accompany prolonged services codes CPT® 99354-99357.
(ii) The provider must exceed the average times listed in the E&M section of CPT® by 30 minutes or more, in addition to the prolonged services codes.
(iii) If using time spent (rather than three key components) to justify the level of primary E&M service, the provider must bill the highest level of service available in the applicable E&M subcategory before 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~~.
(iv) The provider billing CPT® 99358 and 99359 for extensive record review shall document the names of providers and dates of service reviewed, as well as briefly summarize each record reviewed.

(b) Prolonged clinical staff services (RNs or LPNs) with physician or other qualified health care professional supervision:

(i) The supervising physician or other qualified health care professional may not bill CPT® 99354-99359 for the time spent supervising clinical staff.
(ii) Clinical staff services cannot be provided in an urgent care or emergency room setting.

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(J) TELEHEALTH

(1) "Telehealth" ~~is~~and "telemedicine" are defined in ~~Rule~~Rules 16-2(X~~).~~) and (Y). The healthcare services listed in Appendix P of CPT® and Division Z-codes (when appropriate) may be provided via telehealth or telemedicine. The provider shall append modifier 95 to the services listed in Appendix P to indicate synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system.

All healthcare services provided through telehealth or telemedicine shall comply with the applicable requirements found in the Colorado Medical Practice Act and Colorado Mental Health Practice Act, as well as the rules and policies adopted by the Colorado Medical Board and the Colorado ~~State~~ Board of Psychologist Examiners.

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

~~Q3014 $35.00 /per 15 minutes~~

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

~~(3~~(2) HIPAA privacy and electronic security standards are required for ~~both~~ the originating site(s) and the rendering ~~providers.~~ provider(s).

~~(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.~~ (3) The originating site is responsible for establishing and verifying injured worker and provider identity. Authorized originating sites include:

(a) The office of a physician or practitioner

(b) A hospital (inpatient or outpatient)

(c) A critical access hospital (CAH)

(d) A rural health clinic (RHC)

(e) A federally qualified health center (FQHC)

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

(g) A skilled nursing facility (SNF)

(h) A community mental health center (CMHC)

~~(5~~(4) The physician-patient / psychologist-patient relationship needs to be established.

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

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

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

~~(6~~(5) Payment for telehealth and telemedicine services:

(a) Telehealth services performed outside of an authorized originating site must be billed without an originating site fee. The distance (rendering) provider may be the only provider involved in the provision of telehealth services. The rendering provider shall bill CPT® place of service (POS) code 02, with a GT modifier. This POS code does not apply to the originating site billing a facility fee.

(b) Professional fees of the supporting providers at originating sites are not separately payable.

(c) For all telehealth services, the provider shall bill the appropriate CPT® code with the GT modifier. Reimbursement is the RBRVS unit value for the CPT® code times the appropriate CF + $5.00 when modifier GT is appended to the appropriate CPT® code(s).

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

(d) ~~from~~Telehealth:

(i) Approved telehealth facilities can bill for the originating fee as follows:
Q3014 $35.00 /per 15 minutes
A private residence at which an injured worker is located when he or she is receiving healthcare services through telehealth may not bill for the originating fee.

(ii) Payment for telehealth services that have professional and technical components:
The originating site provider shall bill the technical component (modifier TC). The distant site ~~practitioners~~provider interpreting the results shall bill the professional component (modifier 26).

~~(a~~(iii)The equipment or supplies at distant sites are not separately payable.

(e) Telemedicine:

(i) The medical providers shall bill codes G0425-G0427 for telehealth consultations, emergency department or initial inpatient. The

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maximum fee values are determined by multiplying the RBRVS RVUs and the E&M conversion factor listed in Rule 18-4.

~~(b~~(ii) The medical providers shall bill codes G0406-G0408 for follow up inpatient telehealth consultations. The maximum fee values are determined by multiplying the RBRVS RVUs and the E&M conversion factor listed in Rule 18-4.

~~(c) For all telehealth services, the provider shall bill the appropriate RBRVS CPT® code with the GT modifier. Reimbursement is the RVU value for the CPT® code times the appropriate CF + $5.00 when modifier GT is appended to the appropriate CPT® code(s).~~

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

18-6 DIVISION ESTABLISHED CODES AND VALUES

(A) FACE-TO-FACE OR TELEPHONIC MEETINGS

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

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

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

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

(i) Who was present at the meeting and their role at the meeting;
(ii) Purpose of the meeting;
(iii) A brief statement of recommendations and actions at the conclusion of the meeting;
(iv) Documented time (both start and end times); and
(v) Billing code DoWC Z0701.
$~~75~~85.00 per 15 minutes for time attending the meeting and preparing the report (no travel time or mileage is separately payable). The fee includes the cost of the report for all parties, including the injured worker.

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

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

Billing Code DoWC Z0601: $~~65~~74.00 per 15 minutes billed to the requesting party.

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

(4) Peer-to-peer review by a treating physician with a medical reviewer, following the treating physician's complete prior authorization request as defined in Rule 16-10(F).

Billing Code DoWC Z0602: $74.00 per 15 minutes billed to the requesting party.

(B) CANCELLATION FEES FOR PAYER-MADE APPOINTMENTS

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

~~One~~ The payer shall pay one-half of the usual fee for the scheduled services, or $~~150~~180.00, whichever is less~~.~~:

Cancellation Fee Billing Code: DoWC Z0720 or the code corresponding to the service that has been cancelled and append modifier 51.

For payer-made appointments scheduled for four (4) hours or longer, the payer shall pay one-half of the usual fee for the scheduled service. The provider shall bill the code corresponding to the service that has been cancelled and append modifier 51.

(2) Missed Appointments:

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

(C) COPYING FEES

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

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

Copying Fee Billing Codes and Maximum Fees:

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

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

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

DoWC Z0727 - $1.50 per microfilm page

DoWC Z0728 - $14.00 per computer disc or as agreed

DoWC Z0729 - $0.10 per electronic page or as agreed

DoWC Z0802 – actual postage paid

(D) DEPOSITION AND TESTIMONY FEES

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

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

(2) By prior agreement, the provider may charge for preparation time for a deposition or testimony, 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~~Physician as defined by Rule 16-5(A)(1)(a) or Psychologist (PsyD, PhD, or EdD):

DoWC Z0730 $367.00 per hour, billed in half-hour increments.

Other providers shall be paid 85% of this fee.

(3) Deposition:

Payment for a treating or non-treating provider's testimony at a deposition shall not exceed $~~325~~367.00 per hour for physicians or psychologists, billed in half-hour increments. Calculation of the provider's time shall be "portal to portal." Other providers shall be paid 85% of this fee.

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

If the provider is notified of the cancellation of the deposition at least 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:~~ Physician as defined by Rule 16-5(A)(1)(a) or Psychologist (PsyD, PhD, or EdD):

DoWC Z0734 $~~325~~367.00 per ~~hr.~~

~~Billed~~hour, billed in half-hour increments.

Other providers shall be paid 85% of this fee.

(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:~~ Physician as defined by Rule 16-5(A)(1)(a) or Psychologist (PsyD, PhD, or EdD):

DoWC Z0738 $~~450~~508.00 per hour, billed in half-hour increments.

Other providers shall be paid 85% of this fee.

(E) INJURED WORKER TRAVEL EXPENSES

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

Mileage Expense Billing Code: DoWC Z0723

Other Travel Expenses Billing Code: DoWC Z0724

(F) PERMANENT IMPAIRMENT RATING

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

(2) Provider Restrictions

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

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

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

(4) MMI Determined with a Calculated Permanent Impairment Rating

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

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

(b) Use the appropriate DoWC code:

(i) Fee for the Level II Accredited Authorized Treating Physician Providing Primary Care:
Bill DoWC Z0759 $~~355~~575.00.

(ii) Fee for the Referral, Level II Accredited Authorized Physician~~.~~ (the claimant is not a previously established patient to that physician):
Bill DoWC Z0760 $~~575~~775.00.

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

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

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

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(G) REPORT PREPARATION

(1) Routine Reports

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

(a) Diagnostic testing

(b) Procedure reports

(c) Progress notes

(d) Office notes

(e) Operative reports

(f) Supply invoices, if requested by the payer

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

(a) Initial Report

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

(b) Closing Report

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

(i) All necessary permanent impairment rating reports, medical reports and narrative relied upon ~~by the~~by the authorized treating physician(ATP), when the ATP (generally the designated or selected physician) managing the total workers' compensation claim of the patient is Level II Accredited, or

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

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(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~~49.00	Initial Report
DoWC Z0751	$~~47~~49.00	Progress Report (Payer Requested or Provider Initiated)
DoWC Z0752	$~~47~~49.00	Closing Report
DoWC Z0753	$~~47~~49.00	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~~49.00 per form completion

(4) Special Reports

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

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

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

Cancellation:

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

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

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

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

Billing Codes:

Written Report Only	DoWC Code:	Z0755
Lengthy Form Completion	DoWC Code:	Z0757
18-5(I)(8) meeting and report with Non-treating Physician	DoWC Code:	Z0758

Special Report Maximum Fees: $367.00 per hour billed in 15- minute increments.

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

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

IME Audio Recording exam	DoWC Code:	Z0766 $~~30~~34.00 per
IME Audio copying fee copy	DoWC Code:	Z0767 $~~20~~23.00 per

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

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

~~IME Fees are established in~~See Rule 11~~.~~ for billing codes and fees

~~Longthy Form Completion DoWC Code: Z0757~~

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

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

All RIME, CIME and DIME reports are due no later than 20 calendar days after the examination.

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

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

(2) Unless other limitations exist in this Rule, medical professionals shall bill supplies, including "Supply et al.," orthotics, prostheses, durable medical equipment (DME) or drugs, including injectables, using Medicare's HCPCS Level II codes, when one exists, as established in the January ~~2016~~2017 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) schedule for rural (R) or non-rural (NR). Rural is identified in Medicare's DME Rural Zip and Formats file on their website or the January ~~2016~~2017 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~~http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html.The Medicare Part B Drug Average Sale Price (ASP) fees can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html?redirect=/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp

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

(3) Payers shall pay medical professionals using Medicare's January ~~2016~~2017 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,

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the payer shall pay 120% of the cost for the item as indicated on the provider's invoice. Payers shall not recognize the KE modifier.

(4) Unless other limitations exist in this Rule, DMEPOS suppliers shall be reimbursed using Medicare's HCPCS Level II codes, when one exists, as established in the ~~January~~July 2016 DMEPOS schedule. Otherwise, the supplier shall be reimbursed at 100% of Colorado Medicaid's January ~~2016~~2017 fee schedule. The Colorado Medicaid Fee Schedule can be found at: ~~https://www.colorado.gov/hcpf/provider-rates-fee-schedule~~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. Shipping and handling charges are not separately payable.

(5) Durable Medical Equipment (DME) is equipment that can withstand repeated use and allows injured workers accessibility in the home, work, and community. DME can be categorized as:

(a) Inexpensive or Routinely Purchased: These items cost less than $50.00. The maximum fee for these items is identified in section (9) of this rule.

(b) Capped Rental/Purchased Equipment:

(i) Rented DME items must be purchased or discontinued after 15 months of continuous use.

(ii) The monthly rental rate cannot exceed 10% of the DMEPOS fee schedule, or if not available, the cost of the item to the provider or the supplier (after taking into account any discounts/rebates the supplier or the provider may have received). The payer shall not pay for rental fees once the ~~purchase~~total fee scheduled price of the rented item has been reached. When the item is purchased, all rental fees shall be deducted from the total fee scheduled price. If necessary, the parties should use an invoice to establish the purchase price.

(iii) Items that cost $100.00 or less (according to provider's invoice) shall be purchased and reimbursed pursuant to section 18-6(H) of this rule.

(iv) Purchased items may require maintenance/servicing agreements or fees. The fees are separately payable. Rented items typically include these fees in the monthly rental rates.

(c) All electrical stimulators are bundled kits that include the portable unit(s), 2 to 4 leads and pads, initial battery(s), electrical adapters, and carrying case. The kits that cost more than $100.00 shall be rented for the first month of use before a potential purchase ~~price.~~. The monthly rental rate shall not exceed 10% of the total fee scheduled price. Provider shall request prior authorization and document the effectiveness of the kit for the injured worker prior to purchasing an item that costs more than $100.00. Effectiveness should include functional improvement and decreased pain. The billing provider shall append modifiers "NU" for new

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or "UE" for used purchased items or modifier "RR" for rented items. Billing codes for the items are as follows:

~~(6~~

(i) TENS (Transcutaneous Electric Nerve Stimulator) machines/kits, IF (Interferential) machines/kits, and any other type of electrical stimulator combination kits: E0720 for a kit with 2 leads or E0730 for a kit with 4 leads;

(ii) Electrical Muscle Stimulation machines/kits: E0744 for scoliosis; or E0745 for neuromuscular stimulator, electric shock unit;

(iii) Osteogenesis electrical stimulation: E0748 or E0749 for non-invasive spinal application, or E0760 for ultrasound low intensity;

(iv) All replacement supplies may be billed no more than once a month using A4595 for electrical stimulator supplies, 2 leads, or A4557 for replacement leads. Code A4557 should not be billed with the first month's rent.

(v) Conductive Garments: E0731;

(d) Continuous Passive Motion Devices (CPMs):

E0935 – continuous passive motion exercise device for use on the knee only; or E0936 – continuous passive motion exercise device for use on body parts other than knee. These devices are bundled into the facility fees and not separately payable.

(e) Intermittent Pneumatic Devices (including, but not limited to, Game Ready and cold compression) are bundled into the facility fees and not separately payable. The use of these devices after discharge requires prior authorization. The billing codes are as follows:

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

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

(6) Auto-shipping of monthly DMEPOS supplies is not allowed.

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

(~~7~~8) Payment for professional services associated with the fabrication and/or modification of orthotics, custom splints, adaptive equipment, and/or adaptation and programming of communication systems and devices shall be paid in accordance with the Colorado Medicare HCPCS Level II values.

(~~8~~9) 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.

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(~~9~~10) Complex Rehabilitation Technology dispensed and billed by Non-Physician DMEPOS Suppliers

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

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

(c) CRT shall be reimbursed as set out in section 18-6(H)(4).

(I) INPATIENT HOSPITAL FACILITY FEES

(1) Provider Restrictions

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

(2) Bills for Services

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

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

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

(c) Exhibit #1 of this Rule establishes the maximum length of stay (LOS) using the "arithmetic mean LOS". However, no additional allowance for exceeding this LOS, other than through the cost outlier criteria under 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:

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

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

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

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(c) Medicare Long Term Care Hospitals (MLTCH)

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

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

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

The "Maximum Fee Allowance" is determined by calculating:

(i) (MS-DRG Relative Wt x Specific hospital base rate x 185%) + (trauma center activation allowance) + (organ acquisition, when appropriate).
(ii) For trauma center activation allowance, (revenue codes 680-685) see section18-6(J)(6)(b)5).
(iii) For organ acquisition allowance, (revenue codes 810-819) see section 18-6(I)(3)(h).

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

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

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(ii) Each hospital's cost-to-charge ratio is given in Exhibit #2 of this Rule.
(iii) The "Difference" = "Hospital's Cost" – "Maximum Fee Allowance" excluding any trauma center activation or organ acquisition allowance (see (c) above).
(iv) If the "Difference" is greater than $~~23,570~~26,713.00, additional reimbursement is warranted. The additional reimbursement is determined by the following equation:

"Difference" x .80 = additional fee allowance

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

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

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

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

(i) The MS-DRG adjusted billed charges to the MS-DRG allowance (including any outlier allowance);
(ii) The trauma center activation billed charge to the trauma center activation allowance; and
(iii) The organ acquisition charges to the organ acquisition maximum fees
(iv) under section 18-6(I)(3)(h).

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

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

(J) OUTPATIENT HOSPITAL FACILITY FEES

(1) Provider Restrictions

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

(b) A separate facility fee is only payable if the location of where the services are provided is licensed as a hospital, or ASC for surgical episodes, by the Colorado Department of Public Health and Environment (CDPHE) or applicable out of state governing agency and statute.

(2) Types of Bills for Service

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

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

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

(3) Outpatient Facility Reimbursement:

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

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

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(b) The CAHs listed in Exhibit #3 to this Rule are reimbursed at 80% of billed outpatient facility charges, except for any associated professional fees.

(c) Exhibit #4 to this Rule:

Hospital reimbursement is based upon Medicare's ~~2016~~2017 Outpatient Prospective Payment System (OPPS) as modified in Exhibit #4 of this Rule. Exhibit #4 lists Medicare's Outpatient Hospital Ambulatory Prospective Payment (APC) Codes and the Division's established rates for hospitals and other types of providers as follows:

(i) Column 1 lists the APC code number.
(ii) Column 2 lists APC code description.
(iii) Column 3 is used to determine maximum fees for all hospital facilities not listed under sections18-6(J)(3)(a) and (b).

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(iv) Column 4 is used to determine maximum fees for all Ambulatory Surgery Centers (ASC) when outpatient surgery is performed in an ASC.

To identify which APC grouper is aligned with an Exhibit #4 APC code # and dollar value, use Medicare's ~~2016~~2017 Addendum B. Spinal fusion CPT® codes listed with a "C" status indicator in Medicare's Addendum B, shall have an equivalent value no greater than APC 5123.

(4) The APC Exhibit #4 values include the services and revenue codes listed below, therefore, these are generally not separately payable. However, the maximum allowable fees in Exhibit #4 may be exceeded in the rare case a more expensive implant is medically necessary. The facility must request prior authorization for additional payment with a separate report documenting medical reasonableness and necessity and submit an invoice showing cost of the implant(s) to the facility. Payers must report authorized exceptions to the Division's Medical Policy Unit on a monthly basis. Drugs and devices having a status indicator of G and H receive a pass-through payment. In some instances, the procedure code may have an APC code assigned. These are separately payable based on APC values if given in Exhibit #4 or cost to the facility.

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(a) nursing, technician, and related services;

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

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

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

(e) surgical dressings;

(f) equipment;

(g) splints, casts and related devices;

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

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

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

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

(l) post-operative pain blocks.

(m) implanted items.

Packaged Services	
Revenue Code	Description

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

Packaged Services	
Revenue Code	Description
0825	Hemodialysis-Outpatient or Home; Support Services
0829	Hemodialysis-Outpatient or Home; Other OP Hemodialysis
0942	Other Therapeutic Services (also see 095X, an extension of 094x); Education/Training
0943	Other Therapeutic Services (also see 095X, an extension of 094X), Cardiac Rehabilitation
0948	Other Therapeutic Services (also see 095X, an extension of 094X), Pulmonary Rehabilitation

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

(a) "A" means use another fee schedule instead of Exhibit #4, i.e., 18-4 Conversion Factors and RBRVS RVUs,18-6(R) Ambulance Fee Schedule, or Exhibit #8.

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

(c) "C" means recognized by Medicare as inpatient only procedures; however, the Division does recognize these procedures can be done outpatient if prior authorization is obtained per Rule 16-10.

(d) "D" means discontinued code and not paid under OPPS by Medicare. Therefore, this code is not separately payable in OPPS by DoWC.

(e) "~~E~~E1" or "E2" means not paid by Medicare when submitted on any outpatient bill type. However, services could still be reasonable and necessary, thus requiring hospital or ASC level of care. The billing party shall submit documentation to substantiate the billed service codes and any similar established codes with fees in Exhibit #4.

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

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

(h) "H" means a "Pass-Through Device" that is separately payable based upon cost to the facility.

(i) "J1" or "J2" means the services are paid through a "comprehensive APC" for Medicare. However, the DoWC has not adopted the "comprehensive APC." Therefore, an agreement between the payer and the provider is necessary to implement "comprehensive APCs."

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

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

(l) Any "Packaged Codes" with Q1, Q2, Q3, Q4 or STVX combinations are not recognized unless the payer and provider make a prior agreement.

(m) "M" means not separately payable.

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

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

(p) "R" means separate payment for blood and blood products under Exhibit #4 APC value.

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

(r) "U" means brachytherapy source and is separately payable under Exhibit #4 APC value.

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

(t) "Y" represents non-implantable Durable Medical Equipment and is paid according to Medicare's Durable Medical Equipment Regional Carrier (DMERC) fee schedule for Colorado.

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

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

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

(i) Hospitals are reimbursed based upon Column 3.
(ii) ASCs are reimbursed based upon Column 4.

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(b) Hospitals billing type "A" or "B" Emergency Department (ED) visits shall meet one of the following hospital licensure and billing criteria:

(i) The EDs must be physically located within a hospital licensed by the CDPHE as a general hospital or meet the out-of-state facility's state's licensure requirements and billed using revenue code 450 with level of care CPT® codes 99281-99285; or
(ii) A free-standing type "B" ED, must have equivalent operations and staffing as a licensed ED, must be physically located inside of a hospital, and meet Emergency Medical Treatment and Active Labor Act (EMTALA) regulations. All type "B" outpatient ED visits must be

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billed using revenue code 456 with level of care HCPCS codes G0380-G0384, even though the facility may not be open 24/7;

(c) Emergency Department (ED) level of care criteria includes:

(i) The ED "Level of Care" is identified based upon one (1) of five (5) levels of care for either a type "A" (CPT® 99281-99285, 99291 or 99292) or type "B" (G0380-G0384) ED visit. The level of care is defined by CPT® E&M definitions and internal level of care guidelines developed by the hospital in compliance with Medicare regulations. The hospital's guidelines should establish an appropriate graduation of hospital resources (ED staff and other resources) as the level of service increases. Upon request the provider shall supply a copy of their level of care guidelines to the payer. (Only the higher one (1) of any ED levels or critical care codes shall be paid).

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(d) APC 5045, Trauma Response with Critical Care, is not recognized for separate payment. Trauma Center fees are not paid for alerts. Trauma activation fees are as follows:

- Revenue Code 681 $3,000.00
- Revenue Code 682 $2,500.00
- Revenue Code 683 $1,000.00
- Revenue Code 684 $0
- These fees are in addition to ED and inpatient fees.
- Activation fees mean a trauma team has been activated, not just alerted.
- The level of trauma activation shall be determined by CDPHE's assigned hospital trauma level designation.

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

(f) Multiple APCs identified by multiple CPT® codes are to be indicated by the use of modifier –51. Bilateral procedures require each procedure to be billed on separate lines using RT and LT for the procedure to be correctly paid. The 50% reduction applies to all lower valued procedures, even if they are identified in the CPT® as modifier -51 exempt. The reduction also applies to the second "primary" procedure of bilateral procedures.

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

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(ii) If an arthroscopic procedure is converted to an open procedure on the same joint, only the open procedure is payable. If an arthroscopic procedure and open procedure are performed on

different joints, the two (2) procedures may be separately payable with anatomic modifiers.

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

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

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

(g) Any diagnostic testing clinical labs or therapies with a status indicator (SI) of "A" may be reimbursed using Exhibit #8 of this Rule or the appropriate CF to the unit values for the specific CPT® code as listed in the RBRVS. Hospital bill types 13x are allowed payment for any clinical laboratory services (even if the SI is "N" for the specific clinical laboratory CPT® code) when these laboratory services are unrelated to any other outpatient services performed that day. Modifier L1 should be appended to the billed laboratory services. The maximum fees are based upon Exhibit #8.

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

Billing Codes:

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

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

(i) ambulance services (Revenue Code 540), see section18-6(R)

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(ii) blood, blood plasma, platelets (Revenue Codes 380X)
(iii) Physician or physician assistant services
(iv) Nurse practitioner services
(v) Licensed clinical psychologist
(vi) Licensed social workers
(vii) Rehabilitation services (PT, OT, Respiratory or Speech/Language, Revenue Codes 420, 430,440) are paid based upon the RBRVS unit value multiplied by the applicable conversion factor. Modifiers are required to indicate the type of care plan or therapist being billed. See Rule 18-5(H) Physical Medicine & Rehabilitation for appropriate modifiers.

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

(k) Clinics (part of a hospital or a freestanding clinic) (Form Locator (FL) 4 are 07xx and revenue codes 51x-53x):

(i) Provider Restrictions - types of facilities that are recognized for separate clinic facility fees:
- Rural Health Clinics as identified under Rule 18, Exhibit #5 and/or as certified by the Colorado Department of Public Health and Environment;
- Critical Access Hospitals as identified under Rule 18, Exhibit #3 and/or as certified by the Colorado Department of Public Health and Environment;
- Any specialty care clinic (wound/infections) that requires expensive drugs/supplies that are not typically provided in a physician's office.

(ii) Billing and Maximum Fees
- Clinics designated as rural health facilities and listed in Exhibit #5 to this Rule may be reimbursed a single separate clinic fee at 80% of billed charges per date of service, regardless of whether the clinic has been designated by the employer, the urgency of the episode of care, or the time of day.
- CAHs listed in Exhibit #5 of this Rule may be reimbursed a single separate clinic fee at 80% of billed charges per date of service.
- Any specialty care clinic (wound/infections) that requires drugs/supplies that are typically not provided in a physician's office may be allowed a separate clinic fee with prior approval from the payer, as outlined in Exhibit #4
- No other clinic facility fees are payable except those listed in sections 18-6(I), (J), (K) or (L).
- Maximum fees for hospital urgent care facilities or services are covered under section 18-6(L). These are identified by either place of service code 20, as billed on a CMS-1500 or by revenue code(s) 456, 516 or 526 on a UB-04.

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

(l) IV Infusions Performed in Outpatient Hospital Facilities

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

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

(K) AMBULATORY SURGERY CENTERS

(1) Provider Restrictions

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

(b) All outpatient surgical procedures performed in an ASC shall be reasonable and necessary and warrant the performance of the procedure at an ASC level.

(2) Billing Codes and Maximum Fees

ASCs are reimbursed in accordance with section18-6(J) for any surgical episodes of care. Column 4 from Exhibit #4 of this Rule lists the dollar value used to determine the maximum fees.

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

(1) Provider Restrictions

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

(2) Billing and Maximum Fees:

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

(b) Urgent Care Facility fee is HCPCS code S9088, $75.00.

(i) No separate facility fees are allowed for follow-up care. To receive a separate facility fee, a subsequent diagnosis shall be based on a new acute care situation and not the initial diagnosis.
(ii) No facility fee is appropriate when the injured worker is sent to the employer's designated provider for a non-urgent episode of care during regular business hours of 8 am to 5 pm, Monday through Friday.
(iii) Hospitals may bill on the UB-04 using revenue code 516 or 526 and the facility HCPCS code S9088 with 1 unit. All maximum fees for other services billed on the UB-04 shall be in accordance with CPT® relative weights from RBRVS, multiplied by the appropriate conversion factor.

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(iv) Hospital and non-hospital based urgent care facilities may bill for the facility fee, HCPCS code S9088, on the CMS-1500 with professional services. All other services and procedures provided in an urgent care facility, including a freestanding facility, are reimbursed according to the appropriate CPT® code relative weight from RBRVS multiplied by the appropriate Rule 18-4 conversion factor.

(c) All professional physician or non-physician fees shall be billed on a CMS-1500 with a Place of Service Code #20. The maximum fees shall be in accordance with the appropriate CPT® code relative weight from RBRVS multiplied by the appropriate Rule 18-4 conversion factor.

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

G0378 Observation rate: $45.00 per hour

(e) All supplies are included in the facility fee for urgent care facilities.

(f) Any prescription for a drug supply to be used for longer than 24 hours, filled at any clinic, shall fall under the requirements of and be reimbursed as a pharmacy fee. See Rule 18-6(N).

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(M) HOME CARE SERVICES

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

(1) Home Infusion Therapy

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

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

(a) Parenteral Nutrition:

S9364	<1 Liter	$160.00/ day
S9365	1 liter	$174.00/ day
S9366	1.1 - 2.0 liter	$200.00/ day

S9367	2.1 - 3.0 liter	$227.00/ day
S9368	> 3.0 liter	$254.00/ day

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

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

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

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

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

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

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

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

S9326	Continuous (24 hrs. or more)	$ 79.00/ day
S9327	Intermittent (less than 24 hrs.)	$103.00/ day

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

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

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

(g) Multiple Therapies:

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

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

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

(2) Nursing Services

(a) Skilled Nursing (LPN & RN)

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

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

(b) Certified Nurse Assistant (CNA):

S9122 CNA $ 45.00/hr.

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

(3) Physical Medicine

Physical medicine procedures are payable at the same rate as provided in section ~~185~~18-5(H), Physical Medicine and Rehabilitation.

(4) Mileage

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

DoWC code: Z0772

(5) Travel Time

Travel is typically included in the fees listed. Travel time greater than one (1) hour one-way shall be reimbursed. The fee shall be agreed upon at the time of prior authorization for payment (see Rule 16-10) and shall not exceed $~~30~~34.00 per hour.

DoWC code: Z0773

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

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

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

(N) DRUGS AND MEDICATIONS

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

(2) Average Wholesale Price (AWP)

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

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

(3) Reimbursement for Drugs & Medications

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

(b) The entity packaging two or more products together makes an implied claim that the products are safe and effective when used together and shall be billed as individual line items identified by their original AWP and NDC. This original AWP and NDC shall be used to determine

reimbursement. Supplies are considered integral to the package are not separately reimbursable.

(c) Reimbursement for an opiate antagonist prescribed or dispensed under §§ 12-36-117.7, 12-38-125.5, 12-42.5-120, 13-21-108.7, C.R.S. (2015), to injured worker at risk of experiencing an opiate-related drug overdose event, or to a family member, friend, an employee or volunteer of a harm reduction organization, or other person in a position to assist the injured worker shall be AWP plus $4.00.

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

~~-~~(e) The provider may bill for the discarded portion of drug from a single use vial or a single use package, appending the JW modifier to the HCPC Level II code. The provider shall bill for the discarded drug amount and the amount administered to the injured worker on two separate lines. The provider must document the discarded drug in the medical record.

(4) Prescription Strength Topical Compounds

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

Category I Z0790 Fee $ ~~75~~80.00 per 30 day supply

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

Category II Z0791 Fee $~~150~~160.00 per 30 day supply

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

Category III Z0792 Fee $~~250~~265.00 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~~370.00 per 30 day supply

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

All ingredient materials must be listed by quantity used per prescription. If the Medical Treatment Guidelines approve some but not all of the active ingredients for a particular diagnosis, the insurer shall count only the number of the approved ingredients to determine the applicable category. In addition, the initial

prescription containing the approved ingredients shall be reimbursed without a medical review. Continued use (refills) may require documentation of effectiveness including functional improvement.

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

(5) Over-the-Counter Medications

(a) Over-the-counter medications, drugs that are safe and effective for use by the general public without a prescription, are reimbursed at NDC/AWP and are not eligible for dispensing fees. If drugs have been repackaged, use the original AWP and NDC that was assigned by the source of the repackaged drugs to determine reimbursement.

(b) The maximum reimbursement for any topical muscle relaxant, analgesic, anti-inflammatory and/or anti-neuritic medications containing only active ingredients available without a prescription shall be reimbursed at cost to the billing provider up to $30.00 per 30 day supply for any application (excludes patches). Maximum reimbursement for a patch is cost to the billing provider up to $70.00 per 30 day supply.

(6) Injured Worker Reimbursement

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

(7) Dietary Supplements, Vitamins and Herbal Medicines

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

(8) Prescription Writing

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

(b) All prescriptions shall be filled with bio-equivalent generic drugs unless the physician indicates "Dispense As Written" (DAW) on the prescription. In addition to the requirements outlined in Rule 16-5(B)(2), providers using pharmacies and prescribing a brand name compounded topical drug with a DAW indication shall provide a written medical justification explaining the reasonableness and necessity of the brand name over the generic equivalent. This rule applies to all pharmacies, whether located in-state or out-of-state.

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

(9) Required Billing Forms

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

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

(ii) With the agreement of the payer, the National Council for Prescription Drug Programs (NCPDP) or ANSI ASC 837 (American National Standards Institute Accredited Standards Committee) electronic billing transaction containing the same information as in (1) or (2) in this 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 RBRVS 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 injured worker or his/her authorized representative has received the prescription.

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

(O) COMPLEMENTARY ALTERNATIVE MEDICINE (CAM)

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

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(P) ACUPUNCTURE

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

(1) Provider Restrictions

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

(2) Billing Restrictions

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

(b) Unless the provider's medical records reflect medical necessity and the provider obtains prior authorization for payment (see Rule 16-10), the maximum amount of time allowed for acupuncture and procedures is one (1) hour of procedures, per day, per discipline.

(3) Billing Codes:

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

(b) Non-Physician evaluation services

(i) New or established patient services are reimbursable only if the medical record specifies the appropriate history, physical examination, treatment plan or evaluation of the treatment plan. Payers are only required to pay for evaluation services directly performed by an LAc. All evaluation notes or reports must be written and signed by the LAc. Without appropriate supporting documentation, the payer may deny payment. (See Rule 16-12)

(ii) LAc new patient visit: DOWC Z0800
Maximum value $99.80

(iii) LAc established patient visit: DOWC Z0801
Maximum value $67.60

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(c) Herbs require prior authorization for payment (see Rule 16-10) and fee agreements as per section18-6(N)(7).

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

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

(Q) USE OF AN INTERPRETER

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

(R) AMBULANCE FEE SCHEDULE

(1) Billing Requirements:

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

(2) General Claims Submission:

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

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

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

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

(3) Ground and Air Ambulance Vehicle and Crew Requirements

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

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

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

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

~~Ground Ambulance~~	HCPCS ~~Code Description~~	~~Urban~~ ~~Medicare~~Base Rate *250%	~~Rural (R = Zip Code) First 17 miles or > if not a Super Rural Medicare Rate~~URBAN BASE RATE / URBAN MILEAGE *250%	~~Super Rural (B =Zip code) Medicare Rate~~RURAL BASE RATE / RURAL MILEAGE *250%	RURAL BA RATE / LOWEST QUARTILE *250%	

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~~Ground Ambulance~~	HCPCS ~~Code Description~~	~~Urban Medicare~~Base Rate *250%		~~Rural (R = Zip Code) First 17 miles or > if not a Super Rural Medicare Rate~~URBAN BASE RATE / URBAN MILEAGE *250%	~~Super Rural (R =Zip code) Medicare Rate~~RURAL BASE RATE / RURAL MILEAGE *250%	RURAL BA RATE LOWEST QUARTILE *250%	
A0425		~~Ground mileage, per statute mile $ 17.88~~		$~~1~~8.~~11~~23	$~~1~~8.~~28~~40	~~$ 18.28~~n/a	$27.60
A0426		~~Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1- Non-Emergency) $~~ 555.73	~~$ 680.67~~	$~~6~~87.~~34~~35	$ ~~842.68~~694.10	$850.98	
A0427		~~Ambulance service, advanced life support, emergency transport, level 1 (ALS1-Emergency) $~~ 555.73	~~$1,077.72~~	$1,088.~~29~~30	$1,~~334.24~~098.98	$1,347.35	n/a
A0428		~~Ambulance service, basic life support, non-emergency transport (BLS) $~~ 555.73	~~$ 567.22~~	$572.~~28~~80	$ ~~702.23~~578.40	$709.13	n/a
A0429		~~Ambulance service, basic life support, emergency transport (BLS-Emergency) $~~ 555.73	~~$ 907.55~~	$~~9~~16.~~45~~48	$925.45	$1,~~123.571~~60	
A0432		~~Paramedic intercept (PI), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers. $~~ 555.73		$~~992.64~~1,002.38	$~~1002.37~~1,012.20	~~$1002.37~~n/a	n/a
A0433		~~Advanced life support, level 2 (ALS2) $~~ 555.73	~~$1,559.86~~	$1,575.~~15~~18	$1,~~931.145~~90.63	$1,950.10	
A0434		~~Specialty care transport (SCT) $~~ 555.73	~~$1,843.47~~	$1,861.~~54~~58	$1,879.83	$2,~~282.253~~68	
A0435		$ 21.40		$21.40	$32.10	n/a	$32.10
A0436		$ 57.10		$57.10	$85.65	n/a	$85.65

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The “urban” base rate(s) and mileage rate(s) as indicated in section 18-6(R) shall be applied to all relevant/applicable ambulance services unless the zip code range area is “Rural” or “Super Rural.”

Medicare MSA zip code grouping is listed on Medicare's webpage with an "R" indicator for "Rural" and "B" indicator for "Super Rural." See Medicare's Zip Code to Carrier Locality File- Updated 08/27/2014.

(5) Modifiers

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

Code	Description
D	Diagnostic or therapeutic site other than "P" or "H"
E	Residential, domiciliary, custodial facility, nursing home other than SNF (other than 1819 facility)
G	Hospital-based dialysis facility (hospital or hospital-related) which includes: - Hospital administered/Hospital located - Non-Hospital administered/Hospital located
GM	Multiple patients on one ambulance trip
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.)
QL	Patient pronounced dead after ambulance called.
QM	Ambulance service under arrangement by a provider of service
QN	Ambulance service furnished directly by a provider of service.
R	Residence
S	Scene of Accident or Acute Event

X Destination Code Only (Intermediate stop at physician's office en route to the hospital, includes HMO non-hospital facility, clinic, etc.)

(6) Mileage

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

18-7 DENTAL FEE SCHEDULE

The dental fee schedule is adopted using the American Dental Association's Current Dental Terminology, ~~2016~~2017 (CDT ~~2016~~2017). However, surgical treatment for dental trauma and subsequent, related procedures may be billed using medical codes from the RBRVS. If billed using medical codes as listed in the RBRVS, reimbursement shall be in accordance with the Surgery/ Anesthesia section of the RBRVS and its corresponding conversion factor. All dental billing and reimbursement shall be in accordance with the Division's Rule 16, Utilization Standards, and Rule 17, Medical Treatment Guidelines. See Exhibit #6 of this Rule for the listing and Maximum Fee Schedule value for CDT ~~2016~~2017 dental codes.

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

18-8 QUALITY INITIATIVES

(A) ~~***CHRONIC***~~ OPIOID MANAGEMENT

(1) ~~(1)~~ Definitions:

(a) Acute opioid use refers to the prescription of opioid medications (single or multiple) for duration of 30 days or less for non-traumatic injuries, or 6 weeks or less for traumatic injuries or post-operatively.

(b) Subacute opioid use refers to the prescription of opioid medications for longer than 30 days for non-surgical cases and longer than 6 weeks for traumatic injuries or post-operatively.

(c) Chronic Opioid use refers to the prescription of opioid medications for longer than 90 days.

(2) Acute opioid prescriptions should be limited to seven (7) days and 50 morphine milliequivalents per day. Providers considering repeat opioid refills at any time during treatment are encouraged to perform the actions in this section and bill accordingly.

(3) When the authorized treating physician (ATP) prescribes ~~long term~~ opioid treatment, s/he shall ~~use~~comply with the Division of Workers' Compensation

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Chronic Pain Disorder Medical Treatment Guidelines and review the Colorado Medical Board Policy #40-26, "Policy for Prescribing and Dispensing Opioids."

(4) Urine drug tests are required for subacute and chronic opioid management and shall employ testing methodologies that meet or exceed industry standards for sensitivity, specificity and accuracy. The 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 subacute or chronic opioid compliance monitoring. Refer to section 18-5(F)(4) for clinical drug screening testing codes and values.

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

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

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

(i) Concern regarding the functional status of the patient;
(ii) Abnormal results on previous testing;
(iii) Change in management of dosage or pain; and
(iv) Chronic daily opioid dosage above ~~100~~50 mg of morphine or equivalent.

(5) The ATP should utilize the Colorado Prescription Drug Monitoring Program (PDMP) when prescribing opioids and must utilize the PDMP when prescribing opioid refills.

(6) The patient should initially and periodically be evaluated for risk of misuse or addiction.

~~(d)~~(7) The opioids classified as Schedule II or Schedule III controlled substances that are prescribed for treatment lasting longer than 30 days shall be provided through a pharmacy.

~~(e)~~(8) The ~~authorized treating physician~~ATP may consider whether the injured worker experienced an opiate-related drug overdose event that resulted in an opiate antagonist being prescribed or dispensed ~~pursuant to §§ 12-36-117.7, 12-38-125.5, 12-42.5-120,~~ or ~~13-21-108.7, C.R.S. (2015). For reimbursement~~if the patient is deemed at risk for an opiate antagonist~~, please~~ (see ~~Rule~~section 18-6(N)(3)(c~~).~~)).

~~(f)~~(9) The prescribing ~~authorized treating physician~~ATP shall review and integrate the drug screening results~~,~~ required for subacute and chronic opioid management as appropriate; the PDMP~~, and~~ results; an evaluation of compliance with treatment and risk for addiction or misuse; as well as the injured worker's past and current functional status ~~on~~in determining the prescribed levels of medications. A written report will document the treating physician's assessment of the patient's past and

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current functional status of work, leisure ~~activities~~, and activities of daily living ~~competencies~~.

(~~2~~10) Codes and maximum fees ~~for~~are payable to the ~~authorized treating physician~~ATP for a written report with all the following review services completed and documented:

(a) Ordering and reviewing drug tests for subacute or chronic opioid management;

(b) Ordering and reviewing PDMP results;

(c) Reviewing the medical records;

(d) Reviewing the injured workers' current functional status;

(e) Evaluating the risk of misuse and abuse periodically; and

~~(e)~~(f) Determining what actions, if any, need to be taken.

~~(f) Appropriate chronic pain diagnostic code (ICD-10)~~

~~Bill using code~~ Opioid Management:

Acute Phase	DoWC ~~Z0765 $75~~Code: Z0771 ~~$84~~.00 per 15 minutes – maximum of 30 minutes per report

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

Subacute/Chronic Phase	DoWC Code: Z0765 $84.00 per 15 minutes – maximum of 30 minutes per report

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(B) FUNCTIONAL ASSESSMENTS

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

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

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

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

(2) If all three elements are documented, the billing codes and maximum fees are as follows:

DOWC Z0811 $~~60~~62.00 per episode for the initial functional assessment of pre-injection care, billed along with the appropriate E&M code, related to spinal or SI joint injections.

DOWC Z0812 $~~31.44~~33.00 for a subsequent visit of therapeutic post-injection care (preferably done by a non-injectionist and at least seven (7) days after the injection), billed along with the appropriate E&M code, related to follow-up care of spinal or SI joint injections. The injured worker should provide post injection pain data, including a pain diary.

DOWC Z0814 $~~31.44~~33.00 for post-diagnostic injection care (repeat functional assessment within the time period for the effective agent given).

(C) QUALITY PERFORMANCE AND OUTCOMES PAYMENTS (QPOP)

(1) Medical providers who are Level I or II accredited, or who have completed the Division-sponsored Level I or II accreditation program and have successfully completed the QPOP training may bill separately for documenting functional progress made by the injured worker. The medical providers must utilize both a ~~validated~~ Division-approved psychological screen and a Division-approved functional tool. The psychological screen and the ~~validated~~ functional ~~data provided~~tool are approved by the ~~injured worker or another health care provider~~Division and are validated for the specific purpose for which they have been created. The medical provider also must document whether the injured worker's perception of function correlates with clinical findings. The documentation of functional progress should assist the provider in preparing a successful plan of care, including specific goals and expected time frames for completion, or for modifying a prior plan of care. The documentation must include:

(a) Specific testing that occurred, interpretation of testing results, and the weight given to these results in forming a reasonable and necessary plan of care;

(b) Explanation of how the testing goes beyond the evaluation and management (E&M) services typically provided by the provider;

(c) Meaningful discussion of actual or expected functional improvement between the provider and the injured worker.

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

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

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

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

(D) PILOT PROGRAMS

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

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

(a) Beginning and end date for the pilot program.

(b) Population to be managed (e.g. size, specific diagnosis codes).

(c) Provider group(s) participating in the program.

(d) Proposed codes and fees.

(e) Process for evaluating the program's success.

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

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
1	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W MCC	25.2117	28.5	36.1
2	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W/O MCC	15.2867	16.9	20.3
3	PRE	SURG	ECMO OR TRACH W MV >96 HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	17.7325	24.3	30.8
4	PRE	SURG	TRACH W MV >96 HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	11.2228	19.6	23.8
5	PRE	SURG	LIVER TRANSPLANT W MCC OR INTESTINAL TRANSPLANT	10.3701	15.3	20.5
6	PRE	SURG	LIVER TRANSPLANT W/O MCC	4.4655	7.8	8.5
7	PRE	SURG	LUNG TRANSPLANT	9.8276	16.1	18.8
8	PRE	SURG	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	5.0846	9.2	10.7
10	PRE	SURG	PANCREAS TRANSPLANT	4.3783	8.1	9.0
11	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W MCC	4.9109	10.9	13.6
12	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W CC	3.5109	8.4	9.7
13	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W/O CC/MCC	2.4030	6.0	6.8
14	PRE	SURG	ALLOGENEIC BONE MARROW TRANSPLANT	11.5318	23.8	27.3
16	PRE	SURG	AUTOLOGOUS BONE MARROW TRANSPLANT W CC/MCC	6.2657	17.2	18.5
17	PRE	SURG	AUTOLOGOUS BONE MARROW TRANSPLANT W/O CC/MCC	4.1772	8.5	11.6
20	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W MCC	10.0449	13.5	16.7
21	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W CC	7.5504	11.8	13.3
22	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W/O CC/MCC	5.8233	7.0	8.6
23	01	SURG	CRANIOTOMY W MAJOR DEVICE IMPLANT OR ACUTE CNS PDX W MCC OR CHEMOTHERAPY IMPLANT OR EPILEPSY W NEUROSTIMULATOR	5.5252	7.6	10.7

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MS-DRG Table						
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MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
24	01	SURG	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W/O MCC	3.8539	4.2	5.5
25	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W MCC	4.3085	7.0	9.1
26	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W CC	3.0000	4.2	5.6
27	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W/O CC/MCC	2.3655	2.2	2.9
28	01	SURG	SPINAL PROCEDURES W MCC	5.5357	9.1	11.7
29	01	SURG	SPINAL PROCEDURES W CC OR SPINAL NEUROSTIMULATORS	3.2706	4.2	5.8
30	01	SURG	SPINAL PROCEDURES W/O CC/MCC	2.1233	2.2	2.8
31	01	SURG	VENTRICULAR SHUNT PROCEDURES W MCC	4.1179	7.0	10.1
32	01	SURG	VENTRICULAR SHUNT PROCEDURES W CC	2.1277	3.2	4.6
33	01	SURG	VENTRICULAR SHUNT PROCEDURES W/O CC/MCC	1.6956	1.9	2.4
34	01	SURG	CAROTID ARTERY STENT PROCEDURE W MCC	4.0289	5.1	7.6
35	01	SURG	CAROTID ARTERY STENT PROCEDURE W CC	2.2355	2.1	3.1
36	01	SURG	CAROTID ARTERY STENT PROCEDURE W/O CC/MCC	1.7633	1.3	1.5
37	01	SURG	EXTRACRANIAL PROCEDURES W MCC	3.1639	5.1	7.4
38	01	SURG	EXTRACRANIAL PROCEDURES W CC	1.5647	2.2	3.1
39	01	SURG	EXTRACRANIAL PROCEDURES W/O CC/MCC	1.1117	1.3	1.5
40	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W MCC	3.6812	7.4	10.2
41	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W CC OR PERIPH NEUROSTIM	2.3414	4.3	5.4
42	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W/O CC/MCC	1.9535	2.6	3.2
52	01	MED	SPINAL DISORDERS & INJURIES W CC/MCC	1.5386	4.1	5.5
53	01	MED	SPINAL DISORDERS & INJURIES W/O CC/MCC	0.9514	2.7	3.3
54	01	MED	NERVOUS SYSTEM NEOPLASMS W MCC	1.3288	3.9	5.3
55	01	MED	NERVOUS SYSTEM NEOPLASMS W/O MCC	1.0026	2.9	4.0
56	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS W MCC	1.9249	5.4	7.7
57	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS W/O MCC	1.1329	3.8	5.4

Exhibit #1 – Proposed						
MS-DRG Table						
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MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
58	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W MCC	1.6924	5.1	6.7
59	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W CC	1.0719	3.7	4.6
60	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W/O CC/MCC	0.8434	3.1	3.6
61	01	MED	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA W THROMBOLYTIC AGENT W MCC	2.8410	5.0	6.5
62	01	MED	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA W THROMBOLYTIC AGENT W CC	1.9528	3.5	4.1
63	01	MED	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA W THROMBOLYTIC AGENT W/O CC/MCC	1.6402	2.6	2.9
64	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	1.7938	4.5	6.1
65	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	1.0330	3.1	3.8
66	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W/O CC/MCC	0.7448	2.2	2.6
67	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W MCC	1.4214	3.5	4.8
68	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W/O MCC	0.8938	2.2	2.8
69	01	MED	TRANSIENT ISCHEMIA W/O THROMBOLYTIC	0.7500	2.1	2.5
70	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W MCC	1.6531	4.6	6.4
71	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	0.9871	3.4	4.4
72	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC/MCC	0.7572	2.4	3.0
73	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W MCC	1.4138	3.9	5.3
74	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O MCC	0.9543	2.9	3.7
75	01	MED	VIRAL MENINGITIS W CC/MCC	1.6583	5.1	6.4
76	01	MED	VIRAL MENINGITIS W/O CC/MCC	0.9584	3.1	3.7

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
77	01	MED	HYPERTENSIVE ENCEPHALOPATHY W MCC	1.5683	4.3	5.5
78	01	MED	HYPERTENSIVE ENCEPHALOPATHY W CC	0.9940	3.2	3.9
79	01	MED	HYPERTENSIVE ENCEPHALOPATHY W/O CC/MCC	0.7663	2.3	2.7
80	01	MED	NONTRAUMATIC STUPOR & COMA W MCC	1.7311	4.5	6.5
81	01	MED	NONTRAUMATIC STUPOR & COMA W/O MCC	0.7512	2.5	3.3
82	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W MCC	2.1988	3.8	6.4
83	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W CC	1.2621	3.3	4.2
84	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W/O CC/MCC	0.8991	2.2	2.7
85	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W MCC	2.0884	4.8	6.6
86	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W CC	1.1938	3.2	4.1
87	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W/O CC/MCC	0.8323	2.2	2.7
88	01	MED	CONCUSSION W MCC	1.4218	3.6	4.6
89	01	MED	CONCUSSION W CC	1.0048	2.7	3.3
90	01	MED	CONCUSSION W/O CC/MCC	0.7805	2.0	2.3
91	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W MCC	1.5437	4.1	5.6
92	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.9368	3.1	3.9
93	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC/MCC	0.7263	2.2	2.7
94	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W MCC	3.4364	7.8	10.2
95	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W CC	2.3653	5.8	7.0
96	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W/O CC/MCC	2.2456	4.7	5.6
97	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W MCC	3.4224	8.5	11.4
98	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W CC	1.8771	5.5	7.3
99	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W/O CC/MCC	1.2062	3.6	4.6
100	01	MED	SEIZURES W MCC	1.6628	4.2	5.7

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
101	01	MED	SEIZURES W/O MCC	0.8310	2.6	3.3
102	01	MED	HEADACHES W MCC	1.0636	3.0	4.1
103	01	MED	HEADACHES W/O MCC	0.7475	2.3	2.9
113	02	SURG	ORBITAL PROCEDURES W CC/MCC	2.1895	4.2	5.9
114	02	SURG	ORBITAL PROCEDURES W/O CC/MCC	1.2730	2.3	3.0
115	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT	1.4918	3.9	4.9
116	02	SURG	INTRAOCULAR PROCEDURES W CC/MCC	1.4965	3.3	4.7
117	02	SURG	INTRAOCULAR PROCEDURES W/O CC/MCC	0.9835	2.1	2.8
121	02	MED	ACUTE MAJOR EYE INFECTIONS W CC/MCC	0.9943	3.8	4.8
122	02	MED	ACUTE MAJOR EYE INFECTIONS W/O CC/MCC	0.7624	3.2	4.1
123	02	MED	NEUROLOGICAL EYE DISORDERS	0.7464	2.1	2.6
124	02	MED	OTHER DISORDERS OF THE EYE W MCC	1.2611	3.6	4.9
125	02	MED	OTHER DISORDERS OF THE EYE W/O MCC	0.7714	2.6	3.3
129	03	SURG	MAJOR HEAD & NECK PROCEDURES W CC/MCC OR MAJOR DEVICE	2.2841	3.7	5.2
130	03	SURG	MAJOR HEAD & NECK PROCEDURES W/O CC/MCC	1.4257	2.3	2.9
131	03	SURG	CRANIAL/FACIAL PROCEDURES W CC/MCC	2.5424	4.4	6.1
132	03	SURG	CRANIAL/FACIAL PROCEDURES W/O CC/MCC	1.5333	2.2	2.8
133	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W CC/MCC	1.9803	3.8	5.4
134	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W/O CC/MCC	1.1548	2.0	2.5
135	03	SURG	SINUS & MASTOID PROCEDURES W CC/MCC	2.2733	4.4	6.3
136	03	SURG	SINUS & MASTOID PROCEDURES W/O CC/MCC	1.3199	2.0	2.7
137	03	SURG	MOUTH PROCEDURES W CC/MCC	1.3491	3.5	4.6
138	03	SURG	MOUTH PROCEDURES W/O CC/MCC	0.8512	1.9	2.4
139	03	SURG	SALIVARY GLAND PROCEDURES	1.1117	1.9	2.7
146	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W MCC	1.9321	5.4	7.8
147	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W CC	1.2413	3.6	5.0
148	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W/O CC/MCC	0.8064	2.1	2.9
149	03	MED	DYSEQUILIBRIUM	0.7007	2.1	2.5
150	03	MED	EPISTAXIS W MCC	1.3374	3.5	4.8
151	03	MED	EPISTAXIS W/O MCC	0.7339	2.3	2.8
152	03	MED	OTITIS MEDIA & URI W MCC	1.0519	3.2	4.1

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
153	03	MED	OTITIS MEDIA & URI W/O MCC	0.7136	2.4	2.9
154	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W MCC	1.4583	4.1	5.5
155	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W CC	0.8990	3.0	3.8
156	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W/O CC/MCC	0.6645	2.2	2.7
157	03	MED	DENTAL & ORAL DISEASES W MCC	1.5609	4.4	5.8
158	03	MED	DENTAL & ORAL DISEASES W CC	0.8864	3.0	3.7
159	03	MED	DENTAL & ORAL DISEASES W/O CC/MCC	0.6709	2.2	2.6
163	04	SURG	MAJOR CHEST PROCEDURES W MCC	5.1039	10.2	12.7
164	04	SURG	MAJOR CHEST PROCEDURES W CC	2.6096	5.1	6.1
165	04	SURG	MAJOR CHEST PROCEDURES W/O CC/MCC	1.8581	3.1	3.7
166	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	3.5128	8.2	10.5
167	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	1.8016	4.4	5.7
168	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC/MCC	1.2768	2.4	3.1
175	04	MED	PULMONARY EMBOLISM W MCC	1.6094	4.6	5.7
176	04	MED	PULMONARY EMBOLISM W/O MCC	0.9555	3.0	3.7
177	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	1.8643	5.7	7.1
178	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W CC	1.3004	4.5	5.4
179	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W/O CC/MCC	0.9302	3.4	4.1
180	04	MED	RESPIRATORY NEOPLASMS W MCC	1.7074	5.0	6.5
181	04	MED	RESPIRATORY NEOPLASMS W CC	1.1585	3.5	4.6
182	04	MED	RESPIRATORY NEOPLASMS W/O CC/MCC	0.8413	2.4	3.1
183	04	MED	MAJOR CHEST TRAUMA W MCC	1.4845	4.5	5.6
184	04	MED	MAJOR CHEST TRAUMA W CC	1.0135	3.3	3.9
185	04	MED	MAJOR CHEST TRAUMA W/O CC/MCC	0.7579	2.5	2.9
186	04	MED	PLEURAL EFFUSION W MCC	1.5313	4.5	5.8
187	04	MED	PLEURAL EFFUSION W CC	1.0572	3.3	4.2
188	04	MED	PLEURAL EFFUSION W/O CC/MCC	0.7996	2.5	3.2
189	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.2265	3.7	4.8
190	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1.1573	3.8	4.7

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
191	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	0.9185	3.1	3.8
192	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	0.7253	2.6	3.0
193	04	MED	SIMPLE PNEUMONIA & PLEURISY W MCC	1.3795	4.5	5.5
194	04	MED	SIMPLE PNEUMONIA & PLEURISY W CC	0.9344	3.4	4.1
195	04	MED	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	0.7089	2.7	3.2
196	04	MED	INTERSTITIAL LUNG DISEASE W MCC	1.6058	5.0	6.3
197	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.0471	3.4	4.2
198	04	MED	INTERSTITIAL LUNG DISEASE W/O CC/MCC	0.7833	2.6	3.1
199	04	MED	PNEUMOTHORAX W MCC	1.8155	5.4	7.0
200	04	MED	PNEUMOTHORAX W CC	1.0613	3.4	4.3
201	04	MED	PNEUMOTHORAX W/O CC/MCC	0.7606	2.5	3.1
202	04	MED	BRONCHITIS & ASTHMA W CC/MCC	0.9280	3.1	3.8
203	04	MED	BRONCHITIS & ASTHMA W/O CC/MCC	0.7039	2.4	2.9
204	04	MED	RESPIRATORY SIGNS & SYMPTOMS	0.7692	2.2	2.8
205	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W MCC	1.5085	4.0	5.4
206	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O MCC	0.8511	2.5	3.1
207	04	MED	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT >96 HOURS	5.5696	12.2	14.1
208	04	MED	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <=96 HOURS	2.3991	5.0	6.8
215	05	SURG	OTHER HEART ASSIST SYSTEM IMPLANT	10.4983	7.3	11.7
216	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W MCC	9.5284	11.1	14.3
217	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W CC	6.2989	7.4	8.9
218	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W/O CC/MCC	5.7015	4.7	5.9
219	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W MCC	7.6245	9.2	11.2
220	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W CC	5.1476	6.2	6.8
221	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W/O CC/MCC	4.5800	4.5	5.0

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
222	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W MCC	8.4910	10.1	12.1
223	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W/O MCC	6.4303	5.6	6.8
224	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W MCC	7.3191	7.4	9.1
225	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W/O MCC	5.6638	4.1	4.8
226	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W MCC	6.8160	6.5	8.5
227	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W/O MCC	5.4019	3.3	4.4
228	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W MCC	6.8436	7.0	10.0
229	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W/O MCC	4.7204	3.7	4.9
231	05	SURG	CORONARY BYPASS W PTCA W MCC	8.1445	10.2	12.0
232	05	SURG	CORONARY BYPASS W PTCA W/O MCC	5.8621	7.6	8.4
233	05	SURG	CORONARY BYPASS W CARDIAC CATH W MCC	7.3640	11.5	12.9
234	05	SURG	CORONARY BYPASS W CARDIAC CATH W/O MCC	5.0756	8.1	8.7
235	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W MCC	5.7970	8.8	10.1
236	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W/O MCC	3.8931	6.0	6.5
239	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W MCC	4.6375	10.2	13.0
240	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W CC	2.6675	6.9	8.4
241	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W/O CC/MCC	1.4778	4.3	5.1
242	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W MCC	3.7192	5.5	7.0
243	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W CC	2.6090	3.4	4.2
244	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W/O CC/MCC	2.1384	2.4	2.8
245	05	SURG	AICD GENERATOR PROCEDURES	5.4414	4.5	6.4
246	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W DRUG-ELUTING STENT W MCC OR 4+ ARTERIES OR STENTS	3.2238	4.2	5.5

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
247	05	SURG	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	2.1227	2.2	2.6
248	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W NON-DRUG-ELUTING STENT W MCC OR 4+ ARTERIES OR STENTS	3.0604	4.7	6.3
249	05	SURG	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MCC	1.9638	2.5	3.0
250	05	SURG	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W MCC	2.5208	4.0	5.3
251	05	SURG	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W/O MCC	1.6707	2.3	2.7
252	05	SURG	OTHER VASCULAR PROCEDURES W MCC	3.2670	5.3	7.6
253	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.6030	4.1	5.5
254	05	SURG	OTHER VASCULAR PROCEDURES W/O CC/MCC	1.8423	2.3	2.8
255	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W MCC	2.5101	6.6	8.3
256	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W CC	1.7431	5.3	6.3
257	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W/O CC/MCC	1.1254	3.4	4.1
258	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT W MCC	3.1313	4.9	6.5
259	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT W/O MCC	2.0909	2.8	3.5
260	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W MCC	3.6283	7.0	9.4
261	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W CC	1.9520	3.3	4.2
262	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W/O CC/MCC	1.6461	2.4	2.8
263	05	SURG	VEIN LIGATION & STRIPPING	2.3563	4.4	6.2
264	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	3.2339	6.7	9.3
265	05	SURG	AICD LEAD PROCEDURES	3.3528	3.7	5.0
266	05	SURG	ENDOVASCULAR CARDIAC VALVE REPLACEMENT W MCC	7.7457	5.0	7.2
267	05	SURG	ENDOVASCULAR CARDIAC VALVE REPLACEMENT W/O MCC	6.1025	2.9	3.5

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
268	05	SURG	AORTIC AND HEART ASSIST PROCEDURES EXCEPT PULSATION BALLOON W MCC	6.5274	6.6	9.6
269	05	SURG	AORTIC AND HEART ASSIST PROCEDURES EXCEPT PULSATION BALLOON W/O MCC	4.1569	1.8	2.5
270	05	SURG	OTHER MAJOR CARDIOVASCULAR PROCEDURES W MCC	4.9547	6.5	9.4
271	05	SURG	OTHER MAJOR CARDIOVASCULAR PROCEDURES W CC	3.3885	4.4	5.8
272	05	SURG	OTHER MAJOR CARDIOVASCULAR PROCEDURES W/O CC/MCC	2.4581	2.2	2.8
273	05	SURG	PERCUTANEOUS INTRACARDIAC PROCEDURES W MCC	3.5838	5.7	7.7
274	05	SURG	PERCUTANEOUS INTRACARDIAC PROCEDURES W/O MCC	2.7696	2.3	3.0
280	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC	1.6683	4.3	5.5
281	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W CC	0.9898	2.7	3.4
282	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W/O CC/MCC	0.7600	1.9	2.3
283	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W MCC	1.7719	3.0	4.8
284	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W CC	0.7919	1.7	2.4
285	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W/O CC/MCC	0.5558	1.3	1.4
286	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W MCC	2.2405	5.3	7.1
287	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O MCC	1.1775	2.5	3.3
288	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W MCC	2.7255	7.3	9.6
289	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W CC	1.7053	5.4	6.8
290	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W/O CC/MCC	1.0907	3.9	4.6
291	05	MED	HEART FAILURE & SHOCK W MCC	1.4825	4.5	5.7
292	05	MED	HEART FAILURE & SHOCK W CC	0.9610	3.5	4.2
293	05	MED	HEART FAILURE & SHOCK W/O CC/MCC	0.6732	2.5	3.0
294	05	MED	DEEP VEIN THROMBOPHLEBITIS W CC/MCC	1.0948	3.6	4.6

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
295	05	MED	DEEP VEIN THROMBOPHLEBITIS W/O CC/MCC	0.8015	2.9	3.5
296	05	MED	CARDIAC ARREST, UNEXPLAINED W MCC	1.4952	2.0	3.1
297	05	MED	CARDIAC ARREST, UNEXPLAINED W CC	0.6576	1.3	1.6
298	05	MED	CARDIAC ARREST, UNEXPLAINED W/O CC/MCC	0.4844	1.1	1.2
299	05	MED	PERIPHERAL VASCULAR DISORDERS W MCC	1.4860	4.1	5.4
300	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	1.0585	3.4	4.2
301	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC/MCC	0.7519	2.4	3.0
302	05	MED	ATHEROSCLEROSIS W MCC	1.0792	2.8	3.9
303	05	MED	ATHEROSCLEROSIS W/O MCC	0.6629	1.9	2.3
304	05	MED	HYPERTENSION W MCC	1.0522	3.1	4.1
305	05	MED	HYPERTENSION W/O MCC	0.6914	2.1	2.6
306	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS W MCC	1.3704	3.8	5.1
307	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS W/O MCC	0.8275	2.5	3.1
308	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W MCC	1.1968	3.6	4.6
309	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.7751	2.5	3.1
310	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC/MCC	0.5631	1.9	2.3
311	05	MED	ANGINA PECTORIS	0.6808	1.9	2.4
312	05	MED	SYNCOPE & COLLAPSE	0.7950	2.4	3.0
313	05	MED	CHEST PAIN	0.6993	1.8	2.2
314	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W MCC	1.9690	4.8	6.5
315	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.9706	2.9	3.7
316	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC/MCC	0.7400	2.0	2.5
326	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W MCC	4.5588	8.8	12.0
327	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W CC	2.1177	4.6	6.0
328	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W/O CC/MCC	1.5028	2.4	3.0
329	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W MCC	4.9255	10.8	13.5

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
330	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	2.4685	6.3	7.5
331	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1.6745	3.8	4.3
332	06	SURG	RECTAL RESECTION W MCC	3.6476	7.7	9.6
333	06	SURG	RECTAL RESECTION W CC	1.9645	4.4	5.5
334	06	SURG	RECTAL RESECTION W/O CC/MCC	1.2915	2.5	3.1
335	06	SURG	PERITONEAL ADHESIOLYSIS W MCC	4.1069	10.3	12.5
336	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.3396	6.5	7.9
337	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC/MCC	1.6132	4.0	5.0
338	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W MCC	2.7662	6.5	8.2
339	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	1.7038	4.3	5.3
340	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC/MCC	1.1980	2.5	3.0
341	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W MCC	2.5000	4.6	6.5
342	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.4868	2.8	3.7
343	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC/MCC	1.0514	1.7	2.0
344	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W MCC	2.7467	7.2	9.6
345	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.5537	4.5	5.6
346	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1.0984	3.2	3.7
347	06	SURG	ANAL & STOMAL PROCEDURES W MCC	2.6309	6.3	8.4
348	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.4093	3.7	4.8
349	06	SURG	ANAL & STOMAL PROCEDURES W/O CC/MCC	1.0083	2.5	3.0
350	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W MCC	2.4607	5.2	7.1
351	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W CC	1.4796	3.4	4.3
352	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W/O CC/MCC	1.0312	2.1	2.5

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
353	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W MCC	3.0125	6.2	8.1
354	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W CC	1.7186	3.9	4.8
355	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W/O CC/MCC	1.3153	2.6	3.1
356	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W MCC	3.8751	7.8	10.5
357	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.1295	4.8	6.2
358	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	1.4039	2.9	3.7
368	06	MED	MAJOR ESOPHAGEAL DISORDERS W MCC	1.8657	4.6	6.1
369	06	MED	MAJOR ESOPHAGEAL DISORDERS W CC	1.0906	3.3	3.9
370	06	MED	MAJOR ESOPHAGEAL DISORDERS W/O CC/MCC	0.7481	2.4	2.9
371	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W MCC	1.7350	5.5	7.1
372	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC	1.0600	4.1	5.0
373	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W/O CC/MCC	0.7611	3.2	3.8
374	06	MED	DIGESTIVE MALIGNANCY W MCC	2.0302	5.7	7.7
375	06	MED	DIGESTIVE MALIGNANCY W CC	1.2356	3.9	5.0
376	06	MED	DIGESTIVE MALIGNANCY W/O CC/MCC	0.9399	2.6	3.2
377	06	MED	G.I. HEMORRHAGE W MCC	1.7359	4.5	5.8
378	06	MED	G.I. HEMORRHAGE W CC	0.9744	3.1	3.6
379	06	MED	G.I. HEMORRHAGE W/O CC/MCC	0.6432	2.2	2.5
380	06	MED	COMPLICATED PEPTIC ULCER W MCC	1.9186	5.2	6.7
381	06	MED	COMPLICATED PEPTIC ULCER W CC	1.0813	3.4	4.1
382	06	MED	COMPLICATED PEPTIC ULCER W/O CC/MCC	0.8018	2.5	3.0
383	06	MED	UNCOMPLICATED PEPTIC ULCER W MCC	1.3666	3.9	5.1
384	06	MED	UNCOMPLICATED PEPTIC ULCER W/O MCC	0.8742	2.7	3.3
385	06	MED	INFLAMMATORY BOWEL DISEASE W MCC	1.6662	5.4	7.2
386	06	MED	INFLAMMATORY BOWEL DISEASE W CC	0.9665	3.6	4.4
387	06	MED	INFLAMMATORY BOWEL DISEASE W/O CC/MCC	0.7368	2.8	3.4
388	06	MED	G.I. OBSTRUCTION W MCC	1.5344	4.9	6.5
389	06	MED	G.I. OBSTRUCTION W CC	0.8529	3.4	4.1

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
390	06	MED	G.I. OBSTRUCTION W/O CC/MCC	0.5949	2.6	3.0
391	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W MCC	1.2402	3.8	5.1
392	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	0.7576	2.7	3.3
393	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W MCC	1.6582	4.6	6.3
394	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W CC	0.9457	3.2	4.1
395	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W/O CC/MCC	0.6722	2.4	2.9
405	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W MCC	5.2915	9.9	13.1
406	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	2.7915	5.7	7.1
407	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC/MCC	2.0128	4.1	4.8
408	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W MCC	3.9489	9.2	11.8
409	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	2.3237	6.0	7.2
410	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC/MCC	1.7216	4.2	4.8
411	07	SURG	CHOLECYSTECTOMY W C.D.E. W MCC	3.3045	7.8	9.5
412	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	2.3762	5.5	6.6
413	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC/MCC	1.6823	3.6	4.4
414	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W MCC	3.5467	8.1	9.9
415	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	2.0132	5.3	6.2
416	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC/MCC	1.4004	3.4	3.9
417	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W MCC	2.3894	5.4	6.7
418	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.6627	3.8	4.5
419	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC/MCC	1.3004	2.5	3.0
420	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W MCC	4.1005	8.1	11.6
421	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W CC	1.8803	4.3	5.6

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
422	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W/O CC/MCC	1.5541	3.1	3.8
423	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W MCC	3.6347	8.1	11.2
424	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W CC	2.2078	5.8	7.5
425	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W/O CC/MCC	1.6155	3.6	4.3
432	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W MCC	1.8127	4.8	6.5
433	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W CC	1.0222	3.4	4.3
434	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W/O CC/MCC	0.6240	2.3	2.7
435	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W MCC	1.6814	4.9	6.4
436	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W CC	1.1327	3.6	4.7
437	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W/O CC/MCC	0.9071	2.6	3.3
438	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W MCC	1.6705	4.8	6.6
439	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W CC	0.8730	3.3	4.1
440	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W/O CC/MCC	0.6365	2.5	3.0
441	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W MCC	1.8237	4.8	6.6
442	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	0.9392	3.3	4.1
443	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC/MCC	0.6772	2.5	3.0
444	07	MED	DISORDERS OF THE BILIARY TRACT W MCC	1.6063	4.4	5.8
445	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.0561	3.2	3.9
446	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC/MCC	0.7882	2.3	2.8
453	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W MCC	9.7066	7.6	9.8
454	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W CC	6.4297	4.1	4.8

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
455	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W/O CC/MCC	5.0622	2.7	3.1
456	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W MCC	9.1643	9.6	11.7
457	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W CC	6.7933	5.4	6.4
458	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W/O CC/MCC	5.3542	3.2	3.7
459	08	SURG	SPINAL FUSION EXCEPT CERVICAL W MCC	6.0301	5.8	7.4
460	08	SURG	SPINAL FUSION EXCEPT CERVICAL W/O MCC	4.0032	2.9	3.4
461	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W MCC	4.9088	6.1	7.8
462	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W/O MCC	3.2606	3.0	3.2
463	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W MCC	5.0018	9.8	13.0
464	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W CC	2.8295	5.5	6.9
465	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W/O CC/MCC	1.8727	3.0	3.7
466	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W MCC	5.0324	6.7	8.3
467	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W CC	3.4652	3.5	4.2
468	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W/O CC/MCC	2.8066	2.4	2.7
469	08	SURG	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W MCC OR TOTAL ANKLE REPLACEMENT	3.1954	5.1	6.3
470	08	SURG	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	2.0473	2.4	2.7
471	08	SURG	CERVICAL SPINAL FUSION W MCC	4.9042	6.3	8.6
472	08	SURG	CERVICAL SPINAL FUSION W CC	2.8444	2.2	3.1
473	08	SURG	CERVICAL SPINAL FUSION W/O CC/MCC	2.2840	1.4	1.7
474	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W MCC	3.8607	9.0	11.5
475	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W CC	2.1480	5.8	7.2

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
476	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W/O CC/MCC	1.1647	3.1	3.9
477	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	3.2310	8.2	10.6
478	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	2.2343	5.4	6.6
479	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	1.7653	3.4	4.2
480	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC	3.0129	6.5	7.6
481	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC	2.0417	4.5	4.9
482	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC	1.6622	3.6	3.8
483	08	SURG	MAJOR JOINT/LIMB REATTACHMENT PROCEDURE OF UPPER EXTREMITIES	2.4185	1.7	2.0
485	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W MCC	3.2509	8.2	9.9
486	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.2116	5.3	6.2
487	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC/MCC	1.6517	3.9	4.3
488	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION W CC/MCC	1.9888	3.8	5.0
489	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION W/O CC/MCC	1.2814	2.2	2.6
492	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W MCC	3.2856	6.2	7.6
493	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W CC	2.1901	4.0	4.8
494	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W/O CC/MCC	1.7462	2.7	3.2
495	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W MCC	3.0039	6.5	8.7
496	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W CC	1.9650	3.5	4.5
497	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W/O CC/MCC	1.3839	1.8	2.2

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
498	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W CC/MCC	2.4277	5.3	7.1
499	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W/O CC/MCC	1.2468	2.3	2.8
500	08	SURG	SOFT TISSUE PROCEDURES W MCC	2.9764	7.1	9.4
501	08	SURG	SOFT TISSUE PROCEDURES W CC	1.6945	4.2	5.3
502	08	SURG	SOFT TISSUE PROCEDURES W/O CC/MCC	1.2649	2.5	3.0
503	08	SURG	FOOT PROCEDURES W MCC	2.4932	6.7	8.4
504	08	SURG	FOOT PROCEDURES W CC	1.7185	4.9	5.9
505	08	SURG	FOOT PROCEDURES W/O CC/MCC	1.5119	3.0	3.6
506	08	SURG	MAJOR THUMB OR JOINT PROCEDURES	1.3760	3.7	4.6
507	08	SURG	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W CC/MCC	1.9034	4.4	5.7
508	08	SURG	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W/O CC/MCC	1.5257	2.1	2.5
509	08	SURG	ARTHROSCOPY	1.8325	3.9	4.9
510	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W MCC	2.4801	4.8	6.0
511	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W CC	1.7728	3.4	3.9
512	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W/O CC/MCC	1.4832	2.3	2.6
513	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W CC/MCC	1.6035	4.2	5.5
514	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W/O CC/MCC	1.0239	2.4	2.9
515	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W MCC	2.8625	6.2	7.9
516	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.8777	3.8	4.8
517	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC/MCC	1.3716	2.2	2.7
518	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W MCC OR DISC DEVICE/NEUROSTIM	2.8795	3.2	5.1
519	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W CC	1.7929	3.2	4.1
520	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC	1.2871	1.9	2.4
533	08	MED	FRACTURES OF FEMUR W MCC	1.4448	4.3	5.7

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
534	08	MED	FRACTURES OF FEMUR W/O MCC	0.7627	2.9	3.5
535	08	MED	FRACTURES OF HIP & PELVIS W MCC	1.2697	3.9	5.0
536	08	MED	FRACTURES OF HIP & PELVIS W/O MCC	0.7517	3.0	3.4
537	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W CC/MCC	0.9713	3.3	4.1
538	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W/O CC/MCC	0.6701	2.5	2.9
539	08	MED	OSTEOMYELITIS W MCC	1.8946	5.9	7.8
540	08	MED	OSTEOMYELITIS W CC	1.2976	4.5	5.7
541	08	MED	OSTEOMYELITIS W/O CC/MCC	0.9440	3.4	4.3
542	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W MCC	1.8089	5.3	7.0
543	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W CC	1.0770	3.7	4.6
544	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W/O CC/MCC	0.7728	3.0	3.4
545	08	MED	CONNECTIVE TISSUE DISORDERS W MCC	2.4075	5.9	8.2
546	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.1297	3.6	4.6
547	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC/MCC	0.8113	2.6	3.2
548	08	MED	SEPTIC ARTHRITIS W MCC	2.0331	6.0	7.9
549	08	MED	SEPTIC ARTHRITIS W CC	1.2021	4.1	5.1
550	08	MED	SEPTIC ARTHRITIS W/O CC/MCC	0.8945	3.0	3.6
551	08	MED	MEDICAL BACK PROBLEMS W MCC	1.5657	4.5	5.8
552	08	MED	MEDICAL BACK PROBLEMS W/O MCC	0.8912	3.0	3.7
553	08	MED	BONE DISEASES & ARTHROPATHIES W MCC	1.2521	4.0	5.2
554	08	MED	BONE DISEASES & ARTHROPATHIES W/O MCC	0.7483	2.8	3.4
555	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W MCC	1.3023	3.9	5.1
556	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC	0.7863	2.7	3.4
557	08	MED	TENDONITIS, MYOSITIS & BURSITIS W MCC	1.4516	4.6	5.8
558	08	MED	TENDONITIS, MYOSITIS & BURSITIS W/O MCC	0.8566	3.2	3.8
559	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	1.6993	4.7	6.3
560	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	1.0790	3.8	4.8

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
561	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	0.7617	2.6	3.4
562	08	MED	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W MCC	1.3888	4.1	5.2
563	08	MED	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W/O MCC	0.8209	3.0	3.4
564	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W MCC	1.4708	4.7	5.9
565	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W CC	0.9539	3.5	4.2
566	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W/O CC/MCC	0.7751	2.6	3.1
570	09	SURG	SKIN DEBRIDEMENT W MCC	2.5922	7.0	9.1
571	09	SURG	SKIN DEBRIDEMENT W CC	1.6247	5.0	6.1
572	09	SURG	SKIN DEBRIDEMENT W/O CC/MCC	1.1689	3.5	4.3
573	09	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W MCC	4.0912	8.8	12.8
574	09	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W CC	2.9289	7.3	9.3
575	09	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	1.7389	4.5	5.6
576	09	SURG	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W MCC	4.5447	9.0	13.0
577	09	SURG	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W CC	2.4236	4.7	6.8
578	09	SURG	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	1.4714	2.7	3.6
579	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W MCC	2.7808	6.9	9.2
580	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.6549	3.9	5.1
581	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC/MCC	1.3030	2.2	2.8
582	09	SURG	MASTECTOMY FOR MALIGNANCY W CC/MCC	1.4695	2.3	3.1
583	09	SURG	MASTECTOMY FOR MALIGNANCY W/O CC/MCC	1.3454	1.7	2.0
584	09	SURG	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W CC/MCC	1.8434	3.7	4.9
585	09	SURG	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W/O CC/MCC	1.5842	2.2	2.7

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
592	09	MED	SKIN ULCERS W MCC	1.4815	5.0	6.6
593	09	MED	SKIN ULCERS W CC	1.0469	4.1	4.9
594	09	MED	SKIN ULCERS W/O CC/MCC	0.7568	3.0	3.7
595	09	MED	MAJOR SKIN DISORDERS W MCC	2.1080	5.5	7.5
596	09	MED	MAJOR SKIN DISORDERS W/O MCC	0.9785	3.5	4.4
597	09	MED	MALIGNANT BREAST DISORDERS W MCC	1.8241	5.3	7.1
598	09	MED	MALIGNANT BREAST DISORDERS W CC	1.0872	3.5	4.5
599	09	MED	MALIGNANT BREAST DISORDERS W/O CC/MCC	0.8761	2.5	3.1
600	09	MED	NON-MALIGNANT BREAST DISORDERS W CC/MCC	0.9557	3.7	4.5
601	09	MED	NON-MALIGNANT BREAST DISORDERS W/O CC/MCC	0.6270	2.6	3.1
602	09	MED	CELLULITIS W MCC	1.4571	4.8	5.9
603	09	MED	CELLULITIS W/O MCC	0.8559	3.4	4.0
604	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W MCC	1.4190	3.9	5.1
605	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W/O MCC	0.8531	2.7	3.3
606	09	MED	MINOR SKIN DISORDERS W MCC	1.3769	4.2	5.7
607	09	MED	MINOR SKIN DISORDERS W/O MCC	0.7901	2.9	3.7
614	10	SURG	ADRENAL & PITUITARY PROCEDURES W CC/MCC	2.3493	3.7	5.0
615	10	SURG	ADRENAL & PITUITARY PROCEDURES W/O CC/MCC	1.4724	2.0	2.4
616	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W MCC	4.0339	10.3	12.6
617	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W CC	2.0926	6.1	7.3
618	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W/O CC/MCC	1.1695	4.1	4.8
619	10	SURG	O.R. PROCEDURES FOR OBESITY W MCC	3.1291	3.6	5.7
620	10	SURG	O.R. PROCEDURES FOR OBESITY W CC	1.8443	2.2	2.6
621	10	SURG	O.R. PROCEDURES FOR OBESITY W/O CC/MCC	1.5876	1.6	1.8
622	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W MCC	3.6089	8.4	11.1
623	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W CC	1.8906	5.5	6.6

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
624	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W/O CC/MCC	1.1632	3.3	4.1
625	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W MCC	2.6784	4.8	7.2
626	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W CC	1.4948	2.3	3.1
627	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W/O CC/MCC	1.0537	1.5	1.8
628	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W MCC	3.4610	6.8	9.8
629	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.3137	6.1	7.2
630	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC/MCC	1.6099	2.8	3.6
637	10	MED	DIABETES W MCC	1.3458	3.9	5.1
638	10	MED	DIABETES W CC	0.8534	2.9	3.6
639	10	MED	DIABETES W/O CC/MCC	0.6250	2.2	2.6
640	10	MED	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W MCC	1.1757	3.3	4.5
641	10	MED	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W/O MCC	0.7456	2.6	3.3
642	10	MED	INBORN AND OTHER DISORDERS OF METABOLISM	1.2612	3.2	4.3
643	10	MED	ENDOCRINE DISORDERS W MCC	1.5996	5.1	6.5
644	10	MED	ENDOCRINE DISORDERS W CC	1.0040	3.6	4.4
645	10	MED	ENDOCRINE DISORDERS W/O CC/MCC	0.7387	2.7	3.3
652	11	SURG	KIDNEY TRANSPLANT	3.3376	5.5	6.4
653	11	SURG	MAJOR BLADDER PROCEDURES W MCC	5.7625	11.3	14.4
654	11	SURG	MAJOR BLADDER PROCEDURES W CC	2.9055	6.6	7.6
655	11	SURG	MAJOR BLADDER PROCEDURES W/O CC/MCC	2.1068	4.1	4.8
656	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W MCC	3.2492	6.0	7.8
657	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W CC	1.9728	3.8	4.5
658	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W/O CC/MCC	1.5580	2.4	2.7

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
659	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W MCC	3.4209	6.7	9.4
660	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W CC	1.8006	3.4	4.5
661	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W/O CC/MCC	1.4519	2.1	2.5
662	11	SURG	MINOR BLADDER PROCEDURES W MCC	3.0450	7.7	10.4
663	11	SURG	MINOR BLADDER PROCEDURES W CC	1.7790	3.9	5.3
664	11	SURG	MINOR BLADDER PROCEDURES W/O CC/MCC	1.2917	1.9	2.4
665	11	SURG	PROSTATECTOMY W MCC	3.1176	8.2	10.6
666	11	SURG	PROSTATECTOMY W CC	1.7342	4.4	5.8
667	11	SURG	PROSTATECTOMY W/O CC/MCC	0.9792	2.2	2.7
668	11	SURG	TRANSURETHRAL PROCEDURES W MCC	2.6316	6.6	8.7
669	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.3804	3.1	4.2
670	11	SURG	TRANSURETHRAL PROCEDURES W/O CC/MCC	0.9801	2.2	2.7
671	11	SURG	URETHRAL PROCEDURES W CC/MCC	1.5289	3.7	5.0
672	11	SURG	URETHRAL PROCEDURES W/O CC/MCC	1.0134	1.9	2.3
673	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W MCC	3.5441	7.7	10.7
674	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W CC	2.3314	5.3	7.0
675	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W/O CC/MCC	1.6581	2.6	3.3
682	11	MED	RENAL FAILURE W MCC	1.4921	4.3	5.8
683	11	MED	RENAL FAILURE W CC	0.9297	3.3	4.1
684	11	MED	RENAL FAILURE W/O CC/MCC	0.6267	2.3	2.8
685	11	MED	ADMIT FOR RENAL DIALYSIS	1.0531	2.7	3.4
686	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W MCC	1.7557	5.2	6.8
687	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.1052	3.5	4.5
688	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC/MCC	0.8523	2.0	2.4
689	11	MED	KIDNEY & URINARY TRACT INFECTIONS W MCC	1.0828	3.9	4.8
690	11	MED	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	0.7940	3.0	3.6
691	11	MED	URINARY STONES W ESW LITHOTRIPSY W CC/MCC	1.5943	2.6	3.4
692	11	MED	URINARY STONES W ESW LITHOTRIPSY W/O CC/MCC	1.1667	1.9	2.3

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
693	11	MED	URINARY STONES W/O ESW LITHOTRIPSY W MCC	1.4505	4.1	5.4
694	11	MED	URINARY STONES W/O ESW LITHOTRIPSY W/O MCC	0.8153	2.1	2.7
695	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W MCC	1.2113	3.9	5.0
696	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W/O MCC	0.7031	2.5	3.1
697	11	MED	URETHRAL STRICTURE	1.0321	2.9	3.8
698	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W MCC	1.6009	5.0	6.3
699	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W CC	1.0331	3.4	4.3
700	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W/O CC/MCC	0.7799	2.4	3.0
707	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC/MCC	1.7951	2.4	3.3
708	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC/MCC	1.3773	1.3	1.5
709	12	SURG	PENIS PROCEDURES W CC/MCC	2.2401	4.2	6.4
710	12	SURG	PENIS PROCEDURES W/O CC/MCC	1.4980	1.8	2.3
711	12	SURG	TESTES PROCEDURES W CC/MCC	2.0228	5.5	7.3
712	12	SURG	TESTES PROCEDURES W/O CC/MCC	0.9232	2.3	2.9
713	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC/MCC	1.4197	2.9	4.2
714	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC/MCC	0.8763	1.7	2.0
715	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W CC/MCC	2.1340	4.8	7.0
716	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W/O CC/MCC	1.4084	1.5	1.7
717	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W CC/MCC	1.9289	4.0	5.4
718	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W/O CC/MCC	1.2447	2.4	2.8
722	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W MCC	1.7556	5.2	7.0
723	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W CC	1.1231	3.6	4.6

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
724	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.7504	1.8	2.3
725	12	MED	BENIGN PROSTATIC HYPERTROPHY W MCC	1.2712	4.2	5.6
726	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O MCC	0.7378	2.6	3.2
727	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W MCC	1.4597	4.7	6.0
728	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W/O MCC	0.8109	3.1	3.7
729	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W CC/MCC	1.0535	3.3	4.3
730	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W/O CC/MCC	0.6343	1.9	2.4
734	13	SURG	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W CC/MCC	2.1648	3.8	5.3
735	13	SURG	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W/O CC/MCC	1.2971	1.8	2.2
736	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W MCC	3.9264	9.2	11.4
737	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W CC	1.9504	4.8	5.6
738	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W/O CC/MCC	1.3806	2.8	3.2
739	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W MCC	3.5399	6.7	9.4
740	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.7129	3.1	4.0
741	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC/MCC	1.2585	1.8	2.1
742	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC/MCC	1.6331	3.1	4.0
743	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	1.0680	1.8	2.0
744	13	SURG	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W CC/MCC	1.6950	4.3	5.7
745	13	SURG	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W/O CC/MCC	1.0578	2.2	2.6
746	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES W CC/MCC	1.6250	3.5	5.1

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
747	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES W/O CC/MCC	0.9144	1.6	2.0
748	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	1.3396	1.7	2.2
749	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W CC/MCC	2.5800	5.8	7.7
750	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	1.2694	2.4	3.0
754	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W MCC	1.7864	5.2	7.0
755	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.1069	3.5	4.6
756	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.6353	2.0	2.5
757	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W MCC	1.4708	5.1	6.5
758	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W CC	1.0093	3.9	4.8
759	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.7152	2.9	3.4
760	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W CC/MCC	0.8696	2.7	3.4
761	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W/O CC/MCC	0.6368	1.7	2.1
765	14	SURG	CESAREAN SECTION W CC/MCC	1.1541	3.7	4.7
766	14	SURG	CESAREAN SECTION W/O CC/MCC	0.8177	2.8	3.1
767	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.9126	2.4	2.9
768	14	SURG	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	1.0173	3.1	3.4
769	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	1.7736	3.3	5.3
770	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.7741	1.8	2.2
774	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.8016	2.6	3.4
775	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.6156	2.1	2.3

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MS-DRG Table						
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MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
776	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.8129	2.5	3.4
777	14	MED	ECTOPIC PREGNANCY	0.8720	1.6	1.9
778	14	MED	THREATENED ABORTION	0.5961	2.1	3.1
779	14	MED	ABORTION W/O D&C	0.6768	1.7	2.4
780	14	MED	FALSE LABOR	0.4401	1.6	2.0
781	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.8556	2.7	4.1
782	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.6033	1.9	2.6
789	15	MED	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.6400	1.8	1.8
790	15	MED	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	5.4079	17.9	17.9
791	15	MED	PREMATURITY W MAJOR PROBLEMS	3.6934	13.3	13.3
792	15	MED	PREMATURITY W/O MAJOR PROBLEMS	2.2285	8.6	8.6
793	15	MED	FULL TERM NEONATE W MAJOR PROBLEMS	3.7940	4.7	4.7
794	15	MED	NEONATE W OTHER SIGNIFICANT PROBLEMS	1.3428	3.4	3.4
795	15	MED	NORMAL NEWBORN	0.1818	3.1	3.1
799	16	SURG	SPLENECTOMY W MCC	4.6581	8.0	10.4
800	16	SURG	SPLENECTOMY W CC	2.6807	5.1	6.5
801	16	SURG	SPLENECTOMY W/O CC/MCC	1.7047	2.6	3.2
802	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W MCC	3.3337	7.5	10.8
803	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W CC	1.8040	4.3	5.6
804	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W/O CC/MCC	1.1968	2.3	2.9
808	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W MCC	2.1388	5.6	7.5
809	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W CC	1.1972	3.6	4.5
810	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W/O CC/MCC	0.9385	2.8	3.4
811	16	MED	RED BLOOD CELL DISORDERS W MCC	1.3467	3.7	4.9
812	16	MED	RED BLOOD CELL DISORDERS W/O MCC	0.8817	2.8	3.5
813	16	MED	COAGULATION DISORDERS	1.7498	3.6	4.9

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MS-DRG Table						
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MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
814	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W MCC	1.7687	4.8	6.6
815	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	1.0006	3.2	4.0
816	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC/MCC	0.7007	2.4	2.9
820	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W MCC	5.3536	11.2	15.2
821	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC	2.3315	4.4	6.1
822	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/O CC/MCC	1.2196	2.0	2.5
823	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER PROC W MCC	4.3480	10.6	13.7
824	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER PROC W CC	2.1737	5.3	7.1
825	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER PROC W/O CC/MCC	1.2700	2.5	3.4
826	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W MCC	5.2297	10.7	14.2
827	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC	2.3548	5.0	6.4
828	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC/MCC	1.6141	3.2	3.9
829	17	SURG	MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS W OTHER PROCEDURE W CC/MCC	3.1042	6.2	9.4
830	17	SURG	MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS W OTHER PROCEDURE W/O CC/MCC	1.2757	2.4	3.0
834	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W MCC	5.5307	10.1	16.8
835	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W CC	2.0965	4.4	7.0
836	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W/O CC/MCC	1.3865	3.0	4.9
837	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX OR W HIGH DOSE CHEMO AGENT W MCC	5.6932	14.0	19.4

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MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
838	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX W CC OR HIGH DOSE CHEMO AGENT	2.3687	6.1	8.2
839	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX W/O CC/MCC	1.3374	4.7	5.3
840	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W MCC	3.6284	8.0	11.1
841	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.7795	4.5	6.1
842	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC/MCC	1.4044	3.2	4.4
843	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W MCC	1.8021	5.3	7.2
844	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.2092	3.9	5.0
845	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC/MCC	0.8984	2.8	3.5
846	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W MCC	2.5766	6.1	8.3
847	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W CC	1.2848	3.6	4.1
848	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W/O CC/MCC	0.9369	2.8	3.3
849	17	MED	RADIOTHERAPY	1.7994	4.8	6.3
853	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	5.1567	10.3	13.3
854	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W CC	2.4260	6.4	7.7
855	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W/O CC/MCC	1.4549	3.4	4.1
856	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W MCC	4.5393	9.4	12.5
857	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W CC	2.0380	5.4	6.8
858	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W/O CC/MCC	1.3531	3.7	4.5
862	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W MCC	1.8700	5.2	6.8
863	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W/O MCC	1.0384	3.7	4.5
864	18	MED	FEVER	0.8705	2.8	3.5

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
865	18	MED	VIRAL ILLNESS W MCC	1.5090	4.1	5.6
866	18	MED	VIRAL ILLNESS W/O MCC	0.7987	2.7	3.4
867	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W MCC	2.1586	5.7	7.7
868	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W CC	1.0660	3.8	4.7
869	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W/O CC/MCC	0.7874	2.9	3.5
870	18	MED	SEPTICEMIA OR SEVERE SEPSIS W MV >96 HOURS	6.1735	12.6	14.6
871	18	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W MCC	1.8410	4.9	6.4
872	18	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W/O MCC	1.0591	3.7	4.5
876	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	3.5205	7.6	14.3
880	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	0.8085	2.7	3.7
881	19	MED	DEPRESSIVE NEUROSES	0.7420	3.8	5.2
882	19	MED	NEUROSES EXCEPT DEPRESSIVE	0.7762	3.2	4.5
883	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	1.1800	4.8	7.8
884	19	MED	ORGANIC DISTURBANCES & INTELLECTUAL DISABILITY	1.2302	4.2	6.4
885	19	MED	PSYCHOSES	1.1660	5.8	8.2
886	19	MED	BEHAVIORAL & DEVELOPMENTAL DISORDERS	1.0647	3.7	6.9
887	19	MED	OTHER MENTAL DISORDER DIAGNOSES	1.0732	3.1	4.6
894	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.5242	2.1	2.9
895	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY	1.3253	9.1	11.9
896	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W MCC	1.6504	4.8	6.7
897	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O MCC	0.7889	3.4	4.3
901	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W MCC	4.1574	9.0	13.1
902	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W CC	1.9938	5.1	6.8

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
903	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W/O CC/MCC	1.2455	3.1	3.9
904	21	SURG	SKIN GRAFTS FOR INJURIES W CC/MCC	3.2158	6.7	9.6
905	21	SURG	SKIN GRAFTS FOR INJURIES W/O CC/MCC	1.4535	3.5	4.4
906	21	SURG	HAND PROCEDURES FOR INJURIES	1.7377	2.9	4.4
907	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W MCC	4.1965	7.3	10.3
908	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.0626	4.0	5.3
909	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC/MCC	1.4323	2.5	3.2
913	21	MED	TRAUMATIC INJURY W MCC	1.4001	3.6	4.9
914	21	MED	TRAUMATIC INJURY W/O MCC	0.8301	2.5	3.2
915	21	MED	ALLERGIC REACTIONS W MCC	1.6317	3.7	5.0
916	21	MED	ALLERGIC REACTIONS W/O MCC	0.6030	1.8	2.1
917	21	MED	POISONING & TOXIC EFFECTS OF DRUGS W MCC	1.4129	3.5	4.8
918	21	MED	POISONING & TOXIC EFFECTS OF DRUGS W/O MCC	0.7522	2.3	3.0
919	21	MED	COMPLICATIONS OF TREATMENT W MCC	1.7831	4.4	6.1
920	21	MED	COMPLICATIONS OF TREATMENT W CC	1.0106	3.0	3.9
921	21	MED	COMPLICATIONS OF TREATMENT W/O CC/MCC	0.7230	2.3	2.8
922	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W MCC	1.5041	4.0	5.5
923	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O MCC	0.8186	2.6	3.6
927	22	SURG	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV >96 HRS W SKIN GRAFT	17.0027	23.9	30.2
928	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC/MCC	5.7285	10.7	14.5
929	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W/O CC/MCC	2.6456	5.6	7.5
933	22	MED	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV >96 HRS W/O SKIN GRAFT	3.2811	2.8	5.9
934	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ	1.7345	4.3	6.2
935	22	MED	NON-EXTENSIVE BURNS	1.6890	3.5	5.0
939	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W MCC	3.4944	6.5	9.6
940	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W CC	2.3390	4.0	5.3

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
941	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W/O CC/MCC	1.8555	2.5	3.2
945	23	MED	REHABILITATION W CC/MCC	1.2405	8.3	10.9
946	23	MED	REHABILITATION W/O CC/MCC	1.1266	6.4	7.3
947	23	MED	SIGNS & SYMPTOMS W MCC	1.1745	3.5	4.8
948	23	MED	SIGNS & SYMPTOMS W/O MCC	0.7711	2.7	3.3
949	23	MED	AFTERCARE W CC/MCC	1.1809	4.4	6.0
950	23	MED	AFTERCARE W/O CC/MCC	0.8042	3.4	4.7
951	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	0.7870	2.4	3.2
955	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	6.0288	7.4	10.9
956	24	SURG	LIMB REATTACHMENT, HIP & FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	3.8425	6.2	7.7
957	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W MCC	7.3069	9.6	13.7
958	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W CC	4.2762	7.1	8.7
959	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	2.7784	4.0	4.9
963	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W MCC	2.7694	5.5	8.1
964	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W CC	1.4301	4.0	4.8
965	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	0.9933	2.9	3.3
969	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE W MCC	5.4154	11.1	15.1
970	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE W/O MCC	2.5664	4.4	7.1
974	25	MED	HIV W MAJOR RELATED CONDITION W MCC	2.8070	6.6	9.2
975	25	MED	HIV W MAJOR RELATED CONDITION W CC	1.3529	4.4	5.8
976	25	MED	HIV W MAJOR RELATED CONDITION W/O CC/MCC	0.9976	3.2	4.3
977	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.3051	3.7	5.2
981		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	4.3369	8.5	11.5
982		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	2.5036	5.0	6.7
983		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.6378	2.5	3.5
987		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	3.3133	8.1	10.7

Exhibit #1 – Proposed						
MS-DRG Table						
Effective for Dates of Service on and After 1/1/2018						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
988		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W CC	1.7448	4.4	6.0
989		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.1192	2.2	2.9
998		**	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS			
999		**	UNGROUPABLE			

Exhibit #2 – Proposed			
Hospital Base Rates and Cost to Charge Ratios (CCR)			
Effective for Hospital Inpatient Discharge Date of Service on or after 1/1/2018			
Provider Number	**Name**	**Base Rate**	**Total CCR**
60001	NORTH COLORADO MEDICAL CENTER	$6,784.96	0.254
60003	LONGMONT UNITED HOSPITAL	$6,241.13	0.309
60004	PLATTE VALLEY MEDICAL CENTER	$6,386.71	0.34
60006	MONTROSE MEMORIAL HOSPITAL	$6,133.97	0.411
60008	SAN LUIS VALLEY HEALTH	$6,242.35	0.373
60009	LUTHERAN MEDICAL CENTER	$6,372.63	0.235
60010	POUDRE VALLEY HOSPITAL	$6,539.44	0.304
60011	DENVER HEALTH MEDICAL CENTER	$8,473.42	0.289
60012	CENTURA HEALTH-ST MARY CORWIN MEDICAL CENTER	$6,675.37	0.249
60013	MERCY REGIONAL MEDICAL CENTER	$7,906.12	0.34
60014	PRESBYTERIAN ST LUKES MEDICAL CENTER	$7,007.25	0.184
60015	CENTURA HEALTH-ST ANTHONY HOSPITAL	$6,331.38	0.201
60016	CENTURA HEALTH-ST THOMAS MORE HOSPITAL	$6,915.90	0.4
60020	PARKVIEW MEDICAL CENTER INC	$6,607.56	0.181
60022	UNIVERSITY COLO HEALTH MEMORIAL HOSPITAL CENTRAL	$6,417.21	0.256
60023	ST MARYS MEDICAL CENTER	$6,886.88	0.303
60024	UNIVERSITY OF COLORADO HOSPITAL AUTHORITY	$8,097.34	0.18
60027	FOOTHILLS HOSPITAL	$6,180.76	0.23
60028	SAINT JOSEPH HOSPITAL	$6,996.82	0.214
60030	MCKEE MEDICAL CENTER	$6,418.54	0.37
60031	CENTURA HEALTH-PENROSE ST FRANCIS HEALTH SERVICES	$6,282.89	0.221
60032	ROSE MEDICAL CENTER	$6,660.80	0.16
60034	SWEDISH MEDICAL CENTER	$6,419.01	0.139
60036	ARKANSAS VALLEY REGIONAL MEDICAL CENTER	$6,222.39	0.527
60043	KEEFE MEMORIAL HOSPITAL	$15,890.85	0.483
60044	COLORADO PLAINS MEDICAL CENTER	$6,519.64	0.276
60049	YAMPA VALLEY MEDICAL CENTER	$9,549.81	0.549
60054	COMMUNITY HOSPITAL	$5,990.97	0.393
60064	CENTURA HEALTH-PORTER ADVENTIST HOSPITAL	$6,246.32	0.21
60065	NORTH SUBURBAN MEDICAL CENTER	$6,590.82	0.143
60071	DELTA COUNTY MEMORIAL HOSPITAL	$6,131.00	0.431
60075	VALLEY VIEW HOSPITAL ASSOCIATION	$8,009.31	0.506

Exhibit #2 – Proposed			
Hospital Base Rates and Cost to Charge Ratios (CCR)			
Effective for Hospital Inpatient Discharge Date of Service on or after 1/1/2018			
Provider Number	**Name**	**Base Rate**	**Total CCR**
60076	STERLING REGIONAL MEDCENTER	$7,753.03	0.524
60096	VAIL VALLEY MEDICAL CENTER	$11,966.12	0.485
60100	MEDICAL CENTER OF AURORA, THE	$6,383.70	0.161
60103	CENTURA HEALTH-AVISTA ADVENTIST HOSPITAL	$6,399.01	0.281
60104	ST ANTHONY NORTH HEALTH CAMPUS	$7,138.78	0.267
60107	NATIONAL JEWISH HEALTH	$6,477.32	0.229
60112	SKY RIDGE MEDICAL CENTER	$6,096.15	0.138
60113	CENTURA HEALTH-LITTLETON ADVENTIST HOSPITAL	$6,093.76	0.186
60114	PARKER ADVENTIST HOSPITAL	$6,212.10	0.209
60116	GOOD SAMARITAN MEDICAL CENTER	$6,031.09	0.21
60117	ANIMAS SURGICAL HOSPITAL, LLC	$5,909.40	0.395
60118	ST ANTHONY SUMMIT MEDICAL CENTER	$6,280.79	0.356
60119	MEDICAL CENTER OF THE ROCKIES	$6,173.86	0.299
60124	ORTHOCOLORADO HOSPITAL AT ST ANTHONY MED CAMPUS	$6,038.42	0.216
60125	CASTLE ROCK ADVENTIST HOSPITAL	$6,095.85	0.297
60126	BANNER FORT COLLINS MEDICAL CENTER	$6,056.28	0.251

Exhibit #3 – Proposed	
Critical Access Hospitals	
Effective for Dates of Service on and After 1/1/2018	
Hospital Name	**Location in Colorado**
Arkansas Valley Regional Medical Center	La Junta
Aspen Valley Hospital	Aspen
Colorado Canyon Hospital and Medical Center	Fruita
East Morgan County Hospital	Brush
Estes Park Medical Center	Estes Park
Grand River Hospital District	Rifle
Gunnison Valley Hospital	Gunnison
Haxtun Hospital District	Haxtun
Heart of the Rockies Regional Medical Center	Salida
Kit Carson County Memorial Hospital	Burlington
Lincoln Community Hospital	Hugo
Melissa Memorial Hospital	Holyoke
Middle Park Medical Center	Kremmling/Granby
Mt San Rafael Hospital	Trinidad
Pagosa Springs Medical Center	Pagosa Springs
Pikes Peak Regional Hospital	Woodland Park
Pioneers Medical Center	Meeker
Prowers Medical Center	Lamar
Rangely District Hospital	Rangely
Rio Grande Hospital	Del Norte
San Luis Valley Hospital	La Jara
Sedgwick County Health Center	Julesburg
Southeast Colorado Hospital	Springfield
Southwest Memorial Hospital	Cortez
Spanish Peaks Regional Health Center	Walsenburg
St Vincent General Hospital District	Leadville
The Memorial Hospital	Craig
Weisbrod Memorial County Hospital	Eads
Wray Community District Hospital	Wray
Yuma District Hospital	Yuma

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
701	Sr89 strontium	$2,295.20	$1,950.92	
726	Dexrazoxane HCl injection	$371.39	$315.68	
731	Sargramostim injection	$66.76	$56.75	
736	Amphotericin b liposome inj	$35.15	$29.88	
738	Rasburicase	$466.47	$396.50	
747	Chlorothiazide sodium inj	$140.22	$119.19	
751	Mechlorethamine hcl inj	$478.60	$406.81	
752	Dactinomycin injection	$2,297.48	$1,952.86	
759	Naltrexone, depot form	$5.85	$4.97	
800	Leuprolide acetate	$1,844.19	$1,567.56	
802	Etoposide oral	$133.65	$113.60	
807	Aldesleukin injection	$5,521.75	$4,693.49	
809	Bcg live intravesical vac	$231.08	$196.42	
810	Goserelin acetate implant	$629.86	$535.38	
812	Carmustine injection	$6,924.53	$5,885.85	
820	Daunorubicin injection	$70.63	$60.04	
821	Daunorubicin citrate inj	$438.84	$373.01	
823	Docetaxel injection	$3.40	$2.89	
825	Nelarabine injection	$273.65	$232.60	
827	Floxuridine injection	$109.06	$92.70	
831	Ifosfamide injection	$50.53	$42.95	
832	Idarubicin hcl injection	$74.77	$63.55	
836	Interferon alfa-2b inj	$51.34	$43.64	
838	Interferon gamma 1-b inj	$11,354.63	$9,651.44	
840	Inj melphalan hydrochl	$3,247.43	$2,760.32	
843	Pegaspargase injection	$25,041.96	$21,285.67	
844	Pentostatin injection	$3,389.62	$2,881.18	
849	Rituximab injection	$1,472.96	$1,252.02	
850	Streptozocin injection	$576.38	$489.92	
851	Thiotepa injection	$1,569.85	$1,334.37	
856	Porfimer sodium injection	$38,195.23	$32,465.95	
858	Inj cladribine	$36.05	$30.64	
864	Mitoxantrone hydrochl	$59.13	$50.26	
868	Oral aprepitant	$21.20	$18.02	
873	Hyalgan/supartz inj per dose	$156.89	$133.36	
874	Synvisc or synvisc-one	$22.57	$19.18	
875	Euflexxa inj per dose	$276.91	$235.37	
877	Orthovisc inj per dose	$276.39	$234.93	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
887	Azathioprine parenteral	$450.81	$383.19	
890	Lymphocyte immune globulin	$2,661.84	$2,262.56	
901	Alpha 1 proteinase inhibitor	$8.68	$7.38	
902	Injection,onabotulinumtoxinA	$10.69	$9.09	
903	Cytomegalovirus imm IV /vial	$2,029.93	$1,725.44	
910	Interferon beta-1b / .25 MG	$677.34	$575.74	
913	Ganciclovir long act implant	$21.08	$17.92	
925	Factor viii	$1.82	$1.55	
927	Factor viii recombinant	$2.16	$1.84	
928	Factor ix complex	$2.41	$2.05	
929	Anti-inhibitor	$3.47	$2.95	
931	Factor IX non-recombinant	$2.09	$1.78	
932	Factor ix recombinant nos	$2.72	$2.31	
943	Octagam injection	$64.96	$55.22	
944	Gammagard liquid injection	$72.77	$61.85	
946	Hepagam b im injection	$105.57	$89.73	
947	Flebogamma injection	$54.32	$46.17	
948	Gamunex-C/Gammaked	$61.07	$51.91	
961	Albumin (human),5%, 50ml	$21.24	$18.05	
963	Albumin (human), 5%, 250 ml	$98.50	$83.73	
964	Albumin (human), 25%, 20 ml	$40.48	$34.41	
965	Albumin (human), 25%, 50ml	$96.19	$81.76	
1015	Injection glatiramer acetate	$356.22	$302.79	
1052	Injection, voriconazole	$6.55	$5.57	
1064	I131 iodide cap, rx	$73.26	$62.27	
1083	Adalimumab injection	$2,118.47	$1,800.70	
1086	Temozolomide	$3.35	$2.85	
1138	Hepagam b intravenous, inj	$105.57	$89.73	
1139	Protein c concentrate	$27.36	$23.26	
1142	Supprelin LA implant	$49,926.47	$42,437.50	
1150	I131 iodide sol, rx	$22.61	$19.22	
1166	Cytarabine liposome inj	$1,069.18	$908.80	
1168	Inj, temsirolimus	$121.14	$102.97	
1178	Busulfan injection	$65.70	$55.85	
1203	Verteporfin injection	$19.37	$16.46	
1207	Octreotide injection, depot	$315.99	$268.59	
1213	Antihemophilic viii/vwf comp	$1.78	$1.51	
1214	Inj IVIG privigen 500 mg	$69.97	$59.47	
1232	Mitomycin injection	$208.22	$176.99	
1235	Valrubicin injection	$2,084.60	$1,771.91	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
1236	Levoleucovorin injection	$1.28	$1.09	
1237	Inj iron dextran	$22.43	$19.07	
1238	Topotecan oral	$186.82	$158.80	
1253	Triamcinolone A inj PRS-free	$6.73	$5.72	
1263	Antithrombin iii injection	$5.80	$4.93	
1268	Xyntha inj	$2.20	$1.87	
1274	Edetate calcium disodium inj	$10,069.96	$8,559.47	
1280	Corticotropin injection	$6,366.76	$5,411.75	
1281	Bevacizumab injection	$3.31	$2.81	
1289	AbobotulinumtoxinA	$14.35	$12.20	
1291	Rilonacept injection	$43.36	$36.86	
1295	Sm 153 lexidronam	$21,700.64	$18,445.54	
1296	Degarelix injection	$6.53	$5.55	
1297	Ferumoxytol, non-esrd	$1.60	$1.36	
1311	Canakinumab injection	$166.52	$141.54	
1312	Hizentra injection	$17.69	$15.04	
1327	Imiglucerase injection	$75.24	$63.95	
1331	Olanzapine long-acting inj	$5.26	$4.47	
1332	Antithrombin recombinant	$186.03	$158.13	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
1338	Methyl aminolevulinate, top	$150.64	$128.04	
1340	Collagenase, clost hist inj	$73.24	$62.25	
1341	Amobarbital 125 MG inj	$349.67	$297.22	
1352	Wilate injection	$1.82	$1.55	
1353	Belimumab injection	$76.64	$65.14	
1354	Hydroxyprogesterone caproate	$4.93	$4.19	
1361	Enfuvirtide injection	$33.53	$28.50	
1408	Cyclophosphamide 100 MG inj	$76.16	$64.74	
1413	Lumizyme injection	$287.53	$244.40	
1415	Glassia injection	$7.85	$6.67	
1416	Factor xiii anti-hem factor	$14.74	$12.53	
1417	Gel-one	$978.50	$831.73	
1420	Aflibercept injection	$1,764.25	$1,499.61	
1421	Imported lipodox inj	$915.17	$777.89	
1424	Nabilone oral	$68.76	$58.45	
1426	Eribulin mesylate injection	$194.96	$165.72	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
1431	Centruroides immune f(ab)	$7,644.04	$6,497.43	
1433	Calcitonin salmon injection	$4,082.20	$3,469.87	
1440	Inj desmopressin acetate	$23.67	$20.12	
1442	Non-HEU TC-99M add-on/dose	$18.00	$15.30	
1443	Icatibant injection	$586.10	$498.19	
1446	Visualization adjunct	$5.35	$4.55	
1457	Totazoline hcl injection	$2,880.72	$2,448.61	
1458	Phentolaine mesylate inj	$602.86	$512.43	
1460	Interferon alfa-2a inj	$58.01	$49.31	
1464	Factor VIII (porcine)	$0.36	$0.31	
1466	Inj, vincristine sul lip 1mg	$4,680.65	$3,978.55	
1467	Factor ix recombinan rixubis	$2.25	$1.91	
1468	Inj Aripiprazole Ext Rel 1mg	$8.24	$7.00	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
1469	Inj filgrastim excl biosimil	$1.82	$1.55	
1471	Injection, Pertuzumab, 1 mg	$19.58	$16.64	
1472	Inj beta interferon im 1 mcg	$83.18	$70.70	
1474	Certolizumab pegol inj 1mg	$13.21	$11.23	
1475	Golimumab for iv use 1mg	$44.98	$38.23	
1476	Obinutuzumab inj	$103.25	$87.76	
1478	Human fibrinogen conc inj	$2.07	$1.76	
1480	Elosulfase alfa, injection	$403.87	$343.29	
1482	Darbepoetin alfa, esrd use	$6.93	$5.89	
1484	Pentazocine injection	$246.08	$209.17	
1485	Ferumoxytol, esrd use	$1.60	$1.36	
1486	Factor ix fc fusion recomb	$5.27	$4.48	
1488	Injection, ramucirumab	$101.29	$86.10	
1489	Injection, vedolizumab	$32.63	$27.74	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
1490	Inj pembrolizumab	$85.14	$72.37	
1491	New Technology - Level 1A ($0-$10)	$9.00	$7.65	
1492	New Technology - Level 1B ($11-$20)	$27.90	$23.72	
1493	New Technology - Level 1C ($21-$30)	$45.90	$39.02	
1494	New Technology - Level 1D ($31-$40)	$63.90	$54.32	
1495	New Technology - Level 1E ($41-$50)	$81.90	$69.62	
1496	New Technology - Level 1A ($0-$10)	$9.00	$7.65	
1497	New Technology - Level 1B ($11-$20)	$27.90	$23.72	
1498	New Technology - Level 1C ($21-$30)	$45.90	$39.02	
1499	New Technology - Level 1D ($31-$40)	$63.90	$54.32	
1500	New Technology - Level 1E ($41-$50)	$81.90	$69.62	
1502	New Technology - Level 2 ($51 - $100)	$135.90	$115.52	
1503	New Technology - Level 3 ($101 - $200)	$270.90	$230.27	
1504	New Technology - Level 4 ($201 - $300)	$450.90	$383.27	
1505	New Technology - Level 5 ($301 - $400)	$630.90	$536.27	
1506	New Technology - Level 6 ($401 - $500)	$810.90	$689.27	
1507	New Technology - Level 7 ($501 - $600)	$990.90	$842.27	
1508	New Technology - Level 8 ($601 - $700)	$1,170.90	$995.27	
1509	New Technology - Level 9 ($701 - $800)	$1,350.90	$1,148.27	
1510	New Technology - Level 10 ($801 - $900)	$1,530.90	$1,301.27	
1511	New Technology - Level 11 ($901 - $1000)	$1,710.90	$1,454.27	
1512	New Technology - Level 12 ($1001 - $1100)	$1,890.90	$1,607.27	
1513	New Technology - Level 13 ($1101 - $1200)	$2,070.90	$1,760.27	
1514	New Technology - Level 14 ($1201- $1300)	$2,250.90	$1,913.27	
1515	New Technology - Level 15 ($1301 - $1400)	$2,430.90	$2,066.27	
1516	New Technology - Level 16 ($1401 - $1500)	$2,610.90	$2,219.27	
1517	New Technology - Level 17 ($1501-$1600)	$2,790.90	$2,372.27	
1518	New Technology - Level 18 ($1601-$1700)	$2,970.90	$2,525.27	
1519	New Technology - Level 19 ($1701-$1800)	$3,150.90	$2,678.27	
1520	New Technology - Level 20 ($1801-$1900)	$3,330.90	$2,831.27	
1521	New Technology - Level 21 ($1901-$2000)	$3,510.90	$2,984.27	
1522	New Technology - Level 22 ($2001-$2500)	$4,050.90	$3,443.27	
1523	New Technology - Level 23 ($2501-$3000)	$4,950.90	$4,208.27	
1524	New Technology - Level 24 ($3001-$3500)	$5,850.90	$4,973.27	
1525	New Technology - Level 25 ($3501-$4000)	$6,750.90	$5,738.27	
1526	New Technology - Level 26 ($4001-$4500)	$7,650.90	$6,503.27	
1527	New Technology - Level 27 ($4501-$5000)	$8,550.90	$7,268.27	
1528	New Technology - Level 28 ($5001-$5500)	$9,450.90	$8,033.27	
1529	New Technology - Level 29 ($5501-$6000)	$10,350.90	$8,798.27	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
1530	New Technology - Level 30 ($6001-$6500)	$11,250.90	$9,563.27	
1531	New Technology - Level 31 ($6501-$7000)	$12,150.90	$10,328.27	
1532	New Technology - Level 32 ($7001-$7500)	$13,050.90	$11,093.27	
1533	New Technology - Level 33 ($7501-$8000)	$13,950.90	$11,858.27	
1534	New Technology - Level 34 ($8001-$8500)	$14,850.90	$12,623.27	
1535	New Technology - Level 35 ($8501-$9000)	$15,750.90	$13,388.27	
1536	New Technology - Level 36 ($9001-$9500)	$16,650.90	$14,153.27	
1537	New Technology - Level 37 ($9501-$10000)	$17,550.90	$14,918.27	
1539	New Technology - Level 2 ($51 - $100)	$135.90	$115.52	
1540	New Technology - Level 3 ($101 - $200)	$270.90	$230.27	
1541	New Technology - Level 4 ($201 - $300)	$450.90	$383.27	
1542	New Technology - Level 5 ($301 - $400)	$630.90	$536.27	
1543	New Technology - Level 6 ($401 - $500)	$810.90	$689.27	
1544	New Technology - Level 7 ($501 - $600)	$990.90	$842.27	
1545	New Technology - Level 8 ($601 - $700)	$1,170.90	$995.27	
1546	New Technology - Level 9 ($701 - $800)	$1,350.90	$1,148.27	
1547	New Technology - Level 10 ($801 - $900)	$1,530.90	$1,301.27	
1548	New Technology - Level 11 ($901 - $1000)	$1,710.90	$1,454.27	
1549	New Technology - Level 12 ($1001 - $1100)	$1,890.90	$1,607.27	
1550	New Technology - Level 13 ($1101 - $1200)	$2,070.90	$1,760.27	
1551	New Technology - Level 14 ($1201- $1300)	$2,250.90	$1,913.27	
1552	New Technology - Level 15 ($1301 - $1400)	$2,430.90	$2,066.27	
1553	New Technology - Level 16 ($1401 - $1500)	$2,610.90	$2,219.27	
1554	New Technology - Level 17 ($1501-$1600)	$2,790.90	$2,372.27	
1555	New Technology - Level 18 ($1601-$1700)	$2,970.90	$2,525.27	
1556	New Technology - Level 19 ($1701-$1800)	$3,150.90	$2,678.27	
1557	New Technology - Level 20 ($1801-$1900)	$3,330.90	$2,831.27	
1558	New Technology - Level 21 ($1901-$2000)	$3,510.90	$2,984.27	
1559	New Technology - Level 22 ($2001-$2500)	$4,050.90	$3,443.27	
1560	New Technology - Level 23 ($2501-$3000)	$4,950.90	$4,208.27	
1561	New Technology - Level 24 ($3001-$3500)	$5,850.90	$4,973.27	
1562	New Technology - Level 25 ($3501-$4000)	$6,750.90	$5,738.27	
1563	New Technology - Level 26 ($4001-$4500)	$7,650.90	$6,503.27	
1564	New Technology - Level 27 ($4501-$5000)	$8,550.90	$7,268.27	
1565	New Technology - Level 28 ($5001-$5500)	$9,450.90	$8,033.27	
1566	New Technology - Level 29 ($5501-$6000)	$10,350.90	$8,798.27	
1567	New Technology - Level 30 ($6001-$6500)	$11,250.90	$9,563.27	
1568	New Technology - Level 31 ($6501-$7000)	$12,150.90	$10,328.27	
1569	New Technology - Level 32 ($7001-$7500)	$13,050.90	$11,093.27	
1570	New Technology - Level 33 ($7501-$8000)	$13,950.90	$11,858.27	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
1571	New Technology - Level 34 ($8001-$8500)	$14,850.90	$12,623.27	
1572	New Technology - Level 35 ($8501-$9000)	$15,750.90	$13,388.27	
1573	New Technology - Level 36 ($9001-$9500)	$16,650.90	$14,153.27	
1574	New Technology - Level 37 ($9501-$10000)	$17,550.90	$14,918.27	
1575	New Technology - Level 38 ($10,001-$15,000)	$22,500.90	$19,125.77	
1576	New Technology - Level 39 ($15,001-$20,000)	$31,500.90	$26,775.77	
1577	New Technology - Level 40 ($20,001-$25,000)	$40,500.90	$34,425.77	
1578	New Technology - Level 41 ($25,001-$30,000)	$49,500.90	$42,075.77	
1579	New Technology - Level 42 ($30,001-$40,000)	$63,000.90	$53,550.77	
1580	New Technology - Level 43 ($40,001-$50,000)	$81,000.90	$68,850.77	
1581	New Technology - Level 44 ($50,001-$60,000)	$99,000.90	$84,150.77	
1582	New Technology - Level 45 ($60,001-$70,000)	$117,000.90	$99,450.77	
1583	New Technology - Level 46 ($70,001-$80,000)	$135,000.90	$114,750.77	
1584	New Technology - Level 47 ($80,001-$90,000)	$153,000.90	$130,050.77	
1585	New Technology - Level 48 ($90,001-$100,000)	$171,000.90	$145,350.77	
1589	New Technology - Level 38 ($10,001-$15,000)	$22,500.90	$19,125.77	
1590	New Technology - Level 39 ($15,001-$20,000)	$31,500.90	$26,775.77	
1591	New Technology - Level 40 ($20,001-$25,000)	$40,500.90	$34,425.77	
1592	New Technology - Level 41 ($25,001-$30,000)	$49,500.90	$42,075.77	
1593	New Technology - Level 42 ($30,001-$40,000)	$63,000.90	$53,550.77	
1594	New Technology - Level 43 ($40,001-$50,000)	$81,000.90	$68,850.77	
1595	New Technology - Level 44 ($50,001-$60,000)	$99,000.90	$84,150.77	
1596	New Technology - Level 45 ($60,001-$70,000)	$117,000.90	$99,450.77	
1597	New Technology - Level 46 ($70,001-$80,000)	$135,000.90	$114,750.77	
1598	New Technology - Level 47 ($80,001-$90,000)	$153,000.90	$130,050.77	
1599	New Technology - Level 48 ($90,001-$100,000)	$171,000.90	$145,350.77	
1605	Abciximab injection	$2,073.94	$1,762.85	
1607	Eptifibatide injection	$42.50	$36.13	
1608	Etanercept injection	$787.64	$669.49	
1609	Rho(D) immune globulin h, sd	$40.86	$34.73	
1612	Daclizumab, parenteral	$18.00	$15.30	
1613	Trastuzumab injection	$170.08	$144.57	
1630	Hep b ig, im	$201.53	$171.30	
1631	Baclofen intrathecal trial	$138.31	$117.56	
1633	Alefacept	$74.95	$63.71	
1643	Y90 ibritumomab, rx	$84,801.42	$72,081.21	
1656	Factor viii fc fusion recomb	$3.56	$3.03	
1657	Puraply or puraply am	$187.42	$159.31	
1658	Injection, belinostat, 10mg	$61.90	$52.62	
1660	Injection, oritavancin	$44.21	$37.58	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
1661	Gen, neuro, HF, rechg bat	$0.00	$0.00	
1662	Inj tedizolid phosphate	$2.29	$1.95	
1663	Inj, phenylephrine ketorolac	$878.15	$746.43	
1664	Florbetapir f18	$4,960.80	$4,216.68	
1666	Tetracyclin injection	$13.12	$11.15	
1669	Erythro lactobionate /500 mg	$106.99	$90.94	
1670	Tetanus immune globulin inj	$657.27	$558.68	
1675	P32 Na phosphate	$101.95	$86.66	
1676	P32 chromic phosphate	$128.05	$108.84	
1683	Basiliximab	$6,043.21	$5,136.73	
1684	Corticorelin ovine triflutal	$14.62	$12.43	
1685	Darbepoetin alfa, non-esrd	$6.93	$5.89	
1686	Epoetin alfa, non-esrd	$24.52	$20.84	
1687	Digoxin immune fab (ovine)	$5,881.57	$4,999.33	
1688	Ethanolamine oleate	$760.27	$646.23	
1689	Fomepizole	$14.00	$11.90	
1690	Hemin	$41.15	$34.98	
1693	Lepirudin	$22.88	$19.45	
1694	Ziconotide injection	$13.19	$11.21	
1695	Nesiritide injection	$131.72	$111.96	
1696	Palifermin injection	$31.82	$27.05	
1697	Pegaptanib sodium injection	$1,898.46	$1,613.69	
1700	Inj secretin synthetic human	$62.60	$53.21	
1701	Treprostinil injection	$110.23	$93.70	
1704	Humate-P, inj	$1.96	$1.67	
1705	Factor viia	$3.47	$2.95	
1709	Azacitidine injection	$3.80	$3.23	
1710	Clofarabine injection	$274.27	$233.13	
1711	Vantas implant	$5,631.86	$4,787.08	
1712	Paclitaxel protein bound	$18.81	$15.99	
1738	Oxaliplatin	$0.49	$0.42	
1739	Pegademase bovine, 25 iu	$621.41	$528.20	
1741	Urofollitropin, 75 iu	$238.79	$202.97	
1743	Nandrolone decanoate 50 mg	$240.05	$204.04	
1745	Radium ra223 dichloride ther	$231.75	$196.99	
1746	Factor xiii recomb a-subunit	$26.53	$22.55	
1747	Monovisc inj per dose	$1,611.27	$1,369.58	
1748	Inj tbo filgrastim 1 microg	$1.21	$1.03	
1761	rolapitant, oral, 1mg	$3.87	$3.29	
1809	Injection, alemtuzumab	$3,155.44	$2,682.12	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
1822	Inj filgrastim gcsf biosimil	$1.37	$1.16	
1823	Injection, dalbavancin	$26.51	$22.53	
1824	Ceftaroline fosamil inj	$4.45	$3.78	
1825	Ceftazidime and avibactam	$138.83	$118.01	
1826	Hyqvia 100mg immuneglobulin	$23.33	$19.83	
1827	Factor viii recomb obizur	$7.13	$6.06	
1828	Carbidopa levodopa ent 100ml	$4.03	$3.43	
1829	Penicillin g benzathine inj	$19.35	$16.45	
1832	Dimethyl sulfoxide 50% 50 ml	$960.70	$816.60	
1836	Penicillin g procaine inj	$48.19	$40.96	
1838	Urokinase 250,000 iu inj	$473.02	$402.07	
1839	Oral busulfan	$42.61	$36.22	
1842	Leuprolide acetate implant	$303.26	$257.77	
1844	Factor viii pegylated recomb	$3.08	$2.62	
1845	Tacrol envarsus ex rel oral	$2.21	$1.88	
1846	Factor viii nuwiq recomb 1iu	$2.93	$2.49	
1847	Inj., infliximab biosimilar	$180.56	$153.48	
1848	Artiss fibrin sealant	$201.02	$170.87	
1849	Foscarnet sodium injection	$135.31	$115.01	
1850	Gamma globulin 1 cc inj	$64.33	$54.68	
1851	Gamma globulin > 10 cc inj	$643.28	$546.79	
1852	Interferon beta-1a inj	$867.98	$737.78	
1853	Minocycline hydrochloride	$2.72	$2.31	
1854	Pentobarbital sodium inj	$85.21	$72.43	
1855	Pralidoxime chloride inj	$156.67	$133.17	
1856	Factor viii recomb novoeight	$2.32	$1.97	
1857	Inj, factor x, (human), 1iu	$11.74	$9.98	
1858	Leuprolide acetate injeciton	$46.73	$39.72	
1859	Argatroban nonesrd use 1mg	$2.92	$2.48	
1860	Monoclonal antibodies	$416.20	$353.77	
1861	Inj., bendeka 1 mg	$42.23	$35.90	
1862	Gel-syn injection 0.1 mg	$3.92	$3.33	
1863	Inj diclofenac sodium 0.5mg	$0.29	$0.25	
1901	New Technology - Level 49 ($100,001-$120,000)	$198,000.90	$168,300.77	
1902	New Technology - Level 49 ($100,001-$120,000)	$198,000.90	$168,300.77	
1903	New Technology - Level 50 ($120,001-$140,000)	$234,000.90	$198,900.77	
1904	New Technology - Level 50 ($120,001-$140,000)	$234,000.90	$198,900.77	
1905	New Technology - Level 51 ($140,001-$160,000)	$270,000.90	$229,500.77	
1906	New Technology - Level 51 ($140,001-$160,000)	$270,000.90	$229,500.77	
2613	Lung bx plug w/del sys	$0.00	$0.00	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
2616	Brachytx, non-str,Yttrium-90	$29,713.91	$25,256.82	
2623	Cath, translumin, drug-coat	$0.00	$0.00	
2632	Iodine I-125 sodium iodide	$53.87	$45.79	
2634	Brachytx, non-str, HA, I-125	$216.94	$184.40	
2635	Brachytx, non-str, HA, P-103	$46.26	$39.32	
2636	Brachy linear, non-str,P-103	$33.57	$28.53	
2638	Brachytx, stranded, I-125	$68.35	$58.10	
2639	Brachytx, non-stranded,I-125	$64.26	$54.62	
2640	Brachytx, stranded, P-103	$131.80	$112.03	
2641	Brachytx, non-stranded,P-103	$117.81	$100.14	
2642	Brachytx, stranded, C-131	$157.70	$134.05	
2643	Brachytx, non-stranded,C-131	$106.54	$90.56	
2645	Brachytx, non-str, Gold-198	$243.54	$207.01	
2646	Brachytx, non-str, HDR Ir-192	$506.84	$430.81	
2647	Brachytx, NS, Non-HDRIr-192	$60.89	$51.76	
2648	Brachytx planar, p-103	$8.44	$7.17	
2698	Brachytx, stranded, NOS	$68.35	$58.10	
2699	Brachytx, non-stranded, NOS	$33.57	$28.53	
2731	Immune globulin, powder	$58.75	$49.94	
2770	Quinupristin/dalfopristin	$786.19	$668.26	
3041	Bivalirudin	$2.66	$2.26	
4001	Echo guidance radiotherapy	$39.40	$33.49	
4002	Stereoscopic x-ray guidance	$100.78	$85.66	
4003	Radiation treatment delivery, MeV <= 5; simple	$347.54	$295.41	
4004	Radiation treatment delivery, 6-10 MeV; simple	$263.57	$224.03	
4005	Radiation treatment delivery, 11-19 MeV; simple	$262.93	$223.49	
4006	Radiation treatment delivery, MeV>=20; simple	$262.93	$223.49	
4007	Radiation treatment delivery, MeV<=5; intermediate	$543.28	$461.79	
4008	Radiation treatment delivery, 6-10 MeV; intermediate	$363.04	$308.58	
4009	Radiation treatment delivery, 11-19 MeV; intermediate	$361.76	$307.50	
4010	Radiation treatment delivery, MeV >=20; intermediate	$360.47	$306.40	
4011	Radiation treatment delivery, MeV<=5; complex	$526.48	$447.51	
4012	Radiation treatment delivery, 6-10 MeV; complex	$480.62	$408.53	
4013	Radiation treatment delivery, 11-19 MeV; complex	$481.27	$409.08	
4014	Radiation treatment delivery, MeV >=20; complex	$481.91	$409.62	
5012	Clinic Visits and Related Services	$191.90	$163.12	
5021	Level 1 Type A ED Visits	$110.47	N/A	
5022	Level 2 Type A ED Visits	$200.65	N/A	
5023	Level 3 Type A ED Visits	$362.25	N/A	
5024	Level 4 Type A ED Visits	$598.34	N/A	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
5025	Level 5 Type A ED Visits	$879.73	N/A	
5031	Level 1 Type B ED Visits	$153.23	N/A	
5032	Level 2 Type B ED Visits	$136.03	N/A	
5033	Level 3 Type B ED Visits	$225.00	N/A	
5034	Level 4 Type B ED Visits	$321.39	N/A	
5035	Level 5 Type B ED Visits	$662.20	N/A	
5041	Critical Care	$1,236.91	N/A	
5045	Trauma Response with Critical Care	$0.00	N/A	See Rule 18-6(J) for Trauma Activation Fees
5051	Level 1 Skin Procedures	$275.62	$234.28	
5052	Level 2 Skin Procedures	$526.72	$447.71	
5053	Level 3 Skin Procedures	$815.58	$693.24	
5054	Level 4 Skin Procedures	$2,569.99	$2,184.49	
5055	Level 5 Skin Procedures	$4,508.44	$3,832.17	
5061	Hyperbaric Oxygen	$198.43	$168.67	
5071	Level 1 Excision/ Biopsy/ Incision and Drainage	$970.40	$824.84	
5072	Level 2 Excision/ Biopsy/ Incision and Drainage	$2,225.92	$1,892.03	
5073	Level 3 Excision/ Biopsy/ Incision and Drainage	$3,868.04	$3,287.83	
5091	Level 1 Breast/Lymphatic Surgery and Related Procedures	$4,499.06	$3,824.20	
5092	Level 2 Breast/Lymphatic Surgery and Related Procedures	$7,955.03	$6,761.78	
5093	Level 3 Breast/Lymphatic Surgery and Related Procedures	$11,675.43	$9,924.12	
5094	Level 4 Breast/Lymphatic Surgery and Related Procedures	$18,066.69	$15,356.69	
5101	Level 1 Strapping and Cast Application	$225.27	$191.48	
5102	Level 2 Strapping and Cast Application	$397.35	$337.75	
5111	Level 1 Musculoskeletal Procedures	$359.69	$305.74	
5112	Level 2 Musculoskeletal Procedures	$2,191.36	$1,862.66	
5113	Level 3 Musculoskeletal Procedures	$4,389.01	$3,730.66	
5114	Level 4 Musculoskeletal Procedures	$9,398.83	$7,989.01	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
5115	Level 5 Musculoskeletal Procedures	$17,210.21	$14,628.68	
5116	Level 6 Musculoskeletal Procedures	$26,467.43	$22,497.32	
5151	Level 1 Airway Endoscopy	$263.16	$223.69	
5152	Level 2 Airway Endoscopy	$651.46	$553.74	
5153	Level 3 Airway Endoscopy	$2,285.62	$1,942.78	
5154	Level 4 Airway Endoscopy	$4,376.21	$3,719.78	
5155	Level 5 Airway Endoscopy	$7,853.31	$6,675.31	
5161	Level 1 ENT Procedures	$318.76	$270.95	
5162	Level 2 ENT Procedures	$796.72	$677.21	
5163	Level 3 ENT Procedures	$1,869.39	$1,588.98	
5164	Level 4 ENT Procedures	$3,912.64	$3,325.74	
5165	Level 5 ENT Procedures	$7,435.69	$6,320.34	
5166	Cochlear Implant Procedure	$57,306.58	$48,710.59	
5181	Level 1 Vascular Procedures	$1,231.43	$1,046.72	
5182	Level 2 Vascular Procedures	$4,249.08	$3,611.72	
5183	Level 3 Vascular Procedures	$7,063.70	$6,004.15	
5191	Level 1 Endovascular Procedures	$5,100.39	$4,335.33	
5192	Level 2 Endovascular Procedures	$8,685.36	$7,382.56	
5193	Level 3 Endovascular Procedures	$17,554.37	$14,921.21	
5194	Level 4 Endovascular Procedures	$26,607.85	$22,616.67	
5200	Implantation Wireless PA Pressure Monitor	$53,131.63	$45,161.89	
5211	Level 1 Electrophysiologic Procedures	$1,560.33	$1,326.28	
5212	Level 2 Electrophysiologic Procedures	$9,011.52	$7,659.79	
5213	Level 3 Electrophysiologic Procedures	$30,213.41	$25,681.40	
5221	Level1 Pacemaker and Similar Procedures	$4,607.26	$3,916.17	
5222	Level 2 Pacemaker and Similar Procedures	$12,557.83	$10,674.16	
5223	Level 3 Pacemaker and Similar Procedures	$16,944.57	$14,402.88	
5224	Level 4 Pacemaker and Similar Procedures	$30,180.35	$25,653.30	
5231	Level 1 ICD and Similar Procedures	$39,599.96	$33,659.97	
5232	Level 2 ICD and Similar Procedures	$54,948.98	$46,706.63	
5241	Level 1 Blood Product Exchange and Related Services	$638.17	$542.44	
5242	Level 2 Blood Product Exchange and Related Services	$1,977.62	$1,680.98	
5243	Level 3 Blood Product Exchange and Related Services	$5,738.09	$4,877.38	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
5244	Level 4 Blood Product Exchange and Related Services	$49,976.05	$42,479.64	
5301	Level 1 Upper GI Procedures	$1,259.62	$1,070.68	
5302	Level 2 Upper GI Procedures	$2,402.69	$2,042.29	
5303	Level 3 Upper GI Procedures	$4,519.26	$3,841.37	
5311	Level 1 Lower GI Procedures	$1,201.81	$1,021.54	
5312	Level 2 Lower GI Procedures	$1,579.68	$1,342.73	
5313	Level 3 Lower GI Procedures	$3,901.52	$3,316.29	
5331	Complex GI Procedures	$7,093.10	$6,029.14	
5341	Abdominal/Peritoneal/Biliary and Related Procedures	$5,152.93	$4,379.99	
5361	Level 1 Laparoscopy and Related Services	$7,558.43	$6,424.67	
5362	Level 2 Laparoscopy and Related Services	$12,545.71	$10,663.85	
5371	Level 1 Urology and Related Services	$388.87	$330.54	
5372	Level 2 Urology and Related Services	$988.99	$840.64	
5373	Level 3 Urology and Related Services	$2,960.39	$2,516.33	
5374	Level 4 Urology and Related Services	$4,576.61	$3,890.12	
5375	Level 5 Urology and Related Services	$6,271.22	$5,330.54	
5376	Level 6 Urology and Related Services	$13,414.79	$11,402.57	
5377	Level 7 Urology and Related Services	$25,854.50	$21,976.33	
5401	Dialysis	$994.64	$845.44	
5411	Level 1 Gynecologic Procedures	$273.98	$232.88	
5412	Level 2 Gynecologic Procedures	$496.37	$421.91	
5413	Level 3 Gynecologic Procedures	$1,198.57	$1,018.78	
5414	Level 4 Gynecologic Procedures	$3,753.85	$3,190.77	
5415	Level 5 Gynecologic Procedures	$6,859.53	$5,830.60	
5416	Level 6 Gynecologic Procedures	$10,558.93	$8,975.09	
5431	Level 1 Nerve Procedures	$2,814.16	$2,392.04	
5432	Level 2 Nerve Procedures	$7,473.35	$6,352.35	
5441	Level 1 Nerve Injections	$415.80	$353.43	
5442	Level 2 Nerve Injections	$912.94	$776.00	
5443	Level 3 Nerve Injections	$1,150.07	$977.56	
5461	Level 1 Neurostimulator and Related Procedures	$4,842.83	$4,116.41	
5462	Level 2 Neurostimulator and Related Procedures	$10,341.20	$8,790.02	
5463	Level 3 Neurostimulator and Related Procedures	$32,046.08	$27,239.17	
5464	Level 4 Neurostimulator and Related Procedures	$48,684.80	$41,382.08	
5471	Implantation of Drug Infusion Device	$28,120.63	$23,902.54	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
5481	Laser Eye Procedures	$845.77	$718.90	
5491	Level 1 Intraocular Procedures	$3,283.83	$2,791.26	
5492	Level 2 Intraocular Procedures	$6,153.77	$5,230.70	
5493	Level 3 Intraocular Procedures	$14,762.93	$12,548.49	
5494	Level 4 Intraocular Procedures	$21,685.10	$18,432.34	
5495	Level 5 Intraocular Procedures	$34,185.15	$29,057.38	
5501	Level 1 Extraocular, Repair, and Plastic Eye Procedures	$483.28	$410.79	
5502	Level 2 Extraocular, Repair, and Plastic Eye Procedures	$1,394.23	$1,185.10	
5503	Level 3 Extraocular, Repair, and Plastic Eye Procedures	$3,062.66	$2,603.26	
5504	Level 4 Extraocular, Repair, and Plastic Eye Procedures	$4,994.69	$4,245.49	
5521	Level 1 Imaging without Contrast	$107.75	$91.59	
5522	Level 2 Imaging without Contrast	$202.91	$172.47	
5523	Level 3 Imaging without Contrast	$406.64	$345.64	
5524	Level 4 Imaging without Contrast	$809.42	$688.01	
5571	Level 1 Imaging with Contrast	$477.04	$405.48	
5572	Level 2 Imaging with Contrast	$767.74	$652.58	
5573	Level 3 Imaging with Contrast	$1,182.44	$1,005.07	
5591	Level 1 Nuclear Medicine and Related Services	$599.54	$509.61	
5592	Level 2 Nuclear Medicine and Related Services	$772.43	$656.57	
5593	Level 3 Nuclear Medicine and Related Services	$2,050.09	$1,742.58	
5594	Level 4 Nuclear Medicine and Related Services	$2,378.75	$2,021.94	
5611	Level 1 Therapeutic Radiation Treatment Preparation	$211.66	$179.91	
5612	Level 2 Therapeutic Radiation Treatment Preparation	$560.83	$476.71	
5613	Level 3 Therapeutic Radiation Treatment Preparation	$1,919.23	$1,631.35	
5621	Level 1 Radiation Therapy	$205.83	$174.96	
5622	Level 2 Radiation Therapy	$368.12	$312.90	
5623	Level 3 Radiation Therapy	$890.33	$756.78	
5624	Level 4 Radiation Therapy	$1,329.53	$1,130.10	
5625	Level 5 Radiation Therapy	$1,789.42	$1,521.01	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
5626	Level 6 Radiation Therapy	$2,972.32	$2,526.47	
5627	Level 7 Radiation Therapy	$13,420.78	$11,407.66	
5661	Therapeutic Nuclear Medicine	$390.02	$331.52	
5671	Level 1 Pathology	$71.46	$60.74	
5672	Level 2 Pathology	$186.98	$158.93	
5673	Level 3 Pathology	$331.22	$281.54	
5674	Level 4 Pathology	$817.49	$694.87	
5691	Level 1 Drug Administration	$62.60	$53.21	
5692	Level 2 Drug Administration	$95.71	$81.35	
5693	Level 3 Drug Administration	$323.59	$275.05	
5694	Level 4 Drug Administration	$503.01	$427.56	
5721	Level1 Diagnostic Tests and Related Services	$228.78	$194.46	
5722	Level 2 Diagnostic Tests and Related Services	$418.16	$355.44	
5723	Level 3 Diagnostic Tests and Related Services	$748.57	$636.28	
5724	Level 4 Diagnostic Tests and Related Services	$1,556.17	$1,322.74	
5731	Level 1 Minor Procedures	$22.72	$19.31	
5732	Level 2 Minor Procedures	$51.08	$43.42	
5733	Level 3 Minor Procedures	$98.19	$83.46	
5734	Level 4 Minor Procedures	$180.04	$153.03	
5735	Level 5 Minor Procedures	$474.50	$403.33	
5741	Level 1 Electronic Analysis of Devices	$63.27	$53.78	
5742	Level 2 Electronic Analysis of Devices	$196.60	$167.11	
5743	Level 3 Electronic Analysis of Devices	$454.73	$386.52	
5771	Cardiac Rehabilitation	$198.40	$168.64	
5781	Resuscitation and Cardioversion	$866.41	$736.45	
5791	Pulmonary Treatment	$291.74	$247.98	
5801	Ventilation Initiation and Management	$763.11	$648.64	
5811	Manipulation Therapy	$44.32	N/A	
5821	Level 1 Health and Behavior Services	$45.41	N/A	
5822	Level 2 Health and Behavior Services	$126.47	N/A	
5823	Level 3 Health and Behavior Services	$226.82	N/A	
5853	Partial Hospitalization (3 or more services) for CMHCs	$218.75	N/A	
5863	Partial Hospitalization (3 or more services) for Hospital-based PHPs	$373.25	N/A	
5871	Dental Procedures	$923.53	$785.00	
5881	Ancillary Outpatient Services When Patient Dies	$12,157.83	$10,334.16	
7000	Amifostine	$934.22	$794.09	
7011	Oprelvekin injection	$841.00	$714.85	
7034	Somatropin injection	$146.86	$124.83	
7035	Teniposide	$4,667.02	$3,966.97	
7041	Tirofiban HCl	$17.66	$15.01	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
7043	Infliximab not biosimil 10mg	$154.06	$130.95	
7046	Doxorubicin inj 10mg	$734.67	$624.47	
7048	Alteplase recombinant	$146.43	$124.47	
7308	Aminolevulinic acid hcl top	$662.06	$562.75	
8001	LDR Prostate Brachytherapy Composite	$6,300.45	$5,355.38	
8004	Ultrasound Composite	$519.05	$441.19	
8005	CT and CTA without Contrast Composite	$491.56	$417.83	
8006	CT and CTA with Contrast Composite	$880.87	$748.74	
8007	MRI and MRA without Contrast Composite	$993.15	$844.18	
8008	MRI and MRA with Contrast Composite	$1,533.04	$1,303.08	
8010	Mental Health Services Composite	$373.25	$317.26	
8011	Comprehensive Observation Services	$4,000.75	$3,400.64	
9002	Tenecteplase injection	$184.36	$156.71	
9003	Palivizumab	$317.43	$269.82	
9005	Reteplase injection	$4,143.44	$3,521.92	
9006	Tacrolimus injection	$307.53	$261.40	
9012	Arsenic trioxide injection	$116.87	$99.34	
9018	Inj, rimabotulinumtoxinB	$21.15	$17.98	
9019	Caspofungin acetate	$19.01	$16.16	
9024	Amphotericin b lipid complex	$23.72	$20.16	
9032	Baclofen 10 MG injection	$303.64	$258.09	
9033	Cidofovir injection	$939.82	$798.85	
9038	Inj estrogen conjugate	$501.10	$425.94	
9042	Glucagon hydrochloride	$361.48	$307.26	
9043	Afstyla Factor VIII recomb	$2.56	$2.18	
9044	Ibutilide fumarate injection	$346.50	$294.53	
9052	Fluciciovine F-18	$701.19	$596.01	
9056	Gallium Ga-68	$120.13	$102.11	
9058	Buprenorphine implant 74.2mg	$2,269.06	$1,928.70	
9059	Vonvendi inj 1 iu vwf:rco	$4.09	$3.48	
9060	Diazoxide injection	$1,242.05	$1,055.74	
9061	Inj milrinone lactate / 5 mg	$4.46	$3.79	
9062	Topotecan injection	$2.27	$1.93	
9104	Antithymocyte globuln rabbit	$1,237.99	$1,052.29	
9108	Thyrotropin injection	$2,820.47	$2,397.40	
9119	Injection, pegfilgrastim 6mg	$7,544.41	$6,412.75	
9120	Injection, Fulvestrant	$173.23	$147.25	
9122	Triptorelin pamoate	$657.79	$559.12	
9124	Daptomycin injection	$1.22	$1.04	
9125	Risperidone, long acting	$14.71	$12.50	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
9126	Natalizumab injection	$33.84	$28.76	
9130	Inj, Imm Glob Bivigam, 500mg	$68.96	$58.62	
9131	Inj, Ado-trastuzumab Emt 1mg	$53.14	$45.17	
9132	Kcentra, per i.u.	$3.33	$2.83	
9133	Rabies ig, im/sc	$534.08	$453.97	
9134	Rabies ig, heat treated	$533.41	$453.40	
9135	Varicella-zoster ig, im	$2,215.76	$1,883.40	
9139	Rabies vaccine, im	$485.84	$412.96	
9140	Rabies vaccine, id	$253.84	$215.76	
9171	Factor ix idelvion inj	$7.47	$6.35	
9207	Bortezomib injection	$83.25	$70.76	
9208	Agalsidase beta injection	$298.91	$254.07	
9209	Laronidase injection	$55.10	$46.84	
9210	Palonosetron hcl	$40.73	$34.62	
9213	Pemetrexed injection	$115.27	$97.98	
9214	Bevacizumab injection	$132.48	$112.61	
9215	Cetuximab injection	$101.50	$86.28	
9217	Leuprolide acetate suspnsion	$388.82	$330.50	
9224	Galsulfase injection	$664.96	$565.22	
9225	Fluocinolone acetonide implt	$36,198.70	$30,768.90	
9228	Tigecycline injection	$5.72	$4.86	
9229	Ibandronate sodium injection	$140.92	$119.78	
9230	Abatacept injection	$84.35	$71.70	
9231	Decitabine injection	$32.33	$27.48	
9232	Idursulfase injection	$939.62	$798.68	
9233	Ranibizumab injection	$675.38	$574.07	
9234	Alglucosidase alfa injection	$372.06	$316.25	
9235	Panitumumab injection	$193.88	$164.80	
9236	Eculizumab injection	$407.93	$346.74	
9237	Inj, lanreotide acetate	$97.22	$82.64	
9240	Injection, ixabepilone	$135.65	$115.30	
9242	Injection, fosaprepitant	$3.49	$2.97	
9243	Inj., treanda 1 mg	$50.35	$42.80	
9245	Romiplostim injection	$117.05	$99.49	
9248	Inj, clevidipine butyrate	$3.96	$3.37	
9251	C1 esterase inhibitor inj	$99.95	$84.96	
9252	Plerixafor injection	$561.78	$477.51	
9253	Temozolomide injection	$16.11	$13.69	
9255	Paliperidone palmitate inj	$17.10	$14.54	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
9256	Dexamethasone intra implant	$361.40	$307.19	
9258	Telavancin injection	$9.00	$7.65	
9259	Pralatrexate injection	$429.62	$365.18	
9260	Ofatumumab injection	$96.10	$81.69	
9261	Ustekinumab sub cu inj, 1 mg	$313.56	$266.53	
9263	Ecallantide injection	$758.92	$645.08	
9264	Tocilizumab injection	$7.60	$6.46	
9265	Romidepsin injection	$571.64	$485.89	
9269	C-1 esterase, berinert	$87.66	$74.51	
9270	Gammaplex IVIG	$74.92	$63.68	
9271	Velaglucerase alfa	$616.86	$524.33	
9272	Inj, denosumab	$29.93	$25.44	
9273	Sipuleucel-T auto CD54+	$71,854.22	$61,076.09	
9274	Crotalidae Poly Immune Fab	$5,165.86	$4,390.98	
9276	Cabazitaxel injection	$281.99	$239.69	
9278	Incobotulinumtoxin A	$8.87	$7.54	
9281	Injection, pegloticase	$3,278.75	$2,786.94	
9284	Ipilimumab injection	$260.39	$221.33	
9286	Belatacept injection	$6.89	$5.86	
9287	Brentuximab vedotin inj	$241.47	$205.25	
9289	Erwinaze injection	$724.93	$616.19	
9293	Injection, glucarpidase	$511.60	$434.86	
9294	Inj, Taliglucerace Alfa 10 u	$72.72	$61.81	
9295	Injection, Carfilzomib, 1 mg	$57.96	$49.27	
9296	Inj, ziv-aflibercept, 1mg	$14.62	$12.43	
9297	Inj, Omacetaxine Mep, 0.01mg	$4.90	$4.17	
9298	Inj, Ocriplasmin, 0.125 mg	$1,884.15	$1,601.53	
9300	Omalizumab injection	$60.50	$51.43	
9441	Inj ferric carboxymaltos 1mg	$1.91	$1.62	
9445	Injection, ruconest	$50.29	$42.75	
9448	Netupitant palonosetron oral	$800.84	$680.71	
9449	Injection, blinatumomab	$177.89	$151.21	
9450	Fluocinol acet intravit imp	$883.71	$751.15	
9451	Injection, peramivir	$2.92	$2.48	
9452	Inj ceftolozane tazobactam	$8.53	$7.25	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
9453	Injection, nivolumab	$47.57	$40.43	
9454	Inj, pasireotide long acting	$469.37	$398.96	
9455	Injection, siltuximab	$162.04	$137.73	
9456	Injection, isavuconazonium	$1.13	$0.96	
9457	Inj sulf hexa lipid microsph	$38.90	$33.07	
9458	florbetaben f18 diagnostic	$5,342.40	$4,541.04	
9459	flutemetamol f18 diagnostic	$6,296.40	$5,351.94	
9460	Injection, cangrelor	$27.67	$23.52	
9461	Choline c-11, diagnostic, per study dose up to 20 millicuries	$10,260.00	$8,721.00	
9470	Aripiprazole lauroxil 1mg	$4.30	$3.66	
9471	Hymovis injection 1 mg	$30.17	$25.64	
9472	Inj talimogene laherparepvec	$82.87	$70.44	
9473	Injection, mepolizumab, 1mg	$47.97	$40.77	
9474	Inj irinotecan liposome 1 mg	$71.06	$60.40	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
9475	Injection, necitumumab, 1 mg	$9.45	$8.03	
9476	Injection, daratumumab 10 mg	$86.60	$73.61	
9477	Injection, elotuzumab, 1mg	$11.18	$9.50	
9478	Inj sebelipase alfa 1 mg	$954.00	$810.90	
9479	Instill, ciprofloxacin otic	$53.91	$45.82	
9480	Injection trabectedin 0.1mg	$510.19	$433.66	
9481	Injection, reslizumab	$15.93	$13.54	
9482	Sotalol hydrochloride IV	$17.98	$15.28	
9483	Injection, atezolizumab	$136.12	$115.70	
9484	Injection, eteplirsen	$305.28	$259.49	
9485	Injection, olaratumab	$90.05	$76.54	
9486	Inj, granisetron ext	$9.34	$7.94	
9487	Ustekinumab IV inj, 1 mg	$23.00	$19.55	
9488	Conivaptan HCL	$53.87	$45.79	
9497	Loxapine, inhalation powder	$270.07	$229.56	

Exhibit #4 – Proposed				
Hospital Outpatient APC Codes and Values				
Effective for Dates of Service on and After 1/1/2018				
APC	**Group Title**	**Hospitals**	**ASC**	**Notes**
9500	Platelets, irradiated	$301.36	$256.16	
9501	Platelet pheres leukoreduced	$899.91	$764.92	
9502	Platelet pheresis irradiated	$1,001.84	$851.56	
9503	Fr frz plasma donor retested	$120.94	$102.80	
9504	RBC deglycerolized	$690.44	$586.87	
9505	RBC irradiated	$394.11	$334.99	
9507	Platelets, pheresis	$741.78	$630.51	
9508	Plasma 1 donor frz w/in 8 hr	$132.71	$112.80	
9509	Frozen plasma, pooled, sd	$120.28	$102.24	
9510	Whole blood for transfusion	$279.92	$237.93	
9511	Cryoprecipitate each unit	$95.45	$81.13	
9512	RBC leukocytes reduced	$334.48	$284.31	
9513	Plasma, frz between 8-24hour	$133.20	$113.22	
9514	Plasma protein fract,5%,50ml	$35.57	$30.23	
9515	Platelets, each unit	$173.68	$147.63	
9516	Plaelet rich plasma unit	$237.02	$201.47	
9517	Red blood cells unit	$256.25	$217.81	
9518	Washed red blood cells unit	$619.87	$526.89	
9519	Plasmaprotein fract,5%,250ml	$166.81	$141.79	
9520	Blood split unit	$237.56	$201.93	
9521	Platelets leukoreduced irrad	$291.76	$248.00	
9522	RBC leukoreduced irradiated	$479.30	$407.41	
9523	Cryoprecipitatereducedplasma	$113.92	$96.83	
9524	Blood, l/r, cmv-neg	$371.66	$315.91	
9525	Platelets, hla-m, l/r, unit	$1,328.65	$1,129.35	
9526	Platelets leukocytes reduced	$226.31	$192.36	
9527	Blood, l/r, froz/degly/wash	$496.04	$421.63	
9528	Plt, aph/pher, l/r, cmv-neg	$759.60	$645.66	
9529	Blood, l/r, irradiated	$223.87	$190.29	
9530	Plate pheres leukoredu irrad	$1,165.32	$990.52	
9531	Plt, pher, l/r cmv-neg, irr	$1,114.00	$946.90	
9532	RBC, frz/deg/wsh, l/r, irrad	$373.41	$317.40	
9533	RBC, l/r, cmv-neg, irrad	$450.18	$382.65	
9534	Pathogen reduced plasma pool	$133.20	$113.22	
9535	Pathogen reduced plasma sing	$132.71	$112.80	
9536	Pathogen reduced platelets	$1,165.32	$990.52	

Exhibit #5 - Proposed

Rural Health Clinics

find the most updated list at: https://www.colorado.gov/pacific/cdphe/find-and-compare-facilities
(effective 1/1/2018)

Facility	Address	City	State	Zip	County	Contact
AKRON CLINIC	82 MAIN	Akron	CO	80720	Washington	Phone: (970)345-6336, Fax: (970)345-6576
ARKANSAS VALLEY FAMILY PRACTICE, LLC	2317 SAN JUAN AVE	La Junta	CO	81050	Otero	Phone: (719)383-2325, Fax: (719)383-2327
BANNER HEALTH CENTER STERLING	102 HAYS AVE	Sterling	CO	80751	Logan	Phone: (970)521-3223, Fax: (970)521-3266
BASIN CLINIC	421 WEST ADAMS ROAD	Naturita	CO	80723	Montrose	Phone: (970)865-2665, Fax: (970)825-2674
BRUSH FAMILY CLINIC	2400 W EDISON	Brush	CO	81211	Morgan	Phone: (970)842-6740, Fax: (970)842-6241
BUENA VISTA HEALTH CENTER	28374 COUNTY ROAD 317	Buena Vista	CO	81211	Chaffee	Phone: (719)395-9048, Fax: (719)395-9064
BUTTON FAMILY PRACTICE	715 SOUTH 9TH STREET	Canon City	CO	81212	Fremont	Phone: (719)269-8820, Fax: (719)204-0230
CENTENNIAL FAMILY HEALTH CENTER	319 MAIN STREET	Ordway	CO	81063	Crowley	Phone: (719)267-3503, Fax: (719)267-4153
CORTEZ PRIMARY CARE CLINIC	118 NORTH CHESTNUT	Cortez	CO	81321	Montezuma	Phone: (970)564-9777, Fax: (970)564-8833
CREEDE FAMILY PRACTICE OF RIO GRANDE HOSPITAL	802 RIO GRANDE AVENUE	Creede	CO	81130	Mineral	Phone: (719)658-0929, Fax: (719)657-2851
CUSTER COUNTY MEDICAL CENTER	704 EDWARDS	Westcliffe	CO	81252	Custer	Phone: (719)783-2380, Fax: (719)783-2377
EADS MEDICAL CLINIC	1211 LUTHER STREET	Eads	CO	81036	Kiowa	Phone: (719)438-2251, Fax: (719)438-2254
EASTERN PLAINS MEDICAL CLINIC OF	560 CRYSTOLA STREET	Calhan	CO	80808	El Paso	Phone: (719)347-0100,

Facility	Address	City	State	Zip	County	Contact
CALHAN						Fax: (719)347-0551
FAMILY CARE CLINIC	615 FAIRHURST	Sterling	CO	80751	Logan	Phone: (970)521-3223, Fax: (970)521-3266
FAMILY PRACTICE OF HOLYOKE	1001 EAST JOHNSON STREET	Holyoke	CO	80734	Phillips	Phone: (970)854-2500, Fax: (970)854-3440
FLORENCE MEDICAL CENTER	501 W 5TH ST	Florence	CO	81226	Fremont	Phone: (719)784-4816, Fax: (719)784-6014
GRAND RIVER HEALTH CLINIC WEST	201 SIPPERELLE DRIVE	Parachute	CO	81635	Garfield	Phone: (970)285-7046, Fax: (970)285-6064
GRAND RIVER PRIMARY CARE	501 AIRPORT ROAD	Rifle	CO	81650	Garfield	Phone: (970)625-1100, Fax: (970)625-0725
KIT CARSON CLINIC	102 EAST 2ND AVENUE	Kit Carson	CO	80825	Cheyenne	Phone: (719)962-3501, Fax: (719)962-3403
LAKE CITY AREA MEDICAL CENTER	700 N HENSON STREET	Lake City	CO	81235	Hinsdale	Phone: (970)944-2331, Fax: (970)944-2320
LAMAR MEDICAL CLINIC	403 KENDALL DRIVE	Lamar	CO	81052	Prowers	Phone: (719)336-6767, Fax: (719)336-7217
MANCOS VALLEY HEALTH CENTER	111 RAILROAD AVE	Mancos	CO	81328	Montezuma	Phone: (970)564-2104, Fax: (970)564-2134
MEEKER FAMILY HEALTH CENTER	345 CLEVELAND STREET	Meeker	CO	81641	Rio Blanco	Phone: (970)878-4014, Fax: (970)878-3285
MONTE VISTA RHC OF RIO GRANDE HOSPITAL	1033 2ND AVENUE	Monte Vista	CO	81144	Rio Grande	Phone: (719)852-8827, Fax: (719)852-2739
MT SAN RAFAEL HOSPITAL HEALTH CLINIC	400 BENEDICTA STE A	Trinidad	CO	81082	Las Animas	Phone: (719)846-2206, Fax: (719)846-7823
NORTH PARK MEDICAL CENTER - WALDEN	350 MCKINLEY STREET	Walden	CO	80480	Jackson	Phone: (970)723-4255, Fax: (970)723-4268
PAGOSA MOUNTAIN CLINIC	95 SOUTH PAGOSA BLVD	Pagosa Springs	CO	81147	Archuleta	Phone: (970)731-3700, Fax: (970)731-3707
PARKE HEALTH CLINIC	182 16TH ST	Burlington	CO	80807	Kit Carson	Phone: (719)346-9481, Fax: (719)346-9485
PEDIATRIC ASSOCIATION OF CANON CITY	1335 PHAY AVENUE, SUITE A	Canon City	CO	81212	Fremont	Phone: (719)269-1727,

Facility	Address	City	State	Zip	County	Contact
						Fax: (719)269-1730
PRAIRIE VIEW RURAL HEALTH CLINIC	615 WEST 5TH NORTH	Cheyenne Wells	CO	80810	Cheyenne	Phone: (719)767-5669, Fax: (719)767-5098
RIO GRANDE HOSPITAL CLINIC	0310C COUNTY RD 14	Del Norte	CO	81132	Rio Grande	Phone: (719)657-2418, Fax: (719)658-3001
ROCKY FORD FAMILY HEALTH CENTER	1014 ELM AVENUE	Rocky Ford	CO	81067	Otero	Phone: (719)254-7421, Fax: (719)254-6966
SABATINI PEDIATRICS PC	612 YALE PLACE	Canon City	CO	81212	Fremont	Phone: (719)275-3442, Fax: (719)275-2306
SAN LUIS VALLEY HEALTH ANTONITO CLINIC	115 MAIN STREET	Antonito	CO	81120	Conejos	Phone: (719)376-2308, Fax: (719)376-2395
SAN LUIS VALLEY LA JARA MEDICAL CLINIC	509 MAIN STREET	La Jara	CO	81140	Conejos	Phone: (719)274-5000, Fax: (719)274-4111
SOUTHEAST COLORADO PHYSICIANS CLINIC	900 CHURCH STREET	Springfield	CO	81073	Baca	Phone: (719)523-6628, Fax: (719)523-4513
SOUTHWEST MEMORIAL PRIMARY CARE	33 NORTH ELM STREET	Cortez	CO	81321	Montezuma	Phone: (970)565-8556, Fax: (970)564-1134
SOUTHWEST SCHOOL-BASED HEALTH CENTER	418 S SLIGO STREET	Cortez	CO	81321	Montezuma	Phone: (970)564-2104, Fax: (970)564-2134
SOUTHWEST WALK-IN CARE	2095 NORTH DOLORES ROAD, STE C	Cortez	CO	81321	Montezuma	Phone: (970)564-1037, Fax: (970)564-1041
SPANISH PEAKS FAMILY CLINIC	23400 US HIGHWAY 160	Walsenburg	CO	81089	Huerfano	Phone: (719)738-4591, Fax: (719)738-4553
STRATTON MEDICAL CLINIC	500 NEBRASKA AVENUE	Stratton	CO	80836	Kit Carson	Phone: (719)348-4650, Fax: (719)348-4653
SURFACE CREEK FAMILY PRACTICE	255 SW 8TH AVE	Cedaredge	CO	81413	Delta	Phone: (970)856-3146, Fax: (970)856-4385
VALLEY MEDICAL CLINIC	116 E NINTH STREET	Julesburg	CO	80737	Sedgwick	Phone: (970)474-3376, Fax: (970)474-2461
WALSH MEDICAL CLINIC	137 KANSAS STREET	Walsh	CO	81090	Baca	Phone: (719)324-5253, Fax: (719)324-5621
WASHINGTON COUNTY CLINIC	482 ADAMS AVENUE	Akron	CO	80720	Washington	Phone: (970)345-2262,

Facility	Address	City	State	Zip	County	Contact
						Fax: (970)345-2265
YUMA CLINIC	1000 W 8TH AVENUE	Yuma	CO	80759	Yuma	Phone: (970)848-4676, Fax: (970)848-4952

Exhibit #6 – Proposed Dental Fees Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D0120	$67.15
D0140	$112.29
D0145	$104.19
D0150	$118.08
D0160	$237.31
D0170	$78.72
D0171	$71.25
D0180	$128.50
D0190	$62.00
D0191	$44.00
D0210	$187.18
D0220	$37.68
D0230	$34.03
D0240	$58.35
D0250	$71.72
D0251	BR
D0270	$38.89
D0272	$63.21
D0273	$76.58
D0274	$88.74
D0277	$133.71
D0310	$556.70
D0320	$948.10
D0321	BR
D0322	$765.77
D0330	$165.54
D0340	$186.38
D0350	$89.13
D0351	$73.75
D0364	$1,251.00
D0365	$1,251.00
D0366	$1,251.00

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	2018 fees
D0367	$1,251.00
D0368	$1,831.00
D0369	$3,274.00
D0370	$1,102.00
D0371	BR
D0380	$998.00
D0381	$998.00
D0382	$998.00
D0383	$998.00
D0384	$1,459.00
D0385	$2,382.00
D0386	$596.00
D0391	BR
D0393	BR
D0394	BR
D0395	BR
D0414	BR
D0415	$72.00
D0416	$106.00
D0417	$97.00
D0418	$100.00
D0422	BR
D0423	BR
D0425	$62.00
D0431	$100.00
D0460	$100.00
D0470	$219.00
D0472	$137.00
D0473	$290.00
D0474	$325.00
D0475	$175.00
D0476	$170.00
D0477	$232.00
D0478	$212.00
D0479	$325.00
D0480	$200.00
D0481	$858.14
D0482	$250.00
D0483	$250.00

Exhibit #6 – Proposed Dental Fees Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D0484	$375.00
D0485	$517.00
D0486	$240.00
D0502	BR
D0600	BR
D0601	$93.00
D0602	$93.00
D0603	$93.00
D0999	BR
D1110	$120.33
D1120	$83.87
D1206	$72.93
D1208	$45.15
D1310	$70.61
D1320	$77.56
D1330	$97.24
D1351	$78.72
D1352	$94.50
D1353	$80.75
D1354	BR
D1510	$503.57
D1515	$704.99
D1520	$554.51
D1525	$856.64
D1550	$108.82
D1555	$104.19
D1575	BR
D1999	BR
D2140	$262.55
D2150	$339.13
D2160	$410.84
D2161	$500.79
D2330	$239.45
D2331	$306.31
D2332	$374.38
D2335	$443.66
D2390	$491.06
D2391	$280.78
D2392	$368.30

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D2393	$457.03
D2394	$560.35
D2410	$457.26
D2420	$762.88
D2430	$1,322.01
D2510	$1,209.72
D2520	$1,372.95
D2530	$1,582.48
D2542	$1,551.22
D2543	$1,623.00
D2544	$1,687.82
D2610	$1,423.88
D2620	$1,502.60
D2630	$1,601.00
D2642	$1,555.85
D2643	$1,677.40
D2644	$1,779.27
D2650	$935.36
D2651	$1,114.80
D2652	$1,171.52
D2662	$1,016.40
D2663	$1,195.82
D2664	$1,281.49
D2710	$628.41
D2712	$628.41
D2720	$1,548.55
D2721	$1,451.31
D2722	$1,482.92
D2740	$1,588.67
D2750	$1,568.01
D2751	$1,459.83
D2752	$1,495.07
D2780	$1,503.58
D2781	$1,414.85
D2782	$1,461.04
D2783	$1,546.13
D2790	$1,512.09
D2791	$1,433.08
D2792	$1,459.83

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	2018 fees
D2794	$1,548.55
D2799	$628.41
D2910	$143.43
D2915	$143.43
D2920	$144.65
D2921	$179.50
D2929	$543.00
D2930	$395.04
D2931	$447.31
D2932	$476.48
D2933	$545.76
D2934	$545.76
D2940	$150.73
D2941	$130.00
D2949	$130.00
D2950	$376.80
D2951	$85.08
D2952	$595.60
D2953	$297.80
D2954	$476.48
D2955	$367.08
D2957	$238.23
D2960	$1,152.30
D2961	$1,306.67
D2962	$1,419.72
D2971	$228.51
D2975	$695.27
D2980	BR
D2981	BR
D2982	BR
D2983	BR
D2990	$94.00
D2999	BR
D3110	$131.25
D3120	$105.35
D3220	$268.80
D3221	$295.20
D3222	$273.20
D3230	$307.52

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	2018 fees
D3240	$379.24
D3310	$1,207.00
D3320	$1,479.27
D3330	$1,834.20
D3331	$472.84
D3332	$899.47
D3333	$414.49
D3346	$1,609.34
D3347	$1,893.76
D3348	$2,343.50
D3351	$968.76
D3352	$433.93
D3353	$1,335.84
D3355	$577.25
D3356	$259.00
D3357	BR
D3410	$1,920.50
D3421	$2,138.07
D3425	$2,421.29
D3426	$818.03
D3427	$1,035.75
D3428	$1,509.25
D3429	$1,439.50
D3430	$601.67
D3431	$1,772.25
D3432	$1,523.50
D3450	$1,251.97
D3460	$4,676.05
D3470	$2,388.47
D3910	$334.27
D3920	$951.74
D3950	$433.93
D3999	BR
D4210	$1,603.00
D4211	$712.00
D4212	$570.00
D4230	$2,244.00
D4231	$1,096.39
D4240	$2,030.00

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	2018 fees
D4241	$1,175.00
D4245	$1,496.00
D4249	$2,226.00
D4260	$3,383.00
D4261	$1,816.00
D4263	$1,211.00
D4264	$1,033.00
D4265	BR
D4266	$1,247.00
D4267	$1,603.00
D4268	BR
D4270	$2,404.00
D4273	$2,938.00
D4274	$1,667.00
D4275	$2,208.00
D4276	$3,294.00
D4277	$2,493.00
D4278	$819.00
D4283	BR
D4285	BR
D4320	$625.99
D4321	$633.28
D4341	$361.00
D4342	$217.57
D4346	BR
D4355	$246.75
D4381	BR
D4910	$222.44
D4920	$161.66
D4921	BR
D4999	BR
D5110	$2,343.00
D5120	$2,343.00
D5130	$2,555.00
D5140	$2,555.00
D5211	$1,977.00
D5212	$2,298.00
D5213	$2,771.36
D5214	$2,589.00

Exhibit #6 – Proposed Dental Fees Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D5221	BR
D5222	BR
D5223	BR
D5224	BR
D5225	$1,977.00
D5226	$2,298.00
D5281	$1,509.00
D5410	$128.00
D5411	$128.00
D5421	$128.00
D5422	$128.00
D5510	$274.70
D5520	$214.00
D5610	$278.00
D5620	$316.03
D5630	$363.00
D5640	$235.00
D5650	$321.00
D5660	$385.00
D5670	$1,006.44
D5671	$1,006.44
D5710	$951.00
D5711	$909.00
D5720	$898.00
D5721	$898.00
D5730	$537.00
D5731	$537.00
D5740	$492.00
D5741	$492.00
D5750	$716.00
D5751	$716.00
D5760	$705.00
D5761	$705.00
D5810	$1,133.00
D5811	$1,218.00
D5820	$876.00
D5821	$930.00
D5850	$224.00
D5851	$224.00

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	2018 fees
D5862	BR
D5863	$2,295.25
D5864	BR
D5865	$2,295.25
D5866	$3,146.00
D5867	BR
D5875	BR
D5899	BR
D5911	$594.00
D5912	$594.00
D5913	$12,514.00
D5914	$12,514.00
D5915	$16,935.00
D5916	$4,517.00
D5919	BR
D5922	BR
D5923	BR
D5924	BR
D5925	BR
D5926	BR
D5927	BR
D5928	BR
D5929	BR
D5931	$6,738.00
D5932	$12,602.00
D5933	BR
D5934	$11,486.00
D5935	$9,994.00
D5936	$11,225.00
D5937	$1,411.50
D5951	$1,834.00
D5952	$5,956.00
D5953	$11,310.00
D5954	$10,481.00
D5955	$9,694.00
D5958	BR
D5959	BR
D5960	BR
D5982	$997.93

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	2018 fees
D5983	$2,416.43
D5984	$2,416.43
D5985	$2,416.43
D5986	$241.00
D5987	$3,627.07
D5988	$641.00
D5991	$246.00
D5992	BR
D5993	BR
D5994	$227.50
D5999	BR
D6010	$3,914.00
D6011	BR
D6012	$3,698.00
D6013	$3,623.00
D6040	$14,418.34
D6050	$10,047.00
D6051	BR
D6052	$1,535.25
D6055	$1,176.00
D6056	$812.00
D6057	$1,005.00
D6058	$2,253.00
D6059	$2,379.96
D6060	$2,249.90
D6061	$2,294.88
D6062	$2,286.36
D6063	$1,963.04
D6064	$2,079.74
D6065	$2,217.00
D6066	$2,311.89
D6067	$2,242.61
D6068	$2,234.00
D6069	$2,379.96
D6070	$2,249.90
D6071	$2,144.00
D6072	$2,343.50
D6073	$2,121.06
D6074	$2,106.00

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D6075	$2,217.00
D6076	$2,311.89
D6077	$2,242.61
D6080	$184.00
D6081	BR
D6085	BR
D6090	BR
D6091	$887.00
D6092	$173.00
D6093	$271.00
D6094	$1,887.68
D6095	BR
D6100	BR
D6101	$587.50
D6102	$769.75
D6103	$672.50
D6104	$672.50
D6110	$2,705.00
D6111	$2,705.00
D6112	$2,705.00
D6113	$2,705.00
D6114	BR
D6115	BR
D6116	BR
D6117	BR
D6190	$395.00
D6194	$1,817.00
D6199	BR
D6205	$1,016.16
D6210	$1,553.41
D6211	$1,454.96
D6212	$1,514.52
D6214	$1,563.15
D6240	$1,533.97
D6241	$1,416.06
D6242	$1,493.86
D6245	$1,582.59
D6250	$1,514.52
D6251	$1,396.62

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D6252	$1,441.59
D6253	$652.72
D6545	$610.19
D6548	$651.00
D6549	$377.21
D6600	$1,186.33
D6601	$1,266.56
D6602	$1,294.51
D6603	$1,424.58
D6604	$1,268.99
D6605	$1,344.35
D6606	$1,248.32
D6607	$1,385.67
D6608	$1,277.00
D6609	$1,355.29
D6610	$1,396.62
D6611	$1,527.89
D6612	$1,389.33
D6613	$1,452.53
D6614	$1,358.93
D6615	$1,413.64
D6624	$1,294.51
D6634	$1,358.93
D6710	$1,345.00
D6720	$1,619.06
D6721	$1,535.18
D6722	$1,563.15
D6740	$1,650.00
D6750	$1,656.73
D6751	$1,546.13
D6752	$1,583.81
D6780	$1,563.15
D6781	$1,516.00
D6782	$1,563.15
D6783	$1,561.00
D6790	$1,599.60
D6791	$1,516.96
D6792	$1,571.65
D6793	$637.00

Exhibit #6 – Proposed Dental Fees Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D6794	$1,571.65
D6920	$420.57
D6930	$245.53
D6940	$556.70
D6950	$1,074.51
D6980	BR
D6985	$934.72
D6999	BR
D7111	$229.73
D7140	$305.09
D7210	$405.98
D7220	$509.29
D7230	$678.25
D7240	$796.15
D7241	$1,000.37
D7250	$429.07
D7251	$770.70
D7260	$3,182.19
D7261	$1,104.60
D7270	$828.45
D7272	$1,104.60
D7280	$772.80
D7282	$386.40
D7283	$331.80
D7285	$1,546.65
D7286	$662.55
D7287	$265.65
D7288	$265.65
D7290	$662.55
D7291	$446.76
D7292	$1,060.50
D7293	$662.55
D7294	$552.30
D7295	BR
D7310	$1,009.00
D7311	$883.00
D7320	$1,640.00
D7321	$1,388.00
D7340	$6,938.00

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D7350	$20,182.00
D7410	$3,027.00
D7411	$4, 793.00
D7412	$5,298.00
D7413	$3,532.00
D7414	$5,298.00
D7415	$5,928.00
D7440	$4,793.00
D7441	$7,064.00
D7450	$3,027.00
D7451	$4,137.00
D7460	$3,027.00
D7461	$4,137.00
D7465	$1,640.00
D7471	$3,749.00
D7472	$4,455.00
D7473	$4,203.00
D7485	$3,749.00
D7490	$30,273.00
D7510	$1,085.00
D7511	$1,640.00
D7520	$5,167.00
D7521	$5,676.00
D7530	$1,862.00
D7540	$2,064.00
D7550	$1,287.00
D7560	$10,217.00
D7610	$16,524.00
D7620	$12,392.00
D7630	$21,484.00
D7640	$13,633.00
D7650	$10,328.00
D7660	$6,090.00
D7670	$4,753.00
D7671	$8,956.00
D7680	$30,984.00
D7710	$19,420.00
D7720	$13,633.00
D7730	$28,093.00

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D7740	$13,900.00
D7750	$17,679.00
D7760	$7,094.00
D7770	$9,612.00
D7771	$7,417.00
D7780	$41,313.00
D7810	$18,174.00
D7820	$2,977.00
D7830	$1,705.00
D7840	$24,773.00
D7850	$21,393.00
D7852	$24,496.00
D7854	$25,278.00
D7856	$17,937.00
D7858	$51,126.00
D7860	$21,792.00
D7865	$35,117.00
D7870	$1,160.00
D7871	$2,321.00
D7872	$12,387.00
D7873	$14,914.00
D7874	$21,393.00
D7875	$23,436.00
D7876	$25,268.00
D7877	$22,301.00
D7880	$2,785.00
D7881	BR
D7899	BR
D7910	$1,655.00
D7911	$4,132.00
D7912	$7,437.00
D7920	$12,185.00
D7921	$1,125.00
D7940	BR
D7941	$31,030.00
D7943	$28,507.00
D7944	$25,404.00
D7945	$33,805.00
D7946	$41,878.00

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	2018 fees
D7947	$35,218.00
D7948	$45,712.00
D7949	$59,537.00
D7950	BR
D7951	BR
D7952	BR
D7953	$858.00
D7955	BR
D7960	$1,388.00
D7963	$2,270.00
D7970	$2,018.00
D7971	$757.00
D7972	$2,825.00
D7980	$3,179.00
D7981	BR
D7982	$7,518.00
D7983	$7,215.00
D7990	$6,206.00
D7991	$5,137.00
D7995	BR
D7996	BR
D7997	$1,160.00
D7998	$5,046.00
D7999	BR
D8010	BR
D8020	BR
D8030	BR
D8040	BR
D8050	BR
D8060	BR
D8070	BR
D8080	BR
D8090	BR
D8210	BR
D8220	BR
D8660	$700.13
D8670	$525.09
D8680	$1,154.73
D8681	BR

Exhibit #6 – Proposed Dental Fees Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D8690	$545.76
D8691	$512.95
D8692	$571.28
D8693	$528.75
D8694	BR
D8999	BR
D9110	$215.15
D9120	$243.11
D9210	$181.65
D9211	$200.55
D9212	$312.90
D9215	$150.15
D9219	BR
D9223	BR
D9230	BR
D9243	BR
D9248	$437.85
D9310	$487.42
D9311	BR
D9410	$557.92
D9420	$903.13
D9430	$151.94
D9440	$305.09
D9450	$151.94
D9610	BR
D9612	BR
D9630	BR
D9910	$103.03
D9911	$144.70
D9920	BR
D9930	BR
D9932	BR
D9933	BR
D9934	BR
D9935	BR
D9940	$940.80
D9941	$307.52
D9942	$354.24
D9943	BR

Exhibit #6 – Proposed Dental Fees	
Effective for Dates of Service on and After 1/1/2018	
CDT 2017	**2018 fees**
D9950	$560.29
D9951	$251.20
D9952	$1,179.62
D9970	$133.13
D9971	$171.33
D9972	$590.39
D9973	$97.24
D9974	$516.31
D9975	$576.00
D9985	BR
D9986	BR
D9987	BR
D9991	BR
D9992	BR
D9993	BR
D9994	BR
D9999	BR

Exhibit 7

Effective for Dates of Service On and After 1/1/2018

Evaluation and Management (E&M) Documentation Guidelines

for

Colorado Workers' Compensation Claims

This E&M Guidelines for Colorado Workers' Compensation Claims is intended for the physicians who manage injured workers' medical and non-medical care. Providers may also use the "1997 Documentation Guidelines for Evaluation and Management Services" as developed by Medicare. The Level of Service is determined by:

1. History (Hx),
2. Examination (Exam), and
3. Medical Decision Making (MDM)

Documentation requirements for any billed office visit:

- Chief complaint and medical necessity
- Patient specific and pertain directly to the current visit.
- Information copied directly from prior records without change is not considered current or counted.
- CPT© criteria for a consultation is required to bill a consultation code

Table I – History (Hx) Component: The overall level of history is determined based upon all three of the history elements (HPI, ROS, and PMFSW) being at the same level or higher.

HISTORY ELEMENTS	Requirements for a Problem Focused (PF) Level	Requirements for an Extended Problem Focused (EPF) Level	Requirements for a Detailed (D) Level	Requirements for a Comprehensive (C) Level
A. History of Present Illness/Injury (HPI)	Brief 1-3 elements	Brief 1-3 elements	Extended 4+ elements **(Initial visits require(s) an injury causation statement and or an objective functional goal treatment plan. Follow-up visits require objective functional gains/losses, ADLs etc)**	Extended 4+ elements **(Initial visits require(s) an injury causation statement and or an objective functional goal treatment plan. Follow-up visits require objective functional gains/losses, ADLs etc)**
B. Review of Systems (ROS) (not required for established patient visits)	None	Problem pertinent-limited to injured body part	2-9 body parts or body systems	Complete 10+
C. Past Medical, Family and Social/Work History (PMFSH)	None	None	Pertinent 1 of 4 types of histories	2 or more of the 4 types of histories

A. HPI Elements represents the injured worker relaying their condition to the physician and should include the following:

1. Location (where?)
2. Quality (sharp, dull)
3. Severity (pain level 1-10 or pain diagram)
4. Duration (how long?)
5. Timing (how often, regularity of occurrence, only at night etc?)
6. Context (what ADLs or functions aggravates/relieves, accident described,?)
7. Modifying factors (doing what, what makes it worse or better, ?)

8. Associated signs (nausea, numbness or tingling when?)

For the provider to achieve an *"extended" or greater HPI* in an initial patient/injured workers visit it is required for the provider to discuss the causality of the patient/injured worker's work related injury(s) to the patient/injured worker's job duties and or create and implement a treatment plan with objective functional measureable goals.

For the provider to achieve an *"extended" or greater HPI* in an established patient/injured worker visit it is required to document a detailed description of the patient's objective functional gains or losses since the last visit with current treatment plan, such as ADLs, physical therapy goals and return to work.

B. Review of Systems (ROS): each system/body part is counted once whether positive or negative. Identify, perform and documentation of all pertinent ROS systems with either a "positive or negative" response is necessary to be counted.

1. Constitutional symptoms (e.g., fever, weight loss)
2. Eyes
3. Ears, Nose, Mouth, Throat
4. Cardiovascular
5. Respiratory
6. Gastrointestinal
7. Genitourinary
8. Musculoskeletal
9. Integumentary (skin and/or breast)
10. Neurological
11. Psychiatric
12. Endocrine
13. Hematologic/Lymphatic
14. Allergic/Immunologic

C. PMFSH consists of a review of four areas (NOTE: Employers should **not** have access to any patient's or the family's generic/hereditary diagnoses or testing information, etc.)

1. Past history – the patient's past experiences with illnesses, operations, injuries and treatments.

2. Family history – a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk and any family situations that can interfere with or support the injured worker's treatment plan and returning to work.

3. Occupational/Social History/Military – an age appropriate review of past and current work activities, occupational history, current work status, any work situations that support or interfere with return to work. For established visits specific updates of progress must be discussed.

4. Non-Occupational/Social History – Hobbies, current recreational physical activities and the patient's support relationships, etc. For established visits specific updates of progress must be discussed.

TABLE II: Examination Component: Each bullet is counted only when it is pertinent and related to the workers' compensation injury and is part of the medical decision making process. The total number of bullets determines the overall level of examination.

Physician's Examination Component	
Level of Examination Performed and Documented	**# of Bullets Required for each level**
Problem Focused	1-5 elements identified by a bullet as indicated in the guideline
Expanded Problem Focused	6 elements identified by a bullet as indicated in this guideline
Detailed	7-12 elements identified by a bullet as indicated in this guideline
Comprehensive	>13 elements identified by a bullet as indicated in this guideline

Examination Components:

Constitutional Measurement:

- Vital signs (may be measured and recorded by ancillary staff) – any of three (3) vital signs is counted as one bullet:

  1. sitting or standing blood pressure
  2. supine blood pressure
  3. pulse rate and regularity
  4. respiration
  5. temperature
  6. height
  7. weight or BMI

- One bullet for commenting on the general appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)

Musculoskeletal: Each of the six body areas with three (3) assessments is counted as one bullet.

1. head and or neck
2. spine or ribs and pelvis or all three
3. right upper extremity (shoulder, elbow, wrist, entire hand)
4. left upper extremity (shoulder, elbow, wrist, entire hand)
5. right lower extremity (hip, knee, ankle, entire foot)
6. left lower extremity (hip, knee, ankle, entire foot)

Assessment of a given body area includes:

- Inspection, percussion and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions
- Assessment of range of motion with notation of any pain (e.g., straight leg raise), crepitation or contracture
- Assessment of stability with notation of any dislocation (luxation), subluxation or laxity
- Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (fasciculation, tardive dyskinesia)
- Examination of gait and station
- Inspection and/or palpation of digits and nails (e.g., clubbing, cyanosis, inflammatory conditions, petechia, ischemia, infections, nodes)

Neck: One bullet for both examinations

- Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) and
- Examination of thyroid (e.g., enlargement, tenderness, mass)

Neurological: One bullet for each neurological examination/assessment(s) per extremity:

1. Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities)
2. Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (e.g., Babinski)
3. Examination of sensation (e.g., by touch, pin, vibration, proprioception)
4. One bullet for all of the 12 cranial nerves assessments with notations of any deficits

Cardiovascular:

1. One bullet per extremity examination/assessment of peripheral vascular system by:

a. Observation (e.g., swelling, varicosities)

b. Palpation (e.g., pulses, temperature, edema, tenderness)

2. One bullet for palpation of heart (e.g., location, size, thrills)

3. One bullet for auscultation of heart with notation of abnormal sounds and murmurs

4. One bullet for examination of each one of the following:

a. carotid arteries (e.g., pulse amplitude, bruits)

b. abdominal aorta (e.g., size, bruits)

c. femoral arteries (e.g., pulse amplitude, bruits)

Skin: One bullet for pertinent body part(s) inspection and/or palpation of skin and subcutaneous tissue (e.g., scars, rashes, lesions, café au lait spots, ulcers)

Respiratory: (one bullet for each examination/assessment)

1. Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)

2. Percussion of chest (e.g., dullness, flatness, hyperresonance)

3. Palpation of chest (e.g., tactile fremitus)

4. Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)

Gastrointestinal: One bullet for each examination /assessment

1. Examination of abdomen with notation of presence of masses or tenderness and liver and spleen

2. Examination of presence or absence of hernia

3. Examination (when indicated) of anus, perineum and rectum, including sphincter tone, present of hemorrhoids, rectal masses and/or obtain stool sample of occult blood test when indicated

Psychiatric:

1. One bullet for assessment of mood and affect (e.g., depression, anxiety, agitation) if not counted under the Neurological system

2. One bullet for a mental status examination which includes:

a. Attention span and concentration; and

b. Language (e.g., naming objects, repeating phrases, spontaneous speech) orientation to time, place and person; and

c. Recent and remote memory; and

d. Fund of knowledge (e.g., awareness of current events, past history, vocabulary)

Eyes: One bullet for both eyes and all three examinations/assessments

1. Inspection of conjunctivae and lids; and

2. Examination of pupils and irises (e.g., reaction of light and accommodation, size and symmetry); and

3. Opthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)

Ears and Nose, Mouth and Throat:

One bullet for all of the following examination/assessment:

1. External inspection of ears and nose (e.g., overall appearance, scars, lesions, asses)
2. Otoscopic examination of external auditory canals and tympanic membranes
3. Assessment of hearing with tuning fork and clinical speech reception thresholds (e.g., whispered voice, finger rub, tuning fork)

One bullet for all of the following examinations/assessments:

1. Inspection of nasal mucosa, septum and turbinates
2. Inspection of lips, teeth and gums
3. Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx (e.g., asymmetry, lesions, hydration of mucosal surfaces)

Genitourinary MALE –

One bullet for each of the following examination of the male genitalia:

1. The scrotal contents (e.g., hydrocele, spermatocele, tenderness of cord, testicular mass)
2. Epididymides (e.g., size, symmetry, masses)
3. Testes (e.g., size symmetry, masses)
4. Urethral meatus (e.g., size location, lesions, discharge)
5. Examination of the penis (e.g., lesions, presence of absence of foreskin, foreskin retract ability, plaque, masses, scarring, deformities)
6. Digital rectal examination of prostate gland (e.g., size, symmetry, nodularity, tenderness)
7. Inspection of anus and perineum

Genitourinary FEMALE –

One bullet for each of the following female pelvic examination(s) (with or without specimen collection for smears and cultures):

1. Examination of external genitalia (e.g., general appearance, hair distribution, lesions) and vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele rectocele)
2. Examination of urethra (e.g., masses, tenderness, scarring)
3. Examination of bladder (e.g., fullness, masses, tenderness)
4. Cervix (e.g., general appearance, lesions, discharge)
5. Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent or support)
6. Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity)

Chest:

One bullet for both examinations/assessments of both breasts

1. Inspection of breasts (e.g., symmetry, nipple discharge); and
2. Palpation of breasts and axillae (e.g., masses or lumps, tenderness)

Lymphatic palpation of lymph nodes -- Two or more areas is counted as one bullet:

1. Neck
2. Axillae
3. Groin
4. Other

Verify all of the completed examination components listed in the report documents the relevance/relatedness to the injurty and or “reasonable and necessity” for that specified patient’s condition. Any examination bullet that is not clearly related to the injury or a patient’s specific condition will not be counted/considered in the total number of bullets for the level of service.

TABLE III: Medical Decision Making Component (MDM) is comprised of Tables A, B, AND C. Two of the three highest levels from Tables A., B., and C. determines the overall level of risk)

TABLE III A:

A. Number of Diagnosis & Management Options					
Category of Problem(s)	**Occurrence of Problem(s)**		**Value**		**Total**
Self-limited or minor problem	(max 2)	X	1		
Established problem, stable or improved		X	1		
Established problem, minor worsening with improvement with expected time frames		X	2		
Established problem without improvement within expected time frame that requires treatment plan changes with or without additional workup		X	4		
New problem with no additional workup planned or established patient with worsening of condition and no additional workup planned	(max 1)	X	3		
New problem, additional workup planned or established patient with worsening of condition and no additional workup planned		X	4		

TABLE III B:

B. Amount and/or Complexity of Data Reviewed	
Date Type:	Points
Lab(s) ordered and/or reports reviewed	1
X-ray (s) ordered and/or reports reviewed	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than the patient	1
Medicine section (90701-99199) ordered and /or physical therapy records reviewed and commented on progress 9state whether the patient is progressing and how they are functionally progressing or not and document any planned changes to the plan of care	2
Review and summary of old records and/or discussion with other health provider	2
Independent visualization of images, tracing or specimen	2
TOTAL	

TABLE III C:

C. Table of Risk (the highest one in any one category determines the overall risk for this portion)			
Level of Risk	**Presenting Problem(s)**	**Diagnostic Procedure(s) Ordered or Addressed**	**Management Option(s) Selected**
Minimal	One self-limited or minor problem, e.g., cold, insect bite, tinea corpori, minor non-sutured laceration	Lab tests requiring venipuncture Chest x-rays EKG/EEG Urinalysis Ultrasound KOH prep	Rest Gargles Elastic bandages Superficial dressings
Low	Two or more self-limited or minor problems One stable chronic illness, e.g., well-controlled HTN, NIDDM, cataract, BPH Acute, uncomplicated illness or injury, e.g., allergic rhinitis or simple sprain cyctitis Acute laceration repair	Physiologic tests nor under stress, e.g., PFTs Non-cardiovascular imaging studies w/contrast, e.g., barium enema Superficial needle biopsies Lab tests requiring arterial puncture Skin biopsies	Over-the-counter drugs Minor surgery w/no identified risk factors PT/OT IV fluids w/o additives Simple or layered closure Vaccine injection
Moderate	One of more chronic illnesses with mild exacerabation, progression or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis, e.g., new extremity neurologic complaints Acute illness with systemic symptoms, e.g., pyelonephritis, colitis Acute complicated injury, e.g., head injury with brief loss of consciousness	Physiologic tests under stress, e.g. cardiac stress test, Discography, stress tests Diagnostic injections Deep needle or incisional biopsies Cardiovascular imaging studies with contrast and no identified risk factors e.g. arteriogram, cardiac cath Obtain fluid from body cavity, e.g. lumbar puncture, thoracentesis, culdocentesis	Minor surgery with identified risk factors Elective major surgery (open, percutaneous, or endoscopic) with no identified risk factors Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed Tx of Fx or dislocation w/o manipulation Inability to return the injured worker to work and requires detailed functional improvement plan.

TABLE III C:

C. Table of Risk (the highest one in any one category determines the overall risk for this portion)			
Level of Risk	**Presenting Problem(s)**	**Diagnostic Procedure(s) Ordered or Addressed**	**Management Option(s) Selected**
High	One or more chronic illness with severe exacerbation, progression or side effects of treatment Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g., multiple trauma, acute MI, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others; An abrupt change in neurological status, e.g., seizure, TIA, weakness, sensory loss	Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic endoscopies with identified risk factors	Elective major surgery with identified risk factors Emergency major surgery Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis, Potential for significant permanent work restrictions or total disability Management of addiction behavior or other significant psychiatric condition Treatment plan for patients with symptoms causing severe functional deficits without supporting physiological \findings or verified related medical diagnosis.

IV. Time Component: Time can determine the level of service if:

1. Greater than fifty percent of a physician's time at an E&M visit is spent either face-to-face with the patient counseling and/or coordination of care; and
2. There is detailed patient specific documentation of the counseling and/or coordination of care, including patient questions and or responses; and
3. The amount of time for the entire office visit and the amount of time counseling and/or coordination of care with the injured worker is documented.

If time is used to establish the level of visit and total amount of time falls in between two levels, then the provider's time shall be more than half way to reaching the higher level.

A. Counseling: Primary care physicians should have *shared decision making conferences* with their patients to *establish viable functional goals* prior to making referrals for diagnostic testing and/or to specialists. Shared decision making occurs when the physician shares with the patient all the treatment alternatives reflected in the Colorado Medical Treatment Guidelines as well as any possible side effects or limitations, and the patient shares with the primary physician their desired outcome from the treatment. Patients should be encouraged to express their goals, outcome expectations and desires from treatment as well as any personal habits or traits that may be impacted by procedures or their possible side effects.

1. The physician's time spent face-to-face with the patient and/or their family counseling him/her or them in one or more of the following:

- Injury/disease education that includes discussion of diagnostic tests results and a disease specific treatment plan.
- Return to work
- Temporary and/or permanent restrictions
- Self-management of symptoms while at home and/or work
- Correct posture/mechanics to perform work functions
- Job task exercises for muscle strengthening and stretching
- Appropriate tool and equipment use to prevent re-injury and/or worsening of the existing injury/condition
- Patient/injured worker expectations and specific goals
- Family and other interpersonal relationships and how they relate to psychological/social issues
- Discussion of pharmaceutical management (includes drug dosage, specific drug side effects and potential of addiction /problems
- Assessment of vocational plans (i.e., restrictions as they relate to current and future employment job requirements)

B. Coordination of Care: Coordination of care requires the physician to either call another health care provider (outside of their own clinic) regarding the patient's diagnosis and/or treatment or the physician telephones or visits the employer in person to safely return the patient to work.

Table V: New Patient/Office Consultations Level of Service: CPT consultation criteria must be met before a consultation can be billed for any level of service.

New Patient/Level of Service (Requires all three key components at the same level or higher)	**History**	**Examination**	**Medical Decision Making (MDM)**	**Avg. time (minutes) as listed for the specific CPT code**
99201/99241	Problem Focused (PF)	PF	Straight Forward (SF)	10
99202/99242	Extended Problem Focused (EPF)	EPF	SF	20
99203/99243	Detailed (D)	D	Low	30
99204/99244	Comprehensive(C)	C	Moderate	45
99205/99245	C	C	High	60

Table VI: Established Patient Office Visit Level of Service

Established Patient/Level of Service (Requires at least two of the three key components at the same level or higher and *one of the two must be MDM)*	**History**	**Examination**	**Medical Decision Making (MDM)**	**Avg. time (minutes) as listed for the specific CPT code**
99211	N/A	N/A	N/A	5
99212	PF	PF	SF	10
99213	EPF	EPF	Low	15
99214	D	D	Moderate	25
99215	C	C	High	40

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
36415		5.10	Routine venipuncture
36416		5.10	
78267		18.33	Breath tst attain/anal c-14
78268		157.08	Breath test analysis c-14
80047		19.72	Metabolic panel ionized ca
80047	QW	19.72	Metabolic panel ionized ca
80048		19.72	Metabolic panel total ca
80048	QW	19.72	Metabolic panel total ca
80050		52.75	General Health panel(85025,85004,80053)
80051		16.35	Electrolyte panel
80051	QW	16.35	Electrolyte panel
80053		24.63	Comprehen metabolic panel
80053	QW	24.63	Comprehen metabolic panel
80055		111.49	Obstetric panel
80061		31.23	Lipid panel
80061	QW	31.23	Lipid panel
80069		20.25	Renal function panel
80069	QW	20.25	Renal function panel
80074		111.08	Acute hepatitis panel
80076		19.06	Hepatic function panel
80081		174.57	Obstetric panel
80150		35.16	Assay of amikacin
80155		32.98	Drug screen quant caffeine
80156		33.97	Assay carbamazepine total
80157		30.91	Assay carbamazepine free
80158		42.09	Assay of cyclosporine
80159		43.13	Drug screen quant clozapine
80162		30.96	Assay of digoxin
80163		30.96	Assay of digoxin free
80164		31.59	Assay dipropylacetic acid
80165		31.59	Dipropylacetic acid free
80168		38.10	Assay of ethosuximide
80169		32.03	Drug screen quant everolimus
80170		38.20	Assay of gentamicin
80171		30.91	Drug screen quant gabapentin
80173		33.97	Assay of haloperidol

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
80175		30.91	Drug screen quan lamotrigine
80176		34.26	Assay of lidocaine
80177		30.91	Drug scrn quan levetiracetam
80178		15.42	Assay of lithium
80178	QW	15.42	Assay of lithium
80180		42.09	Drug scrn quan mycophenolate
80183		30.91	Drug scrn quant oxcarbazepin
80184		26.71	Assay of phenobarbital
80185		30.91	Assay of phenytoin total
80186		32.10	Assay of phenytoin free
80188		38.69	Assay of primidone
80190		39.07	Assay of procainamide
80192		39.07	Assay of procainamide
80194		34.05	Assay of quinidine
80195		32.03	Assay of sirolimus
80197		32.03	Assay of tacrolimus
80198		32.98	Assay of theophylline
80199		42.11	Drug screen quant tiagabine
80200		37.60	Assay of tobramycin
80201		27.80	Assay of topiramate
80202		31.59	Assay of vancomycin
80203		30.91	Drug screen quant zonisamide
80299		31.94	Quantitative assay drug
80305		25.43	Drug test prsmv dir opt obs
80306		33.92	Drug test prsmv instrmnt
80307		135.68	Drug test prsmv chem anlyzr
80400		76.06	Acth stimulation panel
80402		202.78	Acth stimulation panel
80406		145.67	Acth stimulation panel
80408		292.66	Aldosterone suppression eval
80410		187.36	Calcitonin stimul panel
80412		768.67	CRH stimulation panel
80414		120.41	Testosterone response
80415		130.32	Estradiol response panel
80416		307.73	Renin stimulation panel
80417		102.58	Renin stimulation panel
80418		1351.60	Pituitary evaluation panel
80420		168.01	Dexamethasone panel

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
80422		107.44	Glucagon tolerance panel
80424		117.76	Glucagon tolerance panel
80426		346.09	Gonadotropin hormone panel
80428		155.55	Growth hormone panel
80430		183.02	Growth hormone panel
80432		275.09	Insulin suppression panel
80434		235.93	Insulin tolerance panel
80435		240.23	Insulin tolerance panel
80436		212.59	Metyrapone panel
80438		117.56	TRH stimulation panel
80439		156.74	TRH stimulation panel
81000		7.40	Urinalysis nonauto w/scope
81001		7.40	Urinalysis auto w/scope
81002		5.95	Urinalysis nonauto w/o scope
81003		5.24	Urinalysis auto w/o scope
81003	QW	5.24	Urinalysis auto w/o scope
81005		5.05	Urinalysis
81007		5.98	Urine screen for bacteria
81007	QW	5.98	Urine screen for bacteria
81015		7.11	Microscopic exam of urine
81020		8.60	Urinalysis glass test
81025		14.74	Urine pregnancy test
81050		7.00	Urinalysis volume measure
81161		239.90	Dmd dup/delet analysis
81162		4255.54	Brca1&2 seq & full dup/del
81170		564.09	Abl1 gene
81206		382.35	Bcr/abl1 gene major bp
81207		337.76	Bcr/abl1 gene minor bp
81208		375.07	Bcr/abl1 gene other bp
81210		306.39	Braf gene
81211		3732.32	Brca1&2 seq & com dup/del
81212		302.06	Brca1&2 185&5385&6174 var
81213		996.05	Brca1&2 uncom dup/del var
81214		2458.23	Brca1 full seq & com dup/del
81215		159.38	Brca1 gene known fam variant
81217		159.38	Brca2 gene known fam variant
81218		564.09	Cebpa gene full sequence
81219		283.63	Calr gene com variants

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
81225		498.78	Cyp2c19 gene com variants
81226		771.92	Cyp2d6 gene com variants
81227		299.25	Cyp2c9 gene com variants
81235		564.09	Egfr gene com variants
81240		114.75	F2 gene
81241		142.49	F5 gene
81245		283.63	Flt3 gene
81246		142.15	Flt3 gene analysis
81256		152.42	Hfe gene
81261		461.70	Igh gene rearrange amp meth
81262		101.80	Igh gene rearrang dir probe
81263		686.80	Igh vari regional mutation
81264		348.21	Igk rearrangeabn clonal pop
81265		501.48	Str markers specimen anal
81267		483.79	Chimerism anal no cell selec
81268		608.14	Chimerism anal w/cell select
81270		213.76	Jak2 gene
81272		564.09	Kit gene targeted seq analys
81273		213.76	Kit gene analys d816 variant
81275		337.57	Kras gene
81276		337.57	Kras gene addl variants
81287		142.24	Mgmt gene methylation anal
81288		273.29	Mlh1 gene
81291		101.80	Mthfr gene
81292		1104.63	Mlh1 gene full seq
81293		442.82	Mlh1 gene known variants
81294		325.92	Mlh1 gene dup/delete variant
81295		259.32	Msh2 gene full seq
81296		221.43	Msh2 gene known variants
81297		259.32	Msh2 gene dup/delete variant
81298		492.00	Msh6 gene full seq
81299		275.62	Msh6 gene known variants
81300		276.37	Msh6 gene dup/delete variant
81301		675.24	Microsatellite instability
81310		422.45	Npm1 gene
81311		506.36	Nras gene variants exon 2&3
81313		445.54	Pca3/klk3 antigen
81314		564.09	Pdgfra gene

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
81315		483.45	Pml/raralpha com breakpoints
81316		737.39	Pml/raralpha 1 breakpoint
81317		1335.49	Pms2 gene full seq analysis
81318		315.55	Pms2 known familial variants
81319		378.90	Pms2 gene dup/delet variants
81321		1026.80	Pten gene full sequence
81322		99.82	Pten gene known fam variant
81323		149.74	Pten gene dup/delet variant
81327		142.24	Sept9 methylation analysis
81332		101.80	Serpina1 gene
81340		487.19	Trb@ gene rearrange amplify
81341		115.63	Trb@ gene rearrange dirprobe
81342		469.88	Trg gene rearrangement anal
81370		937.74	Hla i & ii typing lr
81371		561.29	Hla i & ii type verify lr
81372		515.13	Hla i typing complete lr
81373		259.69	Hla i typing 1 locus lr
81374		169.64	Hla i typing 1 antigen lr
81375		514.76	Hla ii typing ag equiv lr
81376		285.02	Hla ii typing 1 locus lr
81377		214.10	Hla ii type 1 ag equiv lr
81378		805.85	Hla i & ii typing hr
81379		782.10	Hla i typing complete hr
81380		413.34	Hla i typing 1 locus hr
81381		220.56	Hla i typing 1 allele hr
81382		288.42	Hla ii typing 1 loc hr
81383		254.49	Hla ii typing 1 allele hr
81410		0.00	Aortic dysfunction/dilation
81411		0.00	Aortic dysfunction/dilation
81412		1023.57	Ashkenazi jewish assoc dis
81413		1363.96	Car ion chnnlpath inc 10 gns
81414		1363.96	Car ion chnnlpath inc 2 gns
81415		0.00	Exome sequence analysis
81416		0.00	Exome sequence analysis
81417		0.00	Exome re-evaluation
81420		1363.96	Fetal chrmoml aneuploidy
81422		1363.96	Fetal chrmoml microdeltj
81425		0.00	Genome sequence analysis

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
81426		0.00	Genome sequence analysis
81427		0.00	Genome re-evaluation
81430		0.00	Hearing loss sequence analys
81431		0.00	Hearing loss dup/del analys
81432		1583.52	Hrdtry brst ca-rlatd dsordrs
81433		1023.57	Hrdtry brst ca-rlatd dsordrs
81434		1023.57	Hereditary retinal disorders
81435		1363.96	Hereditary colon cancer
81436		1363.96	Hereditary colon ca synd
81437		1023.57	Heredtry nurondcrn tum dsrdr
81438		1023.57	Heredtry nurondcrn tum dsrdr
81439		1363.96	Inherited cardmypthy 5 gns
81440		0.00	Mitochondrial gene
81442		1023.57	Noonan spectrum disorders
81445		1023.57	Targeted genomic seq analys
81450		1110.00	Targeted genomic seq analys
81455		0.00	Targeted genomic seq analys
81460		0.00	Whole mitochondrial genome
81465		0.00	Whole mitochondrial genome
81470		0.00	X-linked intellectual dblt
81471		0.00	X-linked intellectual dblt
81490		1004.04	Autoimmune rheumatoid arthr
81493		1772.00	Cor artery disease mrna
81519		5853.71	Oncology breast mrna
81525		5313.74	Oncology colon mrna
81528		871.13	Oncology colorectal scr
81535		991.98	Oncology gynecologic
81536		303.96	Oncology gynecologic
81538		3615.53	Oncology lung
81539		1023.57	Oncology prostate prob score
81540		4964.51	Oncology tum unknown origin
81545		5478.08	Oncology thyroid
81595		4829.28	Cardiology hrt trnspl mrna
82009		10.54	Test for acetone/ketones
82010		19.06	Acetone assay
82010	QW	19.06	Acetone assay
82013		26.04	Acetylcholinesterase assay
82016		32.35	Acylcarnitines qual

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
82017		6.15	Acylcarnitines quant
82024		90.07	Assay of acth
82030		33.05	Assay of adp & amp
82040		11.54	Assay of serum albumin
82040	QW	11.54	Assay of serum albumin
82042		6.77	Assay of urine albumin
82042	QW	6.77	Assay of urine albumin
82043		13.48	Microalbumin quantitative
82043	QW	13.48	Microalbumin quantitative
82044		10.68	Microalbumin semiquant
82044	QW	10.68	Microalbumin semiquant
82045		76.04	Albumin ischemia modified
82075		28.10	Assay of breath ethanol
82085		22.64	Assay of aldolase
82088		95.03	Assay of aldosterone
82103		31.33	Alpha-1-antitrypsin total
82104		33.73	Alpha-1-antitrypsin pheno
82105		39.12	Alpha-fetoprotein serum
82106		39.12	Alpha-fetoprotein amniotic
82107		150.21	Alpha-fetoprotein l3
82108		59.42	Assay of aluminum
82120		4.03	Amines vaginal fluid qual
82120	QW	4.03	Amines vaginal fluid qual
82127		32.35	Amino acid single qual
82128		32.35	Amino acids mult qual
82131		39.34	Amino acids single quant
82135		38.37	Assay aminolevulinic acid
82136		6.15	Amino acids quant 2-5
82139		6.15	Amino acids quan 6 or more
82140		33.98	Assay of ammonia
82143		16.01	Amniotic fluid scan
82150		15.11	Assay of amylase
82150	QW	15.11	Assay of amylase
82154		34.80	Androstanediol glucuronide
82157		68.27	Assay of androstenedione
82160		58.31	Assay of androsterone
82163		47.86	Assay of angiotensin II
82164		34.05	Angiotensin I enzyme test

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
82172		36.14	Assay of apolipoprotein
82175		44.23	Assay of arsenic
82180		23.05	Assay of ascorbic acid
82190		34.77	Atomic absorption
82232		37.72	Assay of beta-2 protein
82239		19.67	Bile acids total
82240		29.84	Bile acids cholylglycine
82247		11.70	Bilirubin total
82247	QW	11.70	Bilirubin total
82248		11.70	Bilirubin direct
82252		3.26	Fecal bilirubin test
82261		6.15	Assay of biotinidase
82270		7.58	Occult blood feces
82271		7.58	Occult blood other sources
82271	QW	7.58	Occult blood other sources
82272		7.58	Occult bld feces 1-3 tests
82274		37.09	Assay test for blood fecal
82274	QW	37.09	Assay test for blood fecal
82286		16.07	Assay of bradykinin
82300		53.98	Assay of cadmium
82306		69.04	Vitamin d 25 hydroxy
82308		62.48	Assay of calcitonin
82310		12.04	Assay of calcium
82310	QW	12.04	Assay of calcium
82330		31.89	Assay of calcium
82330	QW	31.89	Assay of calcium
82331		12.07	Calcium infusion test
82340		14.06	Assay of calcium in urine
82355		27.00	Calculus analysis qual
82360		30.02	Calculus assay quant
82365		30.07	Calculus spectroscopy
82370		29.21	X-ray assay calculus
82373		42.11	Assay c-d transfer measure
82374		6.63	Assay blood carbon dioxide
82374	QW	6.63	Assay blood carbon dioxide
82375		28.73	Assay carboxyhb quant
82376		11.63	Assay carboxyhb qual
82378		44.22	Carcinoembryonic antigen

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
82379		6.15	Assay of carnitine
82380		21.51	Assay of carotene
82382		40.09	Assay urine catecholamines
82383		58.43	Assay blood catecholamines
82384		58.89	Assay three catecholamines
82387		18.85	Assay of cathepsin-d
82390		25.04	Assay of ceruloplasmin
82397		18.85	Chemiluminescent assay
82415		29.55	Assay of chloramphenicol
82435		6.49	Assay of blood chloride
82435	QW	6.49	Assay of blood chloride
82436		11.73	Assay of urine chloride
82438		11.39	Assay other fluid chlorides
82441		14.01	Test for chlorohydrocarbons
82465		10.15	Assay bld/serum cholesterol
82465	QW	10.15	Assay bld/serum cholesterol
82480		18.36	Assay serum cholinesterase
82482		17.90	Assay rbc cholinesterase
82485		41.41	Assay chondroitin sulfate
82495		47.29	Assay of chromium
82507		64.84	Assay of citrate
82523		43.57	Collagen crosslinks
82523	QW	43.57	Collagen crosslinks
82525		28.93	Assay of copper
82528		52.51	Assay of corticosterone
82530		38.96	Cortisol free
82533		38.01	Total cortisol
82540		10.81	Assay of creatine
82542		42.11	Column chromotography quant
82550		15.18	Assay of ck (cpk)
82550	QW	15.18	Assay of ck (cpk)
82552		31.23	Assay of cpk in blood
82553		26.93	Creatine mb fraction
82554		27.68	Creatine isoforms
82565		11.95	Assay of creatinine
82565	QW	11.95	Assay of creatinine
82570		12.07	Assay of urine creatinine
82570	QW	12.07	Assay of urine creatinine

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
82575		22.05	Creatinine clearance test
82585		16.52	Assay of cryofibrinogen
82595		15.08	Assay of cryoglobulin
82600		45.24	Assay of cyanide
82607		35.16	Vitamin B-12
82608		33.39	B-12 binding capacity
82610		13.21	Cystatin c
82615		19.04	Test for urine cystines
82626		58.94	Dehydroepiandrosterone
82627		51.85	Dehydroepiandrosterone
82633		72.25	Desoxycorticosterone
82634		68.27	Deoxycortisol
82638		28.56	Assay of dibucaine number
82652		89.78	Vit d 1 25-dihydroxy
82656		26.89	Pancreatic elastase fecal
82657		42.11	Enzyme cell activity
82658		42.11	Enzyme cell activity ra
82664		80.10	Electrophoretic test
82668		43.83	Assay of erythropoietin
82670		65.14	Assay of estradiol
82671		75.33	Assay of estrogens
82672		50.59	Assay of estrogen
82677		56.39	Assay of estriol
82679		58.19	Assay of estrone
82679	QW	58.19	Assay of estrone
82693		34.75	Assay of ethylene glycol
82696		55.00	Assay of etiocholanolone
82705		11.88	Fats/lipids feces qual
82710		39.19	Fats/lipids feces quant
82715		23.17	Assay of fecal fat
82725		31.04	Assay of blood fatty acids
82726		42.11	Long chain fatty acids
82728		31.79	Assay of ferritin
82731		150.21	Assay of fetal fibronectin
82735		43.23	Assay of fluoride
82746		34.29	Assay of folic acid serum
82747		40.12	Assay of folic acid rbc
82757		18.17	Assay of semen fructose

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
82759		36.33	Assay of rbc galactokinase
82760		26.11	Assay of galactose
82775		49.13	Assay galactose transferase
82776		13.29	Galactose transferase test
82777		51.29	Galectin-3
82784		13.29	Assay iga/igd/igg/igm each
82785		38.39	Assay of ige
82787		10.71	Igg 1 2 3 or 4 each
82800		19.74	Blood pH
82803		45.12	Blood gases any combination
82805		66.16	Blood gases w/o2 saturation
82810		20.35	Blood gases o2 sat only
82820		22.59	Hemoglobin-oxygen affinity
82930		12.70	Gastric analy w/ph ea spec
82938		41.26	Gastrin test
82941		41.12	Assay of gastrin
82943		33.32	Assay of glucagon
82945		9.16	Glucose other fluid
82946		31.09	Glucagon tolerance test
82947		9.16	Assay glucose blood quant
82947	QW	9.16	Assay glucose blood quant
82948		7.40	Reagent strip/blood glucose
82950		11.07	Glucose test
82950	QW	11.07	Glucose test
82951		14.96	Glucose tolerance test (GTT)
82951	QW	14.96	Glucose tolerance test (GTT)
82952		9.15	GTT-added samples
82952	QW	9.15	GTT-added samples
82955		22.61	Assay of g6pd enzyme
82960		14.11	Test for G6PD enzyme
82962		4.20	Glucose blood test
82963		50.10	Assay of glucosidase
82965		18.02	Assay of gdh enzyme
82977		16.80	Assay of GGT
82977	QW	16.80	Assay of GGT
82978		24.82	Assay of glutathione
82979		16.07	Assay rbc glutathione
82985		35.16	Assay of glycated protein

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
82985	QW	35.16	Assay of glycated protein
83001		43.33	Assay of gonadotropin (fsh)
83001	QW	43.33	Assay of gonadotropin (fsh)
83002		43.18	Assay of gonadotropin (lh)
83002	QW	43.18	Assay of gonadotropin (lh)
83003		38.88	Assay growth hormone (hgh)
83006		51.29	Growth stimulation gene 2
83009		157.08	H pylori (c-13) blood
83010		15.45	Assay of haptoglobin quant
83012		40.09	Assay of haptoglobins
83013		157.08	H pylori (c-13) breath
83014		18.33	H pylori drug admin
83015		43.91	Heavy metal screen
83018		51.22	Quantitative screen metals
83020		27.10	Hemoglobin electrophoresis
83021		42.11	Hemoglobin chromotography
83026		5.51	Hemoglobin copper sulfate
83030		19.28	Fetal hemoglobin chemical
83033		13.91	Fetal hemoglobin assay qual
83036		22.64	Glycosylated hemoglobin test
83036	QW	22.64	Glycosylated hemoglobin test
83037		22.64	Glycosylated hb home device
83037	QW	22.64	Glycosylated hb home device
83045		11.54	Blood methemoglobin test
83050		17.09	Blood methemoglobin assay
83051		8.16	Assay of plasma hemoglobin
83060		19.28	Blood sulfhemoglobin assay
83065		16.07	Assay of hemoglobin heat
83068		19.74	Hemoglobin stability screen
83069		9.21	Assay of urine hemoglobin
83070		11.07	Assay of hemosiderin qual
83080		6.15	Assay of b hexosaminidase
83088		68.87	Assay of histamine
83090		39.34	Assay of homocystine
83150		45.12	Assay of homovanillic acid
83491		40.87	Assay of corticosteroids 17
83497		30.07	Assay of 5-hiaa
83498		63.36	Assay of progesterone 17-d

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
83499		58.79	Assay of progesterone 20-
83500		52.82	Assay free hydroxyproline
83505		56.68	Assay total hydroxyproline
83516		26.89	Immunoassay nonantibody
83516	QW	26.89	Immunoassay nonantibody
83518		19.77	Immunoassay dipstick
83518	QW	19.77	Immunoassay dipstick
83519		31.50	Ria nonantibody
83520		30.19	Immunoassay quant nos nonab
83520	QW	30.19	Immunoassay quant nos nonab
83525		26.66	Assay of insulin
83527		29.53	Assay of insulin
83528		37.09	Assay of intrinsic factor
83540		15.10	Assay of iron
83550		20.38	Iron binding test
83570		20.64	Assay of idh enzyme
83582		33.05	Assay of ketogenic steroids
83586		29.85	Assay 17- ketosteroids
83593		61.34	Fractionation ketosteroids
83605		3.26	Assay of lactic acid
83605	QW	3.26	Assay of lactic acid
83615		14.08	Lactate (LD) (LDH) enzyme
83625		13.86	Assay of ldh enzymes
83630		45.78	Lactoferrin fecal (qual)
83631		45.78	Lactoferrin fecal (quant)
83632		47.16	Placental lactogen
83633		12.82	Test urine for lactose
83655		28.24	Assay of lead
83655	QW	28.24	Assay of lead
83661		23.17	L/s ratio fetal lung
83662		44.10	Foam stability fetal lung
83663		44.10	Fluoro polarize fetal lung
83664		44.10	Lamellar bdy fetal lung
83670		21.37	Assay of lap enzyme
83690		16.07	Assay of lipase
83695		30.19	Assay of lipoprotein(a)
83698		76.04	Assay lipoprotein pla2
83700		23.04	Lipopro bld electrophoretic

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
83701		57.89	Lipoprotein bld hr fraction
83704		73.58	Lipoprotein bld by nmr
83718		19.11	Assay of lipoprotein
83718	QW	19.11	Assay of lipoprotein
83719		27.13	Assay of blood lipoprotein
83721		22.25	Assay of blood lipoprotein
83721	QW	22.25	Assay of blood lipoprotein
83727		40.09	Assay of lrh hormone
83735		15.62	Assay of magnesium
83775		17.19	Assay malate dehydrogenase
83785		57.36	Assay of manganese
83789		42.11	Mass spectrometry quant
83825		37.91	Assay of mercury
83835		39.51	Assay of metanephrines
83857		25.04	Assay of methemalbumin
83861		38.52	Microfluid analy tears
83861	QW	38.52	Microfluid analy tears
83864		46.44	Mucopolysaccharides
83872		13.67	Assay synovial fluid mucin
83873		40.12	Assay of csf protein
83874		30.12	Assay of myoglobin
83876		76.04	Assay myeloperoxidase
83880		76.04	Assay of natriuretic peptide
83880	QW	76.04	Assay of natriuretic peptide
83883		13.21	Assay nephelometry not spec
83885		57.15	Assay of nickel
83915		26.01	Assay of nucleotidase
83916		46.90	Oligoclonal bands
83918		38.37	Organic acids total quant
83919		38.37	Organic acids qual each
83921		38.37	Organic acid single quant
83930		15.42	Assay of blood osmolality
83935		15.90	Assay of urine osmolality
83937		34.80	Assay of osteocalcin
83945		30.02	Assay of oxalate
83950		150.21	Oncoprotein her-2/neu
83951		150.21	Oncoprotein dcp
83970		96.25	Assay of parathormone

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
83986		8.35	Assay ph body fluid nos
83986	QW	8.35	Assay ph body fluid nos
83987		37.04	Exhaled breath condensate
83992		34.29	Assay for phencyclidine
83993		45.78	Assay for calprotectin fecal
84030		12.82	Assay of blood pku
84035		7.14	Assay of phenylketones
84060		17.22	Assay acid phosphatase
84061		18.45	Phosphatase forensic exam
84066		22.53	Assay prostate phosphatase
84075		12.07	Assay alkaline phosphatase
84075	QW	12.07	Assay alkaline phosphatase
84078		17.02	Assay alkaline phosphatase
84080		34.48	Assay alkaline phosphatases
84081		38.52	Assay phosphatidylglycerol
84085		15.73	Assay of rbc pg6d enzyme
84087		24.07	Assay phosphohexose enzymes
84100		11.05	Assay of phosphorus
84105		12.07	Assay of urine phosphorus
84106		9.91	Test for porphobilinogen
84110		19.69	Assay of porphobilinogen
84112		150.21	Placenta alpha micro ig c/v
84119		20.09	Test urine for porphyrins
84120		34.31	Assay of urine porphyrins
84126		59.40	Assay of feces porphyrins
84132		10.73	Assay of serum potassium
84132	QW	10.73	Assay of serum potassium
84133		10.05	Assay of urine potassium
84134		13.21	Assay of prealbumin
84135		44.63	Assay of pregnanediol
84138		44.15	Assay of pregnanetriol
84140		34.80	Assay of pregnenolone
84143		34.80	Assay of 17-hydroxypregneno
84144		36.33	Assay of progesterone
84145		62.48	Procalcitonin (pct)
84146		45.19	Assay of prolactin
84150		58.19	Assay of prostaglandin
84152		42.89	Assay of psa complexed

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
84153		42.89	Assay of psa total
84154		42.89	Assay of psa free
84155		8.55	Assay of protein serum
84155	QW	8.55	Assay of protein serum
84156		8.55	Assay of protein urine
84157		8.55	Assay of protein other
84157	QW	8.55	Assay of protein other
84160		12.07	Assay of protein any source
84163		35.11	Pappa serum
84165		25.04	Protein e-phoresis serum
84166		41.58	Protein e-phoresis/urine/csf
84181		39.71	Western blot test
84182		41.97	Protein western blot test
84202		33.46	Assay RBC protoporphyrin
84203		20.08	Test RBC protoporphyrin
84206		41.41	Assay of proinsulin
84207		65.52	Assay of vitamin b-6
84210		25.31	Assay of pyruvate
84220		22.02	Assay of pyruvate kinase
84228		27.13	Assay of quinine
84233		150.21	Assay of estrogen
84234		151.30	Assay of progesterone
84235		122.04	Assay of endocrine hormone
84238		85.27	Assay nonendocrine receptor
84244		51.29	Assay of renin
84252		47.19	Assay of vitamin b-2
84255		59.53	Assay of selenium
84260		43.37	Assay of serotonin
84270		50.68	Assay of sex hormone globul
84275		31.33	Assay of sialic acid
84285		54.89	Assay of silica
84295		11.22	Assay of serum sodium
84295	QW	11.22	Assay of serum sodium
84300		11.34	Assay of urine sodium
84302		11.34	Assay of sweat sodium
84305		45.80	Assay of somatomedin
84307		42.62	Assay of somatostatin
84311		16.30	Spectrophotometry

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
84315		5.85	Body fluid specific gravity
84375		5.58	Chromatogram assay sugars
84376		12.82	Sugars single qual
84377		12.82	Sugars multiple qual
84378		26.88	Sugars single quant
84379		26.88	Sugars multiple quant
84392		11.07	Assay of urine sulfate
84402		59.40	Assay of free testosterone
84403		60.20	Assay of total testosterone
84410		123.34	Testosterone bioavailable
84425		49.50	Assay of vitamin b-1
84430		27.13	Assay of thiocyanate
84431		39.19	Thromboxane urine
84432		35.65	Assay of thyroglobulin
84436		16.01	Assay of total thyroxine
84437		15.08	Assay of neonatal thyroxine
84439		19.01	Assay of free thyroxine
84442		27.10	Assay of thyroid activity
84443		39.19	Assay thyroid stim hormone
84443	QW	39.19	Assay thyroid stim hormone
84445		118.59	Assay of tsi globulin
84446		33.07	Assay of vitamin e
84449		34.80	Assay of transcortin
84450		12.07	Transferase (AST) (SGOT)
84450	QW	12.07	Transferase (AST) (SGOT)
84460		12.36	Alanine amino (ALT) (SGPT)
84460	QW	12.36	Alanine amino (ALT) (SGPT)
84466		29.77	Assay of transferrin
84478		13.40	Assay of triglycerides
84478	QW	13.40	Assay of triglycerides
84479		15.08	Assay of thyroid (t3 or t4)
84480		33.07	Assay triiodothyronine (t3)
84481		39.51	Free assay (FT-3)
84482		36.75	T3 reverse
84484		15.59	Assay of troponin quant
84485		9.91	Assay duodenal fluid trypsin
84488		9.91	Test feces for trypsin
84490		13.29	Assay of feces for trypsin

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
84510		24.26	Assay of tyrosine
84512		17.95	Assay of troponin qual
84520		9.21	Assay of urea nitrogen
84520	QW	9.21	Assay of urea nitrogen
84525		4.03	Urea nitrogen semi-quant
84540		11.07	Assay of urine/urea-n
84545		15.42	Urea-N clearance test
84550		10.54	Assay of blood/uric acid
84550	QW	10.54	Assay of blood/uric acid
84560		11.07	Assay of urine/uric acid
84577		29.10	Assay of feces/urobilinogen
84578		3.26	Test urine urobilinogen
84580		16.54	Assay of urine urobilinogen
84583		11.73	Assay of urine urobilinogen
84585		36.14	Assay of urine vma
84586		34.80	Assay of vip
84588		76.04	Assay of vasopressin
84590		27.06	Assay of vitamin a
84591		27.06	Assay of nos vitamin
84597		31.99	Assay of vitamin k
84600		37.50	Assay of volatiles
84620		27.63	Xylose tolerance test
84630		26.55	Assay of zinc
84681		40.53	Assay of c-peptide
84702		35.11	Chorionic gonadotropin test
84703		16.30	Chorionic gonadotropin assay
84703	QW	16.30	Chorionic gonadotropin assay
84704		35.11	Hcg free betachain test
84830		23.39	Ovulation tests
85002		10.52	Bleeding time test
85004		11.63	Automated diff wbc count
85007		8.01	Bl smear w/diff wbc count
85008		8.01	Bl smear w/o diff wbc count
85009		8.69	Manual diff wbc count b-coat
85013		5.53	Spun microhematocrit
85014		5.53	Hematocrit
85014	QW	5.53	Hematocrit
85018		5.53	Hemoglobin

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
85018	QW	5.53	Hemoglobin
85025		16.49	Complete cbc w/auto diff wbc
85027		11.63	Complete cbc automated
85032		10.05	Manual cell count each
85041		7.04	Automated rbc count
85044		10.05	Manual reticulocyte count
85045		9.32	Automated reticulocyte count
85046		12.99	Reticyte/hgb concentrate
85048		5.92	Automated leukocyte count
85049		10.44	Automated platelet count
85055		42.19	Reticulated platelet assay
85130		16.49	Chromogenic substrate assay
85170		8.45	Blood clot retraction
85175		10.63	Blood clot lysis time
85210		30.28	Clot factor ii prothrom spec
85220		41.16	Blooc clot factor v test
85230		41.75	Clot factor vii proconvertin
85240		41.75	Clot factor viii ahg 1 stage
85244		47.62	Clot factor viii reltd antgn
85245		53.50	Clot factor viii vw ristoctn
85246		53.50	Clot factor viii vw antigen
85247		53.50	Clot factor viii multimetric
85250		44.40	Clot factor ix ptc/chrstmas
85260		41.75	Clot factor x stuart-power
85270		41.75	Clot factor xi pta
85280		45.12	Clot factor xii hageman
85290		38.10	Clot factor xiii fibrin stab
85291		20.74	Clot factor xiii fibrin scrn
85292		44.15	Clot factor fletcher fact
85293		44.15	Clot factor wght kininogen
85300		27.64	Antithrombin iii activity
85301		25.21	Antithrombin iii antigen
85302		28.02	Clot inhibit prot c antigen
85303		32.27	Clot inhibit prot c activity
85305		27.06	Clot inhibit prot s total
85306		35.73	Clot inhibit prot s free
85307		35.73	Assay activated protein c
85335		21.49	Factor inhibitor test

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
85337		24.31	Thrombomodulin
85345		10.05	Coagulation time lee & white
85347		9.93	Coagulation time activated
85348		8.69	Coagulation time otr method
85360		10.80	Euglobulin lysis
85362		16.07	Fibrin degradation products
85366		20.09	Fibrinogen test
85370		26.49	Fibrinogen test
85378		16.64	Fibrin degrade semiquant
85379		18.89	Fibrin degradation quant
85380		18.89	Fibrin degradj d-dimer
85384		19.81	Fibrinogen activity
85385		19.81	Fibrinogen antigen
85390		9.91	Fibrinolysins screen i&r
85397		53.50	Clotting funct activity
85400		20.64	Fibrinolytic plasmin
85410		16.52	Fibrinolytic antiplasmin
85415		40.09	Fibrinolytic plasminogen
85420		15.23	Fibrinolytic plasminogen
85421		23.75	Fibrinolytic plasminogen
85441		9.79	Heinz bodies direct
85445		15.90	Heinz bodies induced
85460		18.04	Hemoglobin fetal
85461		15.47	Hemoglobin fetal
85475		20.69	Hemolysin acid
85520		24.82	Heparin assay
85525		27.61	Heparin neutralization
85530		33.07	Heparin-protamine tolerance
85536		15.08	Iron stain peripheral blood
85540		20.06	Wbc alkaline phosphatase
85547		20.06	RBC mechanical fragility
85549		43.72	Muramidase
85555		15.59	RBC osmotic fragility
85557		31.14	RBC osmotic fragility
85576		50.10	Blood platelet aggregation
85576	QW	50.10	Blood platelet aggregation
85597		35.84	Phospholipid pltlt neutraliz
85598		35.84	Hexagnal phosph pltlt neutrl

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
85610		9.16	Prothrombin time
85610	QW	9.16	Prothrombin time
85611		9.20	Prothrombin test
85612		22.34	Viper venom prothrombin time
85613		22.34	Russell viper venom diluted
85635		22.97	Reptilase test
85651		8.28	Rbc sed rate nonautomated
85652		6.29	Rbc sed rate automated
85660		12.85	RBC sickle cell test
85670		13.45	Thrombin time plasma
85675		15.96	Thrombin time titer
85705		16.30	Thromboplastin inhibition
85730		14.01	Thromboplastin time partial
85732		15.08	Thromboplastin time partial
85810		27.22	Blood viscosity examination
86000		16.29	Agglutinins febrile antigen
86001		11.17	Allergen specific igg
86003		11.17	Allergen specific IgE
86005		16.34	Allergen specific IgE
86021		35.11	WBC antibody identification
86022		42.84	Platelet antibodies
86023		29.05	Immunoglobulin assay
86038		28.19	Antinuclear antibodies
86039		26.03	Antinuclear antibodies (ANA)
86060		13.12	Antistreptolysin o titer
86063		8.30	Antistreptolysin o screen
86140		12.07	C-reactive protein
86141		30.19	C-reactive protein hs
86146		35.65	Beta-2 glycoprotein antibody
86147		35.65	Cardiolipin antibody ea ig
86148		37.47	Anti-phospholipid antibody
86152		572.97	Cell enumeration & id
86155		36.33	Chemotaxis assay
86156		15.62	Cold agglutinin screen
86157		18.80	Cold agglutinin titer
86160		27.98	Complement antigen
86161		27.98	Complement/function activity
86162		47.40	Complement total (ch50)

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
86171		23.34	Complement fixation each
86185		20.88	Counterimmunoelectrophoresis
86200		30.19	Ccp antibody
86215		30.89	Deoxyribonuclease antibody
86225		32.05	Dna antibody native
86226		28.24	Dna antibody single strand
86235		34.83	Nuclear antigen antibody
86243		47.84	Fc receptor
86255		28.10	Fluorescent antibody screen
86256		28.10	Fluorescent antibody titer
86277		36.70	Growth hormone antibody
86280		19.11	Hemagglutination inhibition
86294		45.76	Immunoassay tumor qual
86294	QW	45.76	Immunoassay tumor qual
86300		48.54	Immunoassay tumor ca 15-3
86301		48.54	Immunoassay tumor ca 19-9
86304		48.54	Immunoassay tumor ca 125
86305		48.54	Human epididymis protein 4
86308		12.07	Heterophile antibody screen
86308	QW	12.07	Heterophile antibody screen
86309		15.08	Heterophile antibody titer
86310		17.19	Heterophile antibody absrbj
86316		48.54	Immunoassay tumor other
86317		34.95	Immunoassay infectious agent
86318		30.19	Immunoassay infectious agent
86318	QW	30.19	Immunoassay infectious agent
86320		52.28	Serum immunoelectrophoresis
86325		52.16	Other immunoelectrophoresis
86327		52.90	Immunoelectrophoresis assay
86329		32.76	Immunodiffusion nes
86331		27.93	Immunodiffusion ouchterlony
86332		40.15	Immune complex assay
86334		52.11	Immunofix e-phoresis serum
86335		68.44	Immunfix e-phorsis/urine/csf
86336		30.21	Inhibin A
86337		49.93	Insulin antibodies
86340		35.16	Intrinsic factor antibody
86341		31.31	Islet cell antibody

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
86343		29.05	Leukocyte histamine release
86344		18.62	Leukocyte phagocytosis
86352		316.83	Cell function assay w/stim
86353		114.33	Lymphocyte transformation
86355		41.41	B cells total count
86356		42.19	Mononuclear cell antigen
86357		41.41	Nk cells total count
86359		41.41	T cells total count
86360		82.81	T cell absolute count/ratio
86361		42.19	T cell absolute count
86367		41.41	Stem cells total count
86376		33.93	Microsomal antibody each
86378		45.92	Migration inhibitory factor
86382		39.44	Neutralization test viral
86384		26.55	Nitroblue tetrazolium dye
86386		37.25	Nuclear matrix protein 22
86386	QW	37.25	Nuclear matrix protein 22
86403		16.30	Particle agglut antbdy scrn
86406		24.80	Particle agglut antbdy titr
86430		13.23	Rheumatoid factor test qual
86431		13.23	Rheumatoid factor quant
86480		144.53	Tb test cell immun measure
86481		174.74	Tb ag response t-cell susp
86590		24.82	Streptokinase antibody
86592		9.96	Syphilis test non-trep qual
86593		10.27	Syphilis test non-trep quant
86602		23.73	Antinomyces antibody
86603		26.16	Adenovirus antibody
86606		32.79	Aspergillus antibody
86609		30.04	Bacterium antibody
86611		23.73	Bartonella antibody
86612		26.16	Blastomyces antibody
86615		30.75	Bordetella antibody
86617		36.13	Lyme disease antibody
86618		39.71	Lyme disease antibody
86618	QW	39.71	Lyme disease antibody
86619		31.20	Borrelia antibody
86622		19.07	Brucella antibody

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
86625		30.60	Campylobacter antibody
86628		28.00	Candida antibody
86631		27.57	Chlamydia antibody
86632		29.58	Chlamydia igm antibody
86635		26.16	Coccidioides antibody
86638		26.16	Q fever antibody
86641		16.30	Cryptococcus antibody
86644		33.56	CMV antibody
86645		33.30	Cmv antibody igm
86648		35.46	Diphtheria antibody
86651		30.75	Encephalitis californ antbdy
86652		30.75	Encephaltis east eqne anbdy
86653		30.75	Encephaltis st louis antbody
86654		30.75	Encephaltis west eqne antbdy
86658		26.16	Enterovirus antibody
86663		30.60	Epstein-barr antibody
86664		33.30	Epstein-barr nuclear antigen
86665		33.30	Epstein-barr capsid vca
86666		23.73	Ehrlichia antibody
86668		18.17	Francisella tularensis
86671		26.16	Fungus nes antibody
86674		33.30	Giardia lamblia antibody
86677		33.83	Helicobacter pylori antibody
86682		24.12	Helminth antibody
86684		16.30	Hemophilus influenza antibdy
86687		19.57	Htlv-i antibody
86688		23.27	Htlv-ii antibody
86689		45.14	Htlv/hiv confirmj antibody
86692		40.02	Hepatitis delta agent antbdy
86694		33.56	Herpes simplex nes antbdy
86695		30.75	Herpes simplex type 1 test
86696		45.14	Herpes simplex type 2 test
86698		26.16	Histoplasma antibody
86701		20.72	Hiv-1antibody
86701	QW	20.72	Hiv-1antibody
86702		23.27	Hiv-2 antibody
86703		23.27	Hiv-1/hiv-2 1 result antbdy
86704		28.10	Hep b core antibody total

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
86705		27.46	Hep b core antibody igm
86706		25.04	Hep b surface antibody
86707		26.98	Hepatitis be antibody
86708		28.88	Hepatitis a total antibody
86709		26.25	Hepatitis a igm antibody
86710		31.60	Influenza virus antibody
86711		33.56	John cunningham antibody
86713		33.30	Legionella antibody
86717		28.56	Leishmania antibody
86720		30.75	Leptospira antibody
86723		30.75	Listeria monocytogenes
86727		26.16	Lymph choriomeningitis ab
86729		27.85	Lympho venereum antibody
86732		30.75	Mucormycosis antibody
86735		30.43	Mumps antibody
86738		30.87	Mycoplasma antibody
86741		30.75	Neisseria meningitidis
86744		30.75	Nocardia antibody
86747		35.05	Parvovirus antibody
86750		30.75	Malaria antibody
86753		24.12	Protozoa antibody nos
86756		30.06	Respiratory virus antibody
86757		45.14	Rickettsia antibody
86759		30.75	Rotavirus antibody
86762		33.56	Rubella antibody
86765		30.04	Rubeola antibody
86768		30.75	Salmonella antibody
86771		30.75	Shigella antibody
86774		34.51	Tetanus antibody
86777		33.56	Toxoplasma antibody
86778		33.30	Toxoplasma antibody igm
86780		30.87	Treponema pallidum
86780	QW	30.87	Treponema pallidum
86784		14.82	Trichinella antibody
86787		30.04	Varicella-zoster antibody
86788		33.30	West nile virus ab igm
86789		33.56	West nile virus antibody
86790		30.04	Virus antibody nos

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
86793		30.75	Yersinia antibody
86800		37.09	Thyroglobulin antibody
86803		33.27	Hepatitis c ab test
86803	QW	33.27	Hepatitis c ab test
86804		36.13	Hep c ab test confirm
86805		121.94	Lymphocytotoxicity assay
86806		110.98	Lymphocytotoxicity assay
86807		92.29	Cytotoxic antibody screening
86808		69.21	Cytotoxic antibody screening
86812		60.18	Hla typing a b or c
86813		74.46	Hla typing a b or c
86816		64.96	Hla typing dr/dq
86817		150.14	Hla typing dr/dq
86821		131.67	Lymphocyte culture mixed
86822		85.26	Lymphocyte culture primed
86825		126.60	Hla x-math non-cytotoxic
86826		42.19	Hla x-match noncytotoxc addl
86828		92.29	Hla class i&ii antibody qual
86829		69.21	Hla class i/ii antibody qual
86830		188.28	Hla class i phenotype qual
86831		161.38	Hla class ii phenotype qual
86832		295.87	Hla class i high defin qual
86833		268.97	Hla class ii high defin qual
86834		833.82	Hla class i semiquant panel
86835		753.13	Hla class ii semiquant panel
86850		8.93	Rbc antibody screen
86880		12.56	Coombs test direct
86885		13.35	Coombs test indirect qual
86886		12.07	Coombs test indirect titer
86900		6.97	Blood typing abo
86901		6.97	Blood typing rh (d)
86902		8.93	Blood type antigen donor ea
86904		22.19	Blood typing patient serum
86905		8.93	Blood typing rbc antigens
86906		14.96	Blood typing rh phenotype
86940		19.13	Hemolysins/agglutinins auto
86941		28.24	Hemolysins/agglutinins
87003		39.27	Small animal inoculation

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
87015		15.57	Specimen infect agnt concntj
87040		24.07	Blood culture for bacteria
87045		22.02	Feces culture aerobic bact
87046		22.02	Stool cultr aerobic bact ea
87070		20.09	Culture othr specimn aerobic
87071		22.02	Culture aerobic quant other
87073		22.02	Culture bacteria anaerobic
87075		22.08	Cultr bacteria except blood
87076		16.52	Culture anaerobe ident each
87077		16.52	Culture aerobic identify
87077	QW	16.52	Culture aerobic identify
87081		15.45	Culture screen only
87084		20.09	Culture of specimen by kit
87086		18.82	Urine culture/colony count
87088		18.87	Urine bacteria culture
87101		17.97	Skin fungi culture
87102		19.60	Fungus isolation culture
87103		21.03	Blood fungus culture
87106		24.07	Fungi identification yeast
87107		24.07	Fungi identification mold
87109		35.89	Mycoplasma
87110		45.70	Chlamydia culture
87116		25.19	Mycobacteria culture
87118		25.52	Mycobacteric identification
87140		12.99	Culture type immunofluoresc
87143		29.21	Culture typing glc/hplc
87147		12.07	Culture type immunologic
87149		46.77	Dna/rna direct probe
87150		81.84	Dna/rna amplified probe
87152		12.21	Culture type pulse field gel
87153		269.01	Dna/rna sequencing
87158		12.21	Culture typing added method
87164		25.04	Dark field examination
87166		26.35	Dark field examination
87168		9.96	Macroscopic exam arthropod
87169		9.96	Macroscopic exam parasite
87172		9.96	Pinworm exam
87176		13.72	Tissue homogenization cultr

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
87177		20.76	Ova and parasites smears
87181		11.07	Microbe susceptible diffuse
87184		16.08	Microbe susceptible disk
87185		11.07	Microbe susceptible enzyme
87186		20.16	Microbe susceptible mic
87187		24.17	Microbe susceptible mlc
87188		15.49	Microbe suscept macrobroth
87190		9.91	Microbe suscept mycobacteri
87197		35.04	Bactericidal level serum
87205		9.96	Smear gram stain
87206		12.56	Smear fluorescent/acid stai
87207		13.29	Smear special stain
87209		39.90	Smear complex stain
87210		9.96	Smear wet mount saline/ink
87210	QW	9.96	Smear wet mount saline/ink
87220		9.96	Tissue exam for fungi
87230		46.04	Assay toxin or antitoxin
87250		45.61	Virus inoculate eggs/animal
87252		60.79	Virus inoculation tissue
87253		47.11	Virus inoculate tissue addl
87254		45.61	Virus inoculation shell via
87255		78.97	Genet virus isolate hsv
87260		27.95	Adenovirus ag if
87265		27.95	Pertussis ag if
87267		27.95	Enterovirus antibody dfa
87269		27.95	Giardia ag if
87270		27.95	Chlamydia trachomatis ag if
87271		27.95	Cytomegalovirus dfa
87272		27.95	Cryptosporidium ag if
87273		27.95	Herpes simplex 2 ag if
87274		27.95	Herpes simplex 1 ag if
87275		27.95	Influenza b ag if
87276		27.95	Influenza a ag if
87277		27.95	Legionella micdadei ag if
87278		27.95	Legion pneumophilia ag if
87279		27.95	Parainfluenza ag if
87280		27.95	Respiratory syncytial ag if
87281		27.95	Pneumocystis carinii ag if

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
87283		27.95	Rubeola ag if
87285		27.95	Treponema pallidum ag if
87290		27.95	Varicella zoster ag if
87299		27.95	Antibody detection nos if
87300		27.95	Ag detection polyval if
87301		27.95	Adenovirus ag eia
87305		27.95	Aspergillus ag eia
87320		27.95	Chylmd trach ag eia
87324		27.95	Clostridium ag eia
87327		27.95	Cryptococcus neoform ag eia
87328		27.95	Cryptosporidium ag eia
87329		27.95	Giardia ag eia
87332		27.95	Cytomegalovirus ag eia
87335		27.95	E coli 0157 ag eia
87336		27.95	Entamoeb hist dispr ag eia
87337		27.95	Entamoeb hist group ag eia
87338		27.98	Hpylori stool eia
87338	QW	27.98	Hpylori stool ia
87339		27.95	H pylori ag eia
87340		24.09	Hepatitis b surface ag eia
87341		24.09	Hepatitis b surface ag eia
87350		26.88	Hepatitis be ag eia
87380		38.27	Hepatitis delta ag eia
87385		27.95	Histoplasma capsul ag eia
87389		56.15	Hiv-1 ag w/hiv-1 & hiv-2 ab
87389	QW	56.15	Hiv-1 ag w/hiv-1 & hiv-2 ab
87390		41.14	Hiv-1 ag eia
87391		41.14	Hiv-2 ag eia
87400		27.95	Influenza a/b ag eia
87420		27.95	Resp syncytial ag eia
87425		27.95	Rotavirus ag eia
87427		27.95	Shiga-like toxin ag eia
87430		27.95	Strep a ag eia
87449		27.95	Ag detect nos eia mult
87449	QW	27.95	Ag detect nos eia mult
87450		22.37	Ag detect nos eia single
87451		22.37	Ag detect polyval eia mult
87470		46.77	Bartonella dna dir probe

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
87471		81.84	Bartonella dna amp probe
87472		99.89	Bartonella dna quant
87475		46.77	Lyme dis dna dir probe
87476		81.84	Lyme dis dna amp probe
87477		99.89	Lyme dis dna quant
87480		46.77	Candida dna dir probe
87481		81.84	Candida dna amp probe
87482		97.38	Candida dna quant
87483		971.92	Cns dna amp probe type 12-25
87485		46.77	Chylmd pneum dna dir probe
87486		81.84	Chylmd pneum dna amp probe
87487		99.89	Chylmd pneum dna quant
87490		46.77	Chylmd trach dna dir probe
87491		81.84	Chylmd trach dna amp probe
87492		81.52	Chylmd trach dna quant
87493		81.84	C diff amplified probe
87495		46.77	Cytomeg dna dir probe
87496		81.84	Cytomeg dna amp probe
87497		99.89	Cytomeg dna quant
87498		81.84	Enterovirus probe&revrs trns
87500		81.84	Vanomycin dna amp probe
87501		119.66	Influenza dna amp prob 1+
87502		198.44	Influenza dna amp probe
87502	QW	198.44	Influenza dna amp probe
87503		48.43	Influenza dna amp prob addl
87505		299.17	Nfct agent detection gi
87506		497.71	Iadna-dna/rna probe tq 6-11
87507		971.92	Iadna-dna/rna probe tq 12-25
87510		46.77	Gardner vag dna dir probe
87511		81.84	Gardner vag dna amp probe
87512		97.38	Gardner vag dna quant
87515		46.77	Hepatitis b dna dir probe
87516		81.84	Hepatitis b dna amp probe
87517		99.89	Hepatitis b dna quant
87520		46.77	Hepatitis c rna dir probe
87521		81.84	Hepatitis c probe&rvrs trnsc
87522		99.89	Hepatitis c revrs trnscrpj
87525		46.77	Hepatitis g dna dir probe

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
87526		81.84	Hepatitis g dna amp probe
87527		97.38	Hepatitis g dna quant
87528		46.77	Hsv dna dir probe
87529		81.84	Hsv dna amp probe
87530		99.89	Hsv dna quant
87531		46.77	Hhv-6 dna dir probe
87532		81.84	Hhv-6 dna amp probe
87533		97.38	Hhv-6 dna quant
87534		46.77	Hiv-1 dna dir probe
87535		81.84	Hiv-1 probe&reverse trnscrpj
87536		198.44	Hiv-1 quant&revrse trnscrpj
87537		46.77	Hiv-2 dna dir probe
87538		81.84	Hiv-2 probe&revrse trnscripj
87539		99.89	Hiv-2 quant&revrse trnscripj
87540		46.77	Legion pneumo dna dir prob
87541		81.84	Legion pneumo dna amp prob
87542		97.38	Legion pneumo dna quant
87550		46.77	Mycobacteria dna dir probe
87551		81.84	Mycobacteria dna amp probe
87552		99.89	Mycobacteria dna quant
87555		46.77	M.tuberculo dna dir probe
87556		81.84	M.tuberculo dna amp probe
87557		99.89	M.tuberculo dna quant
87560		46.77	M.avium-intra dna dir prob
87561		81.84	M.avium-intra dna amp prob
87562		99.89	M.avium-intra dna quant
87580		46.77	M.pneumon dna dir probe
87581		81.84	M.pneumon dna amp probe
87582		97.38	M.pneumon dna quant
87590		46.77	N.gonorrhoeae dna dir prob
87591		81.84	N.gonorrhoeae dna amp prob
87592		99.89	N.gonorrhoeae dna quant
87623		81.84	Hpv low-risk types
87624		81.84	Hpv high-risk types
87625		81.84	Hpv types 16 & 18 only
87631		299.17	Resp virus 3-11 targets
87631	QW	299.17	Resp virus 3-5 targets
87632		497.71	Resp virus 6-11 targets

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
87633		971.92	Resp virus 12-25 targets
87640		81.84	Staph a dna amp probe
87641		81.84	Mr-staph dna amp probe
87650		46.77	Strep a dna dir probe
87650	QW	46.77	Strep a dna dir probe
87651		81.84	Strep a dna amp probe
87651	QW	81.84	Strep a dna amp probe
87652		97.38	Strep a dna quant
87653		81.84	Strep b dna amp probe
87660		46.77	Trichomonas vagin dir probe
87661		81.84	Trichomonas vaginalis amplif
87797		46.77	Detect agent nos dna dir
87798		81.84	Detect agent nos dna amp
87799		99.89	Detect agent nos dna quant
87800		93.55	Detect agnt mult dna direc
87801		163.69	Detect agnt mult dna ampli
87802		27.95	Strep b assay w/optic
87803		27.95	Clostridium toxin a w/optic
87804		27.95	Influenza assay w/optic
87804	QW	27.95	Influenza assay w/optic
87806		56.15	Hiv antigen w/hiv antibodies
87806	QW	56.15	Hiv antigen w/hiv antibodies
87807		27.95	Rsv assay w/optic
87807	QW	27.95	Rsv assay w/optic
87808		27.95	Trichomonas assay w/optic
87808	QW	27.95	Trichomonas assay w/optic
87809		27.95	Adenovirus assay w/optic
87809	QW	27.95	Adenovirus assay w/optic
87810		27.95	Chylmd trach assay w/optic
87850		27.95	N. gonorrhoeae assay w/optic
87880		27.95	Strep a assay w/optic
87880	QW	27.95	Strep a assay w/optic
87899		27.95	Agent nos assay w/optic
87899	QW	27.95	Agent nos assay w/optic
87900		303.96	Phenotype infect agent drug
87901		600.36	Genotype dna hiv reverse t
87902		600.36	Genotype dna/rna hep c
87903		1139.53	Phenotype dna hiv w/culture

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
87904		60.79	Phenotype dna hiv w/clt add
87905		12.22	Sialidase enzyme assay
87905	QW	12.22	Sialidase enzyme assay
87906		300.19	Genotype dna/rna hiv
87910		600.36	Genotype cytomegalovirus
87912		600.36	Genotype dna hepatitis b
88130		35.11	Sex chromatin identification
88140		6.77	Sex chromatin identification
88142		47.24	Cytopath c/v thin layer
88143		47.24	Cytopath c/v thin layer redo
88147		26.54	Cytopath c/v automated
88148		35.43	Cytopath c/v auto rescreen
88150		24.63	Cytopath c/v manual
88152		24.63	Cytopath c/v auto redo
88153		24.63	Cytopath c/v redo
88154		24.63	Cytopath c/v select
88155		13.97	Cytopath c/v index add-on
88164		24.63	Cytopath tbs c/v manual
88165		24.63	Cytopath tbs c/v redo
88166		24.63	Cytopath tbs c/v auto redo
88167		24.63	Cytopath tbs c/v select
88174		49.83	Cytopath c/v auto in fluid
88175		61.78	Cytopath c/v auto fluid redo
88230		85.99	Tissue culture lymphocyte
88233		171.94	Tissue culture skin/biopsy
88235		171.94	Tissue culture placenta
88237		294.54	Tissue culture bone marrow
88239		344.01	Tissue culture tumor
88240		23.55	Cell cryopreserve/storage
88241		23.55	Frozen cell preparation
88245		347.14	Chromosome analysis 20-25
88248		403.84	Chromosome analysis 50-100
88249		403.84	Chromosome analysis 100
88261		412.17	Chromosome analysis 5
88262		290.67	Chromosome analysis 15-20
88263		350.47	Chromosome analysis 45
88264		290.67	Chromosome analysis 20-25
88267		419.24	Chromosome analys placenta

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
88269		387.87	Chromosome analys amniotic
88271		49.95	Cytogenetics dna probe
88272		62.44	Cytogenetics 3-5
88273		74.92	Cytogenetics 10-30
88274		81.18	Cytogenetics 25-99
88275		93.65	Cytogenetics 100-300
88280		58.51	Chromosome karyotype study
88283		159.97	Chromosome banding study
88285		44.30	Chromosome count additional
88289		80.29	Chromosome study additional
88371		51.78	Protein western blot tissue
88372		46.07	Protein analysis w/probe
88720		11.70	Bilirubin total transcut
88738		11.70	Hgb quant transcutaneous
88740		11.70	Transcutaneous carboxyhb
88741		11.70	Transcutaneous methb
89050		9.91	Body fluid cell count
89051		12.84	Body fluid cell count
89055		9.96	Leukocyte assessment fecal
89060		16.68	Exam synovial fluid crystals
89125		10.08	Specimen fat stain
89160		8.30	Exam feces for meat fibers
89190		8.30	Nasal smear for eosinophils
89300		20.83	Semen analysis w/huhner
89300	QW	20.83	Semen analysis w/huhner
89310		14.82	Semen analysis w/count
89320		28.10	Semen anal vol/count/mot
89321		28.10	Semen anal sperm detection
89321	QW	28.10	Semen anal sperm detection
89322		36.14	Semen anal strict criteria
89325		18.17	Sperm antibody test
89329		48.89	Sperm evaluation test
89330		23.07	Evaluation cervical mucus
89331		45.68	Retrograde ejaculation anal
0006M		0.00	Onc hep gene risk classifier
0007M		0.00	Onc gastro 51 gene nomogram
0008M		5853.71	Onc breast risk score
0009M		1023.57	Fetal aneuploidy trisom risk

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
ATP02		12.16	Auto.Test Panel Pricing Code, 1-2 Tests
ATP03		15.50	Auto.Test Panel Pricing Code, 3 Tests
ATP04		16.35	Auto.Test Panel Pricing Code, 4 Tests
ATP05		18.24	Auto.Test Panel Pricing Code, 5 Tests
ATP06		18.29	Auto.Test Panel Pricing Code, 6 Tests
ATP07		19.06	Auto.Test Panel Pricing Code, 7 Tests
ATP08		19.72	Auto.Test Panel Pricing Code, 8 Tests
ATP09		20.25	Auto.Test Panel Pricing Code, 9 Tests
ATP10		20.25	Auto.Test Panel Pricing Code, 10 Tests
ATP11		20.60	Auto.Test Panel Pricing Code, 11 Tests
ATP12		21.06	Auto.Test Panel Pricing Code, 12 Tests
ATP16		24.63	Auto Test Panel Pricing Code 13-16 Test
ATP18		24.82	Auto Test Panel Pricing Code, 17-18 Test
ATP19		25.81	Auto Test Panel Pricing Code, 19 Tests
ATP20		26.62	Auto Test Panel Pricing Code, 20 Tests
ATP21		27.47	Auto Test Panel Pricing Code, 21 Tests
ATP22		28.29	Auto.Test Panel Pricing Code, 22+ Tests
ATP23		28.29	Auto.Test Panel Pricing Code, 23+ Tests
G0027		15.16	Semen analysis
G0103		42.89	PSA screening
G0123		47.24	Screen cerv/vag thin layer
G0143		47.24	Scr c/v cyto,thinlayer,rescr
G0144		49.83	Scr c/v cyto,thinlayer,rescr
G0145		61.78	Scr c/v cyto,thinlayer,rescr
G0147		26.54	Scr c/v cyto, automated sys
G0148		35.43	Scr c/v cyto, autosys, rescr
G0306		16.49	CBC/diffwbc w/o platelet
G0307		11.63	CBC without platelet
G0328		37.09	Fecal blood scrn immunoassay
G0328	QW	37.09	Fecal blood scrn immunoassay
G0432		23.27	EIA HIV-1/HIV-2 screen
G0433		23.27	ELISA HIV-1/HIV-2 screen
G0433	QW	23.27	ELISA HIV-1/HIV-2 screen
G0435		27.95	Oral HIV-1/HIV-2 screen
G0471		8.50	Ven blood coll SNF/HHA
G0472		33.27	Hep c screen high risk/other
G0472	QW	33.27	Hep c screen high risk/other
G0475		56.15	Hiv combination assay

Exhibit #8 – Proposed Clinical Laboratory Fees			
Effective for Dates of Service On and After 1/1/2018			
HCPCS	**Modifier**	**Maximum Fees**	**SHORTDESC**
G0476		81.84	Hpv combo assay ca screen
G0480		200.01	Drug test def 1-7 classes
G0481		273.68	Drug test def 8-14 classes
G0482		347.38	Drug test def 15-21 classes
G0483		431.58	Drug test def 22+ classes
G0659		135.68	Drug test def simple all cl
G9143		281.50	Warfarin respon genetic test
P2038		11.73	Blood mucoprotein
P3000		24.63	Screen pap by tech w md supv
P9612		5.10	Catheterize for urine spec
P9615		5.10	Urine specimen collect mult
Q0111		9.96	Wet mounts/ w preparations
Q0112		9.96	Potassium hydroxide preps
Q0113		12.61	Pinworm examinations
Q0114		16.68	Fern test
Q0115		23.07	Post-coital mucous exam

Notice of Proposed Rulemaking

Tracking number

2017-00268

Department

1100 - Department of Labor and Employment

Agency

1101 - Division of Oil and Public Safety

CCR number

7 CCR 1101-15

Rule title

LIQUEFIED PETROLEUM GAS (LPG) REGULATIONS

Rulemaking Hearing

Date

08/03/2017

Time

10:00 AM

Location

633 17th Street, Suite 500, Denver, CO 80202

Subjects and issues involved

After review by the Office of Legislative Legal Services it was found that the regulation in Section 1-5-1 Codes Incorporated by Reference, does not comply with the statutory requirements for incorporation by reference pursuant to section 24-4-103 (12.5)(a) of the Colorado Revised Statutes, which requires the division to provide sufficient contact information for interested parties to be able to inspect, and obtain copies of these codes for a reasonable charge. This revision has corrected that issue. There are no changes to the substance or text of the actual regulatory requirements in this new revision.

Statutory authority

Sections 8-20-302, 8-20-402 and 8-20-405

Contact information

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COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT

DIVISION OF OIL AND PUBLIC SAFETY

LIQUEFIED PETROLEUM GAS (LPG) REGULATIONS

7 CCR 1101-15

Effective: ~~**May 1. 2017**~~ **September 30, 2017**

LIQUEFIED PETROLEUM GAS (LPG) REGULATIONS
COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF OIL AND PUBLIC SAFETY

TABLE OF CONTENTS

ARTICLE 1 GENERAL PROVISIONS

Section 1-1 Basis and Purpose

The basis and purpose of these regulations is to: adopt nationally-recognized codes and standards; to add or clarify terminology; to add or clarify the duties of LPG facility owners, delivery drivers and certain users; and to improve the effectiveness of the division's LPG program.

Section 1-2 Technical Rationale

The technical requirements of these regulations are generally accepted as national and international codes and standards governing the minimum levels of acceptability for the design, construction, location installation and operation of equipment for storing, handling, transporting, dispensing and utilizing LPG. The adoption of these consistent standards is necessary for the preservation of the public health, safety and welfare of the citizens of Colorado.

Section 1-3 Statutory Authority

The amendments to these regulations are created pursuant to Sections 8-20-302, 8-20-402 and 8-20-405 of the Colorado Revised Statutes.

Section 1-4 Effective Date

These amended regulations shall be effective on ~~May 1~~September 30, 2017. The previous versions of these regulations were effective February 1, 2011, ~~and~~ September 1, 2005, and ~~TBD~~May 1, 2017.

Section 1-5 Codes Incorporated by Reference

Section 1-5-1 Codes incorporated by reference

The following codes are incorporated by reference:

(a) NFPA 58, Liquefied Petroleum Gas Code, 2017 edition.

(b) NFPA 54, National Fuel Gas Code, 2015 edition.

(c) NFPA 30A, Code for Motor Fuel Dispensing Facilities & Repair Garages, 2015 edition.

(d) NIST Handbook 44, Specifications, Tolerances, and Other Technical Requirements for Weighing and Measuring Devices, 2016 edition.

(e) NIST Handbook 130, Uniform Laws and regulations in the Areas of Legal Metrology and Engine Fuel Quality, 2016 edition.

All NFPA codes incorporated by reference may be purchased from:

National Fire Protection Association
1 Batterymarch Park
Quincy, Massachusetts
USA 02169-7471

1-800-344-3555
http://www.nfpa.org

All NIST codes incorporated by reference may be purchased from:

National Institute of Standards and Technology
100 Bureau Drive
Gaithersburg, MD. 20899

(301)975-4004
https://www.nist.gov

Or for free download:

https://www.nist.gov/pml/weights-and-measures/publications/nist-handbooks

Section 1-5-2 Inspection of incorporated codes

Interested parties may inspect, and obtain copies of excerpts of the referenced incorporated materials for a reasonable charge, by contacting the Division of Oil and Public Safety at ~~LPG Program Manager~~, 633 17th Street, Suite 500, Denver, CO 80202: (303)318-8525

Section 1-5-3 Later amendments not included

These regulations do not include later amendments to or editions of the incorporated material.

Section 1-6 Definitions

Terms in these regulations shall have the same meaning as those found in Title 8, Article 20 and Title 9, Article 4 of the Colorado Revised Statutes. In addition, unless the context otherwise requires:

API – American Petroleum Institute.

ASME International – Formerly the American Society of Mechanical Engineers (ASME).

ASTM International – Formerly the American Society for Testing and Materials.

Condemned – A ***condemned container assembly and piping system*** is one determined by a state inspector to be so unsafe that further use is prohibited until it is satisfactorily repaired or replaced.

Container assembly – A ***container assembly*** includes US Department of Transportation (DOT) and ASME containers, commonly known as tanks or cylinders.

CRS – Colorado Revised Statutes.

Division – The ***Division of Oil and Public Safety***, the regulatory agency of the Colorado Department of Labor and Employment having jurisdiction over propane container assemblies and piping systems as defined in these regulations.

DOT – United States Department of Transportation.

Existing installation – Any LPG container assembly and piping system that has been placed into service and received its initial inspection by a state inspector.

FSA – Fire Safety Analysis, also known as *Product Release Prevention and Incident Preparedness Review* or *Incident Prevention Review*. An FSA is a plan incorporating the various safety features used to control the product and operations at the facility, an evaluation of hazard to the immediate neighborhood and a tool to be used by an emergency response agency, such as the local fire department.

Handling – Transferring LPG into a DOT container or an ASME tank. Handling does not include transporting of LPG.

Incident – A reportable accident, as defined by 8-20-407(1), CRS.

Incident prevention review – See definition under *FSA.*

Installer – Person or company responsible for setting up for use any container assembly and piping system required by LPG statute or regulation to be inspected.

Interruption of service – An interruption of gas service including an out-of-gas call, except for conducting a test.

LPG facility – Facility that has an LPG container assembly and piping system.

LPG liquid meter – A meter designed to measure LPG liquid, with an active National Type Evaluation Program (NTEP) Certificate of Conformance (CC), which includes a metering chamber or device, vapor eliminator, differential valve and register.

Marking – Container information located on container name-plate or stamped into the shell or collar of an LPG container. Marking is done in accordance with the regulations of DOT, ASME or API-ASME and is done by the original container manufacturer or a repair organization authorized by the National Board to utilize the “R” code symbol stamp.

NACE – The National Association of Corrosion Engineers.

National Board – The National Board of Boiler and Pressure Vessel Inspectors.

New installation – Any container assembly that has been placed into service but has not received its initial inspection by a state inspector.

NFPA – The National Fire Protection Association.

NIST – The National Institute of Standards and Technology.

Out-of-gas call – A request for LPG delivery to an empty tank.

PERC – The Propane Education and Resource Council.

Product release prevention and incident preparedness review – see definition under ***FSA.***

Proved – The act of having verified the accuracy of meters used to measure fuel and petroleum products using a prover.

Prover – A calibrated volumetric receiver or mechanical device traceable to NIST standards.

PSI – Pounds per square inch.

Registered serviceperson – Any individual who, for hire, award, commission or any other payment of any kind, installs, services, repairs or reconditions a commercial weighing or measuring device and who voluntarily registers with the division.

Registered service agency (RSA) – Any agency, firm, company or corporation that, for hire, award, commission or any other payment of any kind, installs, services, repairs or reconditions a commercial weighing or measuring device and voluntarily registers with the division. Under agency registration, identification of individual servicepersons shall be required.

Retail – The sale of LPG from fixed dispensing equipment or by means of bobtail delivery truck, or such as at a fueling station, in small or individual quantities for direct consumption by the purchaser.

State inspector – A person who is employed or authorized by the division to perform inspections of LPG facilities.

Section 1-7 Applicability

The regulations contained herein shall apply to the operation of all LPG container assembly and piping systems including the following:

(a) Containers, piping and associated equipment, when delivering LPG to a building for use as a fuel gas.

(b) Pipeline terminals, natural gasoline plants, refineries, tank farms, underground storage facilities, aboveground storage facilities and chemical plants utilizing LPG in the manufacture of their products.

(c) The design, construction, installation and operation of pipeline terminals that receive LPG from pipelines under DOT jurisdiction, whose primary purpose is the receipt of LPG for delivery to transporters, distributors or users. Coverage shall begin downstream of the last pipeline valve or tank manifold inlet.

Section 1-8 Condemning an LPG Container Assembly and Piping System

(a) Conditions which a state inspector may determine to be unsafe include: bypassed safety controls; inoperative relief valves; any gas leak from an LPG container assembly; any excessive gas leak from the piping system; missing nameplate; or any other condition deemed by a state inspector to be unsafe. A container assembly or piping system that meets any condition described above may be condemned by a state inspector.

(b) The owner or user must shut down the condemned LPG container assembly and piping system as directed by a state inspector. If neither the owner nor user is available, a state inspector will cause the system to be shut down.

(c) A state inspector will affix a notice to a condemned LPG container assembly and piping system stating that it has been condemned and may not be used until satisfactory repairs are made, as determined by a re-inspection by a state inspector or other person authorized by the division.

ARTICLE 2 INSTALLATION

Section 2-1 General Requirements

(a) All new LPG installations shall be constructed in accordance with the incorporated editions of the NFPA and NIST codes. (b) All existing LPG installations shall be constructed in accordance with the incorporated editions of the NFPA and NIST codes in effect at the time of construction, including any retroactive requirements adopted by the division.

Section 2-2 Installation-Permits

(a) Plans for all installations utilizing LPG storage containers of over 2,000 gallons water capacity shall be submitted to the division for approval before construction, including installation, replacement or relocation of such installations, begins.

(b) Plans for any of the following shall be submitted to the division for approval before installation:

(1) Service stations supplying LPG for motor fuel.

(2) Installations for filling of DOT and ASME mobile containers and containers marked to demonstrate compliance with Federal Aviation Administration regulations.

(3) Industrial bulk storage installations and all other bulk storage installations utilizing storage containers for LPG of over 2,000 gallons aggregate water capacity.

(c) The permit procedures are as follows:

(1) The permit application shall be submitted on an application form approved and provided by the division.

(2) The application shall include a plot plan containing all elements required by the division.

(3) The division may deny the application if the proposed installation does not conform to the division LPG statute or regulation or to codes adopted by the division, or if the application is incomplete or determined to be inaccurate.

(4) Construction and installation of tank and piping shall conform to code(s) in effect at the time of installation.

(5) The division may revoke a permit if construction is not performed per the approved permit, or if the construction fails to meet operating or fire safety regulations established by the division or by the applicable NFPA Code.

(6) An installation permit approved by the division is automatically revoked if construction does not begin within 6 months of approval, unless a written request for an extension is submitted to and approved by the division.

(7) For new installations with an aggregate over 4,000 gallons, an FSA must be in effect prior to the operation of the installation per NFPA 58, following guidance from Annex A, A.6.29.2 and A.6.29.3 or another nationally-accepted standard approved in advance by the division.

A local authority having jurisdiction, including fire departments, may require and enforce more stringent requirements than these regulations.

Section 2-3 Access Requirements

(a) The division may inspect an LPG facility at any time during its construction. Access shall be provided to the division or its agent for such purpose upon request.

(b) After an LPG container has been installed, the division may inspect the container to verify compliance with design, construction, location, installation and operation requirements. LPG facility owners, tank owners and owners of locations where an LPG container is installed shall grant inspection access to the division or its agent for such purpose upon request.

Section 2-4 Corrosion Prevention Requirements

(a) Corrosion protection is required for all underground steel LPG tanks and piping installed after September 1, 2005, and for all other underground steel LPG tanks by January 1, 2011.

(b) Corrosion protection shall meet the requirements of NFPA 58.

(c) Cathodic protection systems shall be installed and tested in accordance with the provisions of NFPA 58, and documentation of the results of the two most recent tests shall be retained.

(d) Installers of cathodic protection systems shall be trained in the proper installation of cathodic protection systems, using the PERC Cathodic Protection Training Guide. Training shall be documented per Section 4-1 of these regulations, and refresher training shall be required at least every three years.

Section 2-5 Nameplates

(a) When an ASME container assembly has a nameplate with a legible serial number but has insufficient data to be in service, and there is a Manufacturer's Data Report (U1A) with a matching serial number and the container fits the description on the U1A, the owner/operator may then make application to the division for a tag bearing the manufacturer's name, ASME Code symbol, maximum allowable working pressure, UG or AG (or both AG and UG) and water gallon capacity. If granted, the division shall issue an identifying tag to be permanently attached to the container by a state inspector.

(b) When an ASME container assembly has no nameplate but there is sufficient data to prove that it once had a nameplate showing the critical data thereon, the owner/operator may then make application to the division for a tag bearing the manufacturer's name or trademark, ASME Code symbol, maximum allowable working pressure, UG or AG (or both AG and UG) and water gallon capacity. If granted, the division shall issue an identifying tag to be permanently attached to the container by a state inspector. A copy of the container's U1A form shall be considered important data.

(c) When a container assembly and piping system has a nameplate whose stamping becomes indistinct, or the nameplate is lost or illegible but traceability to the original container assembly item is still possible, the owner or user shall have the stamped data replaced as follows:

(1) All re-stamping shall be done in accordance with the version of the code in effect at the time of container construction.

(2) A request for permission to re-stamp or replace a nameplate shall be made in advance to the division. Proof of the original stamping and the manufacturer's data report shall be furnished with the request.

(3) Permission from the division is not required for the reattachment of nameplates that are partially attached.

(4) Re-stamping or replacement authorized by the division shall be witnessed by a state inspector.

(5) The stamping shall be identical to the original stamping. When the Code symbol is to be re-stamped, it shall be done by the original manufacturer and witnessed by a state inspector.

(6) Replacement nameplates shall be clearly marked "replacement."

(7) After replacing a nameplate, the owner or user shall file with the division a copy of the stamping or nameplate as applied and shall include the signature of the state inspector who witnessed the replacement.

(d) If replacement of the nameplate is not possible because the container assembly cannot be traced, a hydrostatic test or other test approved by the division must be performed if the container is to remain in service.

(1) Such test shall be performed by an independent contractor experienced in hydrostatic tests. The test shall be conducted according to the procedure outlined in ASTM International Designation: E 1003 – 95 (Reapproved 2000) at 1.5 times working pressure (250 psi x 1.5 = 375 psi) to evaluate the integrity of the container.

(2)The owner/operator may then make application, including the results of the hydrostatic test, to the division for an exception. If granted, the division shall assign a number to the container and issue an identifying tag with that number to be permanently attached to the container by a state inspector.

(3) With the division's approval, the container may continue to operate at that location indefinitely. The container shall not be moved and reinstalled at any location, including elsewhere at the same facility.

(e) If a container was installed prior to September 1, 2005, and is missing the nameplate, one of the following shall be performed:

(1) The nameplate shall be replaced per Section 2-5-1 (a) of these regulations.

(2) A hydrostatic test or other test approved by the division shall be performed and approval to operate the container granted by the division per Section 2-5 (b) of these regulations.

(3) The container shall be permanently removed from service.

Section 2-6 Fire Safety Analysis (FSA)

(a) For all new LPG installations in excess of 4,000 gallons in aggregate an FSA is required to be completed by the operational date of the installation.

(b) The FSA shall be prepared in accordance with the requirements of NFPA-58, including Annex A, A.6.29.2 and A.6.29.3 or any other nationally-accepted standard approved by the division in advance.

(c) It is not required that the FSA be prepared or approved by a professional engineer: however, the preparation should be completed by someone who, at a minimum, is familiar with the properties of propane, the application of NFPA 58 and the physical layout of the installation. The preparer shall consult with the local fire protection district to complete the FSA. Some modifications to the installation may require the services of a registered professional engineer.

(d) The most current FSA document shall be maintained at the LPG installation, where it shall be available for inspection by the division upon request.

Section 2-7 Marking Underground Containers in Snow Areas

(a) In areas where snow can be expected to cover the dome lids of underground containers, such containers shall be marked so that emergency and propane service company personnel can locate the tank for emergency shut down purposes or to service the tank. Such marking shall be accomplished by placing a stake or other marking that shall be installed higher than the anticipated maximum snow level up to a height of 15 feet.

ARTICLE 3 DELIVERY AND DISPENSING

Section 3-1 LPG Delivery

(a) Containers shall be filled only after determination from the point of transfer that the installation of the container and visible exterior piping system comply with the provisions of NFPA 58 and these regulations.

(b) It is permissible to fill an ASME tank whose nameplate or other marking is damaged, provided the following information can be determined:

(1) If the container is registered with the National Board and the facility can produce the Manufacturer's Data Report (U-1A and/or U-2A) form, the manufacturer's name and container's serial number must be legible.

(2) If the container is not a National Board-registered container, the manufacturer's name, the container's serial number, the ASME stamp and the pressure rating must be legible.

(c) If the nameplate or other marking is missing, delivery to the tank is prohibited. Refer to Section 2-5 of these regulations for instructions on re-attaching or re-placing nameplates.

(d) Delivery to a container with corrosion that appears to be greater than 1/3 of the thickness of the metal is prohibited.

(e) When noncompliance with the provisions of the incorporated codes is found, the container owner or user of record shall be notified in writing.

Section 3-2 Delivery after Interruption of Service

(a) When delivery is made to an LPG container assembly that has had an interruption of service as defined by these regulations, a leak check shall be performed immediately after LPG is introduced into the piping.

(b) The leak check shall be performed according to one of the methods set forth in Annex D (*Suggested Method of Checking for Leakage*) of NFPA 54 or another method approved by the division in advance.

(c) The person performing the leak check shall document that the test was performed. The documentation shall include, at minimum, the following information:

(1) Date the test was performed

(2) Test start time

(3) Test end time

(4) Name of person performing the test

(5) Name of person's employer

(6) Address and phone number of person's employer

(7) Type of test

(8) Test start pressure and end pressure if a constant pressure is used

(d) Documentation of the leak check shall be retained for a minimum of one year by the employer of the person who performed the test.

Section 3-3 Dispensing

(a) The requirements of Section 3-4 of these regulations shall apply to dispensers at retail facilities.

(b) All retail and non-retail LPG dispensers must comply with the minimum standards as prescribed by the applicable sections of the incorporated codes.

Section 3-4 Retail Motor Fuel and Fuel Gas Dispenser Meter Inspection and Testing

(a) All retail LPG dispensers shall be suitable for their intended use, properly installed and accurate, and they shall be maintained in that condition by their owner/operator.

(b) All retail LPG dispensers shall have an active National Type Evaluation Program (NTEP) Certificate of Conformance (CC) prior to their installation or use for commercial purposes.

(c) The division shall be notified when any new or remanufactured retail LPG dispenser is placed in service at a new or existing installation. Notification shall be submitted using a placed in service report provided by the division.

(d) No owner/operator of any retail LPG dispenser shall use the dispenser for the measurement of LPG unless it has been proved in a manner acceptable to the Director of the division and sealed as correct by a state inspector or registered service agency.

(e) If any retail LPG dispenser fails to comply with any of the provisions of this regulation, a state inspector shall seal it in such a manner as to prohibit its use, and it shall remain sealed until it complies with all of the provisions of this regulation.

When a retail LPG dispenser is brought back into compliance with these regulations, it must be placed back in service by a state inspector or registered service agency.

(f) All retail LPG dispensers shall comply with the minimum standards as prescribed by the applicable sections of the incorporated codes, except as modified or rejected by these regulations or by the director.

(g) All retail LPG dispensers shall be labeled in accordance with the minimum standards as prescribed by the applicable sections of the incorporated codes except as modified or rejected by these regulations or by the division.

Section 3-5 Bobtail Delivery Truck Meter Inspection and Testing

(a) All LPG bobtail delivery truck metering systems shall be suitable for their intended use, properly installed and accurate, and they shall be maintained in that condition by their owner/operator.

(b) All LPG bobtail delivery truck metering systems shall have an active National Type Evaluation Program (NTEP) Certificate of Conformance (CC) prior to their installation or use for commercial purposes.

(c) The division shall be notified when any new or remanufactured LPG bobtail delivery truck metering systems is placed in service at a new or existing installation. Notification shall be submitted using a placed in service report provided by the division.

(d) No owner/operator of any LPG bobtail delivery truck metering system shall use the meter for the measurement of LPG unless it has been proved in a manner acceptable to the Director of the division and sealed as correct by a state inspector or registered service agency.

(e) If any LPG bobtail delivery truck metering systems fails to comply with any of the provisions of these regulations, a state inspector shall seal it in such a manner as to prohibit its use, and it shall remain sealed until it complies with all of the provisions of these regulations.

When an LPG bobtail delivery truck metering system is brought back into compliance with these regulations, it must be placed back in service by a state inspector or registered service agency.

(f) All LPG bobtail delivery truck metering systems shall comply with the minimum standards as prescribed by the applicable sections of the incorporated codes except as modified or rejected by these regulations or by the division.

(g) All retail LPG bobtail delivery truck meters shall be labeled in accordance with the minimum standards as prescribed by the applicable sections of the incorporated codes except as modified or rejected by these regulations or by the division.

Section 3-6 Filling Containers by Weight

(a) All cylinders less than 200 pounds water capacity (i.e., 100-pound cylinders), with the exception of fork lift cylinders and hot air balloon containers, shall be filled by weight.

(b) Volumetric filling of forklift cylinders from bobtail delivery trucks shall be allowed in accordance with NFPA 58, Section 6.7 and Table 6.7.2.1, and all personnel shall be trained in proper handling procedures in accordance with NFPA 58, Chapter 7.

(c) Scales used for filling LPG containers must be inspected annually and found to be in compliance with the specifications and tolerances published in NIST Handbook 44. This certification must be performed either by the Colorado Department of Agriculture or by a person authorized by the Colorado Department of Agriculture. Any necessary repairs must be completed within 30 days.

(d) If the Colorado Department of Agriculture fails to perform the annual inspection in a timely fashion, the scale may remain in operation, provided the scale owner has not prohibited or hindered such inspection by the Colorado Department of Agriculture, and further provided that any repairs required at the most recent previous inspection have been completed.

ARTICLE 4 TRAINING REQUIREMENTS

Section 4-1 General Training Requirements

(a) Any person who transfers LPG including, but not limited to, dispenser operators, bobtail delivery drivers and transport operators, , or who services or installs exterior piping of LPG vapor distribution systems, shall receive adequate training to perform all related duties safely and in accordance with the provisions of NFPA 58, Sections 4.4 and 7.2.

(b) The employer of any person referenced in (a) above, shall document that person's training and shall make these records available to the division or its agent upon request. The records shall include the following information, at minimum:

(1) Person's name

(2) Training date(s)

(3) Name of trainer

(4) Topics covered by training

(5) Verification by the person's supervisor or certification described in this Article that the person has demonstrated adequate knowledge and skill to perform assigned duties

(c) For all training required under Sections 4-2 through 4-4 of these regulations, refresher training shall be required at least every three years. The training shall be documented.

(d) The employer of the person who received the training shall maintain that documentation as long as the person remains an employee.

Section 4-2 Dispenser Operator Training

(a) The minimum training requirements for dispenser operators, that shall be completed prior to operating LPG dispensers, may be satisfied by certification by either of the following:

(1) Certified Employee Training Program (CETP) *Basic Principles and Practices* as published by PERC

(2) A training program which contains, at minimum, certification by the PERC *Dispensing Propane Safely* program

Section 4-3 Delivery Personnel Training

(a) The minimum training requirements for delivery personnel shall include:

(1) Proper procedure for filling an ASME container

(2) Knowledge of when a leak check is required

(3) Proper procedure for conducting and documenting a leak check

(4) Criteria for determining when filling a container is prohibited because of improper installation or because of excessive corrosion, dents or gouges

(5) Emergency procedures as outlined in the employer's FSA

(6) Completion of the following training programs published by PERC

(A) CETP *Basic Principles and Practices*

(B) CETP *Bobtail Delivery Operations*

(C) CETP *Basic Plant Operations*

(b) All CETP training for delivery personnel shall be completed within one year of assuming current job duties.

Section 4-4 Service and Installation Personnel Training

(a) The minimum training requirements for those who service or install exterior piping of LPG vapor distribution systems may be satisfied by completing the following training programs published by PERC.

(1) CETP *Basic Principles and Practices*

(2) CETP *Designing & Installing Exterior Vapor Distribution Systems*

(3) CETP *Placing Vapor Distribution Systems and Appliances into Operation*

(b) All CETP training for those who service or install exterior piping of LPG vapor distribution systems shall be completed within one year of assuming current job duties.

Section 4-5 Transport Operator Training

(a) The minimum training requirements for transport operators may be satisfied by completing the following training programs published by PERC.

(1) CETP Basic Principles and Practices

(2) PERC Transport Operator Training Program

(b) All CETP training for transport operators shall be completed within one year of assuming current job duties.

ARTICLE 5 ACCIDENT REPORTS AND INVESTIGATIONS

Section 5-1 Reportable Accidents

(a) Reports of accidents, fires, explosions, injuries, damage to property or loss of life at installations using liquefied petroleum gas shall be reported to the division within 24 hours after their occurrence.

(b) Subsection (a) of this Section includes accidents resulting from the improper use of equipment, appliances and appurtenances to LPG systems. The division may investigate such occurrences and shall maintain a written record of findings, which shall be available for public examination.

Section 5-2 Reporting Requirements

(a) The following persons are required to notify the division of an LPG accident that meets any of the criteria of Section 5-1 of these regulations:

(1) Owner or the owner's representative of the LPG facility, if the accident occurred at the facility

(2) Employer of the delivery personnel, if the accident occurred during delivery

(3) Employer of the delivery personnel, if the accident occurred post-delivery and the employer received notification of it

(b) Accidents may be reported by telephone or email using the following information:

(1) Telephone: 303-318-8547

(2) Email: cdle_oil_inspection@state.co.us

(c) The accident report shall include, at minimum, the following information.

(1) The names of the operator and person making the report and their telephone numbers

(2) The date, time and location of the accident

(3) The number of fatalities and personal injuries

(4) All other significant facts known by the person making the report that are relevant to the cause of the accident or extent of the damages

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT

DIVISION OF OIL AND PUBLIC SAFETY

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ASME International – Formerly the American Society of Mechanical Engineers (ASME).

ASTM International – Formerly the American Society for Testing and Materials.

Condemned – A ***condemned container assembly and piping system*** is one determined by a state inspector to be so unsafe that further use is prohibited until it is satisfactorily repaired or replaced.

Container assembly – A ***container assembly*** includes US Department of Transportation (DOT) and ASME containers, commonly known as tanks or cylinders.

CRS – Colorado Revised Statutes.

Division – The ***Division of Oil and Public Safety***, the regulatory agency of the Colorado Department of Labor and Employment having jurisdiction over propane container assemblies and piping systems as defined in these regulations.

DOT – United States Department of Transportation.

Existing installation – Any LPG container assembly and piping system that has been placed into service and received its initial inspection by a state inspector.

FSA – Fire Safety Analysis, also known as *Product Release Prevention and Incident Preparedness Review* or *Incident Prevention Review*. An FSA is a plan incorporating the various safety features used to control the product and operations at the facility, an evaluation of hazard to the immediate neighborhood and a tool to be used by an emergency response agency, such as the local fire department.

Handling – Transferring LPG into a DOT container or an ASME tank. Handling does not include transporting of LPG.

Incident – A reportable accident, as defined by 8-20-407(1), CRS.

Incident prevention review – See definition under *FSA.*

Installer – Person or company responsible for setting up for use any container assembly and piping system required by LPG statute or regulation to be inspected.

Interruption of service – An interruption of gas service including an out-of-gas call, except for conducting a test.

LPG facility – Facility that has an LPG container assembly and piping system.

LPG liquid meter – A meter designed to measure LPG liquid, with an active National Type Evaluation Program (NTEP) Certificate of Conformance (CC), which includes a metering chamber or device, vapor eliminator, differential valve and register.

Marking – Container information located on container name-plate or stamped into the shell or collar of an LPG container. Marking is done in accordance with the regulations of DOT, ASME or API-ASME and is done by the original container manufacturer or a repair organization authorized by the National Board to utilize the “R” code symbol stamp.

NACE – The National Association of Corrosion Engineers.

National Board – The National Board of Boiler and Pressure Vessel Inspectors.

New installation – Any container assembly that has been placed into service but has not received its initial inspection by a state inspector.

NFPA – The National Fire Protection Association.

NIST – The National Institute of Standards and Technology.

Out-of-gas call – A request for LPG delivery to an empty tank.

PERC – The Propane Education and Resource Council.

Product release prevention and incident preparedness review – see definition under ***FSA.***

Proved – The act of having verified the accuracy of meters used to measure fuel and petroleum products using a prover.

Prover – A calibrated volumetric receiver or mechanical device traceable to NIST standards.

PSI – Pounds per square inch.

Registered serviceperson – Any individual who, for hire, award, commission or any other payment of any kind, installs, services, repairs or reconditions a commercial weighing or measuring device and who voluntarily registers with the division.

Registered service agency (RSA) – Any agency, firm, company or corporation that, for hire, award, commission or any other payment of any kind, installs, services, repairs or reconditions a commercial weighing or measuring device and voluntarily registers with the division. Under agency registration, identification of individual servicepersons shall be required.

Retail – The sale of LPG from fixed dispensing equipment or by means of bobtail delivery truck, or such as at a fueling station, in small or individual quantities for direct consumption by the purchaser.

State inspector – A person who is employed or authorized by the division to perform inspections of LPG facilities.

Section 1-7 Applicability

The regulations contained herein shall apply to the operation of all LPG container assembly and piping systems including the following:

(a) Containers, piping and associated equipment, when delivering LPG to a building for use as a fuel gas.

(b) Pipeline terminals, natural gasoline plants, refineries, tank farms, underground storage facilities, aboveground storage facilities and chemical plants utilizing LPG in the manufacture of their products.

(c) The design, construction, installation and operation of pipeline terminals that receive LPG from pipelines under DOT jurisdiction, whose primary purpose is the receipt of LPG for delivery to transporters, distributors or users. Coverage shall begin downstream of the last pipeline valve or tank manifold inlet.

Section 1-8 Condemning an LPG Container Assembly and Piping System

(a) Conditions which a state inspector may determine to be unsafe include: bypassed safety controls; inoperative relief valves; any gas leak from an LPG container assembly; any excessive gas leak from the piping system; missing nameplate; or any other condition deemed by a state inspector to be unsafe. A container assembly or piping system that meets any condition described above may be condemned by a state inspector.

(b) The owner or user must shut down the condemned LPG container assembly and piping system as directed by a state inspector. If neither the owner nor user is available, a state inspector will cause the system to be shut down.

(c) A state inspector will affix a notice to a condemned LPG container assembly and piping system stating that it has been condemned and may not be used until satisfactory repairs are made, as determined by a re-inspection by a state inspector or other person authorized by the division.

ARTICLE 2 INSTALLATION

Section 2-1 General Requirements

(a) All new LPG installations shall be constructed in accordance with the incorporated editions of the NFPA and NIST codes. (b) All existing LPG installations shall be constructed in accordance with the incorporated editions of the NFPA and NIST codes in effect at the time of construction, including any retroactive requirements adopted by the division.

Section 2-2 Installation-Permits

(a) Plans for all installations utilizing LPG storage containers of over 2,000 gallons water capacity shall be submitted to the division for approval before construction, including installation, replacement or relocation of such installations, begins.

(b) Plans for any of the following shall be submitted to the division for approval before installation:

(1) Service stations supplying LPG for motor fuel.

(2) Installations for filling of DOT and ASME mobile containers and containers marked to demonstrate compliance with Federal Aviation Administration regulations.

(3) Industrial bulk storage installations and all other bulk storage installations utilizing storage containers for LPG of over 2,000 gallons aggregate water capacity.

(c) The permit procedures are as follows:

(1) The permit application shall be submitted on an application form approved and provided by the division.

(2) The application shall include a plot plan containing all elements required by the division.

(3) The division may deny the application if the proposed installation does not conform to the division LPG statute or regulation or to codes adopted by the division, or if the application is incomplete or determined to be inaccurate.

(4) Construction and installation of tank and piping shall conform to code(s) in effect at the time of installation.

(5) The division may revoke a permit if construction is not performed per the approved permit, or if the construction fails to meet operating or fire safety regulations established by the division or by the applicable NFPA Code.

(6) An installation permit approved by the division is automatically revoked if construction does not begin within 6 months of approval, unless a written request for an extension is submitted to and approved by the division.

(7) For new installations with an aggregate over 4,000 gallons, an FSA must be in effect prior to the operation of the installation per NFPA 58, following guidance from Annex A, A.6.29.2 and A.6.29.3 or another nationally-accepted standard approved in advance by the division.

A local authority having jurisdiction, including fire departments, may require and enforce more stringent requirements than these regulations.

Section 2-3 Access Requirements

(a) The division may inspect an LPG facility at any time during its construction. Access shall be provided to the division or its agent for such purpose upon request.

(b) After an LPG container has been installed, the division may inspect the container to verify compliance with design, construction, location, installation and operation requirements. LPG facility owners, tank owners and owners of locations where an LPG container is installed shall grant inspection access to the division or its agent for such purpose upon request.

Section 2-4 Corrosion Prevention Requirements

(a) Corrosion protection is required for all underground steel LPG tanks and piping installed after September 1, 2005, and for all other underground steel LPG tanks by January 1, 2011.

(b) Corrosion protection shall meet the requirements of NFPA 58.

(c) Cathodic protection systems shall be installed and tested in accordance with the provisions of NFPA 58, and documentation of the results of the two most recent tests shall be retained.

(d) Installers of cathodic protection systems shall be trained in the proper installation of cathodic protection systems, using the PERC Cathodic Protection Training Guide. Training shall be documented per Section 4-1 of these regulations, and refresher training shall be required at least every three years.

Section 2-5 Nameplates

(a) When an ASME container assembly has a nameplate with a legible serial number but has insufficient data to be in service, and there is a Manufacturer's Data Report (U1A) with a matching serial number and the container fits the description on the U1A, the owner/operator may then make application to the division for a tag bearing the manufacturer's name, ASME Code symbol, maximum allowable working pressure, UG or AG (or both AG and UG) and water gallon capacity. If granted, the division shall issue an identifying tag to be permanently attached to the container by a state inspector.

(b) When an ASME container assembly has no nameplate but there is sufficient data to prove that it once had a nameplate showing the critical data thereon, the owner/operator may then make application to the division for a tag bearing the manufacturer's name or trademark, ASME Code symbol, maximum allowable working pressure, UG or AG (or both AG and UG) and water gallon capacity. If granted, the division shall issue an identifying tag to be permanently attached to the container by a state inspector. A copy of the container's U1A form shall be considered important data.

(c) When a container assembly and piping system has a nameplate whose stamping becomes indistinct, or the nameplate is lost or illegible but traceability to the original container assembly item is still possible, the owner or user shall have the stamped data replaced as follows:

(1) All re-stamping shall be done in accordance with the version of the code in effect at the time of container construction.

(2) A request for permission to re-stamp or replace a nameplate shall be made in advance to the division. Proof of the original stamping and the manufacturer's data report shall be furnished with the request.

(3) Permission from the division is not required for the reattachment of nameplates that are partially attached.

(4) Re-stamping or replacement authorized by the division shall be witnessed by a state inspector.

(5) The stamping shall be identical to the original stamping. When the Code symbol is to be re-stamped, it shall be done by the original manufacturer and witnessed by a state inspector.

(6) Replacement nameplates shall be clearly marked "replacement."

(7) After replacing a nameplate, the owner or user shall file with the division a copy of the stamping or nameplate as applied and shall include the signature of the state inspector who witnessed the replacement.

(d) If replacement of the nameplate is not possible because the container assembly cannot be traced, a hydrostatic test or other test approved by the division must be performed if the container is to remain in service.

(1) Such test shall be performed by an independent contractor experienced in hydrostatic tests. The test shall be conducted according to the procedure outlined in ASTM International Designation: E 1003 – 95 (Reapproved 2000) at 1.5 times working pressure (250 psi x 1.5 = 375 psi) to evaluate the integrity of the container.

(2)The owner/operator may then make application, including the results of the hydrostatic test, to the division for an exception. If granted, the division shall assign a number to the container and issue an identifying tag with that number to be permanently attached to the container by a state inspector.

(3) With the division's approval, the container may continue to operate at that location indefinitely. The container shall not be moved and reinstalled at any location, including elsewhere at the same facility.

(e) If a container was installed prior to September 1, 2005, and is missing the nameplate, one of the following shall be performed:

(1) The nameplate shall be replaced per Section 2-5-1 (a) of these regulations.

(2) A hydrostatic test or other test approved by the division shall be performed and approval to operate the container granted by the division per Section 2-5 (b) of these regulations.

(3) The container shall be permanently removed from service.

Section 2-6 Fire Safety Analysis (FSA)

(a) For all new LPG installations in excess of 4,000 gallons in aggregate an FSA is required to be completed by the operational date of the installation.

(b) The FSA shall be prepared in accordance with the requirements of NFPA-58, including Annex A, A.6.29.2 and A.6.29.3 or any other nationally-accepted standard approved by the division in advance.

(c) It is not required that the FSA be prepared or approved by a professional engineer: however, the preparation should be completed by someone who, at a minimum, is familiar with the properties of propane, the application of NFPA 58 and the physical layout of the installation. The preparer shall consult with the local fire protection district to complete the FSA. Some modifications to the installation may require the services of a registered professional engineer.

(d) The most current FSA document shall be maintained at the LPG installation, where it shall be available for inspection by the division upon request.

Section 2-7 Marking Underground Containers in Snow Areas

(a) In areas where snow can be expected to cover the dome lids of underground containers, such containers shall be marked so that emergency and propane service company personnel can locate the tank for emergency shut down purposes or to service the tank. Such marking shall be accomplished by placing a stake or other marking that shall be installed higher than the anticipated maximum snow level up to a height of 15 feet.

ARTICLE 3 DELIVERY AND DISPENSING

Section 3-1 LPG Delivery

(a) Containers shall be filled only after determination from the point of transfer that the installation of the container and visible exterior piping system comply with the provisions of NFPA 58 and these regulations.

(b) It is permissible to fill an ASME tank whose nameplate or other marking is damaged, provided the following information can be determined:

(1) If the container is registered with the National Board and the facility can produce the Manufacturer's Data Report (U-1A and/or U-2A) form, the manufacturer's name and container's serial number must be legible.

(2) If the container is not a National Board-registered container, the manufacturer's name, the container's serial number, the ASME stamp and the pressure rating must be legible.

(c) If the nameplate or other marking is missing, delivery to the tank is prohibited. Refer to Section 2-5 of these regulations for instructions on re-attaching or re-placing nameplates.

(d) Delivery to a container with corrosion that appears to be greater than 1/3 of the thickness of the metal is prohibited.

(e) When noncompliance with the provisions of the incorporated codes is found, the container owner or user of record shall be notified in writing.

Section 3-2 Delivery after Interruption of Service

(a) When delivery is made to an LPG container assembly that has had an interruption of service as defined by these regulations, a leak check shall be performed immediately after LPG is introduced into the piping.

(b) The leak check shall be performed according to one of the methods set forth in Annex D (*Suggested Method of Checking for Leakage*) of NFPA 54 or another method approved by the division in advance.

(c) The person performing the leak check shall document that the test was performed. The documentation shall include, at minimum, the following information:

(1) Date the test was performed

(2) Test start time

(3) Test end time

(4) Name of person performing the test

(5) Name of person's employer

(6) Address and phone number of person's employer

(7) Type of test

(8) Test start pressure and end pressure if a constant pressure is used

(d) Documentation of the leak check shall be retained for a minimum of one year by the employer of the person who performed the test.

Section 3-3 Dispensing

(a) The requirements of Section 3-4 of these regulations shall apply to dispensers at retail facilities.

(b) All retail and non-retail LPG dispensers must comply with the minimum standards as prescribed by the applicable sections of the incorporated codes.

Section 3-4 Retail Motor Fuel and Fuel Gas Dispenser Meter Inspection and Testing

(a) All retail LPG dispensers shall be suitable for their intended use, properly installed and accurate, and they shall be maintained in that condition by their owner/operator.

(b) All retail LPG dispensers shall have an active National Type Evaluation Program (NTEP) Certificate of Conformance (CC) prior to their installation or use for commercial purposes.

(c) The division shall be notified when any new or remanufactured retail LPG dispenser is placed in service at a new or existing installation. Notification shall be submitted using a placed in service report provided by the division.

(d) No owner/operator of any retail LPG dispenser shall use the dispenser for the measurement of LPG unless it has been proved in a manner acceptable to the Director of the division and sealed as correct by a state inspector or registered service agency.

(e) If any retail LPG dispenser fails to comply with any of the provisions of this regulation, a state inspector shall seal it in such a manner as to prohibit its use, and it shall remain sealed until it complies with all of the provisions of this regulation.

When a retail LPG dispenser is brought back into compliance with these regulations, it must be placed back in service by a state inspector or registered service agency.

(f) All retail LPG dispensers shall comply with the minimum standards as prescribed by the applicable sections of the incorporated codes, except as modified or rejected by these regulations or by the director.

(g) All retail LPG dispensers shall be labeled in accordance with the minimum standards as prescribed by the applicable sections of the incorporated codes except as modified or rejected by these regulations or by the division.

Section 3-5 Bobtail Delivery Truck Meter Inspection and Testing

(a) All LPG bobtail delivery truck metering systems shall be suitable for their intended use, properly installed and accurate, and they shall be maintained in that condition by their owner/operator.

(b) All LPG bobtail delivery truck metering systems shall have an active National Type Evaluation Program (NTEP) Certificate of Conformance (CC) prior to their installation or use for commercial purposes.

(c) The division shall be notified when any new or remanufactured LPG bobtail delivery truck metering systems is placed in service at a new or existing installation. Notification shall be submitted using a placed in service report provided by the division.

(d) No owner/operator of any LPG bobtail delivery truck metering system shall use the meter for the measurement of LPG unless it has been proved in a manner acceptable to the Director of the division and sealed as correct by a state inspector or registered service agency.

(e) If any LPG bobtail delivery truck metering systems fails to comply with any of the provisions of these regulations, a state inspector shall seal it in such a manner as to prohibit its use, and it shall remain sealed until it complies with all of the provisions of these regulations.

When an LPG bobtail delivery truck metering system is brought back into compliance with these regulations, it must be placed back in service by a state inspector or registered service agency.

(f) All LPG bobtail delivery truck metering systems shall comply with the minimum standards as prescribed by the applicable sections of the incorporated codes except as modified or rejected by these regulations or by the division.

(g) All retail LPG bobtail delivery truck meters shall be labeled in accordance with the minimum standards as prescribed by the applicable sections of the incorporated codes except as modified or rejected by these regulations or by the division.

Section 3-6 Filling Containers by Weight

(a) All cylinders less than 200 pounds water capacity (i.e., 100-pound cylinders), with the exception of fork lift cylinders and hot air balloon containers, shall be filled by weight.

(b) Volumetric filling of forklift cylinders from bobtail delivery trucks shall be allowed in accordance with NFPA 58, Section 6.7 and Table 6.7.2.1, and all personnel shall be trained in proper handling procedures in accordance with NFPA 58, Chapter 7.

(c) Scales used for filling LPG containers must be inspected annually and found to be in compliance with the specifications and tolerances published in NIST Handbook 44. This certification must be performed either by the Colorado Department of Agriculture or by a person authorized by the Colorado Department of Agriculture. Any necessary repairs must be completed within 30 days.

(d) If the Colorado Department of Agriculture fails to perform the annual inspection in a timely fashion, the scale may remain in operation, provided the scale owner has not prohibited or hindered such inspection by the Colorado Department of Agriculture, and further provided that any repairs required at the most recent previous inspection have been completed.

ARTICLE 4 TRAINING REQUIREMENTS

Section 4-1 General Training Requirements

(a) Any person who transfers LPG including, but not limited to, dispenser operators, bobtail delivery drivers and transport operators, , or who services or installs exterior piping of LPG vapor distribution systems, shall receive adequate training to perform all related duties safely and in accordance with the provisions of NFPA 58, Sections 4.4 and 7.2.

(b) The employer of any person referenced in (a) above, shall document that person's training and shall make these records available to the division or its agent upon request. The records shall include the following information, at minimum:

(1) Person's name

(2) Training date(s)

(3) Name of trainer

(4) Topics covered by training

(5) Verification by the person's supervisor or certification described in this Article that the person has demonstrated adequate knowledge and skill to perform assigned duties

(c) For all training required under Sections 4-2 through 4-4 of these regulations, refresher training shall be required at least every three years. The training shall be documented.

(d) The employer of the person who received the training shall maintain that documentation as long as the person remains an employee.

Section 4-2 Dispenser Operator Training

(a) The minimum training requirements for dispenser operators, that shall be completed prior to operating LPG dispensers, may be satisfied by certification by either of the following:

(1) Certified Employee Training Program (CETP) *Basic Principles and Practices* as published by PERC

(2) A training program which contains, at minimum, certification by the PERC *Dispensing Propane Safely* program

Section 4-3 Delivery Personnel Training

(a) The minimum training requirements for delivery personnel shall include:

(1) Proper procedure for filling an ASME container

(2) Knowledge of when a leak check is required

(3) Proper procedure for conducting and documenting a leak check

(4) Criteria for determining when filling a container is prohibited because of improper installation or because of excessive corrosion, dents or gouges

(5) Emergency procedures as outlined in the employer's FSA

(6) Completion of the following training programs published by PERC

(A) CETP *Basic Principles and Practices*

(B) CETP *Bobtail Delivery Operations*

(C) CETP *Basic Plant Operations*

(b) All CETP training for delivery personnel shall be completed within one year of assuming current job duties.

Section 4-4 Service and Installation Personnel Training

(a) The minimum training requirements for those who service or install exterior piping of LPG vapor distribution systems may be satisfied by completing the following training programs published by PERC.

(1) CETP *Basic Principles and Practices*

(2) CETP *Designing & Installing Exterior Vapor Distribution Systems*

(3) CETP *Placing Vapor Distribution Systems and Appliances into Operation*

(b) All CETP training for those who service or install exterior piping of LPG vapor distribution systems shall be completed within one year of assuming current job duties.

Section 4-5 Transport Operator Training

(a) The minimum training requirements for transport operators may be satisfied by completing the following training programs published by PERC.

(1) CETP Basic Principles and Practices

(2) PERC Transport Operator Training Program

(b) All CETP training for transport operators shall be completed within one year of assuming current job duties.

ARTICLE 5 ACCIDENT REPORTS AND INVESTIGATIONS

Section 5-1 Reportable Accidents

(a) Reports of accidents, fires, explosions, injuries, damage to property or loss of life at installations using liquefied petroleum gas shall be reported to the division within 24 hours after their occurrence.

(b) Subsection (a) of this Section includes accidents resulting from the improper use of equipment, appliances and appurtenances to LPG systems. The division may investigate such occurrences and shall maintain a written record of findings, which shall be available for public examination.

Section 5-2 Reporting Requirements

(a) The following persons are required to notify the division of an LPG accident that meets any of the criteria of Section 5-1 of these regulations:

(1) Owner or the owner's representative of the LPG facility, if the accident occurred at the facility

(2) Employer of the delivery personnel, if the accident occurred during delivery

(3) Employer of the delivery personnel, if the accident occurred post-delivery and the employer received notification of it

(b) Accidents may be reported by telephone or email using the following information:

(1) Telephone: 303-318-8547

(2) Email: cdle_oil_inspection@state.co.us

(c) The accident report shall include, at minimum, the following information.

(1) The names of the operator and person making the report and their telephone numbers

(2) The date, time and location of the accident

(3) The number of fatalities and personal injuries

(4) All other significant facts known by the person making the report that are relevant to the cause of the accident or extent of the damages

Permanent Rules Adopted

Department

Department of Revenue

Agency

Division of Motor Vehicles

CCR number

1 CCR 204-10

Rule title

1 CCR 204-10 TITLE AND REGISTRATION SECTION 1 - eff 07/30/2017

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DEPARTMENT OF REVENUE

Division of Motor Vehicles – Title and Registration Sections

1 CCR 204-10

RULE 13. PUBLIC TOW REQUIREMENTS FOR ABANDONED VEHICLES

Basis: This regulation is promulgated under the authority of 42-1-204 C.R.S., Part 18 of Article 4 of Title 42 C.R.S.

Purpose The following rules and regulations are promulgated to establish criteria for the notification and title application to the Department when the vehicle is abandoned on public property.

1.0 Definitions

1.1 "Department" means the Department of Revenue, Division of Motor Vehicles.

1.2 "Department Website" means an electronic system whereby an operator registered under 42-4-1806(2) C.R.S. or the agent of such operator shall have access to correct information relating to any owner or lienholder of a vehicle towed by the operator as represented in the Department records at the time of the inquiry.

1.3 "Licensed Motor Vehicle Dealer" means a new or used motor vehicle dealer licensed under Article 6 of Title 12 C.R.S.

1.4 "Operator" means a person or firm licensed by the Public Utilities Commission (PUC) as a towing carrier.

1.5 "Public Tow" A public tow shall result from the abandonment of a vehicle on public property in accordance with 42-4-1802 (1), C.R.S.

1.6 "Rebuilt From Salvage" means a motor vehicle or vehicle that is now roadworthy as defined in 42-6-102(15), C.R.S.

1.7 "Rebuilt from Salvage Brand" means the designation on the Rebuilt from Salvage Certificate of Title and shall become a permanent part of the Certificate of Title and motor vehicle record for such vehicle and shall appear on all subsequent certificates of title for such vehicle.

1.8 "Rebuilt From Salvage Certificate of Title" means a Colorado Certificate of Title issued to a motor vehicle or vehicle as defined in 42-6-136(3)(a), C.R.S.

1.9 "Roadworthy" means a condition in which a motor vehicle has sufficient power and is fit to operate on the roads and highways of this state after visual inspection by appropriate law enforcement authorities. In order to be roadworthy, such vehicle, in accord with its design and use, shall have all major parts and systems permanently attached and functioning and shall not be repaired in such a manner as to make the vehicle unsafe. "Major parts and systems" shall include, but not be limited to, the body of a motor vehicle with related component parts, engine, transmission, tires, wheels, seats, exhaust, brakes, and all other equipment required by Colorado law for the particular vehicle.

1.10 "Salvage" means any motor vehicle or vehicle as defined in 42-6-102(10) and (23) C.R.S. which is damaged as defined by 42-6-102 (17), C.R.S. which shall include any reference to "salvage motor vehicle" or "salvage vehicle".

1.11 "Salvage Brand" means a Salvage Title or Salvage Certificate of Title issued to a salvage motor vehicle or salvage vehicle with the designation 'SALVAGE TITLE' printed on the face of the Certificate of Title and indicated on the motor vehicle record. A motor vehicle registration is not permitted for salvage motor vehicles and salvage vehicles with this designation.

1.12 "Salvage Title or Salvage Certificate of Title" means a Colorado Certificate of Title as defined in 42-6-117, C.R.S issued to a salvage motor vehicle or salvage vehicle.

1.13 "Working Day" means Monday, Tuesday, Wednesday, Thursday and Friday, excluding State Furlough days and Holidays - New Year's Day, Martin Luther King Day, Presidents' Day, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, Christmas Day

2.0 Requirements

2.1 Time Frames - All time frames set forth herein begin with the commencement of a tow of an unattended motor vehicle. Time frames for attended motor vehicles tows begin when the owner or owner of record's agent breaches an agreement with the operator to claim the vehicle. The 'vehicles abandoned on public property' procedure terminates with the release or sale of the vehicle in accordance with Part 18 of Article 4 of Title 42 C.R.S.

2.2 Responsible Law Enforcement Agency – Using the DR 2008 Public Tow Vehicle Information Request form, the responsible law enforcement agency that authorized the tow of the vehicle must report information relating to the tow to the Department no later than 10 working days after having an abandoned vehicle towed.

A. The Department will search its records to determine if there is an owner or lienholder of record. The DR 2008 Public Tow Vehicle Information Request form will serve as notification and search request in the title application upon sale of the vehicle.

B. The law enforcement agency must notify any owner and/or lienholder of record, determined through Department records within 10 working days after receipt of the report from the Department.

C. If no record is found in the Department records, the date of notice shall be the date the search of the Department records was completed.

2.3 Operator - All operators that tow abandoned vehicles from public property must be licensed by the Colorado Public Utilities Commission and shall be registered with the Department.

A. The operator shall submit a DR 2008 Public Tow Vehicle Information Request form to the Department or may perform a record search through the Department Website to obtain owner and lienholder information for a public tow.

B. The date noted on the DR 2008 "Date to DOR" shall be the date used to determine the date that the operator complied with notification to the Department in accordance with 42-4-1804 C.R.S.

C. The operator may collect the amount of the documented direct and indirect costs associated with the notification of the owner and lienholder in accordance with 4 CCR 723-6. Direct costs include the charges paid to the U.S. Postal Service for sending the notice by certified mail, return receipt requested. Indirect costs include, but are not limited to, the administrative costs of labor, equipment and supplies required to send the notice.

2.4 Bond Title Application. If no record is found by the Department through Department records or through the Department Website for vehicles less than five years old, including the current model year, the purchaser shall apply for a bonded title in accordance with the procedure outlined in the

DR 2922 Title or Salvage Title Established by Surety Bond Checklist. When a bond is required, the appraisal on the DR 2173 Motor Vehicle Bill of Sale is valid for 45 days.

2.5 Proceeds of Sale. All proceeds from the sale of a motor vehicle abandoned on private property shall be in accordance with 42-4-1809, C.R.S. Operators are required to complete Section C entitled "Report of Sales of an Abandoned Vehicle" on the DR 2173 Motor Vehicle Bill of Sale.

3.0 Salvage Vehicles

A. Upon receiving record search information from the Department or through the Department Website, and the record indicates that the vehicle is salvage, the responsible law enforcement agency must disclose this information to the buyer.

B. The law enforcement agency must designate the vehicle as "salvage" on the DR 2173 Motor Vehicle Bill of Sale.

C. The responsible law enforcement agency shall provide the buyer with a DR 2444 Statement of Fact indicating the vehicle was purchased as an abandoned vehicle and no repairs were made by the law enforcement agency.

D. The responsible law enforcement agency shall require a DR 2704 Certified VIN Inspection be completed to determine if the vehicle is roadworthy.

E. If the vehicle is roadworthy, then the buyer may apply for a Rebuilt from Salvage Certificate of Title by following the DR 2415 Title Established by Salvage Title Checklist.

F. The buyer will complete a DR 2424 Salvage Title Statement of Fact stating that the vehicle was purchased from the responsible law enforcement agency as an abandoned vehicle and that no repairs have been made.

G. If the completed DR 2704 Certified VIN Inspection indicates that the vehicle is not roadworthy, the buyer may apply for a Salvage Title or Salvage Certificate of Title using the DR 2410 Salvage Title Application.

H. The buyer may apply for a Rebuilt from Salvage Certificate of Title by repairing the vehicle and following the DR 2415 Title Established by Salvage Title Checklist.

I. After repairing the vehicle, a new DR 2704 Certified VIN Inspection is required.

J. A DR 2710 Rebuilt from Salvage Disclosure is required for all subsequent title applications and must indicate "Other – purchased as an abandoned vehicle".

K. If the record search information obtained from the Department or through the Department Website indicates that the vehicle was Rebuilt from Salvage the responsible law enforcement agency shall request a record history from the Department to determine the cause of the initial salvage designation.

L. If reason for initial salvage designation is determined, the responsible law enforcement agency will complete the DR 2710 Rebuilt from Salvage Disclosure to provide the initial salvage designation.

M. If the reason for the initial salvage designation is indeterminate, the responsible law enforcement agency will complete the DR 2710 by marking the "other" box and stating "purchased as an abandoned vehicle, unable to obtain a salvage history, reason for salvage unknown"

4.0 Operator Registration – All operators that tow abandoned vehicles from public property must be issued a permit through the Colorado Public Utilities Commission, and shall be registered with the Department.

5.0 Suspension/Revocation- Upon complaint by the Department, an operator's license may be suspended or revoked by the Colorado Public Utilities Commission, or the Department may cancel the operator's registration when it is established that the operator has violated any of the provisions set forth in part 18 of Article 4 of Title 42 C.R.S.

A. An operator's registration may be canceled and the operator may not complete searches through the Department's website for the following reasons:

I. The operator's PUC status has been revoked by the PUC.

2. The operator is 45 days or more past day on the payment of their monthly bill to the Department for use of the online website search application.

3. The operator has not completed their annual renewal application timely.

6.0 Electronic Search Capability- Whenever possible, operators and the responsible law enforcement agency shall utilize the Department Website to obtain the owner and lienholder information of abandoned vehicles. Use of the Department Website shall be only for the purpose of obtaining the required information to process abandoned vehicles and in full compliance with the Driver Privacy Protection Act. Record search information shall not be provided to the buyer of an abandoned vehicle pursuant to 18 USC 2721. Record search information shall be retained by the operator for a period of three years.

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Office of the Attorney General

Tracking number: 2017-00082

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Motor Vehicles

on 06/02/2017

1 CCR 204-10

TITLE AND REGISTRATION SECTION

The above-referenced rules were submitted to this office on 06/13/2017 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

June 20, 2017 09:09:25

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Permanent Rules Adopted

Department

Department of Revenue

Agency

Division of Motor Vehicles

CCR number

1 CCR 204-10

Rule title

1 CCR 204-10 TITLE AND REGISTRATION SECTION 1 - eff 07/30/2017

Effective date

07/30/2017

DEPARTMENT OF REVENUE

Division of Motor Vehicles – Title and Registration Section

1 CCR 204-10

RULE 12. OBTAINING RECORDS FOR ABANDONED MOTOR VEHICLES

Basis: This rule is promulgated under the authority of section 42-1-204**,** C.R.S., Part 18 of Article 4 of Title 42, and Part 21 of Article 4 of Title 42**,** C.R.S.

Purpose: This rule is promulgated to provide procedures for obtaining records and accessing the Department Website for Abandoned Motor Vehicles.

1.0 Definitions

1.1 "Abandoned Motor Vehicle" for the purpose of this rule includes either or both abandoned motor vehicle on private property defined in section 42-4-2102(1), C.R.S., and abandoned motor vehicle on public property defined in section 42-4-1802(1), C.R.S., as the context of the rule requires.

1.2 "Department Website" means the Colorado Department of Revenue, Title and Registration Section website for acquiring ownership or lienholder information for abandoned vehicles.

1.3 "National Database" means an electronic system that allows the Department to obtain motor vehicle identification numbers, vehicle registration numbers, license plate numbers, and owner(s) and lienholder(s) name and contact information from the motor vehicle records of other states.

1.4 "Operator" has the same meaning as defined in sections 42-4-1802(7) and 42-4-2102(5), C.R.S.

1.5 "Private Tow" means the removal of an Abandoned Motor Vehicle on private property by an Operator pursuant to section 42-4-2103, C.R.S.

1.6 "Public Tow" means the removal of an Abandoned Motor Vehicle on public property in accordance with section 42-4-1803, C.R.S.

1.7 "Towing Law Enforcement Agency" means a law enforcement agency that performs a Public Tow under its own authority.

2.0 Operator and Towing Law Enforcement Agency Registration, Department Website, and National Database

2.1 Only Operators and Towing Law Enforcement Agencies registered with the Department may utilize the Department Website. To register, an Operator must submit a DR 2099 Tow Carrier Registration form, and a Towing Law

Enforcement Agency must submit a DR 2586 Law Enforcement Registration form.

2.2 Operators and Towing Law Enforcement Agencies must renew their Department Website registration annually, as directed in the Department's renewal notification.

2.3 An Operator must attempt to obtain the motor vehicle owner(s) and lienholder(s), name and contact information by submitting a DR 2489A Motor Vehicle Requestor Release Affidavit of Intended Use form with payment to the Department, or by performing a record search through the Department Website.

2.4 An Operator will be invoiced monthly for each Colorado record search completed through the Department Website.

2.5 An accurately completed DR 2008 Public Tow Vehicle Information Request form and DR 2008A Private Tow Vehicle Information Request form submitted with the title application filed upon sale of the motor vehicle is prima facie proof that the owner/lienholder notification and search requirements are satisfied.

2.6 The Department may cancel an Operator's registration and access to the Department Website pursuant to sections 42-4-1806(2)(b), 42-4-2105(2)(b), C.R.S., and for any violation of Part 18 of Article 4 of Title 42 or Part 21 of Article 4 of Title 42, C.R.S., or this Rule, including but not limited to the following:

a. The Operator's permit to operate as a towing carrier has been suspended, cancelled, or revoked by the Department of Regulatory Agencies, Public Utilities Commission.

b. Being forty-five days or more past due on a monthly payment to the Department for use of the Department Website.

c. Obtaining or using records for any purpose not authorized by this rule or Colorado Revised Statutes.

d. Failing to timely file an annual registration renewal for access to the Department Website.

3.0 Abandoned Motor Vehicle Record Search

3.1 A Colorado record search must be performed on all Abandoned Motor Vehicles, regardless of whether the vehicle has Colorado license plates, by submitting a DR 2489A Motor Vehicle Requestor Release Affidavit of Intended Use form or by using the Department Website.

3.2 A National Database record search must be performed if:

a. The Colorado record search results in "no record found".

b. The Abandoned Motor Vehicle displays visual indicators that it is an out-of-state motor vehicle (e.g., another state's license plate or registration number).

3.3 A National Database record search is performed by completing the DR 2489A Motor Vehicle Requestor Release Affidavit of Intended form with payment. An Operator may request the National Database record search at the same time as the Colorado record search if payment for both is remitted at the same time. Where the Colorado record search results in a motor vehicle record found, the Department will not perform a National Database search and will not refund the payment for the National Database record search.

4.0 Operator Access to Department Website and Records Cancelled - Hearing

4.1 Access Cancelled Due to Department of Regulatory Agencies, Public Utilities Commission Actions.

a. The Department will notify and cancel an Operator's access to the Department Website immediately upon receiving a final decision notice that the Operator's towing carrier license issued by the Department of Regulatory Agencies, Public Utilities Commission has been cancelled in accordance with sections 24-4-104 and 24-4-105, C.R.S.

b. An Operator whose access to the Department Website or records is cancelled may request a hearing, in writing, within thirty days after the notice of cancellation is issued. Written hearing requests must be submitted to the Department of Revenue, Hearings Division.

c. The hearing will be held at the Department of Revenue, Hearings Division. The presiding hearing officer shall be an authorized representative designated by the Executive Director. The Department's representative need not be present at the hearing unless his or her presence is required by the presiding officer, or requested by the Operator at the time the written request for hearing is submitted. If the Department's representative is not present at the hearing, any written documents and affidavits submitted by the Department may be considered at the discretion of the hearing officer.

d. The sole issue at hearing will be whether the Department of Regulatory Agencies, Public Utilities Commission issued a final decision revoking the Operator's towing carrier license.

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Tracking number: 2017-00081

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Motor Vehicles

on 06/12/2017

1 CCR 204-10

TITLE AND REGISTRATION SECTION

The above-referenced rules were submitted to this office on 06/13/2017 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

June 20, 2017 09:22:58

Cynthia H. Coffman
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Permanent Rules Adopted

Department

Department of Revenue

Agency

Division of Gaming - Rules promulgated by Gaming Commission

CCR number

1 CCR 207-1

Rule title

1 CCR 207-1 GAMING REGULATIONS 1 - eff 07/30/2017

Effective date

07/30/2017

BASIS AND PURPOSE FOR RULE 3

The purpose of Rule 3 is to establish and provide the specific information required on license applications; to establish yearly license fees for each type of license; to establish nonrefundable application fees; to establish investigation fees for certain applicants and deposit procedures for investigation fees; to establish procedures for conducting background checks on applicants and other interested persons and assessing the costs of such background checks; to require certain information regarding the premises the applicant wishes to be licensed, and to provide a procedure for approval of modifications of such premises; and to provide for the issuance of conditional, temporary, and duplicate licenses. The statutory basis for Rule 3 is found in sections 12-47.1-102, C.R.S., 12-47.1-103, C.R.S., 12-47.1-201, C.R.S., 12-47.1-203, C.R.S., 12-47.1-302, C.R.S., and part 5 of article 47.1 of title 12, C.R.S. *Amended 1/14/15*

RULE 3 APPLICATIONS, INVESTIGATIONS AND LICENSURE

All paragraphs of regulations 47.1-301 through 47.1-304 should remain part of this Rule

47.1-305 Investigation fees.

(1) All applicants for licenses and persons seeking approval of variation games of blackjack, poker, craps, roulette, blackjack-poker combination games and table games with electronic betting terminals, except support licenses, shall pay the costs of investigations into their backgrounds, suitability, and qualifications for licensure. *Eff 04/01/2007 Amended 11/30/2012*

(a) The cost of such investigations shall be at the rate of $69.00 per hour for each hour spent by investigators of the Division, the Colorado Bureau of Investigation, or the Department of Revenue investigating the applicants until the conclusion of the investigation. *Effective 7/1/2011, (47.1-305(a) amended temp. 7/1/16, amended perm. 7/16/16)*

All paragraphs of regulations 47.1-305 (b) through 47.1-325 should remain part of this Rule

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Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Gaming - Rules promulgated by Gaming Commission

on 06/15/2017

1 CCR 207-1

GAMING REGULATIONS

The above-referenced rules were submitted to this office on 06/15/2017 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

June 29, 2017 10:56:04

Cynthia H. Coffman
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Permanent Rules Adopted

Department

Department of Natural Resources

Agency

Colorado Parks and Wildlife (405 Series, Parks)

CCR number

2 CCR 405-3

Rule title

2 CCR 405-3 CHAPTER P-3 - RIVER OUTFITTERS 1 - eff 08/01/2017

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08/01/2017

FILING- 06/28/2017

FINAL REGULATIONS - CHAPTER P-3 - RIVER OUTFITTERS

 # 302 - GUIDE, TRIP LEADER, AND GUIDE INSTRUCTOR TRAINING AND QUALIFICATION RECORDS

1.

a. A guide shall have a minimum of fifty hours of on-river training utilizing paddles and/or oars, and any other equipment that the guide will be using on regulated trips. Of this fifty hours, thirty hours shall be with a qualified guide instructor aboard the same vessel with the trainee. The remaining twenty hours shall be with a qualified guide instructor on the same training trip. Twenty hours of training shall occur on the river on which the guide will be guiding regulated trips or on a river section of comparable difficulty.

b. Minimum guide training shall include the following areas of instruction:

(1) Rigging and maneuvering the vessel;

(2) River currents, eddies, and waves;

(3) River hazards;

(4) Types and causes of river rapids;

(5) Scouting and running rapids;

(6) River rescue and emergency procedures;

(7) Minimizing outdoor recreation resource impacts; and

(8) Proper fit, wearing and use of personal flotation devices.

c. Guides who have worked commercially out-of-state as a river guide must furnish the in-state river outfitter with written documentation that they have received this required minimum guide training, or its equivalent. The river outfitter shall ensure that the documented out-of-state training is adequate to meet the minimum guide training requirements.

2. Prior to guiding a regulated trip, each guide shall have:

a. Completed the required training identified in # 302-1.; and

b. Operated a commercial vessel at least once over the course of each section of river that will be guided.

3. During each guide's first regulated trip, a qualified guide instructor must be aboard the same vessel with the guide.

4. A river outfitter shall maintain a qualification record for each guide, including subcontractors, employed. Such record shall include:

a. The guide's full legal name and date of birth;

b. Evidence of successful completion of a standard hands-on first-aid course, which shall include training and evaluation in cardiopulmonary resuscitation. The following documents shall be accepted by the division as evidence that the guide has qualifying emergency medical care training:

(1) A photocopy of the front and back of the guide's valid standard first-aid card or certificate issued by any institution recognized as a provider of emergency medical care training, for example, the American Red Cross, the National Safety Council, or hospitals. If the first-aid course did not include hands-on training in cardiopulmonary resuscitation, then additionally required is a photocopy of the front and back of the guide's valid cardiopulmonary resuscitation card or certificate issued by any institution recognized as a provider of cardiopulmonary resuscitation training, for example, the American Red Cross or the American Heart Association; or

(2) In lieu of the required card(s) or certificate(s), a copy of a dated letter signed by the instructor(s) stating that the guide has successfully completed the emergency medical care training required, and stating the instructor's address and telephone number;

c. Written documentation that the guide is qualified by meeting the minimum training requirements established in this regulation. Such documentation shall include:

(1) Dates and beginning and ending times of training;

(2) Identification of the training site, including a description of beginning and ending locations for on-river training and a location description or address for classroom training;

(3) The name(s) of the guide instructor(s) who provided the instruction and training; and

(4) The signature(s) of the guide instructor(s) attesting that the minimum guide training requirements established in this regulation have been met.

5. A river outfitter shall maintain a qualification record for each trip leader and guide instructor, including subcontractors, employed. Such record shall include:

a. The trip leader's or guide instructor's full legal name and date of birth;

b. Evidence of successful completion of a standard hands-on first-aid course, which shall include training and evaluation in cardiopulmonary resuscitation, as specified in #302-4.b. (1) or (2);

c. For guide instructors, written documentation that the individual has logged a total of at least fifteen hundred river miles, of which at least seven hundred fifty of those river miles were logged while acting as a qualified guide, and has served as a trip leader on at least five regulated trips. For trip leaders, written documentation that the individual has logged a total of at least five hundred river miles, of which at least two hundred fifty river miles shall have been logged while acting as a qualified guide and no more than two hundred fifty river miles shall have been logged while acting as a guide on non-regulated trips. Such documentation shall consist of a log that is updated annually until the qualifications to be considered a guide instructor have been met and includes:

(1) River name and location (State/Country);

(2) River sections that they have run for a date range per calendar year;

(3) Number of miles per section;

(4) Number of trips they have run per section;

(5) Identification of the trip as either private or commercial;

(6) Identification of all trips during which the individual served as a trip leader; and

(7) Date that the guide met the mileage requirement to be considered a trip leader and/or guide instructor and their employer at that time.

6. Guide qualification records, trip leader qualification records, and guide instructor qualification records shall be maintained by the primary employer at that river outfitter's designated place of business. In the case of a river outfitter who temporarily hires the services of a guide, trip leader, or guide instructor who is primarily employed by a different river outfitter, the following regulations apply:

   a. A river outfitter who temporarily uses the services of a guide or trip leader who is primarily employed by a different river outfitter shall identify in the applicable trip log(s) the river outfitter that maintains the guide qualification record for the guide or trip leader.

   b. A river outfitter who temporarily uses the services of a guide instructor who is primarily employed by a different river outfitter shall identify, in each guide's qualification record for all guides trained by the instructor, the river outfitter that maintains the guide instructor qualification record.

   c. River outfitters may only use the services of guides, trip leaders and guide instructors who are primarily employed by different river outfitters if the other river outfitters are licensed in the State of Colorado and maintain their place of business in the State of Colorado.

   d. A river outfitter shall not provide any guide, trip leader, or guide instructor to another river outfitter unless the employee is qualified for the position requested.

7. A river outfitter shall maintain all guide, trip leader, and guide instructor qualification records during the period of such employee’s employment and for a period of three years after his/her termination. These required records shall be maintained at the river outfitter's designated place of business. The river outfitter, or any employee having access to such records, shall provide them at all reasonable times to any peace officer enforcing the provisions of Article 32 of Title 33, C.R.S., and these regulations, upon request.

8. In the event that a guide, trip leader, or guide instructor, who received their initial guide training in Colorado, has training documentation that is incomplete (due to an administrative error), lost, or destroyed, the individual may submit to the River Outfitter Licensing Program Manager or his/her designee a signed affidavit provided by the Division, stating that the guide, trip leader, or guide instructor has completed the minimum training requirements before guiding a regulated trip. A signed affidavit and completed river log as specified in # 302.4.c or #302.5.c, will be accepted in lieu of initial training documentation.

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Colorado Parks and Wildlife (405 Series, Parks)

on 06/08/2017

2 CCR 405-3

CHAPTER P-3 - RIVER OUTFITTERS

The above-referenced rules were submitted to this office on 06/13/2017 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

June 20, 2017 09:18:27

Cynthia H. Coffman
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Permanent Rules Adopted

Department

Department of Natural Resources

Agency

Colorado Parks and Wildlife (405 Series, Parks)

CCR number

2 CCR 405-7

Rule title

2 CCR 405-7 CHAPTER P-7 - PASSES, PERMITS AND REGISTRATIONS 1 - eff 08/01/2017

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FILING - 06/28/2017

FINAL REGULATIONS - CHAPTER P-7 - PASSES, PERMITS AND REGISTRATIONS

ARTICLE I - GENERAL PROVISIONS AND FEES RELATING TO PASSES, PERMITS AND REGISTRATIONS

VEHICLE PASSES

 # 700 - VEHICLE PASS

1. Except as otherwise provided in these regulations or by Colorado Revised Statutes, no motor vehicle shall be brought onto any Parks and Outdoor Recreation lands unless a valid pass issued by the Division is properly attached. Passes that are designed to be affixed to the windshield shall be attached to the extreme lower right-hand corner of the vehicle's windshield in a position so that the pass may be observed and identified. For an annual vehicle pass, including an aspen leaf annual pass to be properly attached to a windshield it must be permanently affixed. Any vehicle whereby a pass cannot be secured inside the passenger compartment shall be treated as a special case, but evidence of a pass shall be required on the person or in the vehicle. Other types of passes, such as hang tag passes, shall be continuously displayed in the motor vehicle in the manner described on the pass while the motor vehicle is operated or parked on Division properties.

2. No vehicle pass shall be required for:

    a. Any snowmobile as defined in section 33-14-101, C.R.S.;

    b. Any off-highway vehicle as defined in section 33-14.5-101(3), C.R.S.;

    c. Any government-owned vehicle, emergency vehicle, or law enforcement vehicle on official business;

    d. Any commercial delivery vehicle delivering goods to the park or a park concessionaire when the goods are directly related to the operation of the park or concession;

    e. Any resident's vehicle displaying a Colorado disabled veteran's license plate pursuant to section 42-3-213(5)(a), C.R.S., and as provided for in section 33-12-106(1), C.R.S.;

    f. Any vehicle bringing a qualified holder of a transferable Columbine or a Centennial annual pass into a park;

    g. Any vehicle that is not required to have a vehicle pass pursuant to the special activity regulation # 703;

    h. Any vehicle entering a park on Colorado day; or

    i. Any vehicle that is exclusively towed.

    j. Any vehicle occupied by a veteran or current or reserve member of any branch of the armed forces of the United States, on the State observance of Veteran's Day. At least one form of past or present military identification shall be presented at the Park entrance. Acceptable forms of military identification include:

- DD214;
- DD Form 2;
- DD Form 2765;
- Active, retired or veteran military identification cards;
- A current Colorado Driver's License or state issued identification card with the word 'Veteran' printed on it as specified in 42-2-303 (5)(a), C.R.S.;
- VA medical card;
- The display of military license plates.

k. Any vehicle occupied by a veteran, reserve, or active duty member of any branch of the armed forces of the United States, during the month of August. At least one form of past or present military identification shall be presented at any state park or Division office in order to receive a free vehicle hang tag pass. Acceptable forms of military identification include:

- DD214;
- DD Form 2;
- DD Form 2765;
- Active, retired or veteran military identification cards;
- A current Colorado Driver's License or state issued identification card with the word 'Veteran' printed on it as specified in 42-2-303 (5)(a), C.R.S.;
- VA medical card.

(1) As referenced in this chapter, "veteran" means a person who served in the active military, naval, or air service and who was discharged or released under conditions other than dishonorable.

l. Any vehicle entering a state park to participate in the Outdoor Adventure Expo annual weekend event.

3. The types of annual vehicle passes available from the Division are as follows:

a. An Aspen Leaf annual pass as provided for in section 33-12-103, C.R.S.; and

b. An annual vehicle pass, which is available for any vehicle except passenger vans and buses operated by a commercial business.

(1) Commercial passenger vans and buses are eligible to purchase daily, but not annual, vehicle passes.

(2) School buses on official school outings, passenger vans and buses operated by a nonprofit corporation or organization as defined in 13-21-115.5 (3), C.R.S., and passenger vans and buses operated by any government agency are eligible for either daily or annual vehicle passes.

4. Daily vehicle passes are as follows:

a. A fee of $7.00 per vehicle for any vehicle except for:

(1) Passenger vans and buses operated by a commercial business;

(2) A $1.00 per vehicle capacity fee will be added to the cost of daily vehicle passes at Cherry Creek, Chatfield, and Boyd Lake State Recreation Areas, and Eldorado Canyon State Park.

b. School buses on official school outings, passenger vans and buses operated by a nonprofit corporation or organization as defined in 13-21-115.5 (3), C.R.S., and passenger vans and buses operated by any government agency are eligible to purchase a daily vehicle pass.

c. For passenger vans and buses operated by a commercial business, the daily vehicle pass fee will be based upon the number of passengers on-board. The fee shall be $10.00 for up to fifteen passengers on-board, $40.00 for sixteen to thirty passengers on-board, and $50.00 for more than thirty passengers on-board.

5. An annual vehicle pass shall be issued and, by appropriate language, authorize entrance by motor vehicle to all state recreation areas and state parks during the period beginning on the date of purchase through the last day of the same month in the following year. Such authorization shall apply to the user and all passengers in the motor vehicle to which the pass is affixed. One pass shall cover all state recreation areas and state parks.

6. Additional annual vehicle passes may be issued to an owner or to the owner's immediate family members. Additional annual vehicle passes authorize entrance by motor vehicle to all state recreation areas and state parks during the period beginning on the date of purchase of the additional pass through the expiration date of the associated original full-priced annual pass. Owners of school buses, passenger vans and buses owned by a nonprofit corporation or organization as defined in 13-21-115.5 (3), C.R.S., and passenger vans and buses owned by any government agency are limited to purchasing no more than two additional annual vehicle passes at a reduced fee per each annual vehicle pass purchased at the full fee. For the purpose of this regulation, "immediate family members" are defined as spouses and children with valid driver's licenses living at the same address. "Owner" is defined as the person whose name appears on the registration of both the original vehicle for which an annual pass was purchased and the additional vehicle, or a person who can provide proof of ownership of the original and the additional vehicle at a designated Division office.

7. If the motor vehicle for which an annual vehicle pass or additional vehicle pass was issued is sold or traded, or if the pass is lost or destroyed during the period in which it is valid, the person to whom the pass was issued may obtain a duplicate thereof, upon signing an affidavit reciting

where and by whom it was issued and the circumstances under which it was lost or traded. Upon payment of a fee of $5.00, a new pass effective for the remainder of the period that the lost or destroyed pass would have been valid may be issued only by the Division to the original owner of such pass.

8. A daily park pass, valid for one day only, shall authorize entrance by motor vehicle to the state recreation areas and state parks by the user and all passengers in the motor vehicle to which the pass is affixed during the day used and until 12:00 P.M. (noon) the following day.

9. A no fee pass shall be issued to any vehicle towed or carried in by a motor home if a camping permit or proof of a campsite reservation is presented at an attended visitor center, office or entrance station. The no fee pass, valid for the same time period as the camping permit or camping reservation, shall authorize entrance by motor vehicle to the state recreation areas and state parks by the user and all passengers in the motor vehicle to which the pass is affixed. For the purpose of this regulation, motor home means a vehicle designed to provide temporary living quarters and which is built into, as an integral part of or a permanent attachment to, a motor vehicle chassis or van.

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Opinion of the Attorney General rendered in connection with the rules adopted by the

Colorado Parks and Wildlife (405 Series, Parks)

on 06/08/2017

2 CCR 405-7

CHAPTER P-7 - PASSES, PERMITS AND REGISTRATIONS

The above-referenced rules were submitted to this office on 06/13/2017 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

June 20, 2017 09:18:58

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Permanent Rules Adopted

Department

Department of Natural Resources

Agency

Colorado Parks and Wildlife (406 Series, Wildlife)

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2 CCR 406-5 CHAPTER W-5 - MIGRATORY BIRDS 1 - eff 08/01/2017

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FINAL REGULATIONS - CHAPTER W-5 - MIGRATORY BIRDS

ARTICLE I – GENERAL PROVISIONS

#511 – DUCK AND COOT

A. Central Flyway Northeast Zone – All areas east of Interstate 25 and north of Interstate 70.

1. Dates:
   a. First season: October 7 - November 27, 2017.
   b. Second season: December 16, 2017 - January 28, 2018.
2. Daily Bag Limit:
   a. Ducks: Six (6), excluding mergansers. Of the six (6), no more than five (5) mallards, of which no more than two (2) can be female, one (1) pintail, two (2) canvasback, two (2) redheads, three (3) wood ducks, and three (3) scaup.
   b. Mergansers: Five (5), of which no more than two (2) may be hooded mergansers.
   c. Coots: Fifteen (15).
3. Possession limit: Three (3) daily bag limits.

B. Central Flyway Southeast Zone – All areas east of Interstate 25 and south of Interstate 70, and all of El Paso, Pueblo, Huerfano and Las Animas Counties.

1. Dates:
   a. October 25, 2017 - January 28, 2018.
2. Daily Bag Limit:
   a. Ducks: Six (6), excluding mergansers. Of the six (6), no more than five (5) mallards, of which no more than two (2) can be female, one (1) pintail, two (2) canvasback, two (2) redheads, three (3) wood ducks, and three (3) scaup.
   b. Mergansers: Five (5), of which no more than two (2) may be hooded mergansers.
   c. Coots: Fifteen (15).
3. Possession limit: Three (3) daily bag limits.

C. Central Flyway Mountain/Foothills Zone – All areas west of Interstate 25 and east of the Continental Divide, except El Paso, Pueblo, Huerfano and Las Animas Counties.

1. Dates:
   a. First season: September 30 - November 27, 2017.
   b. Second season: December 23, 2017 - January 28, 2018.
2. Daily Bag Limit:
   a. Ducks: Six (6), excluding mergansers. Of the six (6), no more than five (5) mallards, of which no more than two (2) can be female, one (1) pintail, two (2) canvasback, two (2) redheads, three (3) wood ducks, and three (3) scaup.
   b. Mergansers: Five (5), of which no more than two (2) may be hooded mergansers.
   c. Coots: Fifteen (15).
3. Possession limit: Three (3) daily bag limits.

D. Pacific Flyway Western Zone – All areas west of the Continental Divide not included in the Eastern Zone.

1. Dates:
   a. First season: September 30 - October 18, 2017
   b. Second season: November 4, 2017 - January 28, 2018.
2. Daily Bag Limit:

a. Ducks and Mergansers: Seven (7) in the aggregate. Of the 7 (seven), no more than two (2) female mallards, one (1) pintail, two (2) canvasback, two (2) redheads, and three (3) scaup. No scaup may be taken after January 9, 2018.
b. Coots: Twenty-five (25).

3. Possession limit:
   a. Three (3) daily bag limits.

E. Pacific Flyway Eastern Zone - All of Routt, Grand, Summit, Eagle, and Pitkin counties, those portions of Saguache, San Juan, Hinsdale, and Mineral counties west of the Continental Divide, and those portions of Gunnison County except the North Fork of the Gunnison River Valley (GMUs 521, 53, and 63).

1. Dates:
   a. First season: September 30, 2017 - January 12, 2018
2. Daily Bag Limit:
   a. Ducks and Mergansers: Seven (7) in the aggregate. Of the 7 (seven), no more than two (2) female mallards, one (1) pintail, two (2) canvasback, two (2) redheads, and three (3) scaup. No scaup may be taken after December 24, 2017.
   b. Coots: Twenty-five (25).
3. Possession limit:
   a. Three (3) daily bag limits.

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Opinion of the Attorney General rendered in connection with the rules adopted by the

Colorado Parks and Wildlife (406 Series, Wildlife)

on 06/08/2017

2 CCR 406-5

CHAPTER W-5 - MIGRATORY BIRDS

The above-referenced rules were submitted to this office on 06/13/2017 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

June 20, 2017 09:18:04

Frederick R. Yarger

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Permanent Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Insurance

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3 CCR 702-3

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3 CCR 702-3 FINANCIAL ISSUES 1 - eff 08/01/2017

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08/01/2017

DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-3

FINANCIAL ISSUES

Amended Regulation 3-1-11

RISK-BASED CAPITAL (RBC) FOR INSURERS

Section 1 Authority

This Regulation is promulgated under the authority of §§ 10-1-109, 10-3-201(1)(b), 10-6-129, and 10-14-604, C.R.S.

Section 2 Scope and Purpose

The purpose of this Regulation is to establish standards for the minimum capital and surplus to be maintained by insurers, captive insurers and fraternal benefit societies as provided by §§ 10-3-201(1)(b),

10-6-116, and 10-14-604, C.R.S. These standards provide for the early detection of a potentially hazardous or otherwise dangerous condition of an insurer in order to protect its insureds and the general public. This Regulation additionally provides for reporting, corrective measures, and enforcement actions available to the Commissioner.

Section 3 Applicability

This Regulation shall apply to all insurers as defined in Section 4. below.

Section 4 Definitions

As used in this Regulation, these terms shall have the following meanings:

A. "Adjusted RBC Report" shall mean, for the purposes of this regulation, an RBC report which has been adjusted by the Commissioner in accordance with Section 5.E.

B. "Corrective Order" shall mean, for the purposes of this regulation, an order issued by the Commissioner pursuant to § 10-3-404, C.R.S., specifying corrective actions which the Commissioner has determined are required.

C. "Domestic insurer" shall mean, for the purposes of this regulation, any insurance company or fraternal benefit society domiciled in this State.

D. "Foreign insurer" shall mean, for the purposes of this regulation, any insurance company or fraternal benefit society that is licensed to do business in this State, but is not domiciled in this State.

E. "Life and/or health insurer" shall mean, for the purposes of this regulation, any insurance company licensed as a life insurer, health insurer, fraternal benefit society, or a licensed property and casualty insurer writing only accident and health insurance.

F. "NAIC" shall means, for the purposes of this regulation, the National Association of Insurance Commissioners.

G. "Negative trend" shall mean, for the purposes of this regulation, with respect to a life and/or health insurer, a negative trend over a period of time, as determined in accordance with the "Trend Test Calculation" included in the Life RBC Instructions.

H. "Property and casualty insurer" shall mean, for the purposes of this regulation, any licensed property and casualty insurance company, including a group captive insurance company organized pursuant to the provisions of Article 6 of Title 10, C.R.S., but shall not include monoline mortgage guaranty insurers, financial guaranty insurers, title insurers and county mutual protective associations organized on an assessment basis pursuant to § 10-12-101(2), C.R.S.

I. "RBC instructions" shall mean, for the purposes of this regulation, the RBC Report, including risk-based capital instructions and procedures adopted by the NAIC, as part of the required annual filing on the NAIC convention blank.

J. "RBC Level" shall mean, for the purposes of this regulation, an insurer's Company Action Level RBC, Regulatory Action Level RBC, Authorized Control Level RBC, or Mandatory Control Level RBC, where:

1. "Company Action Level RBC" means, with respect to any insurer, the product of 2.0 and its Authorized Control Level RBC;

2. “Regulatory Action Level RBC” means the product of 1.5 and its Authorized Control Level RBC;

3. “Authorized Control Level RBC” means the number determined under the risk-based capital formula in accordance with the RBC Instructions;

4. “Mandatory Control Level RBC” means the product of .70 and the Authorized Control Level RBC.

K. “RBC Plan” shall mean, for the purposes of this regulation, a comprehensive financial plan containing the elements specified in Section 6.B. If the Commissioner rejects the RBC Plan, and it is revised by the insurer, with or without the Commissioner’s recommendation, the plan shall be called the “Revised RBC Plan.”

L. “RBC Report” shall mean, for the purposes of this regulation, the report required in Section 5. of this Regulation.

M. “Total Adjusted Capital” shall mean, for the purposes of this regulation, the sum of:

1. An insurer’s statutory capital and surplus as determined in accordance with the statutory accounting applicable to the annual financial statements; and

2. Such other items, if any, as the RBC Instructions may provide.

Section 5 RBC Reports

A. A domestic insurer shall, on or prior to each March 1 (the “filing date”), prepare and submit to the Commissioner a report of its RBC Levels as of the end of the calendar year just ended, in a form and containing such information as is required by the RBC Instructions. In addition, a domestic insurer shall file its RBC Report:

1. With the NAIC in accordance with the RBC Instructions; and

2. With the insurance commissioner in any state in which the insurer is authorized to do business, if the insurance commissioner has notified the insurer of its request in writing, in which case the insurer shall file its RBC Report not later than the later of:

a. Fifteen (15) days from the receipt of notice to file its RBC Report with that state; or

b. The filing date.

B. A life and/or health insurer’s RBC shall be determined in accordance with the formula set forth in the RBC Instructions. The formula shall take the following into account (and may adjust for the covariance between) determined in each case by applying the factors in the manner set forth in the RBC Instructions:

1. The risk with respect to the insurer’s assets;

2. The risk of adverse insurance experience with respect to the insurer’s liabilities and obligations;

3. The interest rate risk with respect to the insurer’s business; and

4. All other business risks and such other relevant risks as are set forth in the RBC Instructions.

C. A property and casualty insurer's RBC shall be determined in accordance with the formula set forth in the RBC Instructions. The formula shall take the following into account (and may adjust for the covariance between) determined in each case by applying the factors in the manner set forth in the RBC Instructions:

1. Asset risk;

2. Credit risk;

3. Underwriting risk; and

4. All other business risks and such other relevant risks as are set forth in the RBC Instructions.

D. An excess of capital over the amount produced by the risk-based capital requirements contained in this Regulation and the formulas, schedules and instructions referenced in this Regulation is desirable in the business of insurance. Accordingly, insurers should seek to maintain capital above the RBC Levels required by this Regulation. Additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this Regulation.

E. If a domestic insurer files an RBC Report which in the judgment of the Commissioner is inaccurate, then the Commissioner shall adjust the RBC Report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice shall contain a statement of the reason for the adjustment. An RBC Report as so adjusted is referred to as an "Adjusted RBC Report."

Section 6 Company Action Level Event

A. "Company Action Level Event" means any of the following events:

1. The filing of an RBC Report by an insurer, which indicates that:

a. The insurer's Total Adjusted Capital is greater than or equal to its Regulatory Action Level RBC but less than its Company Action Level RBC;

b. If a life and/or health insurer, the insurer has Total Adjusted Capital which is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 3.0 and has a negative trend; or

c. If a property and casualty insurer, the insurer has Total Adjusted Capital which is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the Property and Casualty RBC Instructions;

2. The notification by the Commissioner to the insurer of an Adjusted RBC Report that indicates an event in Paragraph 1. of this subsection, provided the insurer does not challenge the Adjusted RBC Report under Section 10.; or

3. If, pursuant to Section 10., an insurer challenges an Adjusted RBC Report that indicates the event in Paragraph 1. of this subsection, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

B. In the event of a Company Action Level Event, the insurer shall prepare and submit to the Commissioner an RBC Plan which shall:

1. Identify the conditions which contribute to the Company Action Level Event;

2. Contain proposals of corrective actions which the insurer intends to take and that would be expected to result in the elimination of the Company Action Level Event;

3. Provide projections of the insurer's financial results in the current year and at least the four (4) succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital and surplus. (The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense and benefit component);

4. Identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

5. Identify the quality of, and problems associated with, the insurer's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

C. The RBC Plan shall be submitted:

1. Within forty-five (45) days of the Company Action Level Event; or

2. If the insurer challenges an Adjusted RBC Report pursuant to Section 10., within forty-five (45) days after notification to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

D. Within sixty (60) days after the submission by an insurer of an RBC Plan to the Commissioner, the Commissioner shall notify the insurer whether the RBC Plan shall be implemented or is, in the judgment of the Commissioner, unsatisfactory. If the Commissioner determines the RBC Plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination, and may set forth proposed revisions which will render the RBC Plan satisfactory, in the judgment of the Commissioner. Upon notification from the Commissioner, the insurer shall prepare a Revised RBC Plan, which may incorporate by reference any revisions proposed by the Commissioner, and shall submit the Revised RBC Plan to the Commissioner:

1. Within forty-five (45) days after the notification from the Commissioner; or

2. If the insurer challenges the notification from the Commissioner under Section 10., within forty-five (45) days after a notification to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

E. In the event of a notification by the Commissioner to an insurer that the insurer's RBC Plan or Revised RBC Plan is unsatisfactory, the Commissioner may at the Commissioner's discretion, subject to the insurer's right to a hearing under Section 10., specify in the notification that the notification constitutes a Regulatory Action Level Event.

F. Every domestic insurer that files an RBC Plan or Revised RBC Plan with the Commissioner shall file a copy of the RBC Plan or Revised RBC Plan with the insurance commissioner or other regulatory authority in any state in which the insurer is authorized to do business if:

1. Such state has a provision substantially similar to Section 11.A.; and

2. The insurance commissioner of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the RBC Plan or Revised RBC Plan in that state no later than the later of:

a. Fifteen (15) days after the receipt of notice to file a copy of its RBC Plan or Revised RBC Plan with the state; or

b. The date on which the RBC Plan or Revised RBC Plan is filed under Section 6.C. and 6.D. of this Regulation.

Section 7 Regulatory Action Level Event

A. "Regulatory Action Level Event" means any of the following events:

1. The filing of an RBC Report by the insurer which indicates that the insurer's Total Adjusted Capital is greater than or equal to its Authorized Control Level RBC but less than its Regulatory Action Level RBC;

2. Notification by the Commissioner to an insurer of an Adjusted RBC Report that indicates the event in Paragraph 1., provided the insurer does not challenge the Adjusted RBC Report under Section 10.;

3. If, pursuant to Section 10., the insurer challenges an Adjusted RBC Report that indicates the event in Paragraph 1., the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge;

4. The failure of the insurer to file an RBC Report by the filing date, unless the insurer has provided an explanation for such failure which is satisfactory to the Commissioner and has cured the failure within ten (10) days after the filing date;

5. The failure of the insurer to submit an RBC Plan to the Commissioner within the time period set forth in Section 6.C. of this Regulation;

6. Notification by the Commissioner to the insurer that:

a. The RBC Plan or Revised RBC Plan submitted by the insurer is, in the judgment of the Commissioner, unsatisfactory; and

b. Such notification constitutes a Regulatory Action Level Event with respect to the insurer, provided the insurer has not challenged the determination under Section 10.;

7. If, pursuant to Section 10., the insurer challenges a determination by the Commissioner under Paragraph 6., the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected such challenge;

8. Notification by the Commissioner to the insurer that the insurer has failed to adhere to its RBC Plan or Revised RBC Plan, but only if the failure has a substantial adverse effect on the ability of the insurer to eliminate the Company Action Level Event in accordance with its RBC Plan or Revised RBC Plan and the Commissioner has so stated in the notification, provided the insurer has not challenged the determination under Section 10.; or

9. If, pursuant to Section 10., the insurer challenges a determination by the Commissioner under Paragraph 8., the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the challenge.

B. In the event of a Regulatory Action Level Event the Commissioner shall:

1. Require the insurer to prepare and submit an RBC Plan or, if applicable, a Revised RBC Plan;

2. Perform such examination or analysis as the Commissioner deems necessary of the assets, liabilities and operations of the insurer including a review of its RBC Plan or Revised RBC Plan; and

3. Subsequent to the examination or analysis, issue an order specifying such corrective actions as the Commissioner shall determine are required (a "Corrective Order").

C. In determining corrective actions, the Commissioner may take into account factors the Commissioner deems relevant with respect to the insurer based upon the Commissioner's examination or analysis of the assets, liabilities and operations of the insurer, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC Instructions. The RBC Plan or Revised RBC Plan shall be submitted:

1. Within forty-five (45) days after the occurrence of the Regulatory Action Level Event;

2. If the insurer challenges an Adjusted RBC Report pursuant to Section 10. and the challenge is not frivolous in the judgment of the Commissioner, within forty-five (45) days after the notification to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge; or

3. If the insurer challenges a Revised RBC Plan pursuant to Section 10. and the challenge is not frivolous in the judgment of the Commissioner, within forty-five (45) days after the notification to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

D. The Commissioner may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the Commissioner to review the insurer's RBC Plan or Revised RBC Plan, examine or analyze the assets, liabilities and operations of the insurer and formulate the Corrective Order with respect to the insurer. The fees, costs and expenses relating to consultants shall be borne by the affected insurer or such other party as directed by the Commissioner.

Section 8 Authorized Control Level Event

A. "Authorized Control Level Event" means any of the following events:

1. The filing of an RBC Report by the insurer which indicates that the insurer's Total Adjusted Capital is greater than or equal to its Mandatory Control Level RBC but less than its Authorized Control Level RBC;

2. The notification by the Commissioner to the insurer of an Adjusted RBC Report that indicates the event in Paragraph 1., provided the insurer does not challenge the Adjusted RBC Report under Section 10.;

3. If, pursuant to Section 10., the insurer challenges an Adjusted RBC Report that indicates the event in Paragraph 1., notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge;

4. The failure of the insurer to respond, in a manner satisfactory to the Commissioner, to a Corrective Order (provided the insurer has not challenged the Corrective Order under Section 10.); or

5. If the insurer has challenged a Corrective Order under Section 10. and the Commissioner has, after a hearing, rejected the challenge or modified the Corrective Order, the failure of the insurer to respond, in a manner satisfactory to the Commissioner, to the Corrective Order subsequent to rejection or modification by the Commissioner.

B. In the event of an Authorized Control Level Event with respect to an insurer, the Commissioner shall:

1. Take such actions as are required under Section 7. regarding an insurer with respect to which an Regulatory Action Level Event has occurred; or

2. If the Commissioner deems it to be in the best interests of the policyholders and creditors of the insurer and of the public, take such actions as are necessary to cause the insurer to be placed under regulatory control pursuant to § 10-3-501 et seq., C.R.S. In the event the Commissioner takes such actions, the Authorized Control Level Event shall be deemed sufficient grounds for the Commissioner to take action pursuant to § 10-3-501 et seq., C.R.S., and the Commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in § 10-3-501 et seq., C.R.S. In the event the Commissioner takes actions under this paragraph pursuant to an Adjusted RBC Report, the insurer shall be entitled to such protections as are afforded to insurers under the provisions of § 10-3-501 et seq., C.R.S.

Section 9 Mandatory Control Level Event

A. "Mandatory Control Level Event" means any of the following events:

1. The filing of an RBC Report which indicates that the insurer's Total Adjusted Capital is less than its Mandatory Control Level RBC;

2. Notification by the Commissioner to the insurer of an Adjusted RBC Report that indicates the event in Paragraph 1., provided the insurer does not challenge the Adjusted RBC Report under Section 10.; or

3. If, pursuant to Section 10., the insurer challenges an Adjusted RBC Report that indicates the event in Paragraph 1., notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

B. In the event of a Mandatory Control Level Event:

1. With respect to a life and/or health insurer, the Commissioner shall take such actions as are necessary to place the insurer under regulatory control pursuant to § 10-3-501 et seq., C.R.S. In that event, the Mandatory Control Level Event shall be deemed sufficient grounds for the Commissioner to take action under § 10-3-501 et seq., C.R.S., and the Commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in § 10-3-501 et seq., C.R.S.. If the Commissioner takes actions pursuant to an Adjusted RBC Report, the insurer shall be entitled to the protections of § 10-3-501 et seq., C.R.S. pertaining to summary proceedings. Notwithstanding any of the foregoing, the Commissioner may forego action for up to ninety (90) days after the Mandatory Control Level Event if the Commissioner finds there is a reasonable expectation that the Mandatory Control Level Event may be eliminated within the ninety (90) day period.

2. With respect to a property and casualty insurer, the Commissioner shall take such actions as are necessary to place the insurer under regulatory control pursuant to § 10-3-501 et seq., C.R.S., or, in the case of an insurer which is writing no business and which is running-off its existing business, may allow the insurer to continue its run-off under the supervision of the Commissioner. In either event, the Mandatory Control Level Event shall be deemed sufficient grounds for the Commissioner to take action under § 10-3-501 et seq., C.R.S., and the Commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in § 10-3-501 et seq., C.R.S. If the Commissioner takes actions pursuant to an Adjusted RBC Report, the insurer shall be entitled to the protections of § 10-3-501 et seq., C.R.S. pertaining to summary proceedings. Notwithstanding any of the foregoing, the Commissioner may forego action for up to ninety (90) days after the Mandatory Control Level Event if the Commissioner finds there

is a reasonable expectation that the Mandatory Control Level Event may be eliminated within the ninety (90) day period.

Section 10 Hearings

Upon the occurrence of any of the following events, the insurer shall have the right to a confidential departmental hearing pursuant to § 24-4-105, C.R.S., on a record, at which the insurer may challenge any determination or action by the Commissioner. The insurer shall notify the Commissioner of its request for a hearing within five (5) days after the notification by the Commissioner under Subsection A., B., C. or D. Upon receipt of the insurer's request for a hearing, the Commissioner shall set a date for the hearing, which shall be no less than ten (10) nor more than thirty (30) days after the date of the insurer's request. The events include:

A. Notification to an insurer by the Commissioner of an Adjusted RBC Report; or

B. Notification to an insurer by the Commissioner that:

1. The insurer's RBC Plan or Revised RBC Plan is unsatisfactory; and

2. Such notification constitutes a Regulatory Action Level Event with respect to such insurer; or

C. Notification to an insurer by the Commissioner that the insurer has failed to adhere to its RBC Plan or Revised RBC Plan and that such failure has a substantial adverse effect on the ability of the insurer to eliminate the Company Action Level Event with respect to the insurer in accordance with its RBC Plan or Revised RBC Plan; or

D. Notification to an insurer by the Commissioner of a Corrective Order with respect to the insurer.

Section 11 Confidentiality and Prohibition on Announcements

A. All RBC Reports (to the extent the information therein is not required to be set forth in a publicly available annual statement schedule) and RBC Plans (including the results or report of any examination or analysis of an insurer performed pursuant hereto and any Corrective Order issued by the Commissioner pursuant to examination or analysis) with respect to a domestic insurer or foreign insurer that are in the possession or control of the Commissioner shall be confidential by law and privileged, pursuant to § 24-72-204(3)(a)(IV), C.R.S., and shall not be subject to § 24-72-201, et. seq. C.R.S., shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties.

B. Neither the Commissioner nor any person who received documents, materials or other information while acting under the authority of the Commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to Subsection A.

C. In order to assist in the performance of the Commissioner's duties, the Commissioner:

1. May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Subsection A., with other state, federal and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information; and

2. May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the NAIC and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information.

D. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in Section 11.C.

E. The comparison of an insurer's Total Adjusted Capital to any of its RBC Levels is a regulatory tool which may indicate the need for possible corrective action with respect to the insurer, and is not intended as a means to rank insurers generally. Therefore, except as otherwise required under the provisions of this Regulation, the making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement with regard to the RBC Levels of any insurer, or of any component derived in the calculation, by any insurer, agent, broker or other person engaged in any manner in the insurance business would be misleading and a violation of § 10-3-1104, C.R.S., and is therefore prohibited; provided, however, that if any materially false statement with respect to the comparison regarding an insurer's Total Adjusted Capital to its RBC Levels (or any of them) or an inappropriate comparison of any other amount to the insurers' RBC Levels is published in any written publication and the insurer is able to demonstrate to the Commissioner with substantial proof the falsity of such statement, or the inappropriateness, as the case may be, then the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

Section 12 Foreign Insurers

A. Any foreign insurer shall, upon the written request of the Commissioner, submit to the Commissioner an RBC Report as of the end of the calendar year just ended the later of:

1. The date an RBC Report would be required to be filed by a domestic insurer under this Regulation; or

2. Fifteen (15) days after the request is received by the foreign insurer.

B. Any foreign insurer shall, at the written request of the Commissioner, promptly submit to the Commissioner a copy of any RBC Plan that is filed with the insurance commissioner of any other state.

C. In the event of a Company Action Level Event, Regulatory Action Level Event or Authorized Control Level Event with respect to any foreign insurer as determined under the RBC statute or regulation applicable in the state of domicile of the insurer (or, if no RBC statute or regulation is in force in that state, under the provisions of this Regulation), if the insurance commissioner of the state of domicile of the foreign insurer fails to require the foreign insurer to file an RBC Plan in the manner specified under that state's RBC statute or regulation (or, if no RBC statute or regulation is in force in that state, under Section 6. hereof), the Commissioner may require the foreign insurer to file an RBC Plan with the Commissioner. In such event, the failure of the foreign insurer to file an RBC Plan with the Commissioner shall be grounds to order the insurer to cease and desist from writing new insurance business in this State.

D. In the event of a Mandatory Control Level Event with respect to a foreign insurer, if no domiciliary receiver has been appointed with respect to the foreign insurer under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign insurer, the Commissioner may make application to the Denver District Court permitted under § 10-3-501 et. seq., C.R.S., with respect to the liquidation of property of foreign insurers found in this State, and the occurrence of the Mandatory Control Level Event shall be considered adequate grounds for the application.

Section 13 Notices

All notices by the Commissioner to an insurer which may result in regulatory action thereunder shall be effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmission shall be effective upon the insurer's receipt of such notice.

Section 14 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 15 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 16 Effective Date

This Regulation shall become effective on August 1, 2017.

Section 17 History

Originally effective March 31, 1994.

Amended Regulation, effective August 31, 1997.

Amended Regulation, effective November 1, 1999.

Amended Regulation, effective April 1, 2002.

Repealed and Repromulgated Regulation, effective February 1, 2012

Amended Regulation, effective August 1, 2013

Amended Regulation, effective August 1, 2017

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Office of the Attorney General

Tracking number: 2017-00173

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Insurance

on 06/09/2017

3 CCR 702-3

FINANCIAL ISSUES

The above-referenced rules were submitted to this office on 06/09/2017 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

June 20, 2017 09:20:00

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Permanent Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - Board of Psychologists Examiners

CCR number

3 CCR 721-1

Rule title

3 CCR 721-1 COLORADO STATE BOARD OF PSYCHOLOGIST EXAMINERS RULES 1 - eff 07/30/2017

Effective date

07/30/2017

RULE 13- REINSTATEMENT OF A LICENSE (section 12-43-204, C.R.S.)

(a) General. A license that has expired is subject to the following reinstatement provisions.

(b) Application Requirements. To be considered for licensure reinstatement, an applicant must submit a completed reinstatement application form, and the reinstatement fee.

(c) Required statements. Each applicant for reinstatement shall certify the following:

(1) Every license, certificate, listing or registration to practice psychology held by applicant is in good standing;

(2) Applicant has reported to the Board any injunction or disciplinary action completed or pending against her/his license, certificate, registration, or listing to practice psychology or psychotherapy;

(3) Applicant has reported to the Board any malpractice judgment against her/him, any settlement of a malpractice action or claim against her/him, and any malpractice action or claim pending against her/him in which the malpractice alleged relates to her/his practice of psychology or psychotherapy;

(4) Applicant has reported to the Board any inquiry/complaint pending, investigation being conducted by, or disciplinary proceeding pending before the licensing, grievance, or disciplinary board of any jurisdiction in which s/he is licensed, certified, registered, or listed to practice psychology or psychotherapy in which the complaint, investigation, or proceeding concerns her/his practice of psychology or psychotherapy.

(d) Pending discipline or complaints. The Board may decline to issue a license to an applicant for reinstatement if disciplinary action is pending or if there is an unresolved complaint.

(e) Continuing Professional Competence. Pursuant to section 12-43-307, C.R.S., effective September 1, 2017, a licensed psychologist shall complete continuing professional development in order to reinstate a license.

(1) An applicant for reinstatement must comply with all continuing professional development requirements pursuant to Rule 20 within the two (2) years immediately preceding the application receipt date.

(2) An applicant for reinstatement applying between September 1, 2017 and August 31, 2019 must complete 1.67 continuing professional development hours per month for the period the license was expired.

(f) Criteria. The Board has established the following criteria for determining whether an applicant for reinstatement has demonstrated her/his continued professional competence as required by section 12-43-204(3), C.R.S.. An applicant must meet all applicable criteria to establish her/his continued professional competence.

(1) License expired more than two (2) years. An applicant whose license has been expired more than two (2) years shall pass a Board developed jurisprudence examination and demonstrate her/his continued professional competence by either:

(A)Completion of an average of twenty (20) Professional Development Hours (PDH) pursuant to section 12-43-307(2)(b), C.R.S., and Rule 20 for each year the license has been expired (1.67 for each month); or.

(B) Retaking and passing the Examination for Professional Practice in Psychology (EPPP) national examination; or.

(C) If an applicant for reinstatement has been licensed and performing work in another jurisdiction that does not require continuing professional development then verification of licensure from each jurisdiction is required as well as a written statement detailing work experience related to the practice of psychology during the time the Colorado license has been expired.

(D) Any other means approved by the Board.

RULE 20 – CONTINUING PROFESSIONAL DEVELOPMENT (PURSUANT TO SECTION 12-43-307, C.R.S.)

(a) TERMS/DEFINITIONS.

(1) CONTINUING EDUCATION UNITS (CEU)/ CONTINUING MEDICAL EDUCATION (CME)/CONTINUING EDUCATION(CE) MEANS LEARNING ACTIVITIES APPROVED AND/OR ACCREDITED BY THE AMERICAN PSYCHOLOGICAL ASSOCIATION, STATE MEDICAL ASSOCIATION OR ACCREDITATION COUNCIL FOR CONTINUING MEDICAL EDUCATION OR BY A REGIONALLY ACCREDITED INSTITUTION OF HIGHER EDUCATION.

(2) CONTINUING PROFESSIONAL DEVELOPMENT (CPD) IS THE BOARD'S PROGRAM THROUGH WHICH A LICENSED PSYCHOLOGIST SATISFIES THE REQUIREMENTS SET FORTH IN SECTION 12-43-307, C.R.S. AND ENSURES THE ONGOING ABILITY OF A LICENSED PSYCHOLOGIST TO LEARN, INTEGRATE, AND APPLY THE KNOWLEDGE, SKILL, AND JUDGEMENT TO PRACTICE PSYCHOLOGY ACCORDING TO GENERALLY ACCEPTED INDUSTRY STANDARDS AND PROFESSIONAL ETHICAL STANDARDS.

(3) CONTINUING PROFESSIONAL DEVELOPMENT MANUAL (CPD MANUAL) IS AN INSTRUCTIONAL GUIDE AND WORKBOOK FOR THE CPD PROGRAM.

(4) LEARNING PLAN IS THE BOARD APPROVED FORM USED TO DEVELOP, EXECUTE, AND DOCUMENT PDH FOR EACH CYCLE IN THE CPD PROGRAM AS SET FORTH IN SECTION 12-43-307(2)(A), C.R.S.

(5) MILITARY EXEMPTION IS A METHOD TO SATISFY CONTINUING PROFESSIONAL DEVELOPMENT REQUIREMENTS. A LICENSED PSYCHOLOGIST WHO HAS BEEN APPROVED FOR THIS EXEMPTION WILL NOT BE REQUIRED TO MEET CONTINUING PROFESSIONAL DEVELOPMENT REQUIREMENTS DURING THE RENEWAL PERIOD IN WHICH THE MILITARY EXEMPTION WAS APPROVED BY THE DIVISION OF PROFESSIONS AND OCCUPATIONS (DPO).

(6) PROFESSIONAL DEVELOPMENT HOURS (PDH) ARE THE UNITS OF MEASUREMENT OF ACTIVE LEARNING USED TO ACCRUE CREDIT IN THE CPD PROGRAM. PDH ARE EQUIVALENT TO CLOCK HOURS.

(7) REFLECTIVE SELF-ASSESSMENT TOOL (RSAT) IS AN OPTIONAL SELF-REFLECTIVE PRACTICE TOOL THAT CAN BE USED TO ASSIST A LICENSED PSYCHOLOGIST IN DEVELOPING A LEARNING PLAN.

(b) CONTINUING PROFESSIONAL DEVELOPMENT REQUIREMENTS.

(1) A LICENSED PSYCHOLOGIST SHALL COMPLETE CONTINUING PROFESSIONAL DEVELOPMENT REQUIREMENTS IN ORDER TO RENEW A LICENSE TO PRACTICE PSYCHOLOGY IN THE STATE OF COLORADO BY:

(A) SUCCESSFULLY PARTICIPATING IN THE CPD PROGRAM; OR

(B) RECEIVING AN EXEMPTION FOR MILITARY SERVICE AS DEFINED IN SECTION 12-70-102, C.R.S., AND SECTION (E) OF THIS RULE.

(2) A LICENSED PSYCHOLOGIST SHALL ATTEST AT THE TIME OF THE RENEWAL OF A LICENSE TO COMPLIANCE WITH CONTINUING PROFESSIONAL DEVELOPMENT REQUIREMENTS.

(c) CONTINUING PROFESSIONAL DEVELOPMENT (CPD) PROGRAM.

(1) IN ACCORDANCE WITH SECTION 12-43-307(2), C.R.S., AND THE CURRENT CPD MANUAL, THE CPD PROGRAM CONSISTS OF THE FOLLOWING ELEMENTS:

(A) DEVELOPMENT, EXECUTION, AND DOCUMENTATION OF A LEARNING PLAN:

1. A LICENSED PSYCHOLOGIST SHALL DEVELOP A LEARNING PLAN CONSISTING OF PDH AS SET FORTH IN SECTION 12-43-307(2)(B), C.R.S., AND THIS RULE.

2. A LICENSED PSYCHOLOGIST SHALL EXECUTE THIS LEARNING PLAN BY COMPLETING AND DOCUMENTING ALL PDH BEFORE THE DATE UPON WHICH THE LICENSED PSYCHOLOGIST RENEWS HIS/HER LICENSE. CHANGES TO THE LEARNING PLAN SHALL NOT BE ALLOWED AFTER A LICENSE IS RENEWED.

3. A LICENSED PSYCHOLOGIST CAN CHOOSE TO USE THE OPTIONAL REFLECTIVE SELF-ASSESSMENT TOOL (RSAT) WHEN CREATING A LEARNING PLAN.

(B) COMPLETION OF 40 HOURS OF PDH THROUGH A COMBINATION OF ALLOWED ACTIVITIES AS DESCRIBED IN SECTION 12-43-307(2)(B), C.R.S., AND AS CHOSEN BY THE LICENSED PSYCHOLOGIST; AND

(C) MAINTAINING DOCUMENTATION OF COMPLETED PDH AS DESCRIBED IN SECTIONS 12-43-307(2)(B) AND (C), C.R.S.

(2) A LICENSED PSYCHOLOGIST SHALL COMPLETE FORTY (40) PDH EACH RENEWAL CYCLE BEFORE RENEWING A LICENSE.

(A) PDH MUST BE RELEVANT TO THE LICENSED PSYCHOLOGIST'S LEARNING PLAN AND MAINTAIN OR ENHANCE COMPETENCE AS A LICENSED PSYCHOLOGIST. THE LICENSED PSYCHOLOGIST SHOULD BE ABLE TO DESCRIBE HOW LEARNING ACTIVITIES SHARPENED EXISTING AND/OR PROVIDED NEW KNOWLEDGE OR SKILLS.

(B) PDH CREDIT CAN ONLY BE EARNED FOR ACTIVITIES AS SPECIFICALLY DESCRIBED IN SECTION 12-43-307(2), C.R.S., AND SECTION (E) OF THIS RULE.

(C) THE BOARD WILL NOT PRE-APPROVE COURSES OR PROVIDERS AND HAS SOLE DISCRETION TO ACCEPT OR REJECT PDH THAT DO NOT MEET THE CRITERIA ESTABLISHED IN SECTION 12-43-307(2)(B), C.R.S., AND THE CPD MANUAL.

(D) A LICENSED PSYCHOLOGIST WHO RECEIVES AN ORIGINAL, REINSTATED, OR REACTIVATED LICENSE DURING THE RENEWAL CYCLE MUST ACCRUE 1.67 PDH FOR EACH MONTH OR PORTION THEREOF HE/SHE IS LICENSED PRIOR TO THE END OF THE RENEWAL CYCLE.

(E) A LICENSED PSYCHOLOGIST SHALL DOCUMENT COMPLETION OF PDH ACCORDING TO THE GUIDELINES SET FORTH IN SECTION 12-43-307(2), C.R.S., AND THE CURRENT CPD MANUAL AND MUST BE PREPARED TO SUBMIT DOCUMENTATION OF COMPLIANCE UPON REQUEST BY THE BOARD.

(F) A MAXIMUM OF TEN (10) PDH MAY BE CARRIED FROM THE LAST RENEWAL CYCLE TO THE NEXT RENEWAL CYCLE IF THE PDH WERE EARNED WITHIN THREE (3) MONTHS OF LICENSE EXPIRATION AND ARE IN EXCESS OF THE FORTY (40) PDH REQUIRED FOR THE CURRENT RENEWAL CYCLE. FOR THE 2017 TO 2019 RENEWAL CYCLE, A MAXIMUM OF TEN (10) PDH MAY BE CARRIED OVER IF THE PDH WERE EARNED FROM JUNE 1, 2017 TO AUGUST 31, 2017.

(3) TO QUALIFY FOR PDH CREDIT, A PSYCHOLOGIST MUST SELECT LEARNING ACTIVITIES AS DEFINED IN SECTION 12-43-307(2)(B), C.R.S. PDH MUST INCLUDE ONE OR MORE OF THE FOLLOWING ACTIVITIES, IN ANY COMBINATION:

(A) ATTENDING WORKSHOPS, SEMINARS, SYMPOSIA, COLLOQUIA, INVITED SPEAKER SESSIONS, POSTDOCTORAL INSTITUTES, OR SCIENTIFIC OR PROFESSIONAL PROGRAMS OFFERED AT MEETINGS OF LOCAL, STATE, REGIONAL, NATIONAL, OR INTERNATIONAL PROFESSIONAL OR SCIENTIFIC ORGANIZATIONS.

1. WITH THE EXCEPTION OF FIVE (5) PDH, ACTIVITIES MUST QUALIFY AS CONTINUING EDUCATION UNITS , CONTINUING MEDICAL EDUCATION , or continuing education AS APPROVED AND/OR ACCREDITED BY THE AMERICAN PSYCHOLOGICAL ASSOCIATION, STATE MEDICAL ASSOCIATION, ACCREDITATION COUNCIL FOR CONTINUING MEDICAL EDUCATION, OR BY A REGIONALLY ACCREDITED INSTITUTION OF HIGHER EDUCATION.

2. ACTIVITIES MAY INCLUDE ONLINE CONTINUING EDUCATION.

3. ONE CONTINUING EDUCATION HOUR IS EQUIVALENT TO ONE PDH.

4. DOCUMENTATION OF LEARNING ACTIVITIES SHALL INCLUDE A TRANSCRIPT OR CERTIFICATE OF ATTENDANCE WITH A STATEMENT OF THE CREDITS EARNED, WHICH INCLUDES THE NAME OF THE PARTICIPANT, THE DATE(S) OF ATTENDANCE, THE NAME OF PROVIDER(S), THE NUMBER OF HOURS EARNED, ETC.

(B) COMPLETING AN ETHICS COURSE OFFERED BY THE AMERICAN PSYCHOLOGICAL ASSOCIATION, STATE MEDICAL ASSOCIATION, ACCREDITATION COUNCIL FOR CONTINUING MEDICAL EDUCATION, OR A REGIONALLY ACCREDITED INSTITUTION OF HIGHER EDUCATION.

1. ONE (1) CONTINUING EDUCATION HOUR IS EQUIVALENT TO ONE PDH.

2. DOCUMENTATION OF COMPLETION OF AN ETHICS COURSE SHALL INCLUDE A TRANSCRIPT OR CERTIFICATE OF ATTENDANCE WITH A STATEMENT OF THE CREDITS EARNED, WHICH INCLUDES THE NAME OF

THE PARTICIPANT, THE DATE(S) OF ATTENDANCE, THE NAME OF THE PROVIDER(S), THE NUMBER OF HOURS EARNED, ETC.

(C) DEVELOPING AND TEACHING AN ACADEMIC COURSE IN PSYCHOLOGY AT AN INSTITUTION ACCREDITED BY A REGIONAL ACCREDITING ASSOCIATION.

1. CREDIT CAN BE EARNED FOR THE FIRST TIME WITHIN A GIVEN LICENSURE CYCLE THAT THE LICENSED PSYCHOLOGIST DEVELOPS AND TEACHES THE COURSE.

2. ONE (1) ACADEMIC CREDIT, UNIT, OR HOUR IS EQUIVALENT TO TEN (10) PDH.

3. DOCUMENTATION OF THE DEVELOPMENT AND TEACHING OF AN ACADEMIC COURSE SHALL INCLUDE WRITTEN VERIFICATION BY THE DEAN OR HEAD OF THE DEPARTMENT OF THE INSTITUTION IN WHICH THE COURSE WAS TAUGHT.

(D) SUCCESSFULLY COMPLETING A GRADUATE COURSE IN PSYCHOLOGY OFFERED BY AN INSTITUTION ACCREDITED BY A REGIONAL ACCREDITING ASSOCIATION.

1. ONE (1) ACADEMIC CREDIT, UNIT, OR HOUR IS EQUIVALENT TO TEN (10) PDH.

2. DOCUMENTATION SHALL INCLUDE AN ACADEMIC TRANSCRIPT SHOWING THE GRADUATE CREDITS EARNED.

(E) DEVELOPING AND PRESENTING A WORKSHOP, SEMINAR, SYMPOSIUM, COLLOQUIUM, OR INVITED SPEAKING SESSION, AT A MEETING OF A PROFESSIONAL OR A SCIENTIFIC ORGANIZATION OR A POSTDOCTORAL INSTITUTE.

1. CREDIT CAN BE EARNED FOR THE FIRST TIME WITHIN A GIVEN LICENSURE CYCLE THAT THE WORKSHOP, SEMINAR, SYMPOSIUM, COLLOQUIUM, OR INVITED SPEAKING SESSION IS DEVELOPED AND PRESENTED.

2. ONE (1) HOUR OF WORKSHOP, SEMINAR, SYMPOSIUM, COLLOQUIAL PRESENTATION, OR INVITED SPEAKING SESSION IS EQUIVALENT TO THREE (3) PDH.

3. DOCUMENTATION SHALL INCLUDE A PRINTED PROGRAM OR AGENDA SHOWING THE NAME OF THE LICENSED PSYCHOLOGIST, THE DATE(S) OF THE PRESENTATION, THE NAME OF THE ORGANIZATION, THE TOTAL NUMBER OF HOURS PRESENTED, ETC.

(F) AUTHORING OR EDITING A PSYCHOLOGY PUBLICATION, MAXIMUM HOURS EARNED AS FOLLOWING:

1. AUTHORING A PROFESSIONAL OR SCIENTIFIC BOOK IS EQUIVALENT TO FORTY (40) PDH.

2. AUTHORING A PROFESSIONAL OR SCIENTIFIC BOOK CHAPTER OR JOURNAL ARTICLE IS EQUIVALENT TO TWENTY (20) PDH.

3. EDITING A PROFESSIONAL OR SCIENTIFIC BOOK OR JOURNAL IS EQUIVALENT TO THIRTY (30) PDH.

4. DOCUMENTATION SHALL INCLUDE A COVERSHEET, MASTHEAD, OR TABLE OF CONTENTS FROM THE PUBLICATION SHOWING THE NAME OF THE LICENSED PSYCHOLOGIST, THE DATE OF AUTHORING OR EDITING, ETC.

(G) PROVIDING EDITORIAL REVIEW OF A PROFESSIONAL PSYCHOLOGICAL OR SCIENTIFIC JOURNAL ARTICLE AT THE REQUEST OF THE JOURNAL'S EDITORIAL STAFF.

1. COMPLETION OF ACTIVITY IS EQUIVALENT TO ONE (1) PDH.

2. DOCUMENTATION SHALL INCLUDE THE ACKNOWLEDGMENT OF THE COMPLETED REVIEW BY THE EDITORIAL STAFF WITH THE NAME OF THE LICENSED PSYCHOLOGIST, DATE OF REVIEW, ETC.

(d) AUDIT OF COMPLIANCE. AS SET FORTH IN SECTION 12-43-307(4), C.R.S., THE BOARD MAY AUDIT UP TO 5% OF LICENSED PSYCHOLOGISTS EACH TWO-YEAR CYCLE TO DETERMINE COMPLIANCE WITH CONTINUING PROFESSIONAL DEVELOPMENT REQUIREMENTS.

(1) THE FOLLOWING DOCUMENTATION IS REQUIRED FOR AN AUDIT OF COMPLIANCE:

(A) A LEARNING PLAN SIGNED BY THE LICENSED PSYCHOLOGIST THAT CONTAINS THE LICENSED PSYCHOLOGIST'S COMPLETED PDH IN THE MANNER SET FORTH IN THE CURRENT CPD MANUAL;

(B) DOCUMENTATION OF THE REQUIRED PDH IN COMPLIANCE WITH STATUTE, THIS RULE, AND THE CURRENT CPD MANUAL; AND

(C) THE BOARD HAS SOLE DISCRETION TO ACCEPT OR REJECT PDH THAT DO NOT MEET THE CRITERIA ESTABLISHED AS DEFINED IN SECTION 12-43-307(2), C.R.S., THIS RULE, AND THE CURRENT CPD MANUAL.

(2) AS SET FORTH IN SECTION 12-43-307(5)(A), C.R.S., RECORDS OF ASSESSMENT OR OTHER DOCUMENTATION DEVELOPED OR SUBMITTED IN CONNECTION WITH THE CONTINUING PROFESSIONAL DEVELOPMENT PROGRAM ARE CONFIDENTIAL AND NOT SUBJECT TO INSPECTION BY THE PUBLIC OR DISCOVERY IN CONNECTION WITH A CIVIL ACTION AGAINST A LICENSED PSYCHOLOGIST. THE RECORDS OR DOCUMENTS SHALL BE USED ONLY BY THE BOARD FOR THE PURPOSE OF DETERMINING WHETHER A LICENSED PSYCHOLOGIST IS MAINTAINING CONTINUING PROFESSIONAL DEVELOPMENT NECESSARY TO ENGAGE IN THE PROFESSION.

(3) THE CURRENT CPD MANUAL WILL SET FORTH THE DOCUMENTATION METHODS AND STANDARDS FOR COMPLIANCE WITH THIS RULE.

(e) MILITARY EXEMPTION. PURSUANT TO SECTION 12-70-102, C.R.S., A LICENSED PSYCHOLOGIST WHO HAS BEEN CALLED TO FEDERALLY FUNDED ACTIVE DUTY FOR MORE THAN 120 DAYS FOR THE PURPOSE OF SERVING IN A WAR, EMERGENCY, OR CONTINGENCY MAY REQUEST AN EXEMPTION FROM CONTINUING PROFESSIONAL DEVELOPMENT REQUIREMENTS FOR THE RENEWAL, REINSTATEMENT, OR REACTIVATION OF HIS/HER LICENSE FOR THE TWO-YEAR RENEWAL PERIOD THAT FALLS WITHIN THE PERIOD OF SERVICE OR WITHIN SIX (6) MONTHS FOLLOWING THE COMPLETION OF SERVICE.

(1) MILITARY EXEMPTIONS MUST BE APPROVED BY THE DPO. A LICENSED PSYCHOLOGIST SEEKING A MILITARY EXEMPTION SHALL SUBMIT A REQUEST IN WRITING WITH EVIDENCE THAT HIS/HER MILITARY SERVICE MEETS THE CRITERIA ESTABLISHED IN SECTION 12-70-102, C.R.S.

(2) AFTER BEING GRANTED A MILITARY EXEMPTION, IN ORDER TO COMPLETE THE RENEWAL PROCESS, THE LICENSED PSYCHOLOGIST SHALL ATTEST TO HIS/HER MILITARY EXEMPTION.

(f) RECORDS RETENTION. A LICENSED PSYCHOLOGIST SHALL RETAIN DOCUMENTATION OF COMPLIANCE FOR A MINIMUM OF FIVE (5) YEARS FROM THE LICENSE EXPIRATION DATE FOR THE RENEWAL CYCLE DURING WHICH PDH WERE ACCRUED.

(g) NON-COMPLIANCE. FALSIFYING AN ATTESTATION OR OTHER DOCUMENTATION REGARDING A LICENSED PSYCHOLOGIST'S COMPLIANCE WITH CONTINUING PROFESSIONAL DEVELOPMENT REQUIREMENTS CONSTITUTES THE FALSIFICATION OF INFORMATION IN AN APPLICATION AND MAY BE GROUNDS FOR DISCIPLINE PURSUANT TO SECTION 12-43-222(1)(S), C.R.S.

(h) REINSTATEMENT AND REACTIVATION. A LICENSED PSYCHOLOGIST SEEKING TO REINSTATE OR REACTIVATE A LICENSE SHALL MEET CONTINUING PROFESSIONAL DEVELOPMENT REQUIREMENTS DETAILED IN RULE 13 AND RULE 21.

RULE 21 – INACTIVE LICENSE STATUS AND REACTIVATION OF A LICENSE

(A) INACTIVE STATUS. PURSUANT TO SECTION 12-70-101, C.R.S., A LICENSED PSYCHOLOGIST MAY APPLY TO THE BOARD TO BE TRANSFERRED TO AN INACTIVE STATUS. THE HOLDER OF AN INACTIVE LICENSE SHALL NOT BE REQUIRED TO COMPLY WITH THE CONTINUING PROFESSIONAL DEVELOPMENT REQUIREMENTS FOR RENEWAL SO LONG AS HE/SHE REMAINS INACTIVE.

(1) DURING SUCH TIME AS A LICENSED PSYCHOLOGIST REMAINS IN AN INACTIVE STATUS, HE/SHE SHALL NOT PERFORM THOSE ACTS RESTRICTED TO ACTIVE LICENSED PSYCHOLOGISTS PURSUANT TO SECTION 12-43-303, C.R.S. THE BOARD SHALL RETAIN JURISDICTION OVER INACTIVE PSYCHOLOGISTS FOR THE PURPOSES OF DISCIPLINARY ACTION PURSUANT TO SECTION 12-43-221(1)(D), C.R.S.

(2) PRACTICING WITH AN INACTIVE LICENSE SHALL CONSTITUTE UNLICENSED PRACTICE AND, THEREFORE, MAY BE GROUNDS FOR DISCIPLINARY OR INJUNCTIVE ACTION, UP TO AND INCLUDING REVOCATION.

(B) APPLICATION REQUIREMENTS. TO BE CONSIDERED FOR LICENSURE REACTIVATION, AN APPLICANT MUST SUBMIT A COMPLETED REACTIVATION APPLICATION FORM AND THE REACTIVATION FEE.

(C) REQUIRED STATEMENTS. EACH APPLICANT FOR REINSTATEMENT SHALL CERTIFY THE FOLLOWING:

(1) EVERY LICENSE, CERTIFICATE, LISTING, OR REGISTRATION TO PRACTICE PSYCHOLOGY HELD BY APPLICANT IS IN GOOD STANDING;

(2) APPLICANT HAS REPORTED TO THE BOARD ANY INJUNCTION OR DISCIPLINARY ACTION COMPLETED OR PENDING AGAINST HER/HIS LICENSE, CERTIFICATE, REGISTRATION, OR LISTING TO PRACTICE PSYCHOLOGY OR PSYCHOTHERAPY;

(3) APPLICANT HAS REPORTED TO THE BOARD ANY MALPRACTICE JUDGMENT AGAINST HER/HIM, ANY SETTLEMENT OF A MALPRACTICE ACTION OR CLAIM AGAINST HER/HIM, AND ANY MALPRACTICE ACTION OR CLAIM PENDING AGAINST HER/HIM IN WHICH THE MALPRACTICE ALLEGED RELATES TO HER/HIS PRACTICE OF PSYCHOLOGY OR PSYCHOTHERAPY;

(4) APPLICANT HAS REPORTED TO THE BOARD ANY INQUIRY/COMPLAINT PENDING, INVESTIGATION BEING CONDUCTED BY, OR DISCIPLINARY PROCEEDING PENDING BEFORE THE LICENSING, GRIEVANCE, OR DISCIPLINARY BOARD OF ANY JURISDICTION IN WHICH S/HE IS LICENSED, CERTIFIED, REGISTERED, OR LISTED TO PRACTICE PSYCHOLOGY OR PSYCHOTHERAPY IN WHICH THE COMPLAINT, INVESTIGATION, OR PROCEEDING CONCERNS HER/HIS PRACTICE OF PSYCHOLOGY OR PSYCHOTHERAPY.

(D) PENDING DISCIPLINE OR COMPLAINTS. THE BOARD MAY DECLINE TO ISSUE A LICENSE TO AN APPLICANT FOR REACTIVATION IF DISCIPLINARY ACTION IS PENDING OR IF THERE IS AN UNRESOLVED COMPLAINT.

(E) CONTINUING PROFESSIONAL COMPETENCE. PURSUANT TO SECTION 12-43-307, C.R.S, EFFECTIVE SEPTEMBER 1, 2017, A LICENSED PSYCHOLOGIST SHALL COMPLETE CONTINUING PROFESSIONAL DEVELOPMENT IN ORDER TO REACTIVATE A LICENSE.

(1) AN APPLICANT FOR REACTIVATION MUST COMPLY WITH ALL CONTINUING PROFESSIONAL DEVELOPMENT REQUIREMENTS PURSUANT TO RULE 20 WITHIN THE TWO (2) YEARS IMMEDIATELY PRECEDING THE APPLICATION RECEIPT DATE.

(F) CRITERIA. THE BOARD HAS ESTABLISHED THE FOLLOWING CRITERIA FOR DETERMINING WHETHER AN APPLICANT FOR REACTIVATION HAS DEMONSTRATED HER/HIS CONTINUED PROFESSIONAL COMPETENCE AS REQUIRED BY SECTION 12-43-204(3), C.R.S. AN APPLICANT MUST MEET ALL APPLICABLE CRITERIA TO ESTABLISH HER/HIS CONTINUED PROFESSIONAL COMPETENCE.

(1) LICENSE INACTIVE MORE THAN TWO (2) YEARS. AN APPLICANT WHOSE LICENSE HAS BEEN INACTIVE MORE THAN TWO (2) YEARS SHALL PASS A BOARD DEVELOPED JURISPRUDENCE EXAMINATION AND DEMONSTRATE HER/HIS CONTINUED PROFESSIONAL COMPETENCE BY EITHER:

(A) A WRITTEN STATEMENT DETAILING WORK EXPERIENCE RELATED TO THE PRACTICE OF PSYCHOLOGY DURING THE TIME THE LICENSE HAS BEEN EXPIRED. IF WORK EXPERIENCE WAS IN ANOTHER JURISDICTION(S), VERIFICATION OF LICENSURE FROM EACH JURISDICTION(S) IS REQUIRED; OR

(B) COMPLETION OF AN AVERAGE OF 20 PROFESSIONAL DEVELOPMENT HOURS (PDH) PURSUANT TO SECTION 12-43-307(2)(B), C.R.S. AND RULE 20 FOR EACH YEAR THE LICENSE HAS BEEN EXPIRED (1.67 FOR EACH MONTH); OR

(C) RETAKING AND PASSING THE EXAMINATION FOR PROFESSIONAL PRACTICE IN PSYCHOLOGY (EPPP) NATIONAL EXAMINATION.

(D) ANY OTHER MEANS APPROVED BY THE BOARD.

CYNTHIA H. COFFMAN
Attorney General

DAVID C. BLAKE
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Office of the Attorney General

Tracking number: 2017-00158

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - Board of Psychologists Examiners

on 06/02/2017

3 CCR 721-1

COLORADO STATE BOARD OF PSYCHOLOGIST EXAMINERS RULES

The above-referenced rules were submitted to this office on 06/02/2017 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

June 20, 2017 09:14:54

Frederick R. Yarger

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Permanent Rules Adopted

Department

Department of Public Health and Environment

Agency

Water Quality Control Commission (1002 Series)

CCR number

5 CCR 1002-81

Rule title

5 CCR 1002-81 REGULATION NO. 81 - ANIMAL FEEDING OPERATIONS CONTROL REGULATION 1 - eff 07/31/2017

Effective date

07/31/2017

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Water Quality Control Commission

REGULATION NO. 81 - ANIMAL FEEDING OPERATIONS CONTROL REGULATION

5 CCR 1002-81

Throughout these regulations, standards and requirements by outside organizations have been adopted and incorporated by reference. The materials incorporated by reference cited herein include only those versions that were in effect as of July 31, 2017, and not later amendments to the incorporated material.

Materials incorporated by reference are available for public inspection during regular business hours from the Water Quality Control Division, 4300 Cherry Creek Drive South, Denver, Colorado 80246-1530. Copies may be purchased from the source organization.

81.0 AUTHORITY

Section 25-8-205, C.R.S. as amended of the Colorado Water Quality Control Act.

81.1 APPLICABILITY

The provisions of this control regulation are applicable to all animal feeding operations and concentrated animal feeding operations, except those defined as housed commercial swine feeding operations in section 61.2 of the Colorado Discharge Permit System Regulations, Regulation No. 61. Housed commercial swine feeding operations are subject to permitting requirements as set forth in Regulation No. 61 and financial assurance requirements in Regulation No. 66. A concentrated animal feeding operation is also subject to permitting requirements under Regulation No. 61 where it discharges to waters of the U.S.

81.2 PURPOSE

The purpose of this control regulation is:

(1) To ensure that discharges to ground water from permitted and non-permitted concentrated animal feeding operations are controlled in a manner consistent with the performance standards as set forth in this regulation.

(2) To ensure that non-permitted concentrated animal feeding operations protect surface waters of the state.

(3) To ensure that non-permitted concentrated animal feeding operations register with the Division.

(4) To ensure that animal feeding operations that are not defined as concentrated animal feeding operations protect waters of the state through proper application of "best management practices" that consider existing physical conditions and constraints at the facility site.

This regulation is not intended to address public health nuisance conditions or land use controls such as zoning requirements.

81.3 DEFINITIONS

As used in this regulation, the following definitions of terms apply.

(1) " 25-YEAR, 24-HOUR STORM" means a storm of a 24-hour duration which yields a total rainfall of a magnitude which has a probability of recurring once every twenty-five years.

(2) "AGRONOMIC RATE" means the rate of application of nitrogen to plants that is necessary to satisfy the plants' nutritional requirements while accounting for applicable nitrogen credits.

(3) "ANIMAL FEEDING OPERATION" (AFO) means a lot or facility (other than an aquatic animal production facility) where the following conditions are met:

(a) Animals (other than aquatic animals) have been, are, or will be stabled or confined and fed or maintained for a total of 45 days or more in any 12-month period, and

(b) Crops, vegetation, forage growth, or post-harvest residues are not sustained in the normal growing season over any portion of the lot or facility.

(4) "BEST MANAGEMENT PRACTICE" means an activity, procedure, or practice necessary for the reduction of impacts from AFOs on surface or ground water, as described in section 81.8.

(5) "CHRONIC STORM" means a series of storms that occur during a 10-day period which yield a total precipitation of a magnitude that has a probability of recurring once every 10 years.

(6) "CONCENTRATED ANIMAL FEEDING OPERATIONS" (CAFO) means an AFO that is defined as a Large or Medium CAFO, or that is designated by the Division as a CAFO pursuant to Section 81.4. Two or more AFOs under common ownership are deemed to be a single AFO for the purposes of determining whether they qualify as a Large or Medium CAFO, if they are adjacent to each other or if they use a common area or system for land application of manure or wastewater.

(7) "CONVEYANCE STRUCTURE" means a natural or constructed conduit (e.g., berm, channel, ditch, pipe, or culvert) that carries process-generated wastewater and/or open-lot wastewater from production areas, and diverts the wastewater to an impoundment or between impoundments.

(8) "DISCHARGE" means the introduction or addition of a pollutant into waters of the state.

(9) "DIVISION" means the Division of Administration of which the Water Quality Control Division of the Department of Public Health and Environment is a part. The Environmental Agriculture Program (Ag Program) implements this regulation on behalf of the Division.

(10) "FACILITY" means the production area and land application sites of an AFO or CAFO.

(11) "FREEBOARD" means the vertical distance measured from the liquid surface level (elevation) in an impoundment or tank to the top elevation of the impoundment or tank (for example, berm or wall).

(12) "GROUND WATER" means subsurface waters in a zone of saturation which are or can be brought to the surface of the ground or to surface waters through wells, springs, seeps, or other discharge areas.

(13) "GROUND WATER RECHARGE" means the entry into the saturated zone of water made available at the water-table surface, together with the associated flow away from the water table within the saturated zone.

(14) "IMPOUNDMENT" means a natural topographic depression, man-made excavation, or diked area formed primarily of earthen materials (although it may be lined with man-made materials or other seepage control materials), or any other structure which is used for the storage, treatment, evaporation or discharge of pollutant-containing waters, sludge or associated sediment.

(15) "LAND APPLICATION SITE" means land under the control of an AFO or CAFO, whether it is owned, rented, or leased by the AFO or CAFO, to which manure or wastewater from the production area is or may be applied, or where cropping or nutrient budget decisions for the site are made by the AFO or CAFO.

(16) "LARGE CONCENTRATED ANIMAL FEEDING OPERATION" (Large CAFO) means an AFO that stables or confines as many as or more than the numbers of animals specified in any of the following categories:

(a) 700 mature dairy cows, whether milked or dry;

(b) 1,000 veal calves

(c) 1,000 cattle other than mature dairy cows or veal calves. Cattle includes, but is not limited to, heifers, steers, bulls and cow/calf pairs;

(d) 2,500 swine each weighing 55 pounds or more;

(e) 10,000 swine each weighing less than 55 pounds;

(f) 500 horses;

(g) 10,000 sheep or lambs;

(h) 55,000 turkeys;

(i) 30,000 laying hens or broilers, if the AFO uses a liquid manure handling system;

(j) 125,000 chickens (other than laying hens), if the AFO uses other than a liquid manure handling system;

(k) 82,000 laying hens, if the AFO uses other than a liquid manure handling system;

(l) 30,000 ducks (if the AFO uses other than a liquid manure handling system) or

(m) 5,000 ducks (if the AFO uses a liquid manure handling system).

(17) "MAN-MADE DRAINAGE SYSTEM" means a drainage ditch, flushing system, or other drainage device which was constructed by man and is used for the purpose of transporting manure or wastewater.

(18) "MANURE" means feces, litter, and/or urine and materials, such as bedding, sludge, compost, feed waste, dry harvested forage, and any raw material used in or resulting from the operation of an AFO or CAFO, that have been commingled with feces, litter, and/or urine.

(19) "MEDIUM ANIMAL FEEDING OPERATION" (Medium AFO) means an AFO with the type and number of animals that fall within any of the ranges listed in section 81.3(20), and which has not been defined or designated as a CAFO.

(20) "MEDIUM CONCENTRATED ANIMAL FEEDING OPERATION" (Medium CAFO) means an AFO with the type and number of animals that fall within any of the ranges listed in (a) below and which has been defined or designated as a CAFO. An AFO is defined as a Medium CAFO if:

(a) The type and number of animals that it stables or confines falls within any of the following ranges:

(i) 200 to 699 mature dairy cows, whether milked or dry;

(ii) 300 to 999 veal calves;

(iii) 300 to 999 cattle other than mature dairy cows or veal calves. Cattle includes but is not limited to heifers, steers, bulls, and cow/calf pairs.

(iv) 750 to 2,499 swine each weighing 55 pounds or more;

(v) 3,000 to 9,999 swine each weighing less than 55 pounds;

(vi) 150 to 499 horses;

(vii) 3,000 to 9,999 sheep or lambs;

(viii) 16,500 to 54,999 turkeys;

(ix) 9,000 to 29,999 laying hens or broilers, if the AFO uses a liquid manure handling system;

(x) 37,500 to 124,999 chickens (other than laying hens), if the AFO uses other than a liquid manure handling system;

(xi) 25,000 to 81,999 laying hens, if the AFO uses other than a liquid manure handling system;

(xii) 10,000 to 29,999 ducks (if the AFO uses other than a liquid manure handling system); or

(xiii) 1,500 to 4,999 ducks (if the AFO uses a liquid manure handling system); and

(b) Either one of the following conditions are met:

(i) Pollutants are discharged into surface waters of the state through a man-made drainage system; or

(ii) Pollutants are discharged directly into surface waters of the state which originate outside of and pass over, across, or through the facility or otherwise come into direct contact with the animals confined in the operation.

(21) "NEW SOURCE" means any building, structure, facility, or installation from which there is or may be a discharge of pollutants, the construction of which commenced after the promulgation of standards of performance for the particular source, pursuant to section 306 of the Clean Water Act. The term also applies where a standard of performance has been proposed, provided that the standard is promulgated within 120 days of its proposal. Except as otherwise provided in an applicable new source performance standard, a source is a "new source" if it meets this definition of "new source", and:

(a) It is constructed at a site at which no other source is located; or

(b) It totally replaces the process or production equipment that causes the discharge of pollutants at an existing source; or

(c) Its processes are substantially independent of an existing source at the same site. In determining whether these processes are substantially independent, the Division shall consider such factors as the extent to which the new facility is integrated with the existing source; and the extent to which the new facility is engaged in the same general type of activity as the existing source.

(22) "OPEN-LOT WASTEWATER" means any precipitation that comes into contact with manure or feed, any spillage or overflow from animal or poultry watering systems in production area facilities that are not roof-covered (except livestock drinking water in constant-flow watering troughs that overflow into in-trough drain pipes and is retained separately from wastewater storage), or, spray-cooling water used in open-sided pole sheds that are not flushed.

(23) "OPERATOR" means any person who owns, leases, operates, controls, or supervises an AFO or CAFO

(24) "PERMIT" means a permit issued pursuant to Colorado Water Quality Control Commission Regulation No. 61.

(25) "PERSON" means an individual, corporation, partnership, association, state or political subdivision thereof, federal agency, state agency, municipality, commission, or interstate body.

(26) "POLLUTANT" means dredged spoil, dirt, slurry, solid waste, incinerator residue, sewage, sewage sludge, garbage, trash, chemical waste, biological nutrient, biological material, radioactive material, heat, wrecked or discarded equipment, rock, sand, or any industrial, municipal, or agricultural waste.

(27) "PROCESS-GENERATED WASTEWATER" means wastewater resulting from water being directly or indirectly used in the operation of an AFO or CAFO for any or all of the following:

(a) Spillage or overflow from animal or poultry watering systems in roof-covered production area facilities (except livestock drinking water in constant-flow watering troughs that overflows into in-trough drain pipes and is retained separately from wastewater storage);

(b) Washing, cleaning or flushing pens, barns, manure pits, or other roof-covered production area facilities;

(c) Direct contact swimming, washing or spray cooling of animals (except in open-sided pole barns in open lots);

(d) Dust control; or

(e) Water which comes into contact with any products or byproducts including manure litter, feed, milk, eggs, or bedding that is not defined as open-lot wastewater.

(28) "PRODUCTION AREA" means that part of an AFO or CAFO that includes the animal confinement area, the manure storage area, the raw materials storage area, and wastewater containment areas. Also included in the definition of production area is any egg washing or egg processing facility, and any area used in the storage, handling, treatment, or disposal of mortalities.

The animal confinement area includes but is not limited to:

(a) Open lots, housed lots and feedlots;

(b) Confinement houses;

(c) Stall barns and free stall barns;

(d) Milkrooms and milking centers;

(e) Cowyards, barnyards and stables;

(f) Medication and hospital pens;

(g) Walkers and animal walkways.

The manure and residual solids storage area includes but is not limited to:

(a) Lagoons, runoff ponds, liquid impoundments and tanks;

(b) Storage sheds, under house or pit storages;

(c) Stockpiles, static piles and composting piles.

The raw materials storage area includes but is not limited to:

(a) Feed silos, silage bunkers and bedding materials.

The waste containment area includes but is not limited to:

(a) Settling basins; and

(b) Areas within berms and diversions which separate uncontaminated stormwater.

(29) "PUBLIC DRINKING WATER SYSTEM" means a system for the provision to the public of piped water for human consumption, if such system has at least 15 service connections or serves an average of at least 25 persons daily at least 60 days out of the year. A public drinking water system includes both community and non-community systems.

(30) "SETBACK" means a specified distance from waters of the state, or potential conduits to waters of the state.

(31) "SMALL CONCENTRATED ANIMAL FEEDING OPERATION" (Small CAFO) means an AFO that is designated by the Division as a CAFO, and is not a Medium CAFO.

(32) "SOLID/LIQUID WASTE SEPARATION FACILITY" means a filtration or screening device, settling tank, or settling channel used to separate a portion of solids from a liquid wastewater stream.

(33) "STOCK WATERING POINT" means a fenced area with a hardened surface that limits access to surface water for a very small number of animals (typically one or two at a time) for the purpose of the animals obtaining drinking water.

(34) "STORMWATER" means precipitation induced surface runoff from land, except that defined as wastewater.

(35) "SURFACE WATER" means all waters of the state, except ground water, but includes ground water that may be hydrologically connected to non-subsurface water.

(36) "TANK" means a stationary device designed to contain an accumulation of pollutant-containing water, which is constructed primarily of non-earthen materials (e.g., wood, concrete, steel, plastic) which provide structural support.

(37) "WASTEWATER" means water defined as process-generated wastewater and/or open-lot wastewater.

(38) "WASTEWATER TREATMENT STRIP" means a treatment component of an agricultural waste management system consisting of a strip or area of herbaceous vegetation that assimilates pollutants and within which wastewater runs via sheet flow.

(39) "WATERS OF THE STATE" means any and all surface and subsurface waters which are contained in or flow in or through this state, except waters in sewage systems, waters in treatment works of disposal systems, waters in potable water distribution systems, and all water withdrawn for use until use and treatment have been completed.

(40) "WATERS OF THE U.S." means waters of the United States as defined in 40 C.F.R. Part 122.2.

(41) "WATER QUALITY STANDARD" means any standard promulgated pursuant to section 25-8-204, C.R.S.

81.4 DESIGNATION OF AN AFO AS A CAFO

The Division may designate any AFO as a CAFO upon performing an on-site inspection and determining that it reasonably could be a significant contributor of pollutants to waters of the U.S.

(1) The following criteria shall be considered to determine if an AFO will be designated as a CAFO:

(a) The size of the AFO and the amount of manure and wastewater reaching waters of the U.S;

(b) The location of the AFO relative to waters of the U.S.;

(c) The means of conveyance of manure and wastewater into waters of the U.S.;

(d) The slope, vegetation, rainfall, and other factors affecting the likelihood or frequency of discharge of manure and wastewater into waters of the U.S.; and

(e) Other relevant factors.

(2) No AFO with animal numbers below those established for a Medium CAFO shall be designated as a CAFO unless:

(a) Pollutants are discharged into waters of the U.S. through a manmade ditch, flushing system, or other similar manmade device from the AFO; or

(b) Pollutants from the AFO are discharged directly into waters of the U.S. that originate outside of the facility and pass over, across, or through the facility or otherwise come into contact with the animals confined in the operation.

(3) Where an AFO is at risk of being designated a CAFO, the AFO operator shall submit to the Division, within 60 days of receiving written notice by the Division of such a risk, one of the following:

(a) In consultation with the Division, an approvable work plan and associated timeline for reducing actual or potential environmental impacts such that the Division would not designate the AFO as a CAFO. The operator shall implement the plan within 30 days of it being approved by the Division; or

(b) A written statement signed by the operator indicating the operator's intention to do one of the following:

(i) Operate as a CAFO and submit a complete application to be covered under a CAFO discharge permit within 180 days of the date of the written statement; or,

(ii) Comply with all of the CAFO surface water and ground water protection provisions of this control regulation.

(4) Where an operator does not complete and implement a work plan pursuant to section 81.4(3)(a), does not submit a written statement pursuant to section 81.4(3)(b), or evidence exists of a discharge from the facility to waters of the U.S., the AFO may be designated a CAFO by the Division and be required to submit a complete application to be covered under a CAFO discharge permit within 90 days of receiving written notice by the Division of such a designation and permit application requirement.

81.5 REQUIREMENTS – NON-PERMITTED CAFOs

(1) Performance Standards – Surface Water Protection

(a) There shall be no discharge of manure or wastewater from the production area to waters of the U.S. without a discharge permit.

(b) There shall be no discharge of manure or wastewater from the production area to surface water, except whenever precipitation causes a discharge and the production area is designed, constructed, operated, and maintained to contain all manure and wastewater, including the runoff and direct precipitation from a 25-year, 24-hour storm or Chronic Storm, whichever is greater.

(c) The discharge of manure and wastewater to waters of the U.S. from a CAFO as the result of the application of that manure or wastewater by the CAFO to a land application site is a discharge from that CAFO subject to permit requirements, except where it is an agricultural stormwater discharge. Where the manure or wastewater has been applied in accordance with the requirements of sections 81.6(2)(a-d), a precipitation-related discharge of manure or wastewater from the site to waters of the U.S. is an agricultural stormwater discharge.

(d) Manure and wastewater shall not be applied directly to surface water.

(2) Requirement to register with the Division - The operator of a non-permitted CAFO shall register the facility with the Division by no later than February 27, 2009 or upon being defined as a CAFO.

(a) The registration shall be submitted to the Division and include the following information about the facility:

(i) Legal name;

(ii) Names of legal owner and current operator;

(iii) Facility phone number;

(iv) Physical address;

(v) Mailing address;

(vi) County in which the facility exists;

(vii) Latitude/longitude coordinates at the entrance of the facility and source of the datum;

(viii) Maximum number and type of all animals the facility will confine in the production area;

(ix) A Standard Operating Procedure (SOP) for removal of manure from impoundments in accordance with section 81.7(3), unless the facility has previously submitted a SOP; and

(x) Evidence of impoundment liner certification, unless previously submitted.

(b) At such time that any of the above information changes, the operator shall submit to the Division a revised registration by no later than 30 days after a change occurs.

(3) Discharge Reporting – The operator shall notify the Colorado Release and Incident Reporting Line at 1-877-518-5608 of a discharge of manure or wastewater to surface water.

(a) Such notification shall be made within 24-hours after the operator becomes aware of the discharge.

(b) The notification shall describe, at minimum, the date, time, cause of the discharge, approximate volume of the discharge, the estimated length of time of the discharge, the level of wastewater in the discharging impoundment(s), and whether the discharge entered, or could enter, waters of the U.S.

(4) Fees – Non-permitted CAFOs shall pay fees in accordance with the schedule set forth in section 25-8-502(1.1)(a)(III), C.R.S.

(a) All annual fees must be paid within 30 days of receipt of the Division's billing statement.

(b) All fees collected under this regulation shall be made payable to the Colorado Department of Public Health and Environment.

(c) Failure to pay annual fees in accordance with 25-8-502(1.1)(a)(III) shall result in the initiation of enforcement action by the Division.

(d) The annual fee for non-permitted CAFOs shall be prorated if the following occur during a fiscal year in which a fee has been paid:

(i) Issuance of a CAFO discharge permit; or

(ii) Termination of a registration at the registrant's request with Division approval.

(A) The prorated fee for terminations shall be based on the period of time the registration is in effect for the fiscal year during which the termination is requested, except that the period of time shall not exceed 90 days from the date the registration termination request is received by the Division. Prorated amounts less than $75 will not be refunded.

(e) The administrative fee shall be applicable to all non-permitted CAFOs as of July 1, 2009, regardless of the date upon which registration with the Division is made.

81.6 FACILITY MANAGEMENT PLAN: NON-PERMITTED CAFOs

The operator of a non-permitted CAFO shall compile and maintain on-site a facility management plan (FMP) that includes, to the extent applicable, the information specified in sections 81.6(1), 81.6(2), 81.6(3) and 81.6(4).

(1) Surface water protection elements – Production Area. The operator of a non-permitted CAFO must develop, document in the FMP and implement the following design, construction and performance requirements for the production area by no later than May 30, 2011 or upon being defined as a CAFO.

(a) Use of the following structures, methods and procedures to control wastewater:

(i) Impoundments

(A) All impoundments must be designed, constructed, and maintained to be capable of storing, the volume of all manure and wastewater, including the runoff resulting from a 25-year, 24-hour storm or Chronic Storm, whichever is greater, plus two feet of freeboard, except where the operator requests, and the Division approves, an alternative freeboard level.

(B) All requests for an alternative freeboard level shall include documentation that the alternative freeboard level will protect the structural integrity of the impoundments and terminal tanks, and will be functionally equivalent to two feet of freeboard to prevent overflows caused by factors such as wind and receipt of direct precipitation.

(ii) Conveyance Structures

(A) All conveyance structures must be designed, constructed, and maintained to be capable of carrying the flow expected from a 25-year, 24-hour storm or Chronic Storm, whichever is greater.

(iii) For open-lot wastewater only; a solid/liquid waste separation facility used in conjunction with a wastewater treatment strip

(A) The solid/liquid waste separation facility in conjunction with a wastewater treatment strip shall be designed, constructed, and maintained so that it is capable of managing the flow expected from a 25-year, 24-hour storm or Chronic Storm, whichever is greater.

(B) The system described in subsection (A) above shall also be designed in accordance with United States Department of Agriculture – Natural Resources Conservation Service standards, or other standards approved by the Division.

(iv) For process-generated wastewater, the operator may use the wastewater control system described in section 81.6(1)(a)(iii) where the Division approves a plan submitted by the operator demonstrating that the system will be sustainable, including that wastewater released into the treatment strip will be properly assimilated by the vegetation.

(v) A method approved by the Division.

(b) Install a depth marker in all impoundments indicated in the facility design calculations as being necessary to contain a 25-year, 24-hour storm or Chronic Storm, whichever is greater. Depth markers must be clearly marked, at minimum, in one foot increments and shall clearly indicate the minimum capacity necessary to contain the greater storm event.

(i) Perform weekly inspections of depth markers and record the wastewater level in each impoundment containing a depth marker.

(c) Design, construct, and maintain structures that are sized to divert stormwater from running onto a production area as appropriate.

(d) Procedures to ensure proper operation and maintenance of the impoundments, including the following:

(i) Whenever the storage capacity of impoundments and tanks is less than the volume required to store runoff from the designed storm event, the structures shall be dewatered to a level that restores the required capacity once soils on a land application site have the water holding capacity to receive the wastewater, or in accordance with section 81.6(2)(a)(i)(C).

(2) Surface water protection elements – Land Application Sites. The operator of a non-permitted CAFO shall develop, document in the FMP and implement the following practices and procedures for land application sites by no later than February 27, 2009 or upon being defined as a CAFO.

(a) Apply manure and wastewater to a land application site in accordance with the following practices and procedures:

(i) Conservation Practices - Site-specific conservation practices that have been identified and implemented, including as appropriate, buffers or equivalent practices, to control runoff of pollutants to surface water. Such practices shall include, but are not limited to:

(A) Solid manure shall be incorporated as soon as possible after application, unless the application site has perennial vegetation or is no-till cropped, or except where the operator adequately demonstrates that surface water quality will be protected where manure is not so incorporated.

(B) Where wastewater is applied to a land application site via furrow- or flood-irrigation, it shall be applied in a manner that prevents any wastewater runoff into surface water.

(C) There shall be no discharge to surface water from land application activities when the ground is frozen or saturated.

(D) Manure or wastewater shall not be land-applied within 150 feet of domestic water supply wells, and within 300 feet of community domestic water supply wells.

(ii) Sampling and Analysis - Manure, wastewater, and soil shall be sampled and analyzed with the following frequency. The results of the analyses shall be used in determining application rates for manure and wastewater.

(A) Manure and wastewater shall be sampled and analyzed a minimum of once annually for nitrogen and phosphorus content.

(B) The soil of land application sites shall be sampled and analyzed a minimum of once annually for available nutrients, including nitrate-nitrogen.

(C) The top one foot of soil of land application sites shall be sampled and analyzed for available phosphorus a minimum of once every five years, or as specified in section 81.6(2)(b)(v), below.

(iii) Protocols established by the operator for land applying manure or wastewater in accordance with site specific nutrient management practices that ensure appropriate utilization of the nutrients in the manure or wastewater. Such protocols shall include, but are not limited to:

(A) No application of manure or wastewater shall be made to a land application site at a rate that will exceed the capacity of the soil and the planned crops to assimilate plant available nitrogen within 12 months of the manure or wastewater being applied.

(B) Manure and wastewater shall be applied as uniformly as possible with properly calibrated equipment.

(C) Application rates of manure and wastewater shall be calculated using one of the following methods: the most current published fertilizer suggestions of Cooperative Extension in Colorado or adjacent states; the most current nutrient management planning guidelines for Colorado as published by the USDA, NRCS; or an alternative method approved by the Division.

(b) Nutrient Transport Minimization - Application rates for manure and wastewater applied to a land application site must minimize phosphorus and nitrogen transport from the sites to surface water and shall be in accordance with the following standards:

(i) Assessments shall be made for each land application site of the potential for phosphorus and nitrogen transport from the site to surface water and that address the form, source, amount, timing, and method of application of nitrogen and phosphorus to achieve realistic yield goals, while minimizing nitrogen and phosphorus movement to surface water.

(A) Phosphorus transport risk assessments shall be made using the most current USDA, NRCS Colorado Phosphorus Index Risk Assessment tool or other Division-approved method. The approved risk assessment tool shall provide for off-site transport risk scores of either 'low', 'medium', 'high', or 'very high'.

(B) An initial assessment of the potential for phosphorus and nitrogen transport risk to surface water shall be made prior to manure or wastewater being applied to an application site after the operator’s FMP is implemented.

(ii) Where the assessed risk of off-site phosphorus transport for a land application site is rated as 'high', phosphorus-based manure and wastewater application rates may be applied at crop phosphorus removal rates only if a phosphorus draw-down strategy is implemented for the crop rotation (i.e. rotational phosphorus application rate is less than the rotational crop removal).

(iii) No application of manure or wastewater shall be made to a land application site where the assessed risk of off-site phosphorus transport is rated as 'very high' until the risk of phosphorus movement off-site has been decreased to a phosphorus transport risk assessment rating of 'high' or less.

(iv) No application of manure or wastewater shall be made to a land application site where the risk of off-site nitrogen transport to surface water is not minimized.

(v) After an initial assessment is made of the potential for phosphorus and/or nitrogen transport from a land application site to surface water, additional assessments shall be made at the following frequency, whichever is sooner:

(A) Of both phosphorus and nitrogen transport risk, every five years; or,

(B) Where a crop management change has occurred, assess phosphorus transport risk within one year after such change would reasonably result in an increase in the phosphorus transport risk assessment score, and assess nitrogen transport risk within one year after such a change would reasonably result in the nitrogen transport to surface water not being minimized; or,

(C) Where a phosphorus transport risk assessment score was 'very high', assess phosphorus transport risk within six months of intending to apply manure or wastewater, except as provided in section 81.6(2)(b)(iv), above.

(D) Where a nitrogen transport risk assessment reveals that nitrogen transport to surface water is not minimized, assess nitrogen transport risk within six months of intending to apply manure or wastewater.

(vi) Where a multi-year phosphorus application was made to a land application site, no additional manure or wastewater shall be applied to the same site in subsequent years until the applied phosphorus has been removed from the site via harvest and crop removal.

(c) Inspect Land Application Equipment - Periodically inspect for leaks from equipment used for land application of manure or wastewater. At minimum, such inspection shall be made annually and within the six month period prior to the first application of manure or wastewater, and at least once daily when wastewater is being applied.

(d) Setback Requirements – Unless the operator exercises one of the alternatives provided below, manure and wastewater shall not be applied closer than 100 feet to any down-gradient surface waters, open tile line intake structures, sinkholes, agricultural well heads, or other conduits to surface water.

(i) As a setback alternative, the operator may substitute the 100-foot setback with a 35-foot wide vegetated buffer where applications of manure or wastewater are prohibited.

(ii) The Division may approve an alternative setback or buffer based on a demonstration by the operator that a required setback or buffer is not necessary because implementation of alternative conservation practices or land application site conditions will provide pollutant reductions equivalent or better than the reductions that would be achieved by the 100-foot setback.

(e) Mortalities – Mortalities shall remain on the production area until disposal and shall be managed to ensure that they are not disposed of in a wastewater storage system that is not specifically designed to treat animal mortalities.

(f) Prevent direct contact of confined animals with surface water.

(g) Ensure that chemicals and other contaminants handled on-site are not disposed of in any manure or wastewater storage system unless specifically designed to treat such chemicals and other contaminants.

(3) Ground water protection elements – Production Area. The operator of a non-permitted CAFO shall include in the FMP the following information by no later than February 27, 2009 or upon being defined as a CAFO. The FMP shall be updated as necessary to meet the requirements of the sections of this regulation cited below.

(a) The impoundment liner records and certifications specified in sections 81.7(2)(b) and (c).

(b) The current approved Standard Operating Procedure (SOP) specified in section 81.7(3)(a), and manure/sludge removal certifications specified in section 81.7(3)(d).

(c) Information demonstrating that the facility is in compliance with the depth marker, conveyance structure, and setback requirements specified in sections 81.7(4),(5) and (6).

(4) Recordkeeping – The operator shall create, maintain at the facility for five years from the date they are created, and make available to the Division or its designee, upon request, the following records:

(a) Records identified by the operator that will be maintained to document the implementation and management of the surface water protection elements described in sections 81.6(2)(a) through (g).

(b) Weekly records of the depth of the manure and wastewater as indicated by the depth markers in the impoundments required to be inspected by section 81.6(1)(b)(i), or as indicated by an alternative method approved by the Division.

(c) A copy of the current FMP shall be compiled and maintained in one discrete place at the facility, such as an office or filing cabinet.

81.7 GROUND WATER PROTECTION REQUIREMENTS - CAFO OPERATIONS (PERMITTED AND NON-PERMITTED)

(1) Tanks at CAFOs shall be operated and maintained so as not to discharge wastewater to ground water.

(2) Impoundment liners

(a) An impoundment at a CAFO shall be constructed and maintained to comply with one of the following standards, as applicable:

(i) The seepage rate from an impoundment shall not exceed 1 x 10^{-6} cm/sec; or

(ii) Where approved by the Division for an impoundment with an earthen liner that collects only open-lot runoff, the seepage rate from the impoundment shall not exceed 7.35 x 10^{-6} cm/sec. The operator of the impoundment shall submit to the Division a request that the impoundment be approved to meet this seepage standard. Such a request shall include, but not be limited to, information documenting that only open-lot wastewater will be diverted to the impoundment, that the impoundment is not designed as an evaporation impoundment, and that the ten foot soil depth zone immediately beneath the impoundment has a cation exchange capacity of at least 15 meq/100 g of soil. Demonstration of compliance with the cation exchange capacity criteria requires the following:

(A) At least seven soil samples shall be acquired from below the entire surface area of the impoundment and analyzed for cation exchange capacity.

(B) The soil samples shall be reasonably equidistant from each other, with five locations being within ten feet of, and downslope of, the two-foot freeboard elevation of the impoundment, and two locations from the middle of the impoundment.

(C) The operator shall have available a map of the impoundment and soil sampling locations.

(D) Where soil samples were taken below existing impoundments, the operator shall have available documentation from a professional engineer registered in the State of Colorado of how the core locations were sealed to meet a 1 x 10^{-6} cm/sec maximum seepage rate.

(b) CAFO operators shall have available documentation, including the supporting information required by section 81.7(2)(b)(i), prepared by a professional engineer registered in Colorado certifying that the provisions of section 81.7(2) have been met, and stating what constitutes each constructed liner (e.g., synthetic, clay).

The liner certification and, where applicable (i.e., for impoundments constructed after February 27, 2009), the seepage rate calculations using Darcy's Law shall be available prior to wastewater entering the impoundment.

(i) Copies of the liner certification and supporting information shall be made available to the Division or its designee, upon request.

For a newly constructed impoundment, submit the documents to the Division by no later than 30 days after construction of the impoundment is complete.

(c) A CAFO operator shall visually inspect the exposed liner of an impoundment weekly to identify physical changes or deficiencies that may affect the integrity of the liner. Such deficiencies and physical changes shall be corrected 30 days of having been identified.

(i) The operator shall record the date of the inspection, deficiencies identified, corrective actions taken, and dates that corrective action was completed.

(ii) Deficiencies not corrected within 30 days shall be accompanied by an explanation of the factors preventing completion of corrective actions within this time period.

(iii) The records shall be maintained on-site for five years from the date of creation and shall be made available to the Division upon request.

(3) Removal of manure or wastewater from an impoundment shall be accomplished in a manner that does not damage the integrity of the liner. The operator shall submit to the Division for approval a Standard Operating Procedure (SOP) that demonstrates how manure, including sludge, will be removed such that the liner integrity of impoundments is not damaged. The SOP also shall indicate the expected frequency with which manure will be removed from impoundments.

(a) The approved SOP must be available on-site and be submitted to the Division upon request.

(b) The operator shall follow the approved SOP whenever manure, including sludge, is removed. Where the SOP was not followed, the Division may require that the operator make the liner available for inspection. Where the Division has just cause as a result of the inspection, the Division may require re-certification of the liner by a professional engineer registered in Colorado.

(c) A CAFO shall submit the SOP no later than 120 days after animals are placed on the production area.

(i) The operator shall submit a revised SOP for approval within 30 days of a change having been made to the impoundment(s) at the facility that requires a revision of the SOP, such as a new impoundment or different liner having been constructed.

(d) The operator shall certify after each manure, or sludge removal event that the manure or sludge was removed in accordance with the approved SOP.

(i) The certifications must be available on-site and be submitted to the Division upon request.

(ii) For a concrete-lined impoundment, where a certification for each removal event is not completed, at least once every five years the operator shall:

(A) Drain and clean the impoundment. The operator shall use best professional judgment to determine whether the liner integrity is capable of having a maximum seepage rate of 1×10^{-6} cm/sec.

(B) Where the operator determines that the impoundment remains capable of having a maximum seepage rate of 1×10^{-6} cm/sec, the operator shall document the determination within five days of the liner inspection. The documentation shall include photographs supporting the determination.

(C) Where the operator determines the liner integrity is damaged such that the impoundment is no longer capable of having a maximum seepage rate of 1×10^{-6} cm/sec, the operator shall:

(I) Repair the impoundment within 30 days of the liner inspection so that the impoundment is capable of having a maximum seepage rate of 1×10^{-6} cm/sec.

(II) Within 14 days of repairing the impoundment, submit evidence of the properly completed repair to the Division. The evidence shall consist either of photographs with accompanying written documentation or of other evidence approved by the Division.

(e) Where the SOP is not followed, the operator shall provide notice to the Division within 30 days of the date of manure removal.

(4) Any depth marker in an impoundment shall be installed in a manner that maintains the integrity of the liner and maintains the required seepage rate standard.

(5) Wastewater Conveyance Structures - Conveyance structures shall be designed and maintained to convey but not store any manure or wastewater.

(a) Conveyance structures that carry process-generated wastewater continuously (48 hours or less between conveyance events) shall be constructed and maintained to have a maximum seepage rate of 1×10^{-6} cm/sec.

(b) Where upon inspection the Division has just cause to determine that the required liner is not in place, the Division may require that the operator submit to the Division a certification that the conveyance structure meets the requirements of section 81.7(5)(a). The certification shall be made by a professional engineer registered in the State of Colorado.

(6) Setbacks for New and Expanded Impoundments – A new impoundment constructed after June 30, 2008, or an existing impoundment that is expanded by 50 percent or more of existing storage capacity after June 30, 2008, shall not be located:

(a) Except as provided below, where the seasonally high ground water level is located within four feet of the bottom of the impoundment liner; and

(i) Where the seasonally high ground water level is located within four feet of the bottom of the impoundment liner, the impoundment shall be constructed and maintained in accordance with the design by a professional engineer registered in the state of Colorado that accounts for hydrostatic pressure adversely affecting the integrity of the impoundment's liner.

(b) Within 150 feet of a private domestic water supply well or within 300 feet of a community domestic water supply well.

(7) Ground Water Monitoring - Where an impoundment is not in compliance with section 81.7(2), or where the Division determines that an impoundment liner is not being properly maintained, the Division may require the operator to conduct site-specific ground water quality monitoring of, but not limited to, total nitrogen, ammonia-nitrogen, nitrate-nitrogen, and fecal coliform. In making a determination of whether ground water monitoring is required, the Division shall consider all pertinent factors, including but not limited to: whether the impoundment poses a significant potential risk to beneficial uses of ground water, whether there is suspected contamination of ground water attributable to the facility, whether early detection of ground water contamination is essential to protect valuable drinking water sources, and whether there has been a significant failure on the part of the operator to comply with sections 81.7(2), (3), (4), (6), or (7).

(8) Ground Water Remediation - When the Division determines that non-compliance with sections 81.7(2), (3), (4), (6), or (7) has caused, or contributed to, the exceedance of established ground water quality standards, the operator shall:

(a) Submit, in consultation with the Division, an approvable investigation plan within 60 days of being notified by the Division of the exceedance, unless an extension of time is granted by the Division based on good faith efforts made by the operator.

(i) The investigation plan must indicate how the nature and extent of the contamination will be delineated and shall include the following, at minimum:

(A) A plan to determine the full vertical and horizontal extent of ground water contamination.

(B) All potential human and environmental receptors, including: 1) all surface water features including springs, streams, and lakes that could be impacted; and 2) all municipal, agricultural, and domestic ground water users.

(C) A plan to obtain other site-specific hydrogeologic data necessary to fully determine the nature and extent of the contamination. These shall include, as appropriate, but not be limited to, the hydraulic conductivity of all hydrogeologic units, associated porosity values, ground water flow directions, regional and local hydraulic gradients, and pumping rates associated with all wells. The Division may require that the operator install additional monitoring wells for the purpose of fully determining the nature and extent of the contamination.

(D) A reasonable timeline for completing the investigation.

(ii) The operator shall implement the investigation plan within 30 days of it being approved by the Division.

(b) The operator shall submit the following information by no later than 60 days after completion of the approved investigation plan, unless an extension of time is granted by the Division based on good faith efforts made by the operator:

(i) A summary report of the findings of the investigation conducted pursuant to section 81.7(8)(a).

(ii) A comparison of all appropriate and applicable remediation alternatives, including innovative technologies, the associated performance and costs of each alternative, the estimated timelines to achieve the required remediation goals and the monitoring that will be done until the remediation goal(s) is reached. The Division shall review remediation alternatives based on technological, economic and environmental risk factors. In determining economic reasonableness, the Division shall take into account such factors as costs of the various alternatives, the potential impact of the alternatives on a project's profitability or competitive position and any long-term energy impacts. In determining environmental risk factors the Division will include potential exposures of sensitive human and environmental receptors. In cases where sensitive human and environmental impacts could occur, the Division may require interim, or emergency, remedial activities.

(c) The operator shall submit an approvable remediation plan by no later than 60 days of being notified of the Division's preferred remediation alternative, unless an extension of time is granted by the Division based on good faith efforts made by the operator. The remediation plan shall contain designs and plans for implementation of the preferred alternative.

(i) The operator shall implement the remediation plan within 30 days of it being approved by the Division.

(9) Impoundment Closure – The operator of a facility shall remove manure and wastewater from a closed impoundment, to the fullest extent practicable within 60 days of the impoundment being closed, unless an alternative timeline is approved by the Division. Within 120 days of an impoundment being closed, an impoundment shall be backfilled with soil that is graded to blend with surface topography and prevent ponding, unless an alternative procedure and timeline is approved by the Division.

81.8 BEST MANAGEMENT PRACTICES

The following Best Management Practices (BMPs) shall be utilized by AFOs and CAFOs, as appropriate, based upon existing physical conditions and site constraints. Best management practices means, for purposes of this regulation, activities, procedures, or practices necessary for the reduction of impacts on surface or ground water, as described in this section. Additional surface water and ground water protection elements required of CAFOs are detailed in sections 81.6 and 81.7 of this regulation.

The following practices, designed to decrease runoff volume, are BMPs within the meaning of this regulation:

(1) Divert runoff from uncontaminated areas away from animal confinement areas, and manure and wastewater control facilities to the extent practicable through:

(a) Construction of ditches, terraces or other waterways

(b) Installation of gutters, downspouts and buried conduits to divert roof drainage;

(c) Construction of roofed areas over animal confinement areas everywhere it is practicable.

(2) Decrease open lot surface area, where practicable by:

(a) Reducing lot size;

(b) Improving lot surfacing to support increased animal density;

(c) Providing roofed area to the maximum extent practicable; and

(d) Eliminating animal confinement areas, and manure and wastewater control facilities in areas that slope in directions such that wastewater/rainfall cannot be collected.

(3) Decrease water volume by:

(a) Repairing or adjusting waterers and water systems to minimize water wastage.

(b) Using lowest practical amounts of water for manure and wastewater flushing.

(c) Recycling water used to flush manure from paved surfaces or housed confinement areas, if practical.

(4) Decrease wastewater discharges to surface water by:

(a) Collecting and allowing process-generated wastewater to evaporate.

(i) Additionally, for Medium AFOs that do not apply wastewater to land application sites (i.e. evaporative impoundments only), the impoundment(s) must be capable of storing the volume of all process-generated wastewater for 180 days, at a minimum.

(b) Collecting and evenly applying wastewater to land application sites at agronomic rates.

(i) Additionally, for Medium AFOs that apply wastewater to land application sites, the impoundment(s) must be capable of storing the volume of all open-lot runoff and process-generated wastewater for 120 days, at a minimum.

(ii) For Medium AFOs that land apply wastewater, the operator shall keep records demonstrating that wastewater has been applied to each land application site at an agronomic rate.

(A) Such records shall be maintained on-site for five years from the date they are created.

(B) Such records shall be made available to the Division or its designee, upon request.

(c) Treating open-lot wastewater through use of one of the following:

(i) A wastewater treatment strip; or,

(A) Inflow to a wastewater treatment strip shall be pretreated by a solid/liquid waste separation facility, as appropriate based upon site constraints and to have the wastewater treatment strip adequately assimilate pollutants.

(ii) A method approved by the Division.

(d) Preventing animals from having direct contact with surface water. A stock watering point may be used where animals have access to no other source of drinking water. A stock watering point shall be cleaned frequently of manure and have wastewater diverted at the watering point entry.

(e) Locating wastewater retention structures or collection sites away from areas where stormwater run-off or seasonally high stream flow may carry the waste into waters of the state.

(f) Not locating wastewater retention structures located within a mapped 100 year flood plain as designated by the Colorado Water Conservation Board (CWCB) unless proper flood proofing measures (structures) are designed and constructed.

(g) Managing animal mortalities in a manner that prevents a discharge of pollutants to surface water.

(5) Minimize manure transport to surface water by:

(a) Locating manure stockpiles away from surface water, and above the 100 year flood plain as designated and approved by CWCB, unless adequate flood proofing structures are provided, and bermed to minimize runoff.

(b) Locating manure stockpiles away from areas where stormwater run-off or normally high stream flow will carry the waste manure into the waters of the state, unless the area is bermed to minimize runoff.

(c) Providing adequate manure storage capacity based upon manure and wastewater production.

(d) Removing settleable solids by using solids-settling basins, terraces, diversions, or other solid removal methods approved by the Division. Construction of solids-settling facilities shall not be required where the Division determines existing site conditions provide adequate settleable solids removal. Sufficient capacity shall be provided in the solids-settling facilities to store settled solids between periods of manure and wastewater disposal.

(e) Applying manure to land application sites at an agronomic rate.

(i) For Medium AFOs that land apply manure, the operator shall keep records demonstrating that manure has been applied to each land application site at an agronomic rate.

(A) Such records shall be maintained on-site for five years from the date they are created.

(B) Such records shall be made available to the Division or its designee, upon request.

(f) Avoiding applications on saturated soils and lands subject to excessive erosion.

(g) Using edge-of-field, grassed strips, filter fences or straw bales to separate eroded soil and manure particles from the field runoff.

(h) Collecting manure frequently.

(6) Practices to Protect Groundwater.

(a) Operators shall locate manure and wastewater management facilities hydrologically downgradient and a minimum horizontal distance of 150 feet from all water supply wells.

(b) When applying manure and wastewater to land, operators shall utilize a buffer area around water wells sufficient to prevent the possibility of waste transport to groundwater via the well or well casing.

(c) An impoundment at a Medium AFO shall have a liner that is constructed and maintained such that the seepage rate from the impoundment does not exceed 1×10^{-6} cm/sec.

(i) The operator of such a facility shall have documentation prepared by a professional engineer registered in Colorado certifying that each impoundment has a liner that does not allow a seepage rate in excess of 1×10^{-6} cm/sec. Such documentation shall be available prior to wastewater entering the impoundment.

(ii) The operator shall make a copy of such documentation available to the Division or its designee, upon request.

(d) Where the Division determines that an AFO with animal number below those established for a Medium AFO, could adversely affect ground water quality, the operator of such an AFO shall install a liner in all impoundments such that the seepage rate from each impoundment does not exceed 1×10^{-6} cm/sec.

(i) The Division shall determine that such an AFO could adversely affect ground water quality by demonstrating that it is in a location where:

(A) Significant ground water recharge occurs as determined using the United States Department of Agriculture, Natural Resources Conservation Service's current "Agricultural Waste Management Field Handbook, Part 651, Chapter 7, Geologic and Ground Water Considerations"; or,

(B) Contamination from the AFO could cause ground water to exceed the standards adopted by the Colorado Water Quality Control Commission; or,

(C) A water source susceptibility analysis results in the AFO having a "medium-high" or "high" potential for contaminating existing or reasonably likely future public drinking water system withdrawals. Such an analysis shall examine the physical setting of ground water and the contaminant threat that the AFO poses to the ground water source. Factors that shall be considered in examining the physical setting include aquifer sensitivity at the water source intake location, depth to the water source, structural integrity of the water system at the withdrawal point, flow of the water source and first draw of the water source. Factors that shall be considered in examining the contaminant threat are migration potential, contaminant hazard, potential volume and likelihood of contaminant release.

(ii) A liner, where required, shall be installed according to a work plan approved by the Division.

(A) The operator shall, in consultation with the Division, develop and submit an approvable work plan that includes a timeline for installing each liner within 60 days of receiving the written request from the Division.

(B) The operator shall implement the plan within 30 days of it being approved by the Division.

(C) The operator shall submit to the Division, within 30 days of each liner having been properly constructed, documentation prepared by a professional engineer registered in the State of Colorado certifying that the seepage rate from each impoundment does not exceed 1×10^{-6} cm/sec.

81.9 SEVERABILITY

The provisions of this regulation are severable, and if any provisions or the application of the provisions to any circumstances is held invalid, the application of such provision to other circumstances, and the remainder of this regulation, shall not be affected thereby.

81.10 – 81.14 RESERVED

. . . .

81.26 STATEMENT OF BASIS, SPECIFIC AUTHORITY AND PURPOSE: JUNE 12, 2017 RULEMAKING, EFFECTIVE DATE OF JULY 31, 2017

The provisions of sections 25-8-202, 25-8-205 and 25-8-401, C.R.S., provide the specific statutory authority for adoption of the attached regulatory amendments. The Commission also adopted, in compliance with section 24-4-103(4) C.R.S., the following statement of basis and purpose.

BASIS AND PURPOSE

A. BACKGROUND

This hearing was held to consider changes as recommended during the triennial informational hearing for this regulation on October 11, 2016, and during subsequent discussions with stakeholders and parties to the hearing process.

As a result of this rulemaking proceeding, the commission adopted the following amendments to this regulation.

B. DISCUSSION OF AMENDMENTS

Typographical and Formatting Errors: The commission corrected typographical and formatting errors found throughout the regulation. These corrections have no effect on the substantive meaning of the regulation.

Removal of the Term "Large" from Sections 81.2, 81.5, and 81.6: The commission concluded that use of the term "Large" hindered the division's ability to appropriately regulate facilities that do not meet the definition of a Large CAFO. Any facility, regardless of the number of animals confined, can be required to implement these more stringent regulatory provisions if they are located in areas where the potential adverse impacts associated with a discharge are particularly severe (81.15) Therefore, the commission found it appropriate to remove the term "Large" from sections of the regulation that are applicable to any facility that is either defined or designated as a CAFO.

Definitions [81.3]:

The definition for "Land Application Site" was revised to add clarity and consistency with the corresponding definition found in Regulation No. 61,

Requirements – Non-Permitted CAFOs [81.5]

The Colorado Revised Statute citation in subsection 81.5(4), which requires non-permitted CAFOs to pay an annual registration fee, was updated by the commission to reflect formatting changes made by the legislature. In addition, language was added in 81.5(4)(c) which enables the division to initiate enforcement proceedings against a CAFO that fails to pay the required annual fee. Subsequent subsections of 81.5(4) were renumbered as a result of the added language.

Facility Management Plan: Non-Permitted CAFOs [81.6]

Subsection 81.6(4)(a) was revised by the commission to clarify the recordkeeping requirements for a non-permitted CAFO to demonstrate that the surface water protection elements of the Facility Management Plan have been implemented and are being properly managed.

Best Management Practices [81.8]

During the May 8, 2017 rulemaking hearing, the commission expressed concerns that the regulation did not explicitly state that this section was applicable to both AFOs and CAFOs. Therefore, the term AFO was removed from the section header and the term CAFO was added to the first sentence to specify these best management practices are applicable to both AFOs and CAFOs. Because BMPs are considered the minimum activities, procedures, or practices to be implemented to minimize adverse effects to surface and groundwater, language was included to clarify that CAFOs must also adhere to the surface and groundwater protection elements of sections 81.6 and 81.7.

Subsections 81.8(4)(a) and (b) were reformatted by the commission to clarify the impoundment sizing requirements for Medium AFOs depending on whether they land apply wastewater or collect and allow it to evaporate. No substantive changes were made to the existing language.

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Tracking number: 2017-00018

Opinion of the Attorney General rendered in connection with the rules adopted by the

Water Quality Control Commission (1002 Series)

on 06/12/2017

5 CCR 1002-81

REGULATION NO. 81 - ANIMAL FEEDING OPERATIONS CONTROL REGULATION

The above-referenced rules were submitted to this office on 06/12/2017 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

Frederick R. Yarger

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

June 29, 2017 10:52:52

Permanent Rules Adopted

Department

Department of Public Health and Environment

Agency

Disease Control and Environmental Epidemiology Division

CCR number

6 CCR 1009-2

Rule title

6 CCR 1009-2 THE INFANT IMMUNIZATION PROGRAM AND IMMUNIZATION OF STUDENTS ATTENDING SCHOOL 1 - eff 07/30/2017

Effective date

07/30/2017

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Disease Control and Environmental Epidemiology Division

THE INFANT IMMUNIZATION PROGRAM AND IMMUNIZATION OF STUDENTS ATTENDING SCHOOL

6 CCR 1009-2

Adopted by the Board of Health on June 21, 2017

[Publication Instructions: Replace current existing text from Part I.C through Part IV. A. with the following new text for Part I. C. through Part IV. A.]

I. Definitions

***

C. College or university student - any student who is enrolled for one or more classes at a college or university and who is physically present at the institution. This includes students who are auditing classes but does not include persons taking classes online or by correspondence only.

D. Delegated physician assistant – a licensed physician assistant authorized under Section 12-36-106(5), C.R.S., to execute Certificates of Immunization, medical exemptions and/or supervise a public health or school nurse as authorized by part 9 of article 4 of title 25, C.R.S.

E. Dose - a measured quantity of an immunizing agent; quantity and frequency of administration determined by recognized health authorities and the manufacturer of each agent.

F. Emancipated student - any student who has reached age 18; a lawfully married child of any age; a child 15 years of age or older who is managing his/her own financial affairs and who is living separate and apart from his/her parent.

G. Immunization tracking system - a comprehensive immunization tracking system established by the Department of Public Health and Environment pursuant to Section 25-4-2403(2), C.R.S., that enables the gathering of epidemiological information from the sources delineated in section 25-4-2403(2), C.R.S. and the investigation and control of communicable diseases. Individuals, parents and legal guardians may provide information to the immunization tracking system; however, pursuant to section 25-4-2403(7), C.R.S., they have the option to exclude their or their student's immunization information from the immunization tracking system at any time.

H. Indigent child - any child whose parent cannot afford to have the child immunized or if emancipated, who cannot himself/herself afford immunization and who has not been exempted.

I. Infant - any child up to twenty-four months of age or any child eligible for vaccination and enrolled under the Colorado Medical Assistance Act, Articles 4, 5, and 6 of Title 25.5, C.R.S.

J. In-process student - a student may be considered in-process if:

1. Within fourteen days after receiving direct personal notification that the certificate of immunization is not up-to-date according to the requirements of the state board of health, the parent or emancipated student submits documentation that the next required immunization has been given and a signed written plan for obtaining the remaining required immunizations. The scheduling of immunizations in the written plan shall follow medically recommended minimum intervals consistent with the ACIP. If the student does not fulfill the plan, the student shall be suspended or expelled from school for noncompliance as noted in Section 25-4-907, C.R.S. If the next dose is not medically indicated within fourteen days, then the medically approved minimum intervals would apply.

2. With regard to college or university students as defined in Section I (C), the student must present to the appropriate official of the school either (I) a signed written authorization requesting local health officials to administer required immunizations or (II) a plan for receipt of the required immunization or the next required immunization in a series within either 30 days or the medically approved minimum interval. If this does not occur, the college or university student will not be allowed to enroll, remain enrolled, or audit for the current term or session. Such written authorizations and plans must be signed by one parent or guardian or the emancipated student or the student eighteen years of age or older.

K. Parent - the person or persons with parental or decision-making responsibilities for a child.

L. Practitioner - a duly licensed physician, advanced practice nurse, or other person who is permitted and otherwise qualified to administer vaccines under the laws of this state.

M. School - all child care facilities licensed by the Colorado Department of Human Services including: child care centers, school-age child care center, preschools, day camps, resident camps, day treatment centers, family child care homes, foster care homes, and head start programs; public, private, or parochial kindergarten, elementary or secondary schools through grade twelve, or a college or university. Schools do not include a public services short-term child care facility as defined in Section 26-6-102 (6.7), C.R.S., a guest child care facility as defined in Section 26-6-102 (5), C.R.S., a ski school as defined in Section 26-6-103.5 (6), C.R.S., or college or university classes which are: offered off-campus; offered to nontraditional adult students as defined by the governing board of the institution; offered at colleges or universities which do not have residence hall facilities, or; online only.

N. School health authority - an individual working for or on behalf of the child care facility or school who is knowledgeable about childcare/school immunizations.

O. School official - the school’s chief executive officer or any person designated by him/her as his/her representative.

P. Student - any person enrolled in a Colorado school as defined in Section I (M), except:

1. a child who enrolls and attends a licensed child care center, as defined in section 26-6-102 (1.5), C.R.S., which is located at a ski area, for up to fifteen days or less in a fifteen-consecutive-day period, no more than twice in a calendar year, with each fifteen-consecutive-day period separated by at least sixty days, and

2. college and university students as defined in Section I (C).

Q. Titer – a titer is a laboratory test that measures the presence and amount of antibodies in blood. Antibody titers can be used to show that a person is immune to some diseases.

II. **Minimum Immunization Requirements**

A. To attend school, a student must have an age appropriate Certificate of Immunization. Meeting the initial immunization requirements does not exempt a student from meeting subsequent age requirements. This certificate must demonstrate immunization against the following diseases:

1. Hepatitis B

2. Pertussis

3. Tetanus

4. Diphtheria

5. *Haemophilus Influenzae* Type B (HIB)

6. Pneumococcal disease

7. Polio

8. Measles

9. Mumps

10. Rubella

11. Varicella

B. The minimum number of doses required by age of the student is set forth in the 2017 ACIP Birth – 18 Years Recommended Immunization Schedule or the 2017 ACIP Catch-Up Immunization Schedule.

1. The 2017 ACIP Birth-18 Years Recommended Immunization Schedule (Schedule) is incorporated by reference for only those vaccines required to prevent the diseases listed in Section II (A). Other immunizations included in the ACIP recommendations are not required. This schedule is posted on the Centers for Disease Control and Prevention website at:

https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf or on the Colorado Department of Public Health and Environment website at: [www.coloradoimmunizations.com], and is available for public inspection during regular business hours at the Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South, Denver, Colorado 80246. Copies of the recommended schedules are available from the Colorado Department of Public Health and Environment for a reasonable charge that comports with the Department's record request practices. This rule does not include any later amendments or editions of the ACIP Schedule.

2. In addition, the 2017 ACIP Catch-Up Immunization Schedule is incorporated by reference for those children not fully immunized and only for those vaccines required to prevent the diseases listed in Section ~~III~~ II (A). Other immunizations included in the ACIP recommendations are not required. This recommended schedule is posted on the Centers for Disease Control and Prevention website at: https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf or on the Colorado Department of Public Health and Environment website at [www.coloradoimmunizations.com], and is available for public inspection during regular business hours at the Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South, Denver, Colorado 80246. Copies of the recommended schedules are available from the Colorado Department of Public Health and Environment for a reasonable charge that comports with the department's record request practices. This rule does not include any later amendments or editions of the ACIP Catch-Up Schedule.

C. Students between the ages of 4 through 6 years are required to receive their final doses of Diphtheria, Tetanus, and Pertussis (DTaP), Inactivated Polio Vaccine (IPV), Measles, Mumps, and Rubella (MMR) and Varicella prior to kindergarten entry.

D. Students are required to have administered Tetanus, Diphtheria, Pertussis (Tdap) prior to entry into 6th grade. One dose of Tdap is a requirement for 6th through 12th grades.

E. Positive titers are an acceptable alternative to the following vaccines: DTaP, Hepatitis B, Varicella and MMR. For DTaP substitution, both the diphtheria and tetanus titers must be positive. For MMR substitution, titers for measles, mumps, and rubella must be positive. A titer is not an acceptable replacement for *Haemophilus Influenzae* type b, Pneumococcal, IPV, or Tdap vaccines.

III. Exemptions from Immunization

It is the responsibility of the parent(s) to have his or her student immunized unless the student is exempted. A student may be exempted from receiving the required immunizations in the following manner:

A. Medical exemption - By submitting a medical exemption form with the statement of medical exemption signed by an advanced practice nurse, a delegated physician assistant, or physician licensed to practice medicine or osteopathic medicine in any state or territory of the United States indicating that the physical condition of the student is such that immunizations would endanger his/her life or health or is medically

contraindicated due to other medical conditions. This form is to be submitted once, and must be maintained on file at each new school the student attends.

B. Religious exemption - By submitting a nonmedical exemption form signed by the parent(s) or the emancipated student indicating that the parent(s) or emancipated student is an adherent to a religious belief whose teachings are opposed to immunizations.

Beginning July 1, 2016,

1. Prior to kindergarten entry, a nonmedical exemption form must be submitted at each interval in the ACIP Birth-18 years immunization schedule at which immunizations are due. The ACIP immunization schedule is incorporated in Section II (B). This documentation is required only for those vaccines required to prevent the diseases listed in Section II (A). Exemptions will expire at the time next immunizations are due according to the ACIP birth-18 years immunization schedule or when the student is enrolled to attend kindergarten.

2. From kindergarten through twelfth grade, a nonmedical exemption form must be submitted once per school year. Exemptions will expire annually on June 30th, the last official day of the school year.

C. Personal belief exemption - By submitting a nonmedical exemption form signed by the parent(s) or the emancipated student indicating that the parent(s) or emancipated student has a personal belief that is opposed to immunizations.

Beginning July 1, 2016,

1. Prior to kindergarten entry, a nonmedical exemption form must be submitted at each interval in the ACIP Birth-18 years immunization schedule at which immunizations are due. The ACIP immunization schedule is incorporated in Section II (B). This documentation is required only for those vaccines required to prevent the diseases listed in Section II (A). Exemptions will expire at the time next immunizations are due according to the ACIP birth-18 years immunization schedule or when the student is enrolled to attend kindergarten.

2. From kindergarten through twelfth grade, a nonmedical exemption form must be submitted once per school year. Exemptions will expire annually on June 30th, the last official day of the school year.

D. In the event of an outbreak of disease against which immunization is required, no exemption or exception from immunization shall be recognized and exempted persons may be subject to exclusion from school and quarantine.

E. All information distributed to the parent(s) by school districts regarding immunization shall inform them of their rights under Section III (A-D).

IV. Examination and audit of official school immunization records

The Department of Public Health and Environment's representative shall have the right to audit and verify records to determine compliance with the law. Discrepancies found through audits

shall be corrected by school officials, and any student not in full compliance shall be suspended or expelled from school according to the following rules:

A. If the parent(s) or emancipated student was informed of the deficiencies in the student's official school immunization records pursuant to Section I (J) (1) of the rules, the student shall be suspended or expelled pursuant to Section 25-4-907, C.R.S.

…

[Publication Instructions: Replace current existing text from Part VI. A. through Part VII. A. 11 with the following new text for Part VI. A. through Part VII. A. 11]

VI. Official school immunization records

A. Official school immunization records shall include:

1. An official Certificate of Immunization or an Alternate Certificate of Immunization approved by the Department of Public Health and Environment, which shall include one of the following forms of documentation with the dates and types of immunizations administered to a student:

a. A paper or electronic document that includes information transferred from the records of a licensed physician, registered nurse, a delegated physician assistant, or public health official, or

b. An electronic file or hard copy of an electronic file provided to the school directly from the immunization tracking system established pursuant to Section 25-4-2403, C.R.S., or from a software program approved by the Department of Public Health and Environment, or

2. An official medical exemption form with the date and vaccines exempted from, or

3. A nonmedical exemption form with the date, type of exemption taken and the vaccines exempted from.

B. Any immunization record (original or copy) provided by a physician licensed to practice medicine or osteopathic medicine in any state or territory of the United States, registered nurse, a delegated physician assistant, or public health official may be accepted by the school official as proof of immunization. The information is to be verified by the school official and transferred to an official Certificate of Immunization.

C. Schools shall have on file an official school immunization record for every student enrolled. The official school immunization record will be kept apart from other school records. When a student withdraws, transfers, or is promoted to a new school, the school official shall return the Certificate of Immunization to the parent(s) or emancipated student upon request or transfer it with the student's school records to the new school. Upon a college or university student's request, the Certificate of Immunization shall be forwarded as specified by the student.

VII. Reporting of Statistical Information

A. On December 1, 2016, and each year thereafter, any child care center, preschool or head start program that is licensed by the Colorado Department of Human Services to provide care to ten or more children and are not exempt from reporting pursuant to Paragraph B of this Section, and; public, private, or parochial schools with kindergarten, elementary or secondary schools through grade twelve, shall send aggregate immunization and exemption data, by antigen, to the Department of Public Health and Environment.

Required data shall include:

1. Total number of students and total number of kindergarten students enrolled in the school;

2. Total number of students and total number of kindergarten students who are up-to-date with immunizations as required in Section II;

3. Total number of students and total number of kindergarten students who have a medical exemption for all immunizations as required in Section II;

4. Total number of students and total number of kindergarten students who have a medical exemption for one or more but not all immunizations as required in Section II;

5. Total number of students and total number of kindergarten students who have a religious exemption for all immunizations as required in Section II;

6. Total number of students and total number of kindergarten students who have a religious exemption for one or more but not all immunizations as required in Section II;

7. Total number of students and total number of kindergarten students who have a personal belief exemption for all immunizations as required in Section II;

8. Total number of students and total number of kindergarten students who have a personal belief exemption for one or more but not all immunizations as required in Section II;

9. Total number of in-process students and total number of in-process kindergarten students;

10. Total number of students and total number of kindergarten students not up-to-date for immunizations as required in ~~part III~~ Section II, with no exemption on file, and not in-process; and

11. Total number of students and total number of kindergarten students with no immunization records.

***

[Publication Instructions: Replace current existing text from Part IX. A. 1 with the following new text for Part IX. A. 1]

…

IX. **Requirements for college and university students, colleges and universities.**

The provisions below apply only to colleges or universities, or students enrolled in a college or university.

A. Exemptions from immunization

A college or university student may be exempted from receiving required immunizations in the following manner:

1. Medical exemption - By submitting a medical exemption form with the statement of medical exemption signed by an advanced practice nurse, a delegated physician assistant, or physician licensed to practice medicine or osteopathic medicine in any state or territory of the United States indicating that the physical condition of the college or university student is such that immunizations would endanger his/her life or health or is medically contraindicated due to other medical conditions. This form is to be submitted once, and must be maintained on file at each new school the college or university student attends.

***

[Publication Instructions: Replace current existing text from Part IX. E. through Part IX. F. with the following new text for Part IX. E. through Part IX. F.]

E. Official school immunization records

1. Official school immunization records shall include one of the following:

A. An official Certificate of Immunization or an Alternate Certificate of Immunization approved by the Department of Public Health and Environment, which shall include one of the following forms of documentation with the dates and types of immunizations administered to a college or university student:

1. A paper or electronic document that includes information transferred from the records of a licensed physician, registered nurse, a delegated physician assistant, or public health official, or

2. An electronic file or hard copy of an electronic file provided to the school directly from the immunization tracking system established pursuant to Section 25-4-2403 C.R.S. or from a software program approved by the Department of Public Health and Environment, or

B. An official medical exemption form with the date and vaccines exempted from, or

C. A nonmedical exemption form with the date, type of exemption taken and the vaccines exempted from.

2. Any immunization record (original or copy) provided by a physician licensed to practice medicine or osteopathic medicine in any state or territory of the United States, registered nurse, a delegated physician assistant, or public health official may be accepted by the school official as proof of immunization.

3. Schools shall have on file an official school immunization record for every college or university student enrolled.

F. Reporting of statistical information –on December 1, 2016, and each year thereafter, any college or university that constitutes a school as defined by Section I (M) shall send aggregate immunization and exemption data, by antigen, to the Department of Public Health and Environment:

…

CYNTHIA H. COFFMAN
Attorney General

DAVID C. BLAKE
Chief Deputy Attorney General

MELANIE J. SNYDER
Chief of Staff

FREDERICK R. YARGER
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Office of the Attorney General

Tracking number: 2017-00171

Opinion of the Attorney General rendered in connection with the rules adopted by the

Board of Health

on 06/21/2017

6 CCR 1009-2

THE INFANT IMMUNIZATION PROGRAM AND IMMUNIZATION OF STUDENTS ATTENDING SCHOOL

The above-referenced rules were submitted to this office on 06/27/2017 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

Frederick R. Yarger

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

June 29, 2017 10:59:18

Permanent Rules Adopted

Department

Department of Higher Education

Agency

Historical Society

CCR number

8 CCR 1504-7

Rule title

8 CCR 1504-7 HISTORICAL, PREHISTORICAL, AND ARCHAEOLOGICAL RESOURCES 1 - eff 08/01/2017

Effective date

08/01/2017

DEPARTMENT OF HIGHER EDUCATION

Historical Society

HISTORICAL, PREHISTORICAL, AND ARCHAEOLOGICAL RESOURCES

8 CCR 1504-7

SECTION 9. Curation of collections in approved museums

A. The state of Colorado holds title to all historical, prehistorical and archaeological materials collected from areas owned by the state or any of its political subdivisions.

B. While the society is the official trustee of the State of Colorado (CRS 24-80-202), the society wishes to advance a collaborative partnership with county and local museums or curatorial repositories, (a curatorial repository is a permanent, nonprofit educational or research oriented agency or institution, having professionally trained on-site staff, that provides housing and collections care in-perpetuity), to ensure long-term preservation and interpretation of these items. These institutions help to preserve, interpret and promote the natural and cultural inheritance of humanity in Colorado and work in close collaboration with the communities from which their collections originate as well as those they serve. Such an arrangement with the State is advantageous to everyone in Colorado.

C. All materials, except human remains and associated funerary objects, collected from state lands or political subdivisions must be curated in a museum, unless a reputable museum, university, college or other recognized scientific or educational institution can assure permanent preservation on the site.

1. Historical, archaeological, prehistorical, and paleontological collections made under permit may include ceramic, lithic, glass, metal, faunal, floral, and synthetic materials, as well as documents, photographs, organic samples (such as coprolites or soil samples), fossils (vertebrates, invertebrates, paleobotanical, ichnofossils, and associated rock or sediment samples), and human remains and associated funerary objects.

2. Permittees proposing to transport collections out of Colorado must secure a loan agreement between an out-of-state facility and a permanent approved on-site institution, reputable in-state museum, or curatorial repository, subject to the approval of the society, except that ancillary samples may be transported and analyzed without such a loan agreement. Out-of-state analysis of human remains and associated funerary objects is subject to the approval of the society.

3. Proposed analysis of artifacts or fossils which would cause their destruction or damage, such as trace-element analysis of materials, may be performed only with the written consent of the society through the state archaeologist, who shall consider whether such artifacts are unique or duplicated in state-owned collections. The society will supply notification of consent to the affected museum within thirty days.

4. State, County and local agencies or research/educational institutions wishing to ensure collections care of artifacts or specimens permanently on-site (or within close proximity to the origin of the excavated materials) must either be approved through a request to serve as an approved museum or curatorial repository as specified in Section 9 (I) of this chapter or through execution of a special held-in-trust collections agreement with the society.

D. Reburial or repatriation of human remains may supersede their placement in an approved museum.

E. Collections from state or political subdivision lands obtained from an issued permit in accordance with CRS 24-4-104 must be curated in an approved reputable Colorado museum or curatorial repository. The relationship between the society and another reputable Colorado museum or a curatorial repository is an express trust. Title and ownership of these collections is not transferred and the society has the authority to transfer and approve stewardship of the collections through an on-site held-in-trust collections agreement or through the approval of a reputable museum or curatorial repository as outlined in Section 9 (I) of this chapter.

F. Collections recovered from lands owned or controlled by the state or any of its political subdivisions shall be deposited at an approved museum, curatorial repository, an approved on-site agency, or institution within six months after submission of the permittee's final report. Collections made from permitted archaeological or paleontological projects occurring over multiple years should not be deposited with different museums or curatorial repositories unless an approved museum, curatorial repository, on-site agency or institution, lacks expertise or environmental conditions necessary to ensure the collection's long-term preservation.

G. Responsibilities and requirements of approved museums or curatorial repositories

Museums and curatorial repositories must be open to the public. They must agree to provide curation of archaeological or paleontological resources in a systematic and accessible manner, and to make them available free of charge for study by qualified students and researchers.

1. Provide a copy and maintain a current and active fine art or other commercial insurance policy or if the museum or curatorial repository whose collections are primarily owned or overseen by a governmental entity, acknowledge that the state collection and any associated state property are covered for liability from any loss or damage.

2. If accepting collections from outside researchers, institutions issuing curation or similarly worded "intent-to-curate" agreements to third-party permitted researchers must first have their template agreement language approved by the state archaeologist or his/her staff designee to avoid confusion that the collections have state of Colorado title.

3. Within ten working days refer to the state archaeologist of Colorado all requests (written and oral) for transfer or repatriation of the state collection (or any part thereof).

4. Maintain separately all written and digital descriptive information associated with the curated state collection, including field notes, site forms and reports in a safe and secure manner.

5. Do not release to any third-party any precise information relating to the exact physical location of a prehistoric site (locale) from which the state collection (or any part thereof) derives, except to qualified researchers or after obtaining from the state archaeologist of Colorado prior written permission. If there are questions as to releasing this information, approved museums or curatorial repositories will consult with the state archaeologist of Colorado.

6. In accordance with these regulations, be open and subject to inspection by the state archaeologist or his/her designee at least once every three years.

7. Accept state collections from permitted work for their specific regional or local area guided by these current rules and procedures and the approved museum's or curatorial repository's collection management policy.

8. Annually report back to the state archaeologist or his/her designee any changes to the state's collection condition or insurance policy changes, loan agreement status and any other

tracking requirement methods adopted by the society and the office of the state archaeologist.

9. Properly maintain any State of Colorado property (shelving, cabinetry etc.) in its possession associated with the care of the state collection.

10. Maintain the collection within inert and acid-free storage or packaging.

11. With the exception of approved repatriation, not sell, transfer, assign, pledge, encumber, discard, or otherwise dispose of the state collection (or any part thereof) or any associated State of Colorado property in its possession without written and signed permission from the state archaeologist.

12. Have an established collections management policy and emergency management plan.

13. Within five calendar days of the discovery of any loss or theft of, deterioration or damage to, destruction of the state collection (or any part thereof), or any State of Colorado items of property used to support and care for a state collection in the museum's or curatorial repository's possession, the museum or repository will provide to the society written notification of the circumstances surrounding the loss, theft, deterioration, damage, or destruction, and will report to the state archaeologist or his/her designee those actions taken to stabilize the collection, or State of Colorado items or property, and to correct any deficiencies in the physical plant or operating procedures that may have contributed to the loss, theft, deterioration, damage, or destruction.

14. Other than routine, small and simple paleontological specimen or artifact mending repairs, any planned actions that involve major repair or restoration beyond basic re-attachment of the state collection (or any part thereof) or any other State of Colorado property associated with the state collection must be approved of in advance after consultation with the state archaeologist.

15. The society (in co-ordination with other reputable museums, nonprofit or governmental educational institutions) reserves the right to take custody of state collections in the care of an approved museum, curatorial repository, on-site agency or institution through a loan agreement for temporary exhibit purposes.

H. Approved Uses

1. Approved museums or curatorial repositories and the society may fully exhibit and charge reasonable nondiscriminatory admission fees, comparable to fees charged at similar facilities to view these items prepared for interpretive display (either for permanent, temporary or travelling exhibition purposes). Additionally, approved museums or curatorial repositories and the society may photograph and nondestructively study the state collection (or any part thereof) on the museum or curatorial repository's premises, subject to the museum or repository's own collections management policies and in accordance with these regulations. Physical reproduction of any state collection item(s) must be approved of in advance by the state archaeologist.

2. State paleontological resources curated at an approved museum or curatorial repository may be cleaned, treated, stabilized and prepared for research, exhibition or loan transportation purposes under standard professional best practices for natural history collections.

3. A held-in-trust state collection may be loaned out by an approved museum or curatorial repository to other institutions and organizations (including for temporary exhibition or

study by the society) by securing a loan agreement between the other facilities provided notice of the arrangement is sent to the state archaeologist for tracking purposes. The director of the approved museum or curatorial repository is responsible for all loan transactions of state collections and for ensuring that appropriate and timely administration of the loans is conducted. Relocation inventories must be conducted and included as part of the written loan agreement. Other loan conditions must be addressed in the Collections Management Policy of the curatorial facility that is loaning the material. The loan and transportation of the state collection must be insured for liability purposes through securing a commercial fine art or other insurance policy or be adequately covered by governmental self insurance to fulfill any damage or loss incident. Collections that are not inventoried or cataloged shall not be loaned. Commercial use of loaned collections is prohibited without written consent from the society. Ancillary samples may be transported and analyzed without a formal loan agreement; however, the museum or curatorial repository will provide to the society two copies of any publications, reports, and other documents prepared by researchers studying ancillary samples.

4. All exhibits, reproductions, and studies will credit the state archaeologist of Colorado as follows: “Courtesy of History Colorado, Office of the State Archaeologist.” The museum or curatorial repository will provide to the society two copies of any publications, reports, and other documents prepared by museum or curatorial repository staff studying or exhibiting the state collection (or any part thereof).

5. Approved museums or curatorial repositories and the society may charge a competitive deposit fee for the collections and reasonable administrative processing fees for “curation” or similarly worded “intent-to-curate” agreements with permittees. Permitted researchers that deliver collections not according to the state archaeologist’s current Submission Guidelines for State-Owned Archaeological Collections and these regulations may be subject to corrective hourly labor rate fees plus the cost of supplies by the state approved museum or curatorial repository.

I. Procedures for approving museums

1. Any institution wishing to serve as a museum for collections from state lands (or any subdivision of state lands) or collected as a result of work carried out under a permit issued under authority of this Act shall apply to the society through the state archaeologist for approval.

2. The museum or curatorial repository shall fill out a *Request to Serve as an Approved Museum or Curatorial Repository for Held-in-Trust Collections* form, signed by the director of the institution and must evidence reputable status with any of the following credentials (or their equivalent successor museum program/designations):

   a. Received from the American Association for State and Local History (AASLH) silver or gold certificates by participating in the Standards and Excellence Program for History Organizations (*StEPs*) in the stewardship of collections section within the last five years.

   b. Show evidence of participation in the Museum Assessment Program in the area of collections stewardship from the American Alliance of Museums within the last five years.

   c. Received Core Documents Verification from the American Alliance of Museums within the last five years.

d. Received and maintain formal Accreditation status from the American Alliance of Museums.

e. Considered a designated Federal Repository for curating federally-owned and administered archaeological or paleontological collections under the requirements of Federal Regulations 36 CFR 79.

3. Provide proof to the state archaeologist of a fine art or other appropriate umbrella insurance policy that will adequately cover the care for the state collection from any one claim or aggregate claim arising from a damage or a loss incident. With the insurance policy documents, the society and the approved museum or curatorial repository should be shown as co-beneficiaries (or additionally insured).

   a. If the museum or curatorial repository's collections are primarily owned or overseen by a Colorado governmental entity (considered a "public entity" within the meaning of the Colorado Governmental Immunity Act, CRS 24-10-101, et seq.), the museum or curatorial repository must indicate to the state archaeologist that they are self insured in lieu of the fine art or other umbrella insurance policy requirement stated above. If self insured, it is understood that the public entity of the approved museum or curatorial repository will ensure liability to the state collections under its care arising from a damage or a loss incident.

   b. In the event of a loss incident, a liability assessment of the value of the collection shall be determined by mutual agreement with the society as the sum of the estimated current fair market value and the estimated costs of replacing the scientific and educational information from the lost artifacts or specimen. A determination of these replacement costs may include, but are not limited to: (a) research design development; (b) fieldwork; (c) laboratory analysis; (d) curation; (e) reports or educational materials; and (f) lost visitor services or experience. In some cases, it may be appropriate for the estimated cost of replacement value to be peer reviewed by archaeologists or paleontologists with appropriate expertise and with no conflicts of interest.

4. If the museum or the curatorial repository curates collections from permitted researchers outside of their approved institution, provide a template copy of a "curation" or similarly worded "intent-to-curate" agreement for approval by the state archaeologist or his/her designee. The agreement form must clearly acknowledge that title to the artifacts or specimens as well as all associated reports, original field notes, maps, drawings, photographs etc., resulting from the investigations to be curated remains solely with the State of Colorado.

5. Approval of a museum or a curatorial repository shall be effective for a period of five years, after which time, the curatorial facility may apply for renewal through the procedures in this chapter.

6. The completed documentation shall be reviewed by the state archaeologist or his/her designee within 30 days of receipt. If clarification or additional information is requested by the society, the facility shall have 30 days to furnish the information required.

7. The museum or curatorial repository may discontinue accepting new collections from outside researchers by amending their agreement upon renewal to serve as an approved facility. Once approval of a museum or a curatorial repository has been granted however, the express trust arrangement with the State of Colorado continues and is perpetual for any of the existing collections under the institution's stewardship.

8. The society has sole discretion to approve or not approve a museum's or curatorial repository's application.

9. Approval may be withdrawn by the society through the state archaeologist if deficiencies in collections care and non-compliance to these regulations appear. Approval will be suspended or revoked in accordance with CRS 24-4-104.

10. Under the authority of CRS 24-80-407, the society may exercise the right to enter into agreement with museums, curatorial repositories, or other public or private entities to fulfill the State's needs for held-in-trust state collections concordant to these rules and regulations.

11. For each deposited historical, prehistorical, archaeological or paleontological state collection, the approved museum or curatorial repository will sign and acknowledge an official deposit receipt form with a simple inventory list of items accepted for permanent curation by the facility, a copy of which will be forwarded to the state archaeologist or his/her designee.

J. Continuance of pre-approved museums and repositories

1. Previously approved non-expiring museums and curatorial repositories shall honor existing "intent to curate" or similarly worded executed curation agreements with third-party researchers (permittees) up to five years after the effective date of these revised rules unless individual contractual agreements expire within five years. Notice from an approved museum or curatorial repository for continuing the acceptance of collections from previously dated permittee agreements must be given to the state archaeologist of Colorado or his/her designee within 30 days after the expiration date for renewal of approved status. The notice shall be made through the *Request to Serve as an Approved Museum or Curatorial Repository for Held-in-Trust Collections* form and the museum or repository must list the number and names of all outstanding agreements along with their expiration dates. Extended approval of these previously approved museums or curatorial repositories shall then be made for a period of up to five years based on furthest dated agreement and shall not extend beyond five years following the effective date of these adopted and revised rules.

2. Museums or curatorial repositories that hold in custody held-in-trust state collections that were collected as a result of CRS 24-04-104 that decide not to become a newly approved museum or curatorial repository under these revised rules should nonetheless attempt to provide the highest possible level of care to the existing state collections currently maintained in their facilities. At a minimum, a level of care that prevents deterioration of, damage to or loss of items in the state collection should be maintained.

3. Within five years of the effective date of the adoption of these revised rules, previously approved non-renewing museums or curatorial repositories should either submit a plan for the state archaeologist of Colorado's approval regarding the continued care and management of the state collection or plan for the transfer of the state collections to a museum or curatorial repository approved under the revised 8CCR 1504-7 Section 9 (I) of this chapter.

K. Responsibilities of permittee submitting collection

1. In choosing a museum, permittees should attempt to keep the collection in its area of origin and to keep materials from the same site and the same project together. Permittees should confer with staff of the selected museum and have a written agreement whose

template language was approved by the state archaeologist or his/her designee as specified in Section I (4) of this chapter prior to collecting materials in the field.

2. Permittees should follow the guidance of museum staff in regard to collecting procedures. The permittee should adhere to any specific methods of labeling, packaging, and shipment required by the museum and the state archaeologist's current Submission Guidelines for State-Owned Archaeological Collections. All collections must be placed and delivered within inert and acid-free packaging.

3. The permittee is responsible for returning to the office of the state archaeologist a fully signed official state deposit receipt form by the approved museum, curatorial repository, on-site agency, or institution and the office of the state archaeologist of Colorado. The form must be accompanied by a simple inventory list of items accepted by the approved facility for permanent curation.

CYNTHIA H. COFFMAN
Attorney General

DAVID C. BLAKE
Chief Deputy Attorney General

MELANIE J. SNYDER
Chief of Staff

FREDERICK R. YARGER
Solicitor General

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Office of the Attorney General

Tracking number: 2017-00136

Opinion of the Attorney General rendered in connection with the rules adopted by the

Historical Society

on 06/09/2017

8 CCR 1504-7

HISTORICAL, PREHISTORICAL, AND ARCHAEOLOGICAL RESOURCES

The above-referenced rules were submitted to this office on 06/27/2017 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

June 29, 2017 10:51:15

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Permanent Rules Adopted

Department

Department of Health Care Policy and Financing

Agency

Executive Director of Health Care Policy and Financing

CCR number

10 CCR 2505-5

Rule title

10 CCR 2505-5 Executive Director of Health Care Policy and Financing 1 - eff 07/30/2017

Effective date

07/30/2017

DO NOT PUBLISH

Title of Rule: Revision to the Executive Director of the Department of Health Care Policy and Financing Rule Concerning All-Payers Claims Database. 10 CCR 2505-5, Sections 1.200.1, 1.200.3 and 1.200.5.

Rule Number: MSB 16-12-19-A

Division / Contact / Phone: Health Care Policy and Financing/Health Information Office / HCPF- Chris Underwood, 303.866.4766 / CIVHC-Tracey Campbell, 720-242-7683

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department/Agency Name: Health Care Policy and Financing / Executive Director of Health Care Policy and Financing
2. Title of Rule: ED16-12-19-A,
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 1.200.1, 1.200.3 and 1.200.5, 2505 Colorado Department of Health Care Policy and Financing, Executive Director of Health Care Policy and Financing (10 CCR 2505-5).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text starting at 1.200.1 with the proposed text beginning at 1.200.1 through the end of 1.200.1. Replace the current text at 1.200.3.D with the proposed text through the end of 1.200.3.D. Replace the text at 1.200.5 with the proposed text beginning at 1.200.5 through the end of 1.200.5.C. This rule is effective July 30, 2017.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH

Title of Rule: Revision to the Executive Director of the Department of Health Care Policy and Financing Rule Concerning All-Payers Claims Database. 10 CCR 2505-5, Sections 1.200.1, 1.200.3 and 1.200.5.

Rule Number: MSB 16-12-19-A

Division / Contact / Phone: Health Care Policy and Financing/Health Information Office / HCPF-Chris Underwood, 303.866.4766 / CIVHC-Tracey Campbell, 720-242-7683

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   Purpose:

   Every year CIVHC, current payer submitters and other stakeholders review the Data Submission Guide and determine whether there should be updates, changes, clarifications or corrections to the guide. This collaborative process ensures that the CO APCD is gathering comprehensive data in a manner that is minimally intrusive upon private and public payers and meets the goals and objectives of the CO APCD statute and enabling rules. The proposed change supports health care programs' drive toward the Triple Aim with more recent health care data to help understand progress and make course corrections in a timely manner. The rule has also been clarified to ensure that readers understand health care improvement includes better quality and value as well as clinical care delivery improvement. The rule change also clarifies that, consistent with the APCD enabling statute, the Data Release Review Committee serves as a privacy board and should therefore review requests for data that include Personal Health Information (PHI).

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

Initial Review Final Adoption **06/05/2017**

Proposed Effective Date **07/30/2017** Emergency Adoption

DOCUMENT #01

4. State Authority for the Rule:

   Section 25.5-1-108, C.R.S. (2015);

   Section 25.5-1-204(9), C.R.S. (2015)

DO NOT PUBLISH

Title of Rule: Revision to the Executive Director of the Department of Health Care Policy and Financing Rule Concerning All-Payers Claims Database. 10 CCR 2505-5, Sections 1.200.1, 1.200.3 and 1.200.5.

Rule Number: MSB 16-12-19-A

Division / Contact / Phone: Health Care Policy and Financing/Health Information Office / HCPF- Chris Underwood, 303.866.4766 / CIVHC-Tracey Campbell, 720-242-7683

REGULATORY ANALYSIS

5. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Private and public payers who submit data to the CO APCD using Data Submission guide Version 9 2017 (DSG V9) will need to modify their current file format to accommodate the proposed changes. CIVHC and stakeholders requesting data from the CO APCD will benefit from more comprehensive data that supports the Triple Aim: better health, better care, lower costs.

6. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   CIVHC will work collaboratively with all private health payers to meet the requirements of the revised submission guide, including using the established waiver process to provide a short term relaxed data standard or an extended timeline to submit conforming data.

7. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   The APCD is not state funded; this amendment will have no impact on state appropriations

8. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The state will not incur any costs due to action or inaction. The state would benefit from this rule change because the additional information would add to the

collaborative understanding of health system performance now underway such as the State Innovation Model (SIM) project and other state based projects.

9. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no less costly of intrusive strategies to achieve the purpose of the proposed rule.

10. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

    None

1.200 ALL-PAYERS CLAIMS DATABASE

1.200.1 Definitions

“administrator” means the administrator of the APCD appointed by the director of the department.

“APCD” means the Colorado All-Payer Claims Database.

“dental claims data file” means a file that includes data about dental claims and other encounter information, according to the requirements contained in the submission guide.

“department” means the Colorado Department of Health Care Policy and Financing.

“director” means the Executive Director of the department.

“eligibility data file” means a file that includes data about a person who receives health care coverage from a payer, according to the requirements contained in the submission guide.

“ERISA” means the Employee Retirement Income Security Act of 1974, as codified at 29 U.S.C. ch. 18.

“HIPAA” means the Health Insurance Portability and Accountability Act, U.S.C. § 1320d – 1320d-8, and its implementing regulations, 45 C.F.R. Parts 160, 162 and 164, as may be amended.

“historic data” means eligibility data file(s), medical claims data file(s), pharmacy file(s) and provider file(s) for the period commencing January 1, 2009 through December 31, 2014 (except in the case of a self-insured employer-sponsored health plan, in which case, “historic data” shall mean, at minimum, such data file(s) for the period commencing January 1, 2015 through December 31, 2015).

“medical claims data file” means a file that includes data about medical claims and other encounter information, according to the requirements contained in the submission guide.

“payer” means a private health care payer and a public health care payer.

“pharmacy file” means a file that includes data about prescription medications and claims filed by pharmacies, according to the requirements contained in the submission guide.

“private health care payer” means an insurance carrier as defined in C.R.S. § 10-16-102(8) covering an aggregate of 1,000 or more enrolled lives in health coverage plans as defined in C.R.S. § 10-16-102(34). For purposes, of this regulation, “private health care payer” includes carriers offering health benefits plans under C.R.S. § 10-16-102(32)(a) and dental, vision, limited benefit health insurance, and short-term limited-duration health insurance. For the purposes of this regulation, a “private health care payer” also means a self-insured employer-sponsored health plan covering an aggregate of 100 or more enrolled lives in Colorado. It does not include a self-insured employer-sponsored health plan, if such health plan is administered by a third-party administrator or administrative services only organization (“TPA/ASO”) that services less than an aggregate of 1,000 enrolled lives in Colorado; carriers offering accident only; credit; benefits for long term care, home health care, community-based care, or any combination thereof under Article 19 of Title 10; disability income insurance; liability insurance including general liability insurance and automobile liability insurance; coverage issued as a supplement to liability insurance; worker’s compensation or similar insurance; or automobile medical payment insurance, specified disease, or hospital indemnity and other fixed indemnity insurance.

“protected health information” shall have the same meaning as in the HIPAA Privacy Rule in 45 C.F.R. § 160.103.

“provider file” means a file that includes additional information about the individuals and entities that submitted claims that are included in the medical claims file; and is submitted according to the requirements contained in the submission guide.

“public health care payer” means the Colorado Medicaid program established under articles 4, 5 and 6 of title 25.5, C.R.S., the children’s basic health plan established under article 8 of title 25.5, C.R.S. and Cover Colorado established under part 5 article 8 of title 10, C.R.S.

“submission guide” means the document entitled “Colorado All-Payer Claims Database Data Submission Guide” developed by the administrator that sets forth the required schedules, data file format, record specifications, data elements, definitions, code tables and edit specifications for payer submission of eligibility data files, medical, dental and pharmacy claims data files and provider data files to the APCD dated Version 9 2017, which document is hereby incorporated by reference.

1.200.2 Reporting Requirements

1.200.2.A Payers shall submit complete and accurate eligibility data files, medical claims data files, pharmacy claims data files, dental claims data files and provider files to the APCD pursuant to the submission guide. The administrator may amend the submission guide and shall provide notice of the revisions to payers. Any revision to the submission guide will be effective only when incorporated into this rule and issued in compliance with the requirements of C.R.S. § 24-4-103 (12.5). Reports submitted 120 days following the effective date of the revision of this rule and the submission guide shall follow the revised submission guide.

1.200.2.B. A private health care payer subject to the provisions of ERISA is not required under this rule to submit claims data to the APCD but may continue to submit claims data or elect to submit claims data at any time in accordance with the procedures described in Sections 1.200.2.A and 1.200.3.

1.200.3 Schedule for Mandatory Data Reporting

1.200.3.A. Payers shall submit a test file of its eligibility data, medical and pharmacy claims data and provider files for a consecutive twelve month period to the administrator by no later than March 31, 2012 or no later than 160 calendar days after the effective date of this rule, whichever is later.

1.200.3.B. Payers shall submit complete and accurate historic data to the administrator that conforms to submission guide requirements by no later than June 30, 2012, or no later than 250 calendar days after the effective date of this rule, whichever is later.

1.200.3.C. Payers will transmit complete and accurate eligibility data, medical claims data, pharmacy claims data, dental claims data and provider files covering the period from January 1, 2012 and ending June 30, 2012 to the administrator by no later than August 15, 2012, or for the period as specified by the administrator no later than 305 days after the effective date of this rule, whichever is later.

1.200.3.D. On a monthly basis thereafter, payers will transmit complete and accurate monthly eligibility data, medical claims data, pharmacy claims data, dental claims data and provider files to the administrator. These data files for the period ending July 31, 2012, shall be submitted no later than September 15, 2012, or for the period as specified by the administrator, no later than 305 days after the effective date of this rule, whichever is later. For each month thereafter, files shall be submitted no later than 30 days after the end of the reporting month. Any time extension

shall be provided to payers in writing by administrator at least 30 days prior to established deadlines.

1.200.4 APCD Reports

1.200.4.A. The administrator shall, at a minimum, issue reports from the APCD data at an aggregate level to describe patterns of incidence and variation of targeted medical conditions, state and regional cost patterns and utilization of services.

1.200.4.B. The APCD reports shall be available to the public on consumer facing websites and shall provide aggregate and summary reports to achieve the purposes of the APCD. Any such reports shall protect patient identity in accordance with HIPAA's standard for the de-identification of protected health information.

1.200.5 Requests for Data and Reports

1.200.5.A. A state agency or private entity engaged in efforts to improve health care quality, value or public health outcomes for Colorado residents may request a specialized report or data set from the APCD by submitting to the administrator a written request detailing the purpose of the project, the methodology, the qualifications of the research entity, and by executing a data use agreement, to comply with the requirements of HIPAA.

1.200.5.B. A data release review committee shall review those requests for reports or data sets containing protected health information and shall advise the administrator on whether release of the data is consistent with the statutory purpose of the APCD, will contribute to efforts to improve health care quality, value or public health outcomes for Colorado residents and complies with the requirements of HIPAA. The administrator shall include a representative of a physician organization, hospital organization, non-physician provider organization and a payer organization on the data release review committee.

1.200.5.C. The administrator may charge a reasonable fee to provide the requested data.

1.200.6 Penalties

1.200.6.A. If any payer fails to submit required data to the APCD in a timely basis, or fails to correct submissions rejected because of errors, the administrator shall provide written notice to the payer. The administrator may grant an extension of time for just cause. If the payer fails to provide the required information within thirty days following receipt of said written notice, the administrator shall provide the payer with notice of the failure to report and will notify the director of the payer's failure to report. The director shall assess a penalty of up to $1,000 per week for each week that a payer fails to provide the required data to the APCD up to a maximum penalty of $50,000. In determining whether to impose a penalty, the director may consider mitigating factors such as the size and sophistication of a payer, the reasons for the failure to report and the detrimental impact upon the public purpose served by the APCD.

1.200.6.B The penalties specified in Section 1.200.6.A shall not apply to a private health care payer that is subject to the provisions of ERISA, since those payers are not required under this rule to submit claims data to the APCD.

1.200.7 Interagency Agreement

1.200.7.A. The director may enter into an Interagency Agreement on behalf of the APCD and the administrator with the Division of Insurance in the Colorado Department of Regulatory Agencies

to assist in the enforcement of these regulations and under the Divisions' authority in Title 10 of the Colorado Revised Statues.

1.200.8 Privacy and Confidentiality

1.200.8.A. Pursuant to C.R.S. § 24-72-204(3)(a)(I) medical and other health care data on individual persons is not an open record and the department shall deny any open records request for such information.

1.200.8.B. Certain aggregate and de-identified data reports from the APCD shall be available to the public pursuant to C.R.S. § 25.5-1-204(7) when disclosed in a form and manner that ensures the privacy and security of protected health information in compliance with HIPAA.

1.200.8.C. The administrator shall institute appropriate administrative, physical and technical safeguards to ensure that the APCD, its operations, data collection and storage, and reporting disclosures are in compliance with the requirements of HIPAA. All eligibility claims data, medical, dental, and pharmacy claims data shall be transmitted to the APCD and stored by the APCD in a secure manner compliant with HIPAA.

1.200.9 Incorporation by Reference

1.200.9A The rules incorporate by reference (as indicated within) material originally published elsewhere. Such incorporation, however, excludes later amendments to or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department of Health Care Policy and Financing maintains copies of the incorporated texts in their entirety which shall be available for public inspection during regular business hours at:

Colorado Department of Health Care Policy and Financing
Medical Services Board Coordinator
1570 Grant Street
Denver, CO 80203

Copies of material shall be provided by the department, at cost, upon request.

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Attorney General

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Office of the Attorney General

Tracking number: 2017-00153

Opinion of the Attorney General rendered in connection with the rules adopted by the

Executive Director of Health Care Policy and Financing

on 06/05/2017

10 CCR 2505-5

Executive Director of Health Care Policy and Financing

The above-referenced rules were submitted to this office on 06/05/2017 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

June 20, 2017 09:16:35

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Permanent Rules Adopted

Department

Department of Human Services

Agency

Social Services Rules (Volume 7; Child Welfare, Child Care Facilities)

CCR number

12 CCR 2509-2

Rule title

12 CCR 2509-2 REFERRAL AND ASSESSMENT 1 - eff 08/01/2017

Effective date

08/01/2017

7.100 REFERRAL AND ASSESSMENT [Eff. 8/1/17]

7.101 DOCUMENTATION OF REFERRALS [Eff. 8/1/17]

All reports that meet the definition of a referral for intrafamilial, third party, or institutional abuse and/or neglect shall be entered into the state automated case management system. Any time a case is opened, it shall come through the referral or assessment process in the state automated case management system with the exception of Interstate Compact on the Placement of Children (ICPC), out of state subsidized adoption, and Division of Youth Corrections (DYC) Medicaid-only.

7.102 HOTLINE REQUIREMENTS [Eff. 1/1/15]

The establishment of a statewide child abuse and neglect reporting hotline system is intended to provide an additional resource for the public to make an initial report of suspected or known abuse and/or neglect.

7.102.1 COUNTY HOTLINE RESPONSIBILITIES [Eff. 8/1/17]

A. County departments shall establish a dedicated child abuse and neglect reporting telephone line to receive calls from the statewide child abuse and neglect reporting hotline system.

B. County departments shall ensure that all calls received through the statewide child abuse and neglect reporting hotline system will be answered by a live person designated by the county, which may include county staff, local law enforcement, the Hotline County Connection Center, and/or an answering service.

C. County departments shall ensure that any county department staff that responds to inquiries regarding child abuse and/or neglect or gathers information for reports of child abuse and/or neglect are trained and annually certified according to the requirements outlined in Section 7.603 (12 CCR 2509-7).

D. County departments shall ensure that all reports and inquiries received through the statewide child abuse and neglect reporting hotline system are documented in the state automated case management system by the end of the next business day following receipt as defined in Section 7.103.9.

E. When county departments select a routing method in the statewide child abuse and neglect reporting hotline system that prevents call data from being collected by the hotline system, county departments shall provide the State Department with designated monthly reports.

1. County departments shall use a uniform template, provided by the State Department, to report the following:

    a. Call volume,

    b. Average call duration; and,

    c. Average wait time.

2. The monthly reports shall be due to the State Department by the third business day of the following month.

7.102.2 HOTLINE COUNTY CONNECTION CENTER RESPONSIBILITIES [Eff. 8/1/17]

A. Hotline County Connection Center staff shall be continuously available twenty-four (24) hours a day, seven (7) days a week to receive and immediately route hotline calls to the appropriate county department.

The appropriate county department shall be determined by the following criteria in order of priority:

1. Residence of the child;

2. Current location of the child; or,

3. Incident location.

B. All Hotline County Connection Center staff shall be trained and annually certified according to the requirements outlined in Section 7.603 (12 CCR 2509-7).

C. Hotline County Connection Center staff shall ensure that all hotline calls are documented in the state automated case management system.

7.102.3 TRANSFER OF HOTLINE RESPONSIBILITIES [Eff. 8/1/17]

A. With the express written consent of the Board of County Commissioners of a county, a county department may request that the State Department assist that county with the taking of calls or initial contacts from the public of reports of possible child abuse and/or neglect or of inquiries. The Executive Director of the State Department must approve this arrangement in writing (26-5-111(3)(B), C.R.S.).

B. A county department may request that the State Department receive after-hours reports or inquires on behalf of the county department by submitting a written request to the State Department. The Board of County Commissioners must officially approve the use of the hotline system on behalf of the county. Approval of such arrangement shall be approved by the State Department Executive Director or his/her designee (26-5-111(4) (E), C.R.S.).

C. In the event of a natural disaster or other emergency situation in which county departments cannot receive reports or inquiries from the statewide child abuse and neglect reporting hotline system, county departments may request that the Hotline County Connection Center receive their reports or inquiries, until they are able to resume normal operations.

D. County departments may request another county department to receive reports and inquiries from the statewide child abuse and neglect reporting hotline system on behalf of the county department subject to the Board of County Commissioners' approval. Documentation of agreement from both county departments must be submitted to the State Department's Executive Director or his/her designee prior to implementation.

Reports and inquiries taken by a county department or the Hotline County Connection Center on behalf of another county department must follow the requirements defined in 26-5-111, C.R.S. and Sections 7.101, 7.101.1, 7.102.1 D., 7.103, 7.103.1, and 7.103.2.

E. When the Hotline County Connection Center or another county department enters a report of child abuse and/or neglect into the state automated case management system on behalf of another county department, it shall transfer the referral to the appropriate responsible county department through the state automated case management system within two (2) hours after the call is completed. The method for notification is as follows:

1. When a referral is sent during regular business hours, notification shall be through telephone call, voicemail, e-mail, text, or other emerging technology, and shall be documented in the state automated case management system; or,

2. When a referral is sent outside of regular business hours, notification shall be through personal contact to a person who is the appropriate county department representative, and shall be documented in the state automated case management system.

F. When a county department receives referrals from the Hotline County Connection Center or another county department, the county department shall confirm receipt of the referral within two (2) hours through the state automated case management system.

G. When the Hotline County Connection Center or another county department enters an inquiry into the state automated case management system on behalf of another county department, they shall transfer the inquiry to the appropriate county department as follows:

1. Child welfare inquiries regarding child abuse and/or neglect or families with child welfare involvement shall be transferred to the appropriate county department through the state automated case management system within two (2) hours after the call is completed.

a. When a child welfare inquiry is sent outside of regular business hours, notification shall be through personal contact to a person who is the appropriate county department representative, and shall be documented in the state automated case management system.

2. All other inquiries and requests for non-child welfare information shall be transferred to the appropriate county department through the state automated case management system within two (2) hours after the call is completed.

H. When a county department receives an inquiry from the Hotline County Connection Center or another county department, the county department shall confirm receipt of the inquiry as follows:

1. Child welfare inquiries regarding child abuse and/or neglect or families with child welfare involvement shall be confirmed through the state automated case management system within two (2) hours of receipt.

a. When a child welfare inquiry is received outside of regular business hours the county department shall also confirm receipt through personal contact with the appropriate county department representative, and shall be documented in the state automated case management system.

2. All other inquiries and requests for non-child welfare information shall be confirmed through the state automated case management system by the close of the next business day.

7.103 RECEIPT OF REFERRAL ALLEGING INTRAFAMILIAL OR THIRD PARTY ABUSE AND/OR NEGLECT– INFORMATION TO BE GATHERED [Eff. 8/1/17]

A. Upon receipt of a report alleging intrafamilial or third party abuse and/or neglect, the county departments or the Hotline County Connection Center shall gather and document the following information, when available.

1. Reporting party's:

a. Name;

b. Address;

c. Telephone number;

d. Reporter type; and,

e. Relationship to the alleged victim child(ren)/youth.

2. Alleged victim child(ren)/youth's:

   a. Name;

   b. Address;

   c. Current specific location;

   d. School or child care (if applicable);

   e. Birth date(s) or estimated age(s);

   f. Information as to whether or not the child(ren)/youth have American Indian or native Alaskan heritage, and if so, the tribal affiliation; and,

   g. Any developmental delays, physical disabilities, competency or cultural considerations.

3. Family and household members:

   a. Names;

   b. Birth date(s) or estimated age(s);

   c. Relationship to each other;

   d. Relationship to the alleged victim child(ren)/youth; and,

   e. Any developmental delays, physical disabilities, competency or cultural considerations.

4. Person(s) alleged to be responsible for the abuse and/or neglect:

   a. Name;

   b. Birth date(s) or estimated age(s);

   c. Present location;

   d. Current or last known address;

   e. Relationship to the alleged victim child(ren)/youth; and,

   f. Any developmental delays, physical disabilities, competency or cultural considerations.

5. Narrative describing the presenting problems and specific allegations of the abuse and/or neglect, including but not limited to:

   a. When it occurred;

   b. Location;

   c. Witness(es) of the incident; and,

d. Description of any injury that was sustained.

6. The date, time, and location the alleged victim child(ren)/youth were last seen by the reporting party.

7. The nature of any other environmental hazards in the home which may impact child(ren)/youth or worker safety.

8. The name and contact information of any individuals who may have information about the referral, and/or the identity and contact information of collateral agencies and individuals involved with the family.

9. Date and time referral received.

10. Family strengths and supports, and/or other protective factors or actions taken.

B. If at any point during the referral process, a county department becomes aware of an allegation that a child(ren)/youth is, or may be, a victim of sex trafficking, the county department shall:

1. Report immediately, and no later than twenty-four (24) hours from when the county department becomes aware, to the local law enforcement agency; and,

2. Document the details of the report to law enforcement in the state automated case management system.

7.103.1 Jurisdiction for Referrals Concerning Intrafamilial and Third-Party Abuse and/or Neglect [Eff. 1/1/15]

A. The county department with jurisdiction for responding to a referral concerning intrafamilial or third-party abuse is the department for the county in which the alleged victim child(ren) resides the majority of the time except when custody of the alleged victim child(ren) is shared equally between caregivers. When custody is shared equally between caregivers, the county department with jurisdiction is the department for the county in which the person(s) alleged to be responsible for the abuse and/or neglect reside, if known.

B. When a family is homeless as defined in 42 U.S.C. Section 11302, the county department with jurisdiction is the department for the county in which the alleged victim child(ren)'s primary nighttime residence is located.

C. If the jurisdiction is unable to be determined by A or B, above, the county department with jurisdiction is the department for the county in which the alleged victim child(ren) are currently present, as set forth in Section 19-3-201, C.R.S.

D. County departments shall use available resources to determine jurisdiction including, but not limited to:

1. Colorado benefits management system;

2. Alleged victim child(ren)'s school or daycare;

3. History within the state automated case management system;

4. Colorado courts;

5. Where services may be provided.

7.103.11 Transfer of Jurisdiction [Eff. 1/1/15]

A. If the county department that receives a referral determines that another county department has jurisdiction, the county department that received the referral shall:

1. Gather and document all information as available in Section 7.103.1, A;

2. Gather and document all information necessary to determine jurisdiction; and

3. Contact the county determined to have jurisdiction within the following timeframes:

a. If the referral is assigned an immediate response, within four (4) hours of determining jurisdiction.

b. If the referral is assigned either a three (3) day or five (5) day response, within one (1) business day of determining jurisdiction.

B. The county determined to have jurisdiction shall screen the referral.

C. When the county department that received the referral makes a decision based upon the referral prior to determining jurisdiction, the county department determined to have jurisdiction shall uphold that decision including assignment and response time, unless:

1. Additional or new information is gathered by the county department determined to have jurisdiction.

2. The additional or new information shall relate to the safety of the child.

3. The child welfare or county department director of the county department determined to have jurisdiction overrides the decision.

4. The authorization, information, and justification for any change shall be documented in the referral notes.

D. If an immediate response is necessary, the county department where the child is located at the time of the referral is the responsible county department while jurisdiction is determined.

7.103.2 RECEIPT OF REFERRAL ALLEGING INSTITUTIONAL ABUSE AND/OR NEGLECT – INFORMATION TO BE GATHERED [Eff. 8/1/17]

A. Upon receipt of a report alleging institutional abuse and/or neglect the county departments or the Hotline County Connection Center shall gather and document the following information when available.

1. Reporting party's:

a. Name;

b. Address;

c. Telephone number;

d. Reporter type; and,

e. Relationship to the alleged victim child(ren)/youth.

2. Alleged victim child(ren)/youth's:

a. Name;

b. Address;

c. Current specific location;

d. School or child care (if applicable);

e. Birth date(s) or estimated age(s);

f. Any developmental delays, physical disabilities, competency or cultural considerations; and,

g. Primary language.

3. Narrative describing the presenting problems and specific allegations of the abuse and/or neglect, including but not limited to:

a. Time and date;

b. Location;

c. Witness(es) of the incident;

d. If any injury was sustained; and,

e. Provision of medical treatment, and if no medical treatment has been provided whether in reporter's opinion the injury sustained requires medical services.

4. Person(s) alleged to be responsible for the abuse and/or neglect:

a. Name;

b. Birth date(s) or estimated age(s);

c. Present location;

1. If the person(s) is a staff person(s), determine if the person(s) has been moved to a non-child contact role, and/or separated from the alleged victim child(ren)/youth.

2. If the person(s) is another resident, determine where he/she is in relation to the alleged victim child(ren)/youth.

d. Current or last known address;

e. Any developmental delays, physical disabilities, competency or cultural considerations; and,

f. Telephone number.

5. Institution where the incident occurred:

a. Name;

b. Address;

c. Telephone number;

d. Whether the institution has been notified of the allegation; and,

e. Any actions taken by the institution.

6. Parent(s)/guardian(s) of the alleged victim child(ren)/youth:

a. Name;

b. Address;

c. Telephone number; and,

d. Whether the parent(s)/guardian(s) have been notified.

7. Determine who has legal custody of the alleged victim child(ren)/youth.

When a county department or other state holds legal custody;

a. Obtain the agency's name, telephone number and/or staff representative's name and telephone number; and,

b. Whether the institution has completed notification of the custodial county/agency.

8. Date and time referral received.

B. If at any point during the referral process, a county department becomes aware of an allegation that a child(ren)/youth is, or may be, a victim of sex trafficking, the county department shall:

1. Report immediately, and no later than twenty-four (24) hours from when the county department becomes aware, to the local law enforcement agency; and,

2. Document the details of the report to law enforcement in the state automated case management system.

CYNTHIA H. COFFMAN
Attorney General

DAVID C. BLAKE
Chief Deputy Attorney General

MELANIE J. SNYDER
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Office of the Attorney General

Tracking number: 2017-00129

Opinion of the Attorney General rendered in connection with the rules adopted by the

Social Services Rules (Volume 7; Child Welfare, Child Care Facilities)

on 06/02/2017

12 CCR 2509-2

REFERRAL AND ASSESSMENT

The above-referenced rules were submitted to this office on 06/09/2017 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

June 20, 2017 09:12:36

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Emergency Rules Adopted

Department

Department of Revenue

Agency

Division of Gaming - Rules promulgated by Gaming Commission

CCR number

1 CCR 207-1

Rule title

1 CCR 207-1 GAMING REGULATIONS 1 - eff 07/01/2017

Effective date

07/01/2017

BASIS AND PURPOSE FOR RULE 3

The purpose of Rule 3 is to establish and provide the specific information required on license applications; to establish yearly license fees for each type of license; to establish nonrefundable application fees; to establish investigation fees for certain applicants and deposit procedures for investigation fees; to establish procedures for conducting background checks on applicants and other interested persons and assessing the costs of such background checks; to require certain information regarding the premises the applicant wishes to be licensed, and to provide a procedure for approval of modifications of such premises; and to provide for the issuance of conditional, temporary, and duplicate licenses. The statutory basis for Rule 3 is found in sections 12-47.1-102, C.R.S., 12-47.1-103, C.R.S., 12-47.1-201, C.R.S., 12-47.1-203, C.R.S., 12-47.1-302, C.R.S., and part 5 of article 47.1 of title 12, C.R.S. *Amended 1/14/15*

RULE 3 APPLICATIONS, INVESTIGATIONS AND LICENSURE

All paragraphs of regulations 47.1-301 through 47.1-304 should remain part of this Rule

47.1-305 Investigation fees.

(1) All applicants for licenses and persons seeking approval of variation games of blackjack, poker, craps, roulette, blackjack-poker combination games and table games with electronic betting terminals, except support licenses, shall pay the costs of investigations into their backgrounds, suitability, and qualifications for licensure. *Eff 04/01/2007 Amended 11/30/2012*

(a) The cost of such investigations shall be at the rate of $69.00 per hour for each hour spent by investigators of the Division, the Colorado Bureau of Investigation, or the Department of Revenue investigating the applicants until the conclusion of the investigation. *Effective 7/1/2011, (47.1-305(a) amended temp. 7/1/16, amended perm. 7/16/16)*

All paragraphs of regulations 47.1-305 (b) through 47.1-325 should remain part of this Rule

RESOLUTION CONCERNING EMERGENCY AMENDMENT TO RULE 3

WHEREAS, Section 9 of Article XVIII of the Colorado Constitution requires the Colorado Limited Gaming Control Commission ("Commission") to promulgate all necessary rules and regulations relating to the licensing of limited gaming; and

WHEREAS, pursuant to section 12-47.1-302, C.R.S., and the regulations promulgated thereunder, the Colorado Division of Gaming ("Gaming") performs an annual comprehensive investigation fee analysis, the data for which was not available in time for compliance with all of the requirements of section 24-4-103, C.R.S., and the start of the state fiscal year on July 1, 2017; and

WHEREAS, the annual comprehensive fee analysis showed that the current hourly investigation fee should be reduced by $1.00 to cover the total direct and indirect costs associated with the Division's investigations into an applicant's background; and

WHEREAS, the new fee schedule needs to be in place by July 1, 2017 to maintain consistency among all license applicants and to avoid the possible refunding of fees; and

WHEREAS, the amendments to Rule 3 are necessary to carry out the purposes of the Colorado Limited Gaming Act, Article 47.1 of Title 12, C.R.S.

WHEREAS, a permanent change in the regulations could be achieved no sooner than July 15, 2017, given the process for notice and promulgation of the rule change pursuant to the provisions of section 24-4-103, C.R.S.; and

WHEREAS, published notice of the rulemaking hearing regarding Rule 3 was given on May 25, 2017 in the Colorado Register pursuant to section 24-4-103(6), C.R.S. and a full and public rule-making hearing was held on June 15, 2017, whereafter the permanent identical changes were adopted.

NOW, THEREFORE, IT IS HEREBY RESOLVED by the Colorado Limited Gaming Control Commission, based on the facts recited above, as follows:

The immediate adoption of the amendments to Rule 3, Regulation 47.1-305, effective July 1, 2017, is imperatively necessary to comply with state law and fiscal policy and for the preservation of the public health safety and welfare by ensuring adequate resources are available for the thorough and timely criminal and financial investigation of new licensees as required by the Colorado Limited Gaming Act, and the delay resulting from strict compliance with the requirements of section 24-4-103, C.R.S., would be contrary to the public interest.

Resolved this 15 day of June, 2017.

Roger Hutson, Chairman
Colorado Limited Gaming Control Commission

CYNTHIA H. COFFMAN
Attorney General

DAVID C. BLAKE
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Office of the Attorney General

Tracking number: 2017-00254

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Gaming - Rules promulgated by Gaming Commission

on 06/15/2017

1 CCR 207-1

GAMING REGULATIONS

The above-referenced rules were submitted to this office on 06/22/2017 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

Frederick R. Yarger

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

June 29, 2017 10:54:25

Emergency Rules Adopted

Department

Department of State

Agency

Secretary of State

CCR number

8 CCR 1505-2

Rule title

8 CCR 1505-2 BINGO AND RAFFLES GAMES 1 - eff 06/14/2017

Effective date

06/14/2017

COLORADO SECRETARY OF STATE

[8 CCR 1505-2]

RULES CONCERNING BINGO AND RAFFLES GAMES

Rules as Adopted - Clean

June 14, 2017

(*Publication instructions/notes*):

Amendments to Rule 1.9 correcting a statutory citation:

1.9 "Licensee" has the same meaning as set forth in section 24-21-602(3), C.R.S.

Amendments to Rule 1.15.2 correcting a statutory citation:

1.15.2 "Remuneration" does not include food offered to volunteers in accordance with section 24-21-617(6), C.R.S., when the retail value of the food does not exceed $10.00 per volunteer-duty shift.

Repeal of Rule 2.4.4(c):

2.4.4 Prize information.

(a) At the beginning of each occasion, the licensee must conspicuously post the number and amount of cash prizes and how the prizes may be won, including the cost to players.

(b) The licensee must either display the available merchandise prizes or post a list and complete description of the prizes and how the prizes may be won, including the cost to players. If the licensee designates an alternative cash prize in the case of multiple bingo winners, the licensee must post details about the alternative prize in accordance with Rule 2.4.4(a).

(c) If the licensee offers prize payouts on the basis of number of players or gross amount of sales, the licensee must conspicuously post a statement to that effect.

New Rule 2.5 concerning pre-selling tickets:

2.5 A licensee may presell tickets in accordance with section 24-21-604(4), C.R.S. as follows:

2.5.1 Preselling Is limited to the non-electronic sale, not more than seven days in advance of a bingo gaming event, of a ticket evidencing a person's right to enter the event; and

2.5.2 A licensee may not presell or authorize reserving a:

(a) "Card," as defined in section 24-21-602(7), C.R.S.;

(b) "Pull tab," as used in section 24-21-602(36), C.R.S.; or

(c) Specific seat.

Amendments to Rule 3.1.11 concerning reserving seats during gaming:

3.1.11 Prohibition on saving seats. A specific seat may only be reserved to provide a reasonable accommodation for a player with a disability.

Amendments to Rule 3.4.4 concerning the prohibition on preselling tickets:

3.4 Multiple Bingo Occasions. A licensee may conduct multiple bingo occasions on the same day, if:

3.4.1 The licensee concludes all games of chance from the first occasion and completes all player-related activities, including, but not limited to, the purchase, opening, and redemption of pull tabs, before the end of the occasion.

3.4.2 The licensee does not begin the next occasion for 15 minutes after the conclusion of the previous occasion, or until the final accounting for games of bingo played and pull tabs sold is completed and the books are closed for all of the first occasion activities, whichever comes later.

3.4.3 The licensee does not offer to sell pull tabs or other raffle tickets after an occasion concludes and before the next occasion begins.

3.4.4 The licensee does not continue activities from an occasion during the next occasion, and does not offer to sell, distribute or reserve any cards, sheets, tickets (except as authorized by section 24-21-604(4), C.R.S., and Rule 2.5), or chances for the next occasion during the previous occasion or during the period between the two occasions.

Amendments to Rule 4.1.1(a)(2) correcting a statutory citation:

4.1.1 Player payment method. A licensee may not extend credit to a player.

(a) When accepting payment, the licensee must:

(1) Collect the consideration for playing a game of chance in full, in advance, by check, cash, or debit or credit card.

(2) Directly deposit all proceeds into the licensee's segregated checking or savings account. The licensee may not commingle proceeds with funds in a general account or other account. [Section 24-21-622(3)(a), C.R.S.]

Amendments to Rule 6.4.2 concerning the number of allowable of electronic aid device faces:

6.4.2 Maximum number of faces. A licensee may not program an electronic bingo aid device to play more than 54 faces per bingo game.

Amendments to Rule 7.1.1 correcting a statutory citation:

7.1.1 Reporting requirements. A licensee that conducts a promotion must report awarded prize information to the licensing authority in accordance with section 24-21-604(3)(c), C.R.S.

Amendments to Rule 8.5 correcting a statutory citation:

8.5 Games not classified as raffles. The games of chance commonly known as "Animal Plop Bingo," "Golf Ball Drops," plastic or rubber "Duck Races," "Coin Flip Games," and variations of these games are not raffles as defined by section 24-21-602(38), C.R.S., and are not raffles as authorized by subsections (2) to (4) of Section 2 of Article XVIII of the Colorado Constitution. Therefore, these games of chance are not licensed or regulated by the Secretary of State. In certain circumstances, these games of chance may be considered unlawful gambling. Licensees or other organizations who wish to conduct these games should contact law enforcement authorities or legal counsel to determine how to comply with Colorado law.

Amendments to Rule 10.1.3(a) correcting a statutory citation:

10.1.3 Progressive games

(a) All receipts from the sale of progressive games must be accounted for separately within the licensee's bingo-raffle checking or savings account created in accordance with sections 24-21-622(3)(a) and (b), C.R.S.

Amendments to Rule 14.1.1 and 14.1.1(d) and (e) correcting statutory citations:

14.1.1 Application for approval. Any Colorado licensed manufacturer of an electronic bingo aid device and computer system may apply for a letter ruling in accordance with section 24-21-605(1)(d), C.R.S., by submitting a written request to the Secretary of State. The request must include:

(a) The manufacturer's name, license number, address, telephone and fax numbers, and an email address;

(b) The make, model and description of the bingo aid device and computer system for which approval is sought;

(c) The name and specific contact information of the manufacturer's representative who is an expert on the construction, programming, and operation of the device and system;

(d) A complete user's manual of the bingo aid device or system;

(e) Either a working prototype or a location in Colorado where the manufacturer can demonstrate the prototype;

(f) An affirmation from the manufacturer stating that the manual and prototype submitted to the Secretary of State do not differ materially from the manual, device and system that will be distributed in Colorado after approval of the prototype;

(g) In the case of a bingo aid device, a verified certificate from the manufacturer stating that the device meets all the standards set forth in section 24-21-618(8)(a)(II)(A) through (D), C.R.S., and that the device can and will be restricted to allow the play of no more than 54 faces per bingo game;

(h) In the case of a bingo aid computer system, a verified manufacturer's certificate stating that:

(1) The system meets all the requirements set forth in section 24-21-618(9)(a) through (c), C.R.S.; and

(2) The system, if constructed or intended for more than one licensee's use, can:

(A) Clearly identify each user's data;

(B) Segregate and secure each user's data from others' access; and

(C) Restrict access to each user's data through a unique user identification and password, smart card, token, or other method that limits access solely to the unique identifier's bearer, the Secretary of State and the manufacturer.

Amendments to Rule 15.3.2(g) correcting a statutory citation:

15.3.2 Class 2 violations include:

(g) Reserving or setting aside bingo cards or pull tabs for use by players, except as authorized in section 24-21-618(3)(d), C.R.S., or, except as authorized by these rules, reserving or allowing to be reserved any seat or playing space for use by players.

Amendments to Rule 15.6.1 correcting a statutory citation:

15.6.1 Request for hearing. In accordance with section 24-21-605(1)(a)(II), C.R.S., a licensee may request a hearing before an administrative law judge to appeal the imposition of a fine. The Secretary of State must receive a written request for a hearing within 20 days of the date that the Secretary of State denied a fine suspension or reduction request.

STATE OF COLORADO
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Wayne W. Williams
Secretary of State

Suzanne Staiert
Deputy Secretary of State

Statement of Justification and Reasons for Adoption of Temporary Rules

Office of the Secretary of State
Rules Concerning Bingo and Raffles Games
8 CCR 1505-2

June 14, 2017

New Rule 2.5

Amended Rules: 1.9; 1.15.2; 2.4.4(a); 3.1.11; 3.4.1; 3.4.4; 4.1.1; 4.1.1(a)(2); 6.4.2; 7.1.1; 8.5; 10.1.3(a); 14.1.1; 14.1.1; 15.3.2(g); 15.6.1

Repealed Rule 2.4.4(c)

In accordance with Colorado bingo and raffles laws,[1] the Secretary of State finds that certain amendments to the existing rules concerning bingo and raffles games must be adopted and effective immediately to ensure the uniform and proper administration and enforcement of Colorado bingo and raffles laws.

Temporary adoption is necessary both to comply with law and to preserve the public welfare given the changes made by Senate Bill 17-232. Senate Bill 17-232 amended and relocated the Bingo and Raffles Law to Part 6, Article 21, Title 24 of the Colorado Revised Statutes. The Secretary of State must adopt rules to provide clear guidance to bingo-raffle stakeholders, including current licensees, prospective applicants, charitable game players, and the general public concerning requirements and procedures. The Secretary of State must also correct statutory citations.

For these reasons, and in accordance with the State Administrative Procedure Act, the Secretary of State finds that adoption and immediate effect of the amendments to existing rules concerning bingo and raffles games is imperatively necessary to comply with state and federal law and to promote public interests.[2]

[1] Article XVIII, Section 2 of the Colorado Constitution and Part 6, Article 21, Title 24 of the Colorado Revised Statutes.
[2] Section 24-4-103(3)(6), C.R.S. (2016).

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Tracking number: 2017-00239

Opinion of the Attorney General rendered in connection with the rules adopted by the

Secretary of State

on 06/14/2017

8 CCR 1505-2

BINGO AND RAFFLES GAMES

The above-referenced rules were submitted to this office on 06/15/2017 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

June 29, 2017 10:58:02

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Emergency Rules Adopted

Department

Department of Health Care Policy and Financing

Agency

Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)

CCR number

10 CCR 2505-10

Rule title

10 CCR 2505-10 MEDICAL ASSISTANCE - STATEMENT OF BASIS AND PURPOSE, AND RULE HISTORY 1 - eff 07/01/2017

Effective date

07/01/2017

DO NOT PUBLISH

Title of Rule: Revision to the Federally Qualified Health Center Rule, Section 8.700
Rule Number: MSB 17-03-23-B
Division / Contact / Phone: Payment Reform / Erin Johnson / 303-866-4370

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name:	Health Care Policy and Financing / Medical Services Board
2. Title of Rule:	MSB 17-03-23-B, Revision to the Federally Qualified Health Center Rule, Section 8.700
3. This action is an adoption of:	an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.700, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)?	Yes
If yes, state effective date:	7/1/2017
Is rule to be made permanent? (If yes, please attach notice of hearing).	Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.700 with the proposed text starting beginning at 8.700.1 through the end of 8.700.6. The effective date of this rule is 7/1/2017.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH

Title of Rule: Revision to the Federally Qualified Health Center Rule, Section 8.700
Rule Number: MSB 17-03-23-B
Division / Contact / Phone: Payment Reform / Erin Johnson / 303-866-4370

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The purpose of this Rule is to clarify the Department's payment methodology for services outside of the Federally Qualified Health Center (FQHC) encounter rate. Currently, the rules state that FQHCs are reimbursed a 100% cost-based encounter rate for a one-on-one, face-to-face visit between a client and an eligible provider. This Rule revision is necessary to allow for payments to FQHCs separate from the encounter rate for Long Acting Reversible Contraceptives (LARCs), dentures and partial dentures, services provided at an inpatient hospital setting by the FQHC, the Nurse Home Visitor Program, and the Prenatal+ Program. Services provided by a FQHC at an inpatient hospital setting are not FQHC services and therefore should not be reimbursed at the encounter rate. The provision of LARCs, dentures, and partial dentures is costly for FQHCs and therefore an additional payment separate from the encounter rate is necessary to incentivize access and the provision of LARCs. The Prenatal+ Program and Nurse Home Visitor Program currently have payment methodologies that are separate from the encounter rate and are clarified elsewhere in the Rules.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☒ for the preservation of public health, safety and welfare.

   Explain:

   This rule revision fulfills the necessary requirements to be an Emergency Rule. The purpose of this rule revision is to clarify the Department's payment methodology for Federally Qualified Health Centers (FQHCs), specifically regarding payments separate from the encounter. Currently, our State Plan and rules for FQHCs state that the Department pays the encounter rate for one-on-one, face-to-face visits between a client and eligible provider. However, it is common practice for FQHCs to bill the Department at the Fee Schedule rate for other types of services – such as inpatient hospital services, the cost of LARC devices, dentures, partial dentures, the Prenatal+ Program, and the Nurse Home Visitor Program. These services should not be reimbursed at the encounter rate and instead should be reimbursed the Fee Schedule rate. However, since our current rules and State Plan do not reference this type of payment there is a large amount of confusion and concern among Department staff and FQHC staff about how to reimburse FQHCs. The Department must

revise its rules to reflect payment for these services outside of the encounter rate. If we stop paying for these services outside of the encounter rate they will no longer be provided.

3. Federal authority for the Rule, if any:

   Section 1902(bb) of the Social Security Act states that State Medicaid Agencies may create an alternative payment methodology for FQHCs as long as the FQHC receives at least their Prospective Payment System (PPS) rate.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);
   Section 25.5-4-401 (1)(a), C.R.S.

DO NOT PUBLISH

Title of Rule: Revision to the Federally Qualified Health Center Rule, Section 8.700
Rule Number: MSB 17-03-23-B
Division / Contact / Phone: Payment Reform / Erin Johnson / 303-866-4370

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   This rule will affect the 420,513 Medicaid members that receive medical services at Federally Qualified Health Centers.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   Total expenditures for services received at FQHCs during the last fiscal year was $173,425,927.05 or approximately $412.41 per member. This rule change could cause reimbursement to increase for some services delivered at certain FQHCs and to decrease for other services delivered at FQHCs. Many FQHCs are already billing in this manner, and it would have zero budget impact on those FQHCs.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   It is anticipated that the proposed rule will be budget neutral to the Department. This is a change in policy that primarily codifies already existing practices. For those FQHCs that are not billing in line with the proposed rule, there could be a decrease in payment for services that will be determined unallowable under the proposed rule. There could also be an increase in payment for certain services as it clarifies when encounters and fee-for-service claims can be billed in conjunction with each other. The Department assumes that these two impacts will offset each other, resulting in a net budget neutral change.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   Since many FQHCs are already billing the Department for these services, and other services, outside of the encounter rate, the costs should be minimal. This rule will eliminate improper billing of services and will give the Department the authority to pay for certain services as fee-for-service claims. Inaction could lead to a disallowance from CMS since these payments were not authorized before they began.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   It could potentially be less costly to disallow all payments outside of the encounter rate. However, this would lead to less access to important services such as LARCs, dentures, and partial dentures, or result in an increase in utilization of the services from other provider types.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   The Department seriously considered disallowing all payments for services outside the encounter rate. However, this idea was rejected as it would be too restrictive to FQHCs and decrease access to imperative health services.

8.700 FEDERALLY QUALIFIED HEALTH CENTERS

8.700.1 DEFINITIONS

Federally Qualified Health Center (FQHC) means a hospital-based or freestanding center that meets the FQHC definition found in Title 42 of the Code of Federal Regulations, Part 405, Subpart X (2015). Title 42 of the Code of Federal Regulations, Part 405, Subpart X (2015) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S. 24-4-103(12.5)(V)(b), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule:

Visit means a one-on-one, face-to-face encounter between a center client and physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist, podiatrist or clinical social worker providing the services set forth in 8.700.3.A. Group sessions do not generate a billable encounter for any FQHC services.

8.700.2 CLIENT CARE POLICIES

8.700.2.A The FQHCs health care services shall be furnished in accordance with written policies that are developed with the advice of a group of professional personnel that includes one or more physicians and one or more physician assistants or nurse practitioners. At least one member of the group shall not be a member of the FQHC staff.

8.700.2.B The policies shall include:

1. A description of the services the FQHC furnishes directly and those furnished through agreement or arrangement. See section 8.700.3.A.3.

2. Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or client referral, the maintenance of health care records and procedures for the periodic review and evaluation of the services furnished by the FQHC.

3. Rules for the storage, handling and administration of drugs and biologicals.

8.700.3 SERVICES

8.700.3.A The following services may be provided by a certified FQHC:

1. General services

   a. Outpatient primary care services that are furnished by a physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse midwife visiting nurse, clinical psychologist, podiatrist or clinical social worker as defined in their respective practice acts.

   b. Part-time or intermittent visiting nurse care.

   c. Services and medical supplies, other than pharmaceuticals, that are furnished as a result of professional services provided under 8.700.3.A.1.a and b.

2. Emergency services. FQHCs furnish medical emergency procedures as a first response to common life-threatening injuries and acute illness and must have available the drugs and biologicals commonly used in life saving procedures.

3. Services provided through agreements or arrangements. The FQHC has agreements or arrangements with one or more providers or suppliers participating under Medicare or Medicaid to furnish other services to clients, including physician services (whether furnished in the hospital, the office, the client's home, a skilled nursing facility, or elsewhere) and additional and specialized diagnostic and laboratory services that are not available at the FQHC.

8.700.3.B A certified FQHC may also provide any service authorized for payment outside the per visit encounter rate by 8.700.6.B.

8.700.4 PHYSICIAN RESPONSIBILITIES

8.700.4.A A physician shall provide medical supervision and guidance for physician assistants and nurse practitioners, prepare medical orders, and periodically review the services furnished by the clinic. A physician shall be present at the clinic for sufficient periods of time to fulfill these responsibilities and must be available at all times by direct means of communications for advice and assistance on patient referrals and medical emergencies. A clinic operated by a nurse practitioner or physician assistant may satisfy these requirements through agreements with one or more physicians.

8.700.5 ALLOWABLE COST

8.700.5.A The following types and items of cost for primary care services are included in allowable costs to the extent that they are covered and reasonable:

1. Compensation for the services of a physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, qualified clinical psychologist, podiatrist and clinical social worker who owns, is employed by, or furnishes services under contract to an FQHC.

2. Compensation for the duties that a supervising physician is required to perform.

3. Costs of services and supplies related to the services of a physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, qualified clinical psychologist, podiatrist or clinical social worker.

4. Overhead cost, including clinic or center administration, costs applicable to use and maintenance of the entity, and depreciation costs.

5. Costs of services purchased by the clinic or center.

8.700.5.B Unallowable costs include but are not limited to expenses that are incurred by an FQHC and that are not for the provision of covered services, according to applicable laws, rules, and standards applicable to the Medical Assistance Program in Colorado. An FQHC may expend funds on unallowable cost items, but these costs may not be used in calculating the per visit encounter rate for Medicaid clients.

Unallowable costs, include, but are not necessarily limited to, the following:

1. Offsite Laboratory/X-Ray;

2. Costs associated with services paid by a contracted Behavioral Health Organization (BHO) are costs for provision of covered services but not allowed in the FQHC costs;

3. Costs associated with clinics or cost centers which do not provide services to Medicaid clients; and,

4. Costs of services reimbursed separately from the FQHC encounter rate as described in Section 8.700.6.B.

8.700.6 REIMBURSEMENT

8.700.6.A FQHCs shall be reimbursed a per visit encounter rate based on 100% of reasonable cost. An FQHC may be reimbursed for up to three separate encounters with the same client occurring in one day and at the same location, so long as the encounters submitted for reimbursement are any combination of the following: medical encounter, dental encounter, or mental health encounter. Duplicate encounters of the same service category occurring on the same day and at the same location are prohibited unless it is a distinct mental health encounter, which is allowable only when rendered services are covered and paid by a contracted BHO.

8.700.6.B The following services are reimbursed separately from the FQHC encounter rate. These services shall be reimbursed in accordance with the following:

1. Long-Acting Reversible Contraception (LARC) devices shall be reimbursed separately from the FQHC encounter rate. In addition to payment of the encounter rate for the insertion of the device(s), the LARC device(s) must be billed in accordance with Section 8.730 and shall be reimbursed the lower of:

a. Submitted charges; or

b. Fee schedule as determined by the Department.

2. Services provided in an inpatient hospital setting shall be reimbursed the lower of:

a. Submitted charges; or

b. Fee schedule as determined by the Department.

3. The provision of complete dentures and partial dentures must be billed in accordance with Section 8.201. and Section 8.202. and shall be reimbursed the lower of:

a. Submitted charges; or

b. Fee schedule as determined by the Department. The fee schedule payment includes denture alignments, adjustments, and repairs within the first 6 months after placement of the denture. If the fee schedule amount is less than what would have been reimbursed under the per visit PPS rate, the Department will ensure that full payment has been received by the FQHCs.

4. The Prenatal Plus Program shall be billed and reimbursed in accordance with Section 8.748.

5. The Nurse Home Visitor Program shall be billed and reimbursed in accordance with Section 8.749.

6. A FQHC that operates its own pharmacy that serves Medicaid clients must obtain a separate Medicaid billing number for pharmacy and bill all prescriptions utilizing this number in accordance with Section 8.800.

8.700.6.C A medical encounter, a dental encounter, and a mental health encounter on the same day and at the same location shall count as three separate visits.

1. Encounters with more than one health professional, and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when the client, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

2. Distinct mental health encounters are allowable only when rendered services are covered and paid by a contracted BHO.

8.700.6.D Encounter rate calculation

a) Effective July 1, 2014, the encounter rate shall be the higher of the Prospective Payment System (PPS) rate or the alternative payment rate.

1. The PPS rate is defined by Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554, Dec. 21, 2000. BIPA is incorporated herein by reference. No amendments or later editions are incorporated.

   Copies are available for a reasonable charge and for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library.

2. a) The alternative payment rate shall be the lower of the annual rate or the base rate. The annual rate and the base rate shall be calculated as follows:

   1. Annual rates shall be the FQHCs current year's calculated inflated rate, after audit.

   2. The new base rate shall be the calculated, inflated weighted average encounter rate, after audit, for the past three years. Beginning July 1, 2004 the base encounter rate shall be inflated annually using the Medicare Economic Index to coincide with the federal reimbursement methodology for FQHCs. Base rates shall be recalculated (rebased) every three years.

3. a) New FQHCs shall file a preliminary FQHC Cost Report with the Department. Data from the preliminary report shall be used to set a reimbursement base rate for the first year. The base rate shall be calculated using the audited cost report showing actual data from the first fiscal year of operations as a FQHC. This shall be the FQHCs base rate until the next rebasing period.

   b) New base rates may be calculated using the most recent audited Medicaid FQHC cost report for those FQHCs that have received their first federal Public Health Service grant with the three years prior to

rebasing, rather than using the inflated weighted average of the most recent three years audited encounter rates.

4. a) The Department shall audit the FQHC cost report and calculate the new annual and base reimbursement rates. If the cost report does not contain adequate supporting documentation, the FQHC shall provide requested documentation within ten (10) business days of request. Unsupported costs shall be unallowable for the calculation of the FQHCs new encounter rate.

b) Freestanding FQHCs shall file the Medicaid cost reports with the Department on or before the 90th day after the end of the FQHCs' fiscal year. Freestanding FQHCs shall use the Medicaid FQHC Cost Report developed by the Department to report annual costs and encounters. Failure to submit a cost report within 180 days after the end of a freestanding FQHCs' fiscal year shall result in suspension of payments.

c) The new reimbursement rate for freestanding FQHCs shall be effective 120 days after the FQHCs fiscal year end. The old reimbursement rate (if less than the new audited rate) shall remain in effect for an additional day above the 120 day limit for each day the required information is late; if the old reimbursement rate is more than the new rate, the new rate shall be effective the 120th day after the freestanding FQHCs fiscal year end.

d) The new reimbursement rate for hospital-based FQHCs shall be effective January 1 of each year.

e) If a hospital-based FQHC fails to provide the requested documentation, the costs associated with those activities shall be presumed to be non-primary care services and shall be settled using the Outpatient Hospital reimbursement rate.

f) All hospital-based FQHCs shall submit separate cost centers and settlement worksheets for primary care services and non-primary care services on the Medicare Cost Report for their facilities. Non-primary care services shall be reimbursed according to Section 8.300.6.

5. a) If a FQHC changes its scope of service after the year in which its base PPS rate was determined, the Department will adjust the FQHC's PPS rate in accordance with section 1902(bb) of the Social Security Act.

b) A FQHC must apply to the Department for an adjustment to its PPS rate whenever there is a documented change in the scope of service of the FQHC. The documented change in the scope of service of the FQHC must meet all of the following conditions:

1. The increase or decrease in cost is attributable to an increase or decrease in the scope of service that is a covered benefit, as described in Section 1905(a)(2)(C) of the Social Security Act, and is furnished by the FQHC.

2. The cost is allowable under Medicare reasonable cost principles set forth in 42 CFR Part 413.5.

3. The change in scope of service is a change in the type, intensity, duration, or amount of services, or any combination thereof.

4. The net change in the FQHC's per-visit encounter rate equals or exceeds 3% for the affected FQHC site. For FQHCs that file consolidated cost reports for multiple sites in order to establish the initial PPS rate, the 3% threshold will be applied to the average per-visit encounter rate of all sites for the purposes of calculating the cost associated with a scope-of-service change.

5. The change in scope of service must have existed for at least a full six (6) months.

c) A change in the cost of a service is not considered in and of itself a change in scope of service. The change in cost must meet the conditions set forth in Section 8.700.6.C.5.b and the change in scope of service must include at least one of the following to prompt a scope-of-service rate adjustment. If the change in scope of service does not include at least one of the following, the change in the cost of services will not prompt a scope-of-service rate adjustment.

1. The addition of a new service not incorporated in the baseline PPS rate, or deletion of a service incorporated in the baseline PPS rate;

2. The addition or deletion of a covered Medicaid service under the State Plan;

3. Changes necessary to maintain compliance with amended state or federal regulations or regulatory requirements;

4. Changes in service due to a change in applicable technology and/or medical practices utilized by the FQHC;

5. Changes resulting from the changes in types of patients served, including, but not limited to, populations with HIV/AIDS, populations with other chronic diseases, or homeless, elderly, migrant, or other special populations that require more intensive and frequent care;

6. Changes resulting from a change in the provider mix, including, but not limited to:

i. A transition from mid-level providers (e.g. nurse practitioners) to physicians with a corresponding change in the services provided by the FQHC;

ii. The addition or removal of specialty providers (e.g. pediatric, geriatric, or obstetric specialists) with a corresponding change in the services provided by the FQHC (e.g. delivery services);

iii. Indirect medical education adjustments and a direct graduate medical education payment that reflects the

costs of providing teaching services to interns and/or residents; or,

iv. Changes in operating costs attributable to capital expenditures (including new, expanded, or renovated service facilities), regulatory compliance measures, or changes in technology or medical practices at the FQHC, provided that those expenditures result in a change in the services provided by the FQHC.

d) The following items do not prompt a scope-of-service rate adjustment:

1. An increase or decrease in the cost of supplies or existing services;

2 An increase or decrease in the number of encounters;

3. Changes in office hours or location not directly related to a change in scope of service;

4. Changes in equipment or supplies not directly related to a change in scope of service;

5. Expansion or remodel not directly related to a change in scope of service;

6. The addition of a new site, or removal of an existing site, that offers the same Medicaid-covered services;

7. The addition or removal of administrative staff;

8. The addition or removal of staff members to or from an existing service;

9. Changes in salaries and benefits not directly related to a change in scope of service;

10. Change in patient type and volume without changes in type, duration, or intensity of services;

11. Capital expenditures for losses covered by insurance; or,

12. A change in ownership.

e) A FQHC must apply to the Department by written notice within ninety (90) days of the end of the FQHCs fiscal year in which the change in scope of service occurred, in conjunction with the submission of the FQHC's annual cost report. Only one scope-of-service rate adjustment will be calculated per year. However, more than one type of change in scope of service may be included in a single application.

f) Should the scope-of-service rate application for one year fail to reach the threshold described in Section 8.700.6.C.5.b.4, the FQHC may combine that year's change in scope of service with a valid change in scope of service from the next year or the year after. For example, if a valid

change in scope of service that occurred in FY 2016 fails to reach the threshold needed for a rate adjustment, and the FQHC implements another valid change in scope of service during FY2018, the FQHC may submit a scope-of-service rate adjustment application that captures both of those changes. A FQHC may only combine changes in scope of service that occur within a three-year time frame, and must submit an application for a scope-of-service rate adjustment as soon as possible after each change has been implemented. Once a change in scope of service has resulted in a successful scope-of-service rate adjustment, either individually or in combination with another change in scope of service, that change may no longer be used in an application for another scope-of-service rate adjustment.

g) The documentation for the scope-of-service rate adjustment is the responsibility of the FQHC. Any FQHC requesting a scope-of-service rate adjustment must submit the following to the Department:

1. The Department's application form for a scope-of-service rate adjustment, which includes:

i. The provider number(s) that is/are affected by the change(s) in scope of service;

ii. A date on which the change(s) in scope of service was/were implemented;

iii. A brief narrative description of each change in scope of service, including how services were provided both before and after the change;

iv. Detailed documentation such as cost reports that substantiate the change in total costs, total health care costs, and total visits associated with the change(s) in scope; and

v. An attestation statement that certifies the accuracy, truth, and completeness of the information in the application signed by an officer or administrator of the FQHC;

2. Any additional documentation requested by the Department. If the Department requests additional documentation to calculate the rate for the change(s) in scope of service, the FQHC must provide the additional documentation within thirty (30) days. If the FQHC does not submit the additional documentation within the specified timeframe, the Department, at its discretion, may postpone the implementation of the scope-of-service rate adjustment.

h) The reimbursement rate for a scope-of-service change applied for January 30, 2017 or afterwards will be calculated as follows:

1. The Department will first verify the total costs, the total covered health care costs, and the total number of visits before and after the change in scope of service. The Department will also

calculate the Adjustment Factor (AF = covered health care costs/total cost of FQHC services) associated with the change in scope of service of the FQHC. If the AF is 80% or greater, the Department will accept the total costs as filed by the FQHC. If the AF is less than 80%, the Department will reduce the costs other than covered health care costs (thus reducing the total costs filed by the FQHC) until the AF calculation reaches 80%. These revised total costs will then be the costs used in the scope-of-service rate adjustment calculation.

2. The Department will then use the appropriate costs and visits data to calculate the adjusted PPS rate. The adjusted PPS rate will be the average of the costs/visits rate before and after the change in scope of service, weighted by visits.

3. The Department will calculate the difference between the current PPS rate and the adjusted PPS rate. The "current PPS rate" means the PPS rate in effect on the last day of the reporting period during which the most recent scope-of-service change occurred.

4. The Department will check that the adjusted PPS rate meets the 3% threshold described above. If it does not meet the 3% threshold, no scope-of-service rate adjustment will be implemented.

5. Once the Department has determined that the adjusted PPS rate has met the 3% threshold, the adjusted PPS rate will then be increased by the Medicare Economic Index (MEI) to become the new PPS rate.

i) The Department will review the submitted documentation and will notify the FQHC in writing within one hundred twenty (120) days from the date the Department received the application as to whether a PPS rate change will be implemented. Included with the notification letter will be a rate-setting statement sheet, if applicable. The new PPS rate will take effect one hundred twenty (120) days after the FQHC's fiscal year end.

j) Changes in scope of service, and subsequent scope-of-service rate adjustments, may also be identified by the Department through an audit or review process.

1. If the Department identifies a change in scope of services, the Department may request the documentation as described in Section 8.700.6.C.5.g from the FQHC. The FQHC must submit the documentation within ninety (90) days from the date of the request.

2. The rate adjustment methodology will be the same as described in Section 8.700.6.C.5.h.

3. The Department will review the submitted documentation and will notify the FQHC by written notice within one hundred twenty

(120) days from the date the Department received the application as to whether a PPS rate change will be implemented. Included with the notification letter will be a rate-setting statement sheet, if applicable.

4. The effective date of the scope-of-service rate adjustment will be one hundred twenty (120) days after the end of the fiscal year in which the change in scope of service occurred.

k) A FQHC may request a written informal reconsideration of the Department's decision of the PPS rate change regarding a scope-of-service rate adjustment within thirty (30) days of the date of the Department's notification letter. The informal reconsideration must be mailed to the Department of Health Care Policy and Financing, 1570 Grant St, Denver, CO 80203. To request an informal reconsideration of the decision, a FQHC must file a written request that identifies specific items of disagreement with the Department, reasons for the disagreement, and a new rate calculation. The FQHC should also include any documentation that supports its position. A provider dissatisfied with the Department's decision after the informal reconsideration may appeal that decision through the Office of Administrative Courts according to the procedures set forth in 10 CCR 2505-10 Section 8.050.3, PROVIDER APPEALS.

6. The performance of physician and mid-level medical staff shall be evaluated through application of productivity standards established by the Centers for Medicare and Medicaid Services (CMS) in CMS Publication 27, Section 503; "Medicare Rural Health Clinic and FQHC Manual". If a FQHC does not meet the minimum productivity standards, the productivity standards established by CMS shall be used in the FQHCs' rate calculation.

8.700.6.E The Department shall notify the FQHC of its rate.

8.700.8 REIMBURSEMENT FOR OUTSTATIONING ADMINISTRATIVE COSTS

8.700.8.A The Department shall reimburse freestanding FQHCs for reasonable costs associated with assisting clients in the Medicaid application process. This outstationing payment shall be made based upon actual cost with a reasonable cost-per-application limit to be established by the Department. The reasonable cost-per application limit shall be based upon the lower of the amount allocated to county departments of social services for comparable functions or a provider-specific workload standard. In no case shall the outstationing payment for FQHCs exceed a maximum cap of $60,000 per facility per year for all administrative costs associated with outstationing activities.

8.700.8.B

1. Hospitals with hospital-based FQHCs shall receive federal financial participation for reasonable costs associated with assisting potential beneficiaries in the Medicaid application process. For any hospital-based FQHC Medicaid cost report audited and finalized after July 1, 2005, Denver Health Medical Center shall receive federal financial participation for eligible expenditures. To receive the federal financial participation, Denver Health Medical Center shall provide the state's share of the outstationing payment by certifying that the audited administrative costs associated with outstationing activities are eligible Medicaid public expenditures. Such certifications shall be sent to the Safety Net Programs Manager.

2. Hospitals with hospital-based FQHCs shall receive federal financial participation for reasonable costs associated with assisting potential beneficiaries in the Medicaid application process. Effective with the hospital cost report year 2010 and forward, the Department will make an interim payment to Denver Health Medical Center for estimated reasonable costs associated with outstationing activities based on the costs included in the as-filed Medicare cost report. This interim payment will be reconciled to actual costs after the cost report is audited. Denver Health Medical Center shall receive federal financial participation for eligible expenditures. To receive the federal financial participation, Denver Health Medical Center shall provide the state's share of the outstationing payment by certifying that the interim estimated administrative costs and the final audited administrative costs associated with outstationing activities are eligible Medicaid public expenditures. Such certifications shall be sent to the Safety Net Programs Manager.

8.700.8.C To receive payment, FQHCs shall submit annual logs of applicant information to the Department with their cost report. Applicant logs shall include the applicant's name, date of application, and social security number if available.

8.700.8.D Reimbursement for outstationing administrative costs shall be determined according to the following guidelines:

1. Freestanding FQHCs shall report on a supplementary schedule the administrative and general direct pass-through costs associated with outstationing activities. The Department shall allocate appropriate overhead costs (not separately identified) to calculate the total facility outstationing administrative expenses incurred. Freestanding FQHCs shall receive an annual lump sum retrospective payment based on the audited cost report.

2. Hospitals with hospital-based FQHCs shall submit the administrative and general pass through direct and indirect costs associated with outstationing activities on an extra line on the Medicaid Cost Report and submit all other source documentation to compute allowable outstationing costs. Hospitals with hospital-based FQHCs shall receive payment in accordance with 8.700.8.B. The reimbursement shall be separately identified on the Medicaid Settlement Sheet.

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Benefits Rule Concerning Home Health Services, Section 8.520
Rule Number: MSB 17-04-21-A
Division / Contact / Phone: Health Programs Benefits & Operations Division / Amanda Forsythe / 303-866-6459

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name:	Health Care Policy and Financing / Medical Services Board
2. Title of Rule:	MSB 17-04-21-A, Revision to the Medical Assistance Benefits Rule Concerning Home Health Services, Section 8.520
3. This action is an adoption of:	an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.520, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)?	Yes
If yes, state effective date:	07/01/2017
Is rule to be made permanent? (If yes, please attach notice of hearing).	Yes

PUBLICATION INSTRUCTIONS*

Replace the current text starting at 8.523 through the end of 8.526.21 with the proposed text. This rule is effective 7/1/2017.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Benefits Rule Concerning Home Health Services, Section 8.520
Rule Number: MSB 17-04-21-A
Division / Contact / Phone: Health Programs Benefits & Operations Division / Amanda Forsythe / 303-866-6459

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The rule defines the amount, duration, and scope of covered home health services. This revision updates the home health services rule by adding provisions concerning face-to-face visits and place of service limitations, as required under recently issued federal regulations, both of which must be effective by July 1, 2017. Specifically, this revision aligns the Colorado Medicaid home health services rule with federal regulations by adding: (1) a requirement that the physician must document a face-to-face encounter with the Medicaid client for the authorization of home health services within particular timelines; and (2) language clarifying that Medicaid home health services are not limited solely to home settings.

2. An emergency rule-making is imperatively necessary

   ☒ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

   The recently issued federal home health regulations, concerning documentation of face-to-face encounters and place of service limitations, explicitly require that the Department be in compliance with the new provisions by July 1, 2017.

3. Federal authority for the Rule, if any:

   42 CFR 440.70

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);

Initial Review **06/09/17** Final Adoption
Proposed Effective Date Emergency Adoption **06/09/17**

DOCUMENT #02

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Benefits Rule Concerning Home Health Services, Section 8.520
Rule Number: MSB 17-04-21-A
Division / Contact / Phone: Health Programs Benefits & Operations Division / Amanda Forsythe / 303-866-6459

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   The proposed rule will affect ordering providers by requiring that they must document the occurrence of a face-to-face encounter with any Colorado Medicaid client for whom they order home health services. The proposed rule will also affect home health services clients: First, it will require that the client participates in a face-to-face visit with the ordering provider to receive home health services. Second, by clarifying that home health services may be received in any setting in which normal life activities take place, it will allow many clients to receive home health services out in the community.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   The proposed rule will have a positive impact on those clients who will be able to receive necessary home health services while engaged in normal life activities in the community and not just while in the home.

   The proposed rule's face-to-face documentation requirement will likely have a moderate economic impact on the ordering providers, an analysis of which is detailed in the February 2016 Centers for Medicare & Medicaid Services Final Rule concerning Medicaid home health services.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There is no anticipated cost or effect on state revenues of implementation and enforcement of the proposed rule.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

The cost of inaction is the Department being out of compliance with federal regulations, which could result a corrective action plan, financial penalties, or other federal enforcement actions.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no less costly methods or less intrusive methods for achieving the purpose of the proposed rule, which is the Department's compliance with new federal regulatory requirements.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are no alternative methods for achieving the purpose of the proposed rule, which is the Department's compliance with new federal regulatory requirements.

8.520 HOME HEALTH SERVICES

8.521 LEGAL BASIS

The Medicaid Home Health Program in Colorado is authorized under 1905(a)(7) of the Social Security Act (P.L. 74-271); and by state law at 26-4-202(1) f, C.R.S. (1994 Supp.) and 26-4-302(l) m, C.R.S. (1994 Supp.).

8.522 COVERED SERVICES

All Home Health providers enrolled in the Medicaid program shall be in compliance with the Colorado Medicaid Home Health Services Benefit Coverage Standard, effective January 1, 2013, incorporated by reference. The incorporation of the Home Health Benefit Policy Statement excludes later amendments to, or editions of, the referenced material.

The Benefit Coverage Standard is available from Colorado Medicaid's Benefits Collaborative Web site at Colorado.gov/hcpf. Click "Boards & Committees," and click "Benefits Collaborative," and click "Approved Benefit Standards." Pursuant to 24-4-103 (12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided, at cost, upon request. Any material that has been incorporated by reference may be examined in any Colorado State Publications Depository Library.

8.523 ELIGIBILITY

.10 Home Health services are a benefit available to all Medicaid clients and to all Modified Medical Program clients when all program and services requirements are met. To be eligible for Long Term Home Health services, as set forth at Section 8.523.11.K, Medicaid clients 18 and over shall meet the Level of Care Screening Guidelines for Long Term Care Services at Section 8.401. Medicaid clients under the age of twenty-one may be eligible for special Home Health benefits according to rules at 8.527, PRIOR AUTHORIZATION OF EXTRA-ORDINARY HOME HEALTH AS EPSDT EXPANDED SERVICES.

.11 Home Health services are eligible for reimbursement under Medicaid only when the services meet all of the following requirements:

A. Services are provided for the treatment of an illness, injury, or disability which may include mental disorders.

B. Services are medically necessary.

C. Services are reasonable in amount, duration, and frequency.

D. Services are provided under a plan of care as defined at Section 8.524 DEFINITIONS.

E. Services are provided on an intermittent basis, as defined at Section 8.524, DEFINITIONS.

F. The only alternative to Home Health services is hospitalization or the emergency room; or the client's medical records accurately justify a medical reason that the services should be provided in the client's home instead of a physician's office, clinic, or other out-patient setting, according to one or more of the following guidelines:

1. The client, due to the client's illness, injury or disability, is not able to go to a physician's office, clinic or other out-patient setting for the needed service, for example, a client with quadriplegia who needs aide services to get in and out of bed.

2. If, because of the client's illness, injury, or disability, going to a physician's office, clinic, or other out-patient setting for the needed service would create a medical hardship for the client. Any statement on the plan of care regarding such medical hardship must be supported by the totality of the client's medical records. Examples of medical hardship would include: a client who would require ambulance transportation, a client in severe pain, or a client who is just out of the hospital after major surgery. Some examples of conditions that would not by themselves be considered creation of a medical hardship would include: a client who is on oxygen, a client who walks with a limp, or a client who uses a cane.

3. Going to a physician's office, clinic, or other out-patient setting for the needed service is contra-indicated by the client's documented medical condition, for example, a client who must be protected from exposure to infections.

4. Going to a physician's office, clinic, or other out-patient setting for the needed service would interfere with the effectiveness of the service. Examples include a young child who would not benefit from out-patient therapy because of extreme fear of the hospital where the out-patient setting is located; clients living in regions where traveling to out-patient therapy would require hours of travel; a client who needs a service repeated at frequencies that would be extremely difficult to accommodate in the physician's office, clinic, or other out-patient setting, such as IV care three times per day, or daily insulin injections; a client who needs regular and prn catheter changes and having Home Health in place will prevent emergency room visits for unscheduled catheter changes due to dis-lodgement or blockage; a client who, because of the client's illness, injury or disability, including mental disorders, has demonstrated past failure to comply with going to a physician's office, clinic, or other out-patient setting for the needed service, and has suffered adverse health consequences as a result, including use of emergency room and hospital admissions.

5. The client's medical condition requires teaching which is most effectively accomplished in the client's home on a short-term basis.

G. Services are provided in the client's place of residence. The client's place of residence is where the client lives, except that home health services shall not be reimbursed if the client's place of residence is a nursing facility or hospital. Assisted living faculties of any kind are places of residence. If a client is visiting relatives or staying in a hotel during a trip, or similar temporary accommodations, the place where the client is staying will be considered the temporary place of residence for purposes of this rule. Services shall not be reimbursed if provided at the workplace, school, child day care, adult day care, or any other place that is not the client's place of residence, except when the services are prior authorized according to 8.527, PRIOR AUTHORIZATION OF EXTRA-ORDINARY HOME HEALTH AS EPSDT EXPANDED SERVICES, or Section 8.531 through 8.539, HOME HEALTH AIDE PILOT PROGRAM.

1. Monitoring of health care status may be provided remotely through Home Health Telehealth services.

2. Nothing in this section should be read to prohibit a client from receiving Home Health Services in any setting in which normal life activities take place, other than a hospital, nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

H. Services are provided by a Medicaid-certified Home Health agency.

I. The Client is unable to perform the health care tasks for him or herself, and no unpaid family/caregiver able and willing to perform the tasks.

J. When the client has Medicare or other third-party insurance, Medicaid Home Health shall be reimbursed only if the client's care does not meet the Home Health coverage guidelines for Medicare or other insurance.

K. The Client's care falls under one of the following three categories:

1. Acute Home Health, which means Medicaid-reimbursed Home Health services that are:

a. Provided for 60 calendar days; and

b. Provided for the treatment of any of the acute conditions listed below. A condition is considered acute only until it is resolved or until 60 calendar days after onset, whichever comes first.

1) Infections.

2) New medical conditions such as, but not limited to, stroke, heart attack, cancer, injury, diabetes.

3) Care related to post-surgical recovery.

4) Post-hospital care provided as follow-up care for the condition that required hospitalization, including neonatal disorders.

5) Exacerbation or severe instability of a chronic condition.

6) New diagnosis of a long term chronic condition, such as, but not limited to, diabetes.

7) Complications of pregnancy.

2. Long Term Home Health, which means Medicaid-reimbursed Home Health services that are:

a. Provided for 61 calendar days or longer; or

b. Provided for less than 61 calendar days when services are provided solely for the care of chronic conditions.

3. Long Term with Acute Episode Home Health, which means Medicaid-reimbursed Home Health services that are:

a. Provided for care of long-term chronic conditions; and

b. Additionally provided for the treatment of any of the acute episodes listed below. An episode is considered acute only until it is resolved or until 60 calendar days after onset, whichever comes first.

1) Infections.

2) New medical conditions such as, but not limited to, stroke, heart attack, cancer, injury, decubitus.

3) Care related to post-surgical recovery.

4) Post-hospital care provided as follow-up care for the condition that required hospitalization.

5) Exacerbation of a chronic condition.

6) New diagnosis of a long term chronic condition, such as, but not limited to, diabetes.

7) Complications of pregnancy.

8.524 DEFINITIONS

.10 HOME HEALTH AIDE ASSIGNMENT FORM

Home health aide assignment form means the form which the home health agency uses to list the duties to be performed by the home health aide at each visit.

.11 HOME HEALTH SERVICES

Home Health Services means those services listed at Section 8.522, COVERED SERVICES, and described at Section 8.525, SERVICES REQUIREMENTS.

.12 HOME HEALTH TELEHEALTH

Home Health Telehealth means the remote monitoring of clinical data through electronic information processing technologies.

.13 INTERMITTENT

Intermittent is defined as no more than the combined number of all visits and/or other units of service which will cause the reimbursement per calendar day to equal the maximum reimbursement limits as set forth in the Reimbursement section of these rules. Visits and/or units or combinations thereof may directly follow each other without any break and still be considered intermittent, as long as the maximum reimbursement limit per day is not exceeded.

.14 PLAN OF CARE

A plan of care means a coordinated plan developed by the Home Health agency as ordered by the attending physician for provision of services to a client at his or her residence, and periodically reviewed and signed by the physician in accordance with Medicare requirements.

.15 STATE

State means the state agency designated as the single state Medicaid agency for Colorado, or any divisions or sub-units within that agency.

8.525 SERVICES REQUIREMENTS

.10 NURSING SERVICES

A. Nursing services include those skilled nursing services that are provided by a registered nurse under applicable state and federal laws, and professional standards.

B. Nursing services also includes skilled nursing services which are provided by a licensed practical nurse under the direction of a registered nurse, to the extent allowed under applicable state and federal laws.

C. Nursing services include the remote monitoring of health status through Home Health Telehealth.

.11 HOME HEALTH AIDE SERVICES

A. Home health aide services may be provided when a nurse or therapist determines that an eligible client requires the services of a qualified home health aide, as such services are defined in this section.

B. Home health aide services must be supervised according to Medicare Conditions of Participation for Home Health Agencies found at 42 CFR 84.36 (d). No later amendments to or editions of 42 CFR 484.36 (d) are included. Copies of 42 CFR 484.36 (d) are available for public inspection during normal business hours and will be provided at cost upon request to the Home Health Administrator at the Colorado Department of Health Care policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714; or may be examined at any state publications depository library.

1. If the client receiving home health aide services also requires and receives skilled nursing care or physical, occupational or speech therapy, the supervising registered nurse or therapist must make on-site supervisory visits to the client's home no less frequently than every two weeks.

2. If the client receiving home health aide services does not require skilled nursing care or physical, occupational or speech therapy, the supervising registered nurse must make on-site supervisory visits to the client's home no less frequently than every 62 days. Each supervisory visit must occur while the home health aide is providing care. Visits by the registered nurse to supervise and to reassess the care plan are considered costs of providing the home health aide services, and shall not be billed to Medicaid as nursing visits.

3. Registered nurses and physical, occupational and speech therapists supervising home health aides must comply with applicable State laws governing their respective professions. In addition, the Nurse Aide Practice Act at § 12-38.1-102(5) C.R.S. (1998), which requires supervision of the practice of nurse aide

services, must be followed. No later amendments to or editions of § 12-38.2-102(5) C.R.S. (1998) are included. Copies of § 12-38.1-102(5) C.R.S. (1998) are available for public inspection during normal business hours and will be provided at cost upon request to the Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street. Denver, Colorado 80203-1714; or may be examined at any state publications depository library.

C. Before providing any services, all home health aides shall be trained and certified according to Federal Medicare regulations at 42 CFR 484.36 and all applicable State and Federal laws and regulations governing nurse aide certification, as amended, except that later amendments to or editions of 42 CFR 484.36 shall not be included in this rule. Copies of 42 CFR 484.36 are available for public inspection or will be provided at cost upon request by the Home Health Program Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714; or may be examined at any state publications depository library.

D. Home, health aide services include skilled personal care, unskilled personal care, and homemaking as defined below:

1. Skilled personal care includes nurse aide tasks performed by a certified nurse aide pursuant to the nurse aide scope of practice defined by the State Board of Nursing, but does not include those tasks that are allowed as unskilled personal care, in HCBS personal care regulations at Section 8.489, PERSONAL CARE.

2. Unskilled personal care means those tasks which are allowed as unskilled personal care at Section 8.489, HOME AND COMMUNITY BASED SERVICES-EBD, PERSONAL CARE. Unskilled care shall be provided only as secondary to required skilled personal care, provided within contiguous units of service.

3. Homemaking includes those tasks that are allowed as homemaking tasks at Section 8.490, HOME AND COMMUNITY BASED SERVICES. - EBD, HOMEMAKER SERVICES. Homemaking services shall be provided only as secondary to required skilled personal care provided within contiguous units of service.

4. Home health aide services solely for the purpose of behavior management are not a benefit under Medicaid Home Health, because behavior management is outside the nurse aide scope of practice.

.12 PHYSICAL THERAPY SERVICES

A. Physical therapy includes any evaluations and treatments allowed under state law at 12-41-101 through 130, C.R.S. (1991, as amended), which are applicable to the home setting.

B. When devices and equipment are indicated by the therapy plan of care, the therapist shall assist in initiating or writing the request and shall assist in training or the use of the equipment.

C. Treatment must be provided by or under the supervision of a licensed physical therapist who meets the qualifications prescribed by federal regulation for participation under Medicare, at 42 CFR 484.4; and who meets all requirements under state law. Later

amendments to or editions of 42 CFR 484.4 shall not be included in this rule. Copies of 42 CFR 484.4 are available for public inspection or will be provided at cost upon request by the Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714; or may be examined at any state publications depository library.

D. For clients who do not require skilled nursing care, the physical therapist may open be case and establish the Medicaid plan of care.

E. Effective September 1, 2002, physical therapy services are available for Acute Home Health clients when medically necessary and clients under 18 years of age when medically necessary. EPSDT-Extraordinary home health services are available for clients under 21 years of age. Clients 18 years and over may obtain long-term therapy services in an outpatient hospital setting or by a qualified nonphysician practitioner described at 8.201.A.

.13 OCCUPATIONAL THERAPY SERVICES

A. Occupational therapy includes any evaluations and treatments allowed under the standards of practice authorized by the American Occupational Therapy Association, which are applicable to the home setting.

B. When devices and equipment are indicated by the therapy plan of care, the therapist shall assist in initiating or writing the request and shall assist in training on the use of the equipment.

C. Treatment must be provided by or under the supervision of a certified occupational therapist who meets the qualifications prescribed by federal regulations for participation under Medicare at 42 CFR 484.4. Later amendments to or editions of 42 CFR 484.4 shall not be included in this rule. Copies of 42 CFR 484.4 are available for public inspection or ml be provided at cost upon request by the Home Health Program Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714; or may be examined at any state publications depository library.

D. For clients who do not require skilled nursing care or physical or speech therapy, the occupational therapist may open the case and establish the Medicaid plan of care.

E. Effective September 1, 2002, occupational therapy services are available for Acute Home Health clients when medically necessary and for clients under 18 when medically necessary. EPSDT-Extraordinary home health services are available for clients under 21 years of age. Clients 18 years and over may obtain long-term therapy services in an outpatient hospital setting or by a qualified nonphysician practitioner described at 8.201.A.

.14 SPEECH/LANGUAGE PATHOLOGY SERVICES

A. Speech/language pathology services include any evaluations and treatments allowed under the American Speech-Language-Hearing Association (ASHA) authorized scope of practice statement, which are applicable to the home setting.

B. When devices and equipment are indicated by the therapy plan of care, the therapist shall assist in initiating or writing the request in accordance with Section 8.590 through

8.594.03, Durable Medical Equipment, and shall assist in training on the use of the equipment.

C. Treatment must be provided by a speech/language pathologist who meets the qualifications prescribed by federal regulations for participation under Medicare at 42 CFR 484.4. Later amendments to or editions of 42 CFR 484.4 shall not be included in this rule. Copies of 42 CFR 484.4 are available for public inspection or will be provided at cost upon request by the Home Health Program Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714; or may be examined at any state publications depository library.

D. For clients who do not require skilled nursing care, the speech therapist may open the case and establish the Medicaid plan of care.

E. Effective September 1, 2002; speech/language pathology services are available for Acute Home Health, clients when medically necessary and for clients under 18 when medically necessary. EPSDT-Extraordinary home health services are available for clients under 21 years of age. Clients 18 years and over may obtain long-term therapy services in an outpatient hospital setting or by a qualified nonphysician practitioner described at 8.201A.

.15 HOME HEALTH TELEHEALTH SERVICES

A. The home health telehealth service is the remote monitoring of clinical data through electronic information processing equipment.

B. The information and data collected remotely will be transmitted through electronic information processing equipment from the client to the home health provider. The transmission of the data shall meet HIPAA compliance standards.

C. The home health agency shall create policies and procedures for the use and maintenance of the monitoring equipment and the process of telehealth monitoring. This service shall be used to monitor the client and manage the client's care, and shall include all of the following elements:

1. All data collected must be reviewed by a registered nurse, or licensed practical nurse consistent with state law, within 24 hours of receipt of the ordered transmission,

2. Any planned interventions must be overseen by the client's designated nurse.

3. Collection of clinical data;

4. Transmission of the clinical data from the client to the home health provider;

5. Clinical review and assessment of the clinical data by a registered nurse.

6. Client specific parameters and protocols defined by the agency staff and the client's authorizing physician or podiatrist; and

7. Documentation of the clinical data in the client's chart and a summary of response activities, if needed.

a. Documentation shall be signed and dated by the nurse who assessed the clinical data,

b. Documentation shall include the health care data that was transmitted and the services or activities that are recommended based on the data.

D. Monitoring equipment shall have the capability to measure any changes in the monitored diagnoses, and meet all of the following requirements:

1. Monitoring equipment shall be FDA certified or UL listed, and used according to the manufacturer's instructions;

2. Monitoring equipment shall be maintained in good repair and free from safety hazards; and

3. Monitoring equipment shall be sanitized before it is installed in a client's home.

E. Home health telehealth services are available to clients receiving home health services, when all of the following requirements are met:

1. Client is receiving services from a home health provider for at least one of the following diagnoses:

a. Congestive Heart Failure;

b. Chronic obstructive pulmonary disease;

c. Asthma; or

d. Diabetes.

2. Client requires ongoing and frequent, minimum of 5 times weekly, monitoring to manage their qualifying diagnosis, as defined and ordered by a physician or podiatrist;

3. Client has demonstrated a need for ongoing monitoring as evidenced by having been hospitalized two or more times in the last twelve months for conditions related to the qualifying diagnosis; or, if the client has received home health services for less than six months, the client was hospitalized at least once in the last three months, an acute exacerbation of a qualifying diagnosis that requires telehealth monitoring, or new onset of a qualifying disease that requires ongoing monitoring to manage the client in their residence;

4. Client or caregiver misses no more than 5 transmissions of the provider and agency prescribed monitoring events in a thirty-day period; and

5. Client's home environment has the necessary connections to transmit the telehealth data to the agency and has space to set up and use the equipment as prescribed.

F. The Home Health Agency shall make at least one home health nursing visit every 14 days to a client using Home Health Telehealth services.

G. The Home Health Agency shall develop agency-specific criteria for assessment of the need for home health telehealth services, to include patient selection criteria, home environment compatibility, and patient competency. These assessment forms must be completed prior to the submission of the Enrollment Application and on file at the agency

8.526 PROVIDER AGENCY REQUIREMENTS

.10 A Home Health agency must be a public agency or private organization or part of such an agency or organization which:

A. Is certified for participation as a Medicare Home Health provider under Title XVIII of the Social Security Act; and

B. Has a valid agreement with the State, according to Section 8.130, PROVIDER AGREEMENTS, of this manual, to provide Medicaid Home Health services, as defined above. The Medicaid agreement will cover only those services which are covered by the agency's Medicare certification; and

C. Maintains liability insurance for the minimum amount set annually by the Colorado Department of Health Care Policy and Financing.

.11 Home Health agencies which perform procedures in the client's home that are considered waivered clinical laboratory procedures under the Clinical Laboratory Improvement Act of 1988 must possess a certificate of waiver from the Health Care Financing Administration or its designated agency.

.12 Home Health agencies must have written policies regarding nurse delegation.

.13 For all clients who are expected to need home health aide services for at least a year, the supervising nurse must, during supervisory visits:

A. Obtain the client's, or the-client's designated representative's, input into the home health aide assignment form, including all home health aide tasks to be performed during each scheduled time period. Details such as, but not limited to, housekeeping duties and standby assistance, must be negotiated and included on the home health aide assignment form so that all obligations and expectations are clear. The home health aide assignment form shall contain information regarding special functional limitations and needs, safety considerations, special diets, special equipment, and any other information that is pertinent to the care that will be given by the aide. The client or the client's designated representative must sign the form, and must be given a copy, at the beginning of services, and at least once per year thereafter. For purposes of complying with this rule, once per year shall be defined as sometime within the certification period which includes the anniversary date of the last signature on a home health aide assignment form.

B. Give each client, and/or the client's designated representative, a new copy of the Patient's Rights form, and explain those rights whenever the home health aide assignment form is renegotiated and rewritten.

.14 Home Health agencies shall obtain the official Medicaid rules, 10 CCR 2505-10 also known as Volume 8, and shall subscribe annually to the official updates. These rules shall be made available to all staff.

.15 Home Health agencies shall have written policies regarding maintenance of clients durable medical equipment, and shall make full disclosure of these policies to all clients with durable medical equipment in the home. The policies shall provide such disclosure to the client at the time of intake.

.16 Home Health agencies shall have written policies regarding procedures for communicating with case managers of clients who are also enrolled in HCBS programs. Such policies shall include, at

a minimum, how agencies will inform case managers that services are being provided or are being changed; and procedures for sending copies of plans of care if requested by case managers. These policies shall be developed with input from case managers.

.17 Any Home Health Agency applying to become a Medicaid participating Home Health Agency shall submit an acceptable compliance plan as a condition of eligibility for entering into a Medicaid provider agreement in Colorado. The plan must demonstrate how the agency will assure compliance with Colorado Medicaid rules, and must demonstrate that the applicant agency knows and understands the rules.

18. A home health provider shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

19. A Home Health Agency may be denied or terminated from participation in Colorado Medicaid independently of participation in Medicare, according to procedures found at Section 8.050 through Section 8.051.44, based on good cause, as defined at 8.051.01. Good cause for denial or termination of a Home Health Agency shall include, but not be limited to, the following:

A. Medicare Conditions Out of Compliance. For purposes of this section, the applicable Medicare Conditions of Participation are found in 42 CFR 484, at 484.10,484.12,484.14, 484.16,484.18,484.30, 484.32,484.36,484.48, and 484.52. No later amendments to or editions of 42 CFR 484 are included. Copies of 42 CFR 484 are available for public inspection during normal business hours and will be provided at cost upon request to the Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203 or the material may be examined at any State Publications Depository Library.

1. Any Home Health Agency that is found to be out of compliance with the above-referenced Medicare Conditions of Participation on the first re-certification survey after initial certification, or on a complaint investigation prior to the first re-certification survey.

2. Any Home Health Agency that is found to be out of compliance with the above-referenced Medicare Conditions of Participation on two consecutive surveys and/or complaint investigations.

3. Any Home Health Agency that is found to be out of compliance with the above-referenced Medicare Conditions of Participation on three non-consecutive surveys and/or complaint investigations.

B. Medicare Standards Out of Compliance. For purposes of this section, the applicable Medicare Standards are the Standards under each of the above-referenced Medicare Conditions of Participation, with special emphasis on standards found at 484.10 (b)(4), (b)(5),and (c); 484.12 (a) and (c); 484.14 (c)(d) and (g); 484.18 (b) and (c); 484.30 (a); 484.36 (c); and 484.52 (b). No later amendments to or editions of 42 CFR 484 are included. Copies of 42 CFR 484 are available for public inspection during normal business hours and will be provided at cost upon request to the Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203 or the material may be examined at any State Publications Depository Library.

1. Any Home Health Agency that receives repeated deficiency citations on the same standard, or standards, more man twice, or less often if the scope and severity is high.

2. Number of, as well as severity and scope of deficiency citations against standards shall be considered as factors in decisions to deny or terminate provider agreements.

C. Improper Billing Practices: Any Home Health Agency that is found by .the State or its agent(s) to have engaged in the following practices may he denied or terminated from participation in Colorado Medicaid:

1. Billing for visits without documentation to support the claims billed. Acceptable documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the month, day, year, and the exact time in and time out of the client's home. Providers shall submit or produce requested documentation in accordance with rules at 8.079.62.

    a. Required documentation includes evidence of a face-to-face visit with the client's referring provider, or other appropriate provider, as required at 42 CFR 440.70. Title 42 of the Code of Federal Regulations, Part 440.70 (2016) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

2. Billing for unnecessary visits, or visits that are unreasonable in amount, frequency and duration; especially nursing visits solely for the purpose of assessment and teaching.

3. Billing for home health aide visits on which no skilled tasks were performed and documented, or the skilled tasks performed were not medically necessary.

4. Billing for home health services provided at locations other than the client's, place of residence. This rule shall not apply for out-of-home Services provided with prior authorization as EPSDT extra-ordinary Home Health.

5. Unbundling of home health aide and personal care or homemaker services, which is defined as any and all of the following practices by any Home Health Agency that is also certified as a personal care/homemaker provider, for all time periods during which regulations were in effect that defined the unit for home health aide services as one visit up to a maximum of two and one-half hours:

    a. One employee makes one visit, and the agency bills Medicaid for one home health aide visit, and bills all the hours as HCBS personal care or homemaker.

    b. One employee makes one visit, and the agency bills for one home health aide visit, and bills some of the hours as HCBS personal care or homemaker, when the total tune spent on the visit does not equal at least 2 ½ hours plus the number of hours billed for personal care and homemaker.

c. Two employees make contiguous visits, and the agency bills one visit as home health aide and the other as personal care or homemaker, when the time spent on the home health aide visit was less than 2 ½ hours.

d. One or more employees make two or more visits at different times on the same day, and the agency bills one or more visits as home health aide and one or more visits as personal care or homemaker, when any of the aide visits were less than 2 ½ hours and there is no reason related to the client's medical condition or needs that required the home health aide and personal care or homemaker visits to be scheduled at different times of the day.

e. One or more employees make two or more visits on different days of the week, and the agency bills one or more visits as home health aide and one or more visits as personal care or homemaker, when any of the aide visits were less than 2 ½ hours and there is no reason related to the client's medical condition or needs that required the home health aide and personal care or homemaker visits to be scheduled on different days of the week.

f. Any other practices that circumvent these rules and result in excess Medicaid payment through unbundling of home health aide and personal care or homemaker services.

g. If any of the above practices occur, the Home Health Agency shall not be absolved from liability by failure or refusal to include personal care and/or homemaking needs on the Home Health plan of care.

1. For all time periods during which the unit of reimbursement for home health aide is defined as hour and/or half-hour increments, all the practices described in 5 above shall constitute unbundling if the home health aide does not stay for the maximum amount of time for each unit billed.

2. Billing for excessive units of home health aide services for all time periods during which regulations are in effect defining the unit for home health aide as hour and/or half hour increments.

8. Billing for any services that are found to be out of compliance with any of the rules in this section, including but not limited to, those found in post-payment review rules at 8.529.

D. Prior Termination From Medicaid Participation, A Home Health Agency shall be denied or terminated from Medicaid participation if the agency or its owner(s) have previously been involuntarily terminated from Medicaid participation as a Home Health Agency or any other type of service provider.

E. Abrupt Prior Closure. A Home Health Agency may be denied or terminated from Medicaid participation if the agency or its owner(s) have abruptly closed, as any type of Medicaid provider, without proper prior client notification.

20. Any Medicaid overpayments to a provider for services that should not have been billed shall be subject to recovery. Overpayments that are made as a result of a provider's false representation

shall be subject to recovery plus civil monetary penalties and interest. False representation means an inaccurate statement that is relevant to a claim which is made by a provider who has actual knowledge of the false nature of the statement, or who acts in deliberate ignorance or with reckless disregard for truth. A provider acts with reckless disregard for truth if the provider fails to maintain records required by the department or if the provider fails to become familiar with rules, manuals, and bulletins issued by the State, the Medical Services Board, or the State's fiscal agent.

21. When a Home Health Agency voluntarily discloses improper billing, and makes restitution, the State shall consider deferment of interest and penalties in the context of the particular situation.

8.527 PRIOR AUTHORIZATION

.10 ACUTE HOME HEALTH

Acute Home Health services, as defined at Section 8.523, ELIGIBILITY, do not require prior authorization. This includes episodes of Acute Home Health for Long Term Home Health clients.

.11 LONG TERM HOME HEALTH

Long Term Home Health services, as defined at Section 8.523, ELIGIBILITY, shall be prior authorized according to the requirements below.

A. PRIOR AUTHORIZATION PROCESS

Long Term Home Health services provided to Medicaid clients shall be prior authorized by the Department or its designated review entity.

1. When an agency accepts an HCBS waiver client 18 years of age and older to Long Term Home Health services, the Home Health Agency shall contact the client’s case management agency to inform the case manager of the client's need for Home Health services.

2. The Home Health Agency shall submit the formal written prior authorization request to the Department or its designated review entity within 10 working days of the “from” date on the Home Health plan of care or within 10 working days of the end of the client’s Acute Home Health period or current Long Term Home Health PAR. Physician signature on the plan of care is not needed for prior authorization purposes. The Department or its designated review entity shall not send the prior authorization to the fiscal agent until the Home Health Agency submits the formal, complete, written prior authorization request (PAR).

3. The complete formal written PAR shall include:

a. A completed Department-prescribed Prior Authorization Request Form;

b. A Home Health plan of care which shall include all clinical assessments and current clinical summaries or updates of the client. The plan of care shall be on the HCFA-485 form, or a form that is identical in content to the HCFA-485, and all sections of the form shall be completed. For clients 20 years of age or younger, all therapy services requested shall be included in the plan of care or addendum, which shall list the specific

procedures and modalities to be used and the amount, duration, frequency and goals. If extended aide units, as described in 8.528.11.B and C, are requested, there shall be sufficient information about services on each visit to justify the extended units. Documentation to support any PRN visits shall also be provided. If there are no nursing needs, the plan of care and assessments may be completed by a therapist if the client is 20 years of age or younger and is receiving home health therapy services.

c. If applicable, written instructions from the therapist or other medical professional to support a current need when range of motion or other therapeutic exercise is the only skilled service performed on a home health aide visit;

d. When the PAR includes a request for nursing visits solely for the purpose of pre-pouring medications, the record shall document that the client's pharmacy was contacted and advised/the Home Health Agency that the pharmacy will not provide medication set-ups.

e. When a PAR includes a request for reimbursement for two aides at the same time to perform two-person transfers, the record shall provide documentation supporting the current need for two person transfers and the reason adaptive equipment cannot be used instead.

4. Authorization time frames:

a. Prior authorization requests shall be submitted and may be approved for up to a one year period.

b. Home Health Agencies shall not be required to change dates on the Home Health plans of care to match the client’s waiver program certification dates, if a client is in an HCBS waiver program.

c. Home Health Agencies shall send new plans of care and other documentation as requested by the Department or its designated review entity.

d. The Department or its designated review entity may initiate PAR revisions if the plans of care indicate significantly decreased services.

e. PAR revisions for increases initiated by Home Health Agencies shall be submitted and processed according to the same requirements as for new PARs, except that current written assessment information pertaining to the increase in care may be submitted in lieu of the HCFA-485.

5. The prior authorization request shall be reviewed by the Department or its designated review entity to determine compliance with Medicaid rules, and shall be approved, denied, or returned for additional information within 10 working days of receipt. The PAR shall not be backdated to a date prior to the 'from' date of the HCFA-485.

6. The Department or its designated review entity shall approve or deny according to the following guidelines for safeguarding clients:

a. PAR Approval: If services requested are in compliance with Medicaid rules, and are medically necessary and appropriate for the diagnosis and treatment plan, the services shall be approved retroactively to the start date on the PAR form. Services may be approved retroactively for no more than 10 days prior to the PAR submission date.

b. PAR Denial:

1. The Department or its designated review entity shall notify Home Health Agencies in writing of denials that result from non-compliance with Medicaid rules or failure to establish medical necessity (the PAR is not consistent with the client's documented medical needs and functional capacity). Denials based on medical necessity shall be determined by a registered nurse or physician.

2. The Department or its designated review entity, through the Medicaid fiscal agent, shall notify clients of Long Term Home Health denials, including partial denials, and appeal rights in accordance with Section 8.393.28 and Section 8.057, RECIPIENT APPEALS.

3. If any services have already been provided, but are subsequently denied on the prior authorization request, the Department or its designated review entity shall notify the Home Health Agency of the denial. Services already provided may be approved for payment, retroactive to the start date on the PAR form, or up to 30 working days whichever is shorter. If denied, services shall be approved for 15 additional days after the date on which the notice of denial is mailed to the client, so that the client's right to advance notice is preserved. An informal case conference may be arranged to discuss disagreements. If the disagreement is not satisfactorily resolved, the Home Health Agency may file a provider appeal in accordance with Section 8.050, PROVIDER APPEALS.

7. Neither the presence nor the absence of a preliminary authorization or a formal written PAR approval from the authorizing agent shall exempt a Home Health Agency at any time from:

a. Following all applicable Medicaid rules;

b. Providing only services that are medically necessary to the needs of the client; or

c. Ensuring the accuracy of preliminary and formal written PAR information provided to the Department or its designated review entity.

8. EXPEDITED AUTHORIZATION PROCESS

If requested by a Home Health Agency, for extreme emergencies or complicated cases, following the initial assessment by the Home Health Agency, and after receipt of HCFA-485 or care notes in writing, the Department or its designated review entity may use the information provided by the Home Health Agency to take one of the following actions:

a. Provide preliminary authorization of the services until the formal written PAR procedure delineated at 8.527.11.A.1-8 above is completed, for up to a maximum of 15 calendar days. If an expedited authorization was provided by the Department or its designated review entity the date of service effective under the expedited authorization (never dated back prior to "from" date on HCFA-485) shall be indicated on the prior authorization form that is forwarded to the fiscal agent;

b. Postpone/deny preliminary authorization until the Home Health Agency provides full documentation as delineated at 8.527.11.A. 3. The Home Health Agency shall submit a formal written PAR in order for due process to occur as delineated at 8.527.11.A.6.

9. If the client has an acute episode, the Home Health Agency shall bill for Acute Home Health, in accordance with billing manual instructions, without obtaining prior authorization approval from the Department or its designated review entity. The Home Health Agency shall inform the SEP case manager or the Medicaid fiscal agent within ten (10) working days of the beginning and within ten (10) working days of the end of the acute care episode.

Note: The Section numbered 8.527.10 A was deleted effective August 30, 2012.

Note: The Section numbered 8.527.11 B was deleted effective July 1, 2002.

.12 EPSDT SERVICES

Home Health services may be provided when identified as medically necessary for pediatric clients 20 years of age or younger through Early Periodic Screening Diagnosis and Treatment (EPSDT), and prior authorized according to the requirements below.

A. Home Health services above and beyond the restrictions in these rules at SECTION 8.520 through 8.530 shall be reviewed for medical necessity under the EPSDT Federal requirement.

B. Home Health services above and beyond the restrictions in these rules at SECTION 8.520 through 8.530 shall not include services that are available under other Colorado Medicaid benefits, and for which the client is eligible, including but not limited to, Private Duty Nursing, Section 8.540; HCBS personal care, Section 8.489; School Health and Related Services, Section 8.290, or out-patient therapies, Section 8.330. Exceptions may be made if EPSDT Home Health services will be more cost-effective, provided that client safety is assured. Such exceptions shall in no way be construed as mandating the delegation of nursing tasks.

C. Prior authorization requests for EPSDT Home Health shall be submitted and reviewed as outlined in SECTION 8.527.11 A.

1. The complete prior authorization request shall include all documentation outlined in SECTION 8.527.11.3 and shall include any other medical information which will document the medical necessity for the EPSDT Home Health services. The plan of care shall include the place of service for each Home Health visit.

.13 HOME HEALTH TELEHEALTH SERVICES

A. Home Health Telehealth services are available to clients only after the Home Health Agency has received prior authorization.

B. The Home Health Agency shall request prior authorization every 60 days that continuing telehealth services are needed.

C. The PAR shall include all of the following:

1. A completed Home Health Telehealth enrollment form;

2. An order for Telehealth monitoring signed and dated by the ordering physician or podiatrist;

3. A home health plan of care, which shall include nursing and/or therapy assessments for clients. Telehealth monitoring shall be included on the HCFA-485 form, or a form that contains similar information to the HCFA-485, and all applicable forms shall be completed; and

4. For on-going telehealth, the agency shall include documentation on how Telehealth data has been used to manage the client's care, if the client has been using Telehealth services.

.14 The complete prior authorization request must include:

A. A State-prescribed Prior Authorization Request Form;

B. A physician-signed plan of care on the HCFA-485 or a form that is identical in content to the HCFA-485, which shall include nursing and therapy assessments, current clinical summaries and updates of the client, and all therapy services requested, including the specific procedures and modalities to be used and the amount, duration and frequency;

C. Written documentation of the results of the EPSDT medical screening, or other equivalent examination results provided by the client's third-party insurance; and

D. Any other medical information which will document the medical necessity for the Home Health services.

8.528 REIMBURSEMENT

.10 CLAIMS

Claims shall be submitted to the fiscal agent according to Section 8.040, RULES GOVERNING SUBMISSION OF CLAMS, and Section 8.043, TIMELY FILING REQUIREMENTS.

Home Health providers shall maintain adequate financial records for all claims, including documentation of services as specified at Section 8.040.2, RULES GOVERNING SUBMISSION OF CLAIMS, and Section 8.130, PROVIDER AGREEMENTS.

.11 UNIT OF REIMBURSEMENT

A. The unit of reimbursement for the Home Health services of nursing, physical therapy, occupational therapy, and speech therapy shall be one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in client care or treatment.

B. The Basic Unit of reimbursement for home health aide services shall be up to one hour. A unit of time that is less than fifteen minutes shall not be reimbursable as a basic unit.

C. For home health aide visits that last longer than one hour, Extended Units may be billed in addition to the Basic Unit. Extended Units shall be increments of fifteen minutes up to one-half hour. Any unit of time that is less than fifteen minutes shall not be reimbursable as an extended unit.]

D. Reimbursement for supplies used by Home Health agency staff is included in the reimbursement for nursing, home health aide, physical therapy, occupational therapy, and speech/language pathology services, to the following extent:

1. Supplies used during provision of any Home Health services by Home Health agency staff for the practice of universal precautions shall be the financial responsibility of the Home Health agency. This excludes gloves used for bowel programs and catheter care but includes all other supplies required for the practice of universal precautions by Home Health agency staff. If a Home Health agency asks a client to provide such supplies, this will constitute a failure to accept Medicaid payment in full, in violation of Section 8.012, PROHIBITION OF CHARGES TO RECIPIENTS.

2. Supplies other than those required for practice of universal precautions which are used by the Home Health agency staff to provide Home Health care services shall not be the financial responsibility of the Home Health agency. Such supplies may be requested by the physician as a benefit to the client under Section 8.590, DURABLE MEDICAL EQUIPMENT.

3. Supplies used for the practice of universal precautions by the client's family or other informal caregivers shall not be the financial responsibility of the Home Health agency. Such supplies may be requested by the physician as a benefit to the client under Section 8.590, DURABLE MEDICAL EQUIPMENT.

E. The unit of reimbursement for home health telehealth is one calendar day.

1. The Home Health Agency may bill one initial visit per client each time the monitoring equipment is installed in the home.

2. The Home Health Agency may bill the daily rate for each day the telehealth monitoring equipment is used to monitor and manage the client’s care.

.12 The following restrictions shall be placed on Home Health services for purposes of reimbursement:

A. Nursing visits shall not be reimbursed by Medicaid if solely for the purpose of psychiatric counseling, because that is the responsibility of the Mental Health Assessment and Services Agencies. Nursing visits for mentally ill clients shall be reimbursed under Medicaid Home Health for pre-pouring of medications, venipuncture, or other nursing tasks, provided that all other requirements in this section are met.

B. The state shall not authorize nor reimburse home health aide services for the purpose of providing only unskilled personal care and/or homemaking services. Units during which unskilled personal care and/or homemaking services are provided and billed under the home health aide benefit must be contiguous with units during which services defined as skilled personal care are provided. For clients who are also eligible for HCBS personal care and homemaker services, the units spent on unskilled personal care and homemaker services and billed as aide services shall be reasonable in relation to the

skilled care provided on the contiguous units. For example, if the transfer and bath are skilled, it would be reasonable for the aide to also dress the client, and to wipe up any water spills on the bathroom floor, and to prepare a meal if the aide is there at mealtime. It would not be reasonable for the aide to stay four more hours to do all the weekly cleaning and laundry, unless the client is not eligible for homemaker services under HCBS.

C. The maximum reimbursement for any twenty-four hour period, as measured from midnight to midnight, shall not exceed $270, effective July 1, 2002, for Acute Home Health Services or Long Term with Acute Episode Home Health Services; and shall not exceed $211, effective My 1, 2002, for Long Term Home Health Services.

Effective September 1, 2002, the maximum reimbursement for any twenty-four hour period, as measured from midnight to midnight, shall not exceed S291 for Acute Home Health Services or Long Term with Acute Episode Home Health Services, and shall not exceed $227 for Long Term Home Health Services.

Criteria for the three different categories of care are found at 8.523.11, K in this section. The maximum daily reimbursement includes reimbursement for nursing visits, home health aide units, physical therapy visits, occupational therapy visits, speech/language pathology visits, and any combinations thereof.

D. Medicaid will not reimburse for two nurses during one visit, two home health aides at the same time, two physical therapists during one visit, two occupational therapists during one visit, or two speech therapists during one visit. An exception to this rule is for two home health aides, when two are required for transfers, and there are no other, persons available to assist, and when there is a justifiable reason why adaptive equipment cannot be used instead. Another exception is for two nurses when two are required to perform a procedure. For these exceptions, the provider may bill for two visits, or for all units for both aides. Reimbursement for all visits or units will be counted toward the maximum reimbursement limit.

E. If a client is seen simultaneously by two persons to provide a single service, for which one person supervises or instructs the other, the Home Health agency shall only bill and be reimbursed for one employee's visit or units. For example, if two nurses visit the client, and the first nurse provides care and also orients and trains the second nurse in the client's care, only the first nurse's time counts as a reimbursable visit.

F. Any visit made solely for the purpose of supervising the home health aide shall not be reimbursed.

G. Any visit made by a nurse or therapist to simultaneously serve two or more clients residing in the same household shall be reimbursed as one visit only, unless services to each client are separate and distinct. If two or more clients residing in the same household receive Medicaid home health aide services, the personal care for each client shall be documented and billed separately for each client. Any homemaker services provided during units contiguous to skilled personal care units shall be billed to any one of the clients in the household, but the homemaker services shall not be duplicated and/or billed for more than one client. For example, if more than one client in the household needs meal preparation, it is expected that one aide prepare the meal for all of them. If the clients in the same household use different agencies, the agencies shall coordinate with each other to prevent duplication of homemaking.

H. No more than one Home Health agency shall be reimbursed for providing Home Health services during a specific plan period to the same client, unless the second agency is

providing a Home Health service that is not available from the first agency. The first agency must take responsibility for the coordination of all Home Health services. Home and Community Based Services, including personal care, are not Home Health services.

I. Physical, occupational, or speech therapy visits shall be reimbursed only when:

1. Improvement of functioning is expected or continuing;

2. The therapy assists in overcoming developmental problems;

3. Therapy visits are necessary to prevent deterioration;

4. Therapy visits are indicated to evaluate and change ongoing treatment plans for the purpose of preventing deterioration; and to teach home health aides or others to carry out such plans, when the ongoing treatment does not require the skill level of a therapist; and/or

5. Therapy visits are indicated to assess the safety or optimal functioning of the client in the home, or to train in the use of equipment used in implementation of the therapy plan of care.

J. Nursing visits provided solely for the purpose of assessing and/or teaching shall be reimbursed by Medicaid only under the following guidelines:

1. For an initial assessment visit ordered by a physician when there is a reasonable expectation that ongoing nursing or home health aide care may be needed. Initial nursing assessment visits shall not be reimbursed if provided solely to open the case for physical, occupational, or speech therapy.

2. If a nursing visit involves the nurse performing a nursing task for the purpose of demonstrating to the client or the client's unpaid family/caregiver how to perform the task, that visit shall not be considered as being solely for the purpose of assessing and teaching. A nursing visit during which the nurse does not perform the task, but observes the client or unpaid family/caregiver performing the task to verify that the task is being performed correctly shall be considered a visit that is solely for the purpose of assessing and teaching.

3. Nursing visits solely for the purpose of assessing the client and/or teaching the client or the client's unpaid family/caregiver shall not be reimbursed unless the care is Acute Home Health or Long Term Home Health With Acute Episode, as defined in Section 8.523, ELIGIBILITY, or the care is for extreme instability of a chronic condition under Long Term Home Health, as defined in Section 3.523, ELIGIBILITY.

4. Nursing visits provided solely for the purpose of assessment and/or teaching shall not exceed the frequency that is justified by the client's documented medical condition and symptoms, up to the maximum reimbursement limits. Assessment visits shall continue only as long as there is documented clinical need for assessment, management, and reporting to physician of specific conditions and/or symptoms which are not stable and/or not resolved. Teaching visits shall be as frequent as necessary, up to the maximum reimbursement limits, to teach the client or the client's unpaid family/caregiver, and shall continue only as long as needed for the client or the client's unpaid family/caregiver to demonstrate

understanding or to perform care, or until it is determined that the client or unpaid family/caregiver is unable to learn or to perform the skill being taught. The visit on which the nurse determines that there is no longer a need for assessment and/or teaching shall be reimbursed if it is the last visit provided solely for assessment and/or teaching.

5. Nursing visits provided solely for the purpose of assessment and/or teaching shall not be reimbursed if the client is capable of self-assessment and of contacting the physician as needed; and if the client's medical records do not justify a need for client teaching beyond that already provided by the hospital and/or attending physician, as determined and documented on the initial Home Health assessment

6. Nursing visits provided solely for the purpose of assessment and/or teaching shall not be reimbursed if there is an available and willing unpaid family/caregiver who is capable of assessing the client's condition and needs and contacting the physician as needed; and if the client's medical records do not justify a need for teaching of the client's unpaid family/caregiver beyond the teaching already provided by the hospital and/or attending physician, as determined and documented on the initial Home Health assessment.

K. Nursing visits provided solely for the purpose of assessment and/or teaching and foot care shall not be reimbursed unless the visit meets the guidelines to be reimbursed as a visit provided solely for assessment and/or teaching, and/or the guidelines to be reimbursed as a foot care visit.

Nursing visits provided solely for the purpose of providing foot care shall be reimbursed by Medicaid only if the client has a documented and supported diagnosis that supports the need for foot care to be provided by a nurse, and the client and/or unpaid family/caregiver is not able or willing to provide the foot care. This will include documented and supported diagnoses that involve severe peripheral involvement, anti-coagulation therapy, or other conditions such as, but not limited to, spasticity and compromised immune system which could lead to a high risk of medical complications from injuries to the feet.

Documentation in the medical record shall specifically, accurately, and clearly show the signs and symptoms of the disease process at each visit the clinical record must indicate and describe an assessment of the foot or feet, physical and clinical findings consistent with the diagnosis and the need for foot care to be provided by a nurse. Severe peripheral involvement shall be supported by documentation of more than one of the following:

1. absent (not palpable) posterior tibial pulse;

2. absent (not palpable) dorsalis pedis pulse;

3. three of the advanced trophic changes such as:

    a. hair growth (decrease or absence),

    b. nail changes (thickening),

    c. pigmentary changes (discoloration),

d. skin texture (thin, shiny),

e. skin color (rubor or redness);

4. claudication (limping, lameness);

4. temperature changes (cold feet);

5. edema;

6. parasthesia;

7. burning.

L. Nursing visits provided solely for the purpose of assessment and/or teaching and pre-pouring of medications shall not be reimbursed unless the visit meets either the guidelines to be reimbursed as a visit provided solely for assessment and/or teaching, or the guidelines for reimbursement as a visit solely for the purpose of pre-pouring medications. Nursing visits provided solely for the purpose of pre-pouring medications into medication containers such as med-minders or electronic medication dispensers shall be reimbursed by Medicaid under the following guidelines:

1. The client is not living in a licensed personal care boarding home, including Adult Foster Home or Alternative Care Facility, where the facility staff is trained and qualified to pre-pour medications under the medication administration law at 25-1-107 (ee) (1.5), C.R.S., as amended by House Bill 98-1015. No later amendments to or editions of 25-1-107 (ee) (1.5), C.R.S., as amended by House Bill 98-1015 are included. Copies of 25-1-107 (ee) (L5), C.R.S., as amended by House Bill 98-1015 are available for public inspection during normal business hours and will be provided at cost upon request to the Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714 or the material may be examined at any State Publications Depository Library; and

2. The client is not physically or mentally capable of pre-pouring his/her own medications or has a medical history of non- compliance with taking medications if they are not pre-poured; and

3. The client has no unpaid family/caregiver who is willing or able to pre-pour the medications for the client; and

4. There is documentation in the client's chart that the client's pharmacy was contacted upon admission to the Home Health Agency, and that the pharmacy will not provide this service; or that having the pharmacy provide this service would not be effective for this particular client.

M. Nursing visits solely for the purpose of performing venipuncture, or for venipuncture and assessment and/or teaching, shall be reimbursed only if all the regulations in Section 8.520 through Section 8.530.10, B, HOME HEALTH SERVICES, are met.

.13 RATES OF REIMBURSEMENT

A. Payment for Home Health services, other than nursing visits, shall be the lower of the billed charges or the maximum unit rate of reimbursement.

For nursing visits the payment shall be the lower of the billed charges, the maximum unit rate of reimbursement or prior authorized charges.

Prior authorized charges for stable clients requiring uncomplicated daily visits shall not exceed $50.00 for the first brief nursing visit of the day and $35.00 for the second or subsequent brief nursing visit of the day.

B. Maximum interim payment unit rates are:

Effective July 1, 2002:

1. Nursing visits: $67.85

2. Acute Home Health Aide Basic unit: $22.37

3. Long Term Home Health Aide Basic unit: $30.08

4. Home Health Aide Extended unit: $8.99

5. Physical Therapy visits: $58.36

6. Occupational Therapy visits: $61.98

7. Speech Therapy visits: $63.60

Effective September 1, 2002:

1. Nursing visits: $71.42

2. Any Home Health Aide Basic unit $31.66

3. Home Health Aide Extended unit: $9.46

4. Physical Therapy visits: $61.43

5. Occupational Therapy visits: $65.24

6. Speech Therapy visits: $66.95

Effective February 1, 2000, interim payment rates shall be adjusted to equal no more than 16.5% average increase per unduplicated client for State Fiscal Year 99-00. The interim rates shall not be reduced, if total Medicaid home health expenditures in State FY 99-00 do not exceed $73,571,787. If total expenditures for the Home Health budget do exceed $73,571,787, the Department shall determine which Home Health Agencies received average per unduplicated client payments for State FY 99-00 Home Health services which were more than 16.5% over State FY 98-99 average per unduplicated client payments, and shall recoup from those agencies the amounts over the 16.5% average per unduplicated client increase. This shall be accomplished by decreasing each agency's unit rates, retro-active to February 1, 2000, by a percentage that will bring each agency's average payment per unduplicated client for State FY 99-00 to no more than a 16.5% increase over its State FY 98-99 average per unduplicated client payment. Agencies that became newly certified as Medicare/Medicaid providers in State FY 99-00 and have no Medicaid Home Health payment history for State FY 98-99 shall be exempt.

D. Effective September 1, 2000, interim payment rates shall be adjusted to equal no more than 16.5% average increase per unduplicated client for State Fiscal Year 00-01 with the following exemptions:

1. Exempt Agencies

a) Agencies that became newly certified as Medicare/Medicaid providers in State FY 00-01 and have no Medicaid Home Health payment history for State FY 99-00 shall be exempt.

b) Agencies that had total Medicaid Home Health payments of less than $125,000 in FY 99-00 shall be exempt.

2. Exempt Clients

a) Clients who are newly enrolled in Medicaid shall be exempt if they receive Medicaid Home Health services within thirty days of their very first Medicaid enrollment. Clients with prior spans of Medicaid eligibility shall not be considered newly enrolled even if there was a period of non-enrollment between eligibility spans.

b) Clients who are deinstitutionalized from nursing facilities shall be exempt if the nursing facility care was billed to Medicaid and was not billed as respite care; if they begin receiving Home Health services no later than thirty days after discharge, from the nursing facility; and if they do not return to nursing facility placement after an interim period of Home Health care.

E. The FT 00-01 interim rates shall not be reduced if total Medicaid community long term care expenditures in State FY 00-01 do not exceed $198,862,688. If total expenditures for the community long term care budget do exceed $198,862,688, the Department shall determine which non-exempt Home Health Agencies received average per non-exempt unduplicated client payments for State FY 00-01 Home Health services which were more than 16.5% over State FY 99-00 average per unduplicated client payments, and shall recoup from those agencies the amounts over the 16.5% average per unduplicated client increase. This shall be accomplished by decreasing each non-exempt agency's unit rates, retroactive to September 1, 2000, by a percentage that will bring each agency's average payment per non-exempt unduplicated client for State FY 00-01 to no more than 16.5% increase over its State FY 99-00 average per unduplicated client payment.

F. Services shall be billed according to category of service upon publication of instructions in the provider-billing manual.

1. For Acute Home Health Services, Home Health Agencies shall bill nursing, home health aide, physical therapy, occupational therapy, and speech therapy, as Acute Home Health.

2. For Long Term Home Health Services provided to a minor, Home Health Agencies shall bill nursing, home health aide, physical therapy, occupational therapy, and speech therapy as Long Term Home Health. For Long Term Home

Health Services provided to an adult, Home Health Agencies shall bill nursing, and home health aide services as Long Term Home Health. Clients 18 years and over may obtain long-term therapy services in an outpatient hospital setting or by a qualified nonphysician practitioner described at 8.201.A.

3. For Long Term with Acute Episode Home Health Services, Home Health Agencies shall bill all nursing, home health aide, physical therapy, occupational therapy, and speech therapy, as Acute Home Health, until the client's care becomes Long Term Home Health again.

4. For all nursing visits provided solely for the purpose of assessment and teaching, not including initial assessment visits at the start of care, Home Health Agencies shall bill a revenue code assigned for nursing assessment and teaching visits.

G. Maximum unit rates may be adjusted by the State as funding becomes available.

.14 SPECIAL REIMBURSEMENT CONDITIONS

A. Reimbursement for third party resource and Medicare crossover claims shall not exceed Medicaid costs.

B. When Home Health agencies provide Home Health services, in accordance with these regulations, to clients who receive Home and Community Based Services for the Developmentally Disabled (HCBS-DD), the Home Health agency shall be reimbursed:

1. Under normal procedures for Home Health reimbursement, if the client resides in an Intermediate Care Facility for the Mentally Retarded (ICF/MR), or Individual Residential Services & Supports (IRSS) Host Homes and Settings; or

2. By the group home provider, if the client resides in Group Residential Services & Supports (GRSS), because the provider has already received Medicaid funding for the home health services and is responsible for payment to the Home Health agency.

C. Acute Home Health services provided to Medicaid HMO clients, including Medicaid HMO clients who are also HCBS recipients, shall not be reimbursed under the Medicaid Home Health program, but shall be reimbursed under Medicaid HMO rules. If a client's Home Health service need exceeds 60 days, the Home Health Agency shall submit a Prior Authorization for Long Term: Home Health to the designated review entity.

D. All Medicare requirements shall be met and exhausted prior to any dual eligible client’s claims being billed to Medicaid, as demonstrated by a Medicare denial of benefits, except in the specific cases listed at 8.528.14.D.1 and 8.525.14.D.2.

1. A Home Health Agency may bill Medicaid without billing Medicare if the services below are the only services on the claim:

a. Pre-pouring of medications;

b. Certified Home Health Aide services;

c. Occupational Therapy services when provided as the sole skilled service; or

d. Routine Laboratory Draw services.

2. A Home Health Agency may bill Medicaid at the time of services, if the conditions below apply. The claim must also be submitted to Medicare so that the denial, when received, is part of the client's file.

   a. The client is stable;

   b. The client is not experiencing an acute episode; and

   c. The client routinely leaves the home without taxing effort and unassisted for social, recreational, educational, or employment purposes.

3. The Home Health Agency shall maintain clear documentation in the client's record of the conditions and services that are billed to Medicaid without billing Medicare.

4. A Home Health Advance Beneficiary Notice (HHABN) shall be filled out as prescribed by Medicare.

E. A dual eligible Long Term Home Health Care client who has an Acute Episode shall be switched from Medicaid to Medicare reimbursement. Medicaid resumes as the payer of record when Medicare denies payment as a non-covered benefit and the service is a Medicaid benefit, or when the service consists of those listed in 8.528.14.D.2.

F. If both Medicare and Medicaid reimburse for the same visit or service provided to a client in the same episode, the reimbursement shall be considered a duplication of payment and the Medicaid reimbursement shall be returned to the Department.

1. Upon receiving a duplicate payment, Home Health agencies shall return the payment to Medicaid within sixty (60) calendar days of final Medicare payment.

2. Failure to return the Medicaid payment to the Department shall be deemed a false claim and subject to the provisions set forth in 25.5-4-303.5, C.R.S., et seq. and referred to the Medicaid Fraud Control Unit in the Colorado Department of Law for criminal investigation.

8.529 POST-PAYMENT REVIEW

.10 The Medicaid Quality Assurance Unit shall periodically conduct post-payment reviews of selected Home Health services.

.11 Home Health agencies shall submit or produce requested documentation of services to the Medicaid Quality Assurance Unit in accordance with rules at 8.079.62. Such documentation shall include, at a minimum:

A. Physician-signed plans of care, which shall include nursing and/or therapy assessments, or current clinical summaries or updates of the client. The plan of care must be on the HCFA-485 form, or a form that is identical in format to the HCFA-485, and all sections of the form must be completed. All therapy services provided must be included in the plan of care, which must list the specific procedures and modalities to be used and the amount, duration and frequency.

B. Records documenting the nature and extent of the care actually provided such as, but not limited to, nursing notes.

.12 The Medicaid Quality Assurance Unit shall review all information available from any source, shall contact clients, and may conduct on-site visits to Home Health agencies and/or clients.

.13 The Medicaid Quality Assurance Unit shall initiate appropriate administrative, civil, or criminal investigations and/or sanctions for all services which:

A. Are found to be out of compliance with all applicable regulations;

B. Are not consistent with the client's documented medical needs and functional capacity,

C. Are not reasonable in amount, frequency, and duration;

D. Are duplicative of any other services that the client received or that the client received funds to purchase;

E. Total more than twenty-four hours per day of paid care, regardless of funding source (An example of care totaling more than 24 hours per day would be 5 home health visits plus 12 hours of personal care);

F. Consist of visits or contiguous units which are shorter or longer than the length of time required to perform all the tasks prescribed on the care plan.

.14 Clients and families of clients shall not be billed by home health agencies for any services for which Medicaid reimbursement is recovered as a result of post-payment review.

.15 Providers may appeal post-pay sanctions in accordance with Section 8.050, PROVIDER APPEALS AND HEARINGS.

8.530 DENIAL, TERMINATION, OR REDUCTION IN SERVICES

.10 When services are denied, terminated, or reduced by action of the Home Health agency, the Home Health agency shall notify the client.

A. Termination of Services to Clients Still Medically Eligible for Coverage of Medicaid Home. Health Services

When a Home Health agency decides to terminate services to a client who needs and wants continued Home Health services, and who remains eligible for coverage of services under the Medicaid Home Health rules, the agency shall give the client, and/or the client's designated representative, written advance, notice of at least fifteen business days, and the attending physician shall also be notified. Notice shall be provided in person or by certified mail, and shall be considered given when it is documented that the recipient has received the notice. The notice shall provide the reason for the change in services. The agency shall make a good faith effort to assist the client in securing the services of another agency. If there is indication that ongoing services from another source can not be arranged by the end of the advance notice period, the terminating agency shall ensure client safety by making referrals to appropriate case management agencies and/or County Departments of Social Services; and the attending physician shall be informed about the situation. Exceptions will be made to the requirement for 15 days advance notice when the provider has documented that there is danger to the client, Home Health agency, staff, or when the client has begun to receive Home Health services through a Medicaid HMO. Clients who believe that a Home Health agency has

not acted properly, in terminating services may call me Home Health Hotline, at 1-800-842-8826 to request an investigation.

COLORADO
Department of Health Care Policy & Financing
Medical Services Board

JUNE 2017 EMERGENCY JUSTIFICATION FOR MEDICAL ASSISTANCE RULES ADOPTED AT THE JUNE 9, 2017 MEDICAL SERVICES BOARD MEETING

MSB 17-03-23-B Revision to the Medical Assistance Rule Concerning the Federally Qualified Health Center Rule, Section 8.700

For the preservation of public health, safety and welfare

This rule revision fulfills the necessary requirements to be an Emergency Rule. The purpose of this rule revision is to clarify the Department's payment methodology for Federally Qualified Health Centers (FQHCs), specifically regarding payments separate from the encounter. Currently, our State Plan and rules for FQHCs state that the Department pays the encounter rate for one-on-one, face-to-face visits between a client and eligible provider. However, it is common practice for FQHCs to bill the Department at the Fee Schedule rate for other types of services – such as inpatient hospital services, the cost of LARC devices, dentures, partial dentures, the Prenatal+ Program, and the Nurse Home Visitor Program. These services should not be reimbursed at the encounter rate and instead should be reimbursed the Fee Schedule rate. However, since our current rules and State Plan do not reference this type of payment there is a large amount of confusion and concern among Department staff and FQHC staff about how to reimburse FQHCs. The Department must revise its rules to reflect payment for these services outside of the encounter rate. If we stop paying for these services outside of the encounter rate they will no longer be provided.

The emergency rulemaking is necessary to keep in compliance with the current policy. This rule change is crucial for the preservation of public health, safety, and welfare.

COLORADO
Department of Health Care Policy & Financing
Medical Services Board

JUNE 2017 EMERGENCY JUSTIFICATION FOR MEDICAL ASSISTANCE RULES ADOPTED AT THE JUNE 9, 2017 MEDICAL SERVICES BOARD MEETING

MSB 17-04-21-A Revision to the Medical Assistance Benefits Rule Concerning Home Health Services, Section 8.520

For the preservation of public health, safety and welfare

The rule defines the amount, duration, and scope of covered home health services. This revision updates the home health services rule by adding provisions concerning face-to-face visits and place of service limitations, as required under recently issued federal regulations, both of which must be effective by July 1, 2017. Specifically, this revision aligns the Colorado Medicaid home health services rule with federal regulations by adding: (1) a requirement that the physician must document a face-to-face encounter with the Medicaid client for the authorization of home health services within particular timelines; and (2) language clarifying that Medicaid home health services are not limited solely to home settings.

The recently issued federal home health regulations, concerning documentation of face-to-face encounters and place of service limitations, explicitly require that the Department be in compliance with the new provisions by July 1, 2017.

The emergency rulemaking is necessary to keep in compliance with the current policy. This rule change is crucial for the preservation of public health, safety, and welfare.

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Office of the Attorney General

Tracking number: 2017-00235

Opinion of the Attorney General rendered in connection with the rules adopted by the

Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)

on 06/09/2017

10 CCR 2505-10

MEDICAL ASSISTANCE - STATEMENT OF BASIS AND PURPOSE, AND RULE HISTORY

The above-referenced rules were submitted to this office on 06/12/2017 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

June 20, 2017 09:21:59

Frederick R. Yarger

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Terminated Rulemaking

Department

Department of Revenue

Agency

Division of Motor Vehicles

CCR number

1 CCR 204-10

Tracking number

2017-00079

Termination date

06/23/2017

Reason for termination

The section will be starting the review process over. A new filing will be completed

Terminated Rulemaking

Department

Department of Revenue

Agency

Division of Gaming - Rules promulgated by Gaming Commission

CCR number

1 CCR 207-1

Tracking number

2017-00112

Termination date

06/27/2017

Reason for termination

The Gaming Commission voted to make no changes to the gaming tax rates for FY18.

Calendar of Hearings

Hearing Date/Time	Agency	Location
08/10/2017 01:00 PM	Division of Liquor Enforcement	1881 Pierce Street, Room 110, Lakewood, CO 80214
08/07/2017 10:00 AM	Division of Motor Vehicles	1881 Pierce Street, Lakewood CO 80214: Rm 110 (Board/Commission Meeting Room)
08/18/2017 09:00 AM	Division of Motor Vehicles	1881 Pierce Street, Lakewood CO 80214: Rm 110 (Board/Commission Meeting Room)
08/16/2017 02:00 PM	Colorado State Board of Education	201 E. Colfax Ave, Room 101 - State Board Room
08/01/2017 02:00 PM	Division of Insurance	1560 Broadway, Ste 110 D, Denver CO 80202
08/01/2017 02:00 PM	Division of Insurance	1560 Broadway, Ste 110 D, Denver CO 80202
08/01/2017 02:00 PM	Division of Insurance	1560 Broadway, Ste 110 D, Denver CO 80202
08/16/2017 09:00 AM	Colorado State Board of Health	Northeast Colorado Health Department, 700 Columbine Street, Auditorium, Sterling CO 80751
08/01/2017 09:30 AM	Division of Workers' Compensation	633 17th St. Denver CO 80202
08/03/2017 10:00 AM	Division of Oil and Public Safety	633 17th Street, Suite 500, Denver, CO 80202