

# DEPARTMENT OF LABOR AND EMPLOYMENT

## Division of Workers' Compensation

7 CCR 1101-3

### WORKERS' COMPENSATION RULES OF PROCEDURE

#### Rule 18 MEDICAL FEE SCHEDULE

##### 18-1 STATEMENT OF PURPOSE

Pursuant to § 8-42-101(3)(a)(I) C.R.S. and Section 8-47-107, C.R.S., the Director promulgates this medical fee schedule to review and establish maximum allowable fees for health care services falling within the purview of the Act. The Director adopts and hereby incorporates by reference as modified herein the 2005 edition of the *Relative Values for Physicians (RVP)*, developed by Relative Value Studies, Inc., published by Ingenix® St. Anthony Publishing and version 22.0 of *DRGs: Diagnosis Related Groups, Definitions Manual, (DRGs Definition Manual)* developed and published by 3M Health Information Systems using DRGs effective after October 1, 2004. The incorporation is limited to the specific editions named and does not include later revisions or additions. For information about inspecting or obtaining copies of the incorporated materials, contact the Medical Fee Schedule Administrator, 633 17<sup>th</sup> Street, Suite 400, Denver, Colorado 80202-3660. These materials may be examined at any state publications depository library. All guidelines and instructions are adopted as set forth in the *Relative Values for Physicians* or *DRGs: Diagnosis Related Groups, Definitions Manual*, unless otherwise specified in this rule.

This rule applies to all services rendered on or after January 1, 2006. 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) *RVP* – the 2005 edition of *Relative Values for Physicians*, incorporated by reference in Rule 18-1.
- (B) *DRGs Definitions Manual* – version 22.0 of *DRGs: Diagnosis Related Groups, Definitions Manual*, incorporated by reference in Rule 18-1.
- (C) For other terms, see Rule 16-2, Utilization Standards.

##### 18-3 HOW TO OBTAIN COPIES

All users are responsible for the timely purchase and use of Rule 18 and its supporting documentation as referenced herein. The Division shall make available for public review and inspection copies of all materials incorporated by reference in Rule 18. Copies of the *RVP* may be purchased from St. Anthony Press, the *DRGs Definitions Manual* may be purchased from 3M

Health Information Systems and the *Workers' Compensation Rules of Procedures*, 7 CCR 1101-3, may be purchased from Weil Publishing, Augusta, ME. Unofficial copies of all rules, including Rule 18, are available on the Colorado Department of Labor and Employment web site at [www.coworkforce.com/DWC/](http://www.coworkforce.com/DWC/).

18-4 CONVERSION FACTORS

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

RVP SECTION	CONVERSION FACTOR
Medicine	\$ 7.41/RVU
Evaluation & Management (E&M)	\$ 7.93 /RVU
Physical Medicine	\$ 5.20/RVU
(Codes 97000-97804 and 97810-97814)	
Anesthesia	\$43.60/RVU
Surgery X Codes	\$36.95/RVU
(see Rule 18-5(D)(1)(e))	
Surgery	\$88.61 /RVU
Radiology	\$16.93/RVU
Pathology	\$12.65/RVU

18-5 INSTRUCTIONS AND/OR MODIFICATIONS TO THE *RVP*

- (A) Maximum allowance for all providers under Rule 16-5 is 100 percent of the fees as defined in this Rule 18.
- (B) Interim relative value procedures (marked by an "I" in the left-hand margin of the *RVP*) are accepted as a basis of payment for services; however deleted Current Procedural Terminology codes (CPT codes marked by an "M" in the *RVP*) are not, unless otherwise advised by this rule. The American Medical Association's *Current Procedural Terminology (CPT) 2005* may be referenced for further clarification of descriptions and billing, but if conflicts arise between the *RVP* and the *CPT 2005*, the *RVP* shall prevail.
- (C) *CPT* Category III, temporary codes, may be used for billing with agreement of the payer as to reimbursement. Payment shall be in compliance with Rule 16-6(B).
- (D) Surgery/Anesthesia

(1) Anesthesia Section:(Codes range from 00100 – 01999, and 99100-99140)

- (a) All anesthesia base values shall be established by the use of the codes 00100 - 01999 as set forth in the *RVP*.
- (b) CPT codes 99100-99140, anesthesia add-on codes, are reimbursed using the anesthesia conversion factor (CF) and unit values found in the *RVP*, Anesthesia Guidelines IX, "Qualifying Circumstances."
- (c) Justifying documentation shall be submitted with the billing for all stand-by anesthesia.
- (d) When justified by a report, a second anesthesiologist can be reimbursed as recommended by the anesthesia guidelines in the *RVP*.
- (e) Surgery X Codes

- (1) The following codes limit the list found in the table under the "Anesthesia Value Guidelines" of the *RVP* Section X, "Anesthesia Services Where Time Units Are Not Allowed".

01995	01996	31500	36400	36420	36425
36600	36620	36625	36660	62273	62280
62281	62282	62310	62311	62318	62319
64400	64402	64405	64408	64410	64412
64413	64415	64416	64417	64418	64420
64421	64425	64430	64435	64445	64446
64447	64448	64450	64470	64472	64475
64476	64479	64480	64483	64484	64505
64508	64510	64520	64530	64600	64605
64610	64620	64622	64623	64626	64627
64630	64640	64680			

- (2) The maximum reimbursement for these codes shall be based upon the anesthesia value listed in the table in Section X multiplied by \$36.95 conversion factor. No additional unit values are added for time when calculating the maximum values for reimbursement.
- (3) When performing more than one surgery X code procedure in a single surgical setting, multiple surgery guidelines shall apply (100% of the listed value for the primary procedure and 50% of the listed value for additional procedures). Use modifier -51 to indicate multiple X code procedures performed on the same day during a single operative setting. The 50% reduction does apply to codes that are identified in the *RVP* as "Add-on" codes.
- (4) Codes from Table X not found above may be found in another section of the *RVP* (e.g., surgery). Any codes found in the table

under the “Anesthesia Value Guidelines” of the *RVP*, Section X, “Anesthesia Services Where Time Units Are Not Allowed” but not contained in this list (Rule 18-5(D)(1)(e)(1)) are reimbursed in accordance with the assigned units from their respective sections times their respective conversion factor.

- (2) Surgical Section: (Codes range from 10000-69999)
- (a) The use of assistant surgeons shall be limited according to the American College Of Surgeons' *2002 Study: Physicians as Assistants at Surgery* (April 2002), available from the American College of Surgeons, Chicago, IL, or from their web page at <http://www.facs.org/ahp/pubs/2002physasstsurg.pdf>, (accessed June 3, 2005). The incorporation is limited to the edition named and does not include later revisions or additions. Copies of the material incorporated by reference may be inspected at any State publications depository library. For information about inspecting or obtaining copies of the incorporated material, contact the Medical Fee Schedule Administrator, 633 17<sup>th</sup> Street, Suite 400, Denver, Colorado, 80202-3660. Where the publication restricts use of such assistants to "almost never" or a procedure is not referenced in the publication, prior authorization for payment shall be obtained from the payer.
  - (b) Incidental procedures are commonly performed as an integral part of a total service and do not warrant a separate benefit.
  - (c) No payment shall be made for more than one assistant surgeon or more than one minimum assistant surgeon without prior authorization unless a trauma team was activated due to the emergent nature of the injury(ies).
  - (d) The payer may use available billing information such as provider credential(s) and clinical record(s) to determine if an appropriate modifier should be used on the bill. To modify a billed code refer to Rule 16-11(B)(3).
  - (e) Non-physician providers, used as surgical assistants, shall use the modifier –81 and shall be reimbursed at 10 percent of the listed value.
  - (f) Starred (\*) surgical procedures have been deleted from the CPT coding nomenclature.
  - (g) Global period
    - (1) The following services performed during a global period would warrant separate billing if documentation demonstrates significant identifiable services were involved:
      - ◆ Evaluation and management services unrelated to the primary surgical procedure,

- ◆ Services necessary to stabilize the patient for the primary surgical procedure,
- ◆ Services not usually part of the surgical procedure, including an evaluation and management visit (E&M) by an authorized treating physician (ATP) for disability management.
- ◆ Unusual circumstances, complications, exacerbations, or recurrences,
- ◆ Unrelated diseases or injuries.

(2) Separate identifiable services shall use the –25 modifier in conjunction with the billed service.

(h) Intradiscal Electrothermal Annuloplasty (IDEA) -

This is a new procedure and prior authorization is required. A wire is guided into the identified painful disc using fluoroscopy. The wire is then heated within the disc. The goal of the procedure is to burn the nerves and to tighten the injured tissue within the disc. A physician well trained in the procedure must perform this procedure. Please refer to Rule 17, Exhibit 1, Section F.8 for the required surgical indications for this procedure.

Billing code and maximum fees are as follows:

Billing Code:	S2370	\$2,257.30
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Fees are inclusive of all levels and all professional services except, fluoroscopy guidance; see code 76005.

(E) Radiology Section: (Codes range from 70000 - 79999)

(1) General

- (a) The cost of dyes and contrast shall be reimbursed at 80 percent of billed charges.
- (b) Copying charges for X-Rays and MRIs shall be \$15.00/film regardless of the size of the film.

(2) Modifiers

- (a) The five-digit CPT code without a modifier indicates the provider performed both the professional and technical components of the radiological procedure.

- (b) If the provider supplies only the professional component, as defined in the Radiology Guidelines section of the *RVP* then the five-digit CPT code must carry a modifier –26.
- (c) Modifier –27 is not recognized for the technical component of a radiological procedure. If the provider supplies only the technical component, as defined in the Radiology Guidelines section of the *RVP* the five-digit CPT code must carry a modifier TC.
- (d) The payer may use available billing information such as provider credential(s) and clinical record(s) to determine if an appropriate modifier should be used on the bill. To modify a billed code, refer to Rule 16-11(B)(3).

(3) Thermography

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

American Academy of Thermology;

American Chiropractic College of Infrared Imaging.

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

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

Sympathetically Maintained Pain (SMP);

Autonomic neuropathy;

Chronic Neuropathic Pain (involving small caliber sensory fiber neuropathy).

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

- (d) Thermography Billing Codes:

79993 Upper body w/ Autonomic Stress Testing \$840.00

79995 Lower body w/Autonomic Stress Testing \$840.00

79997 Whole Body w/Autonomic Stress Testing \$1,260.00

When whole body thermography is performed, only "whole body" billing codes can be used; do not use separate upper and lower body billing codes and fees.

- (e) Prior authorization for payment is required for thermography services only if the requested study does not meet the indicators for thermography as outlined in this radiology section. The billing shall include a report supplying the thermographic evaluation and reflecting compliance with Rule 18-5(E)(3).

(F) Pathology Section: (Codes range from 80000 - 89999)

(1) Modifiers

- (a) The five-digit CPT code without a modifier indicates the provider performed both the professional and technical components of the pathological procedure.
- (b) If the provider supplies only the professional component, as defined in the Pathology and Laboratory Guidelines section of the *RVP*, then the five-digit CPT code must carry a modifier –26.
- (c) Modifier –27 is not recognized for the technical component of a pathology procedure. If the provider supplies only the technical component, as defined in the Pathology and Laboratory Guidelines section of the *RVP*, the five-digit CPT code must carry a modifier -TC.
- (d) The payer may use available billing information such as provider credential(s) and clinical record(s) to determine if an appropriate modifier should be used on the bill. To modify a billed code refer to Rule 16-11(B)(3).

(G) Medicine Section: (Codes range from 90000 - 96999 and 98925 - 99199)

- (1) Medicine codes 99500-99602 in the *RVP* are not adopted. For appropriate codes see Rule 18-6(N).
- (2) Codes 99100-99140 are reimbursed in accordance with the anesthesia section of Rule 18.
- (3) Biofeedback (Codes: 90901, 90911)

Prior authorization for payment shall be required from the payer after 12 visits. A licensed physician or psychologist shall prescribe all services and include the number of sessions. Session notes shall be periodically reviewed by the prescribing physician to determine the continued need for the service. All services shall be provided or supervised by an appropriate recognized provider as listed under Rule 16-5. Supervision shall be as defined in an applicable Rule 17 medical treatment guideline. Persons providing biofeedback shall be certified

by the Biofeedback Certification Institution of America, or be a licensed physician or psychologist, as listed under Rule 16-5(A)(1)(a) and (b) with evidence of equivalent biofeedback training.

- (4) Osteopathic (DO) and Medical (MD) Manipulation: (Codes range from 98925 - 98929)

Evaluation and management (E&M) services can be billed separately when the provider's records document significant and identifiable services that are above and beyond the usual services required to perform manipulation. A modifier -25 on the E&M service is required when manipulation is also billed at the same visit for the same patient.

Prior authorization from the payer shall be obtained before billing for more than four body regions in one visit. Manipulative therapy is limited to no more than 34 visits. The provider's medical records shall reflect medical necessity and prior authorization for payment if treatment needs to exceed 34 visits.

For purposes of DO and MD manipulation, body regions referred to are: head region; cervical region; thoracic region; lumbar region; sacral region; pelvic region; lower extremities; upper extremities; rib cage region; abdomen and viscera region.

- (5) Chiropractic (DC) Manipulation: (Codes range from 98940 - 98943)

E&M services can be billed separately when the provider's records document significant and identifiable services that are above and beyond the services required to perform manipulation. A modifier -25 on the E&M service is required when manipulation is also billed at the same visit for the same patient.

Prior authorization from the payer shall be obtained before billing for more than four body regions in one visit. Manipulative therapy is limited to no more than 34 visits. The provider's medical records shall reflect medical necessity and prior authorization for payment if treatment needs to exceed 34 visits.

For purposes of DC manipulation, the five spinal regions referred to are: cervical regions (includes atlanto-occipital joint); thoracic region (includes costovertebral and costotransverse joints); lumbar region; sacral region; and pelvic (sacro-iliac joint) region. The five extraspinal regions referred to are: head region (including temporomandibular joint, excluding atlanto-occipital); lower extremities; upper extremities; rib cage (excluding costotransvers and costovertebral joints) and abdomen.

- (6) Psychiatric/Psychological Services: (Codes range from 90801-90899 and 96100-96117)

- (a) A licensed clinical psychologist is reimbursed a maximum of 90 percent of the medical fee listed in the *RVP*. Other non-physician providers

performing psychological/psychiatric services shall be paid at 75 percent of the fee allowed for physicians.

- (b) Most initial evaluations for delayed recovery can be completed in two (2) hours. Prior authorization for payment is required any time the following limitations are exceeded:

Evaluation Code: 90801-90802 limit: 4 hours

Testing Code: 96100-96117 limit: 6 hours

Psychotherapy Codes: 90804-90829 maximum allowance of 50 minutes per visit.

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 from the payer.

- (7) Hyperbaric Oxygen Therapy Services (Code 99183)

The maximum unit value shall be 24 units, instead of 14 units as listed in the *RVP* for code 99183.

- (H) Physical Medicine and Rehabilitation: (Codes range from 97001 – 97804)

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

- (1) Prior authorization is required for codes 97802-97804. See Rule 18-6(O)(10).

- (2) Recommendations

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

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

Prior authorization shall be obtained from the payer for any physical medicine treatment exceeding the recommendations of the medical treatment guidelines as set forth in Rule 17.

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

(4) Interdisciplinary Rehabilitation Programs – (Requires prior authorization)

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, rehabilitation programs may include, but are not limited to: chronic pain, spinal cord, or brain injury programs.

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

(5) Procedures 97110 – 97535, 97542

Unless the provider's medical records reflect medical necessity and the provider obtains prior authorization for payment from the payer to exceed the one-hour limitation, the maximum amount of time allowed is one hour of procedures per day, per discipline.

(6) Modalities

Codes 97010 – 97028, unattended

Codes 97032 – 97039, attended

Billing Restrictions: There is a total limit of two (2) modalities (whether attended or unattended) per visit per discipline.

NOTE: Instruction and application of a TENS unit for the patient's independent use shall be billed using attended therapy 97032.

(7) Evaluation Services for Therapists: Physical Therapy (PT), Occupational Therapy (OT) (97001 – 97004) and Athletic Trainers (cf. §12-36-106 C.R.S.) (97005-97006)

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

(b) Payers are only required to pay for evaluation services directly performed by a physical therapist (97001-97002), occupational therapist

(97003-97004) or athletic trainer, as defined in §12-36-106 C.R.S., (97005-97006). All evaluation notes or reports must be written and signed by the PT or OT. Physicians shall bill the appropriate E&M code from the E&M section (99201-99499) of the *RVP*.

- (c) A patient may be seen by more than one health care professional on the same day. An evaluation service with appropriate documentation may be charged for each professional per patient per day.
- (d) Reimbursement to physical therapists, occupational therapists, speech language pathologists and audiologists for coordination of care with professionals shall be based upon codes 99371-99373. Coordination of care reimbursement is limited to telephone calls made to professionals outside of the therapist's/pathologist's/audiologist's employment facility(ies) and/or to the injured worker or their family and the prescribing physician.
- (e) All interdisciplinary team conferences shall be billed under the case management services section in the *RVP* using codes 99361 or 99362.

(8) Special Tests

The following codes should be used for the respective tests:

97537	Job Site Evaluation
97750	Computer- Enhanced Evaluation
	Functional Capacity Evaluation
	Work Tolerance Screening
97755	Assistive technology assessment
96105 - 96115	Speech

(a) Billing Restrictions:

- (1) 97537 requires prior authorization if exceeding 2 hours. 97750 requires prior authorization for payment for more than 4 hours.
- (2) The provider shall specify the time required to perform the test in 15-minute increments.
- (3) The value for the analysis and the written report is included in the billing rate codes.
- (4) No E&M services or PT, OT, or acupuncture evaluations shall be charged separately for these tests.

(5) Reports from computerized equipment include a supporting analysis developed by the physical medicine professional performing the evaluation.

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

(9) Speech Therapy/Evaluation and Treatment

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

(10) Supplies

See Rule 18-6(H).

(11) Unattended Treatment

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

97152	fixed fee per day	1.5 RVU
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(12) Non-Medical Facility

Fees, such as gyms, pools, etc., and training or supervision by non-medical providers require prior authorization from the payer and a written negotiated fee.

(13) Unlisted Service Physical Medicine

All unlisted services or procedures require a report.

(14) Work Conditioning, Work Hardening, Work Simulation

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

Restriction: Maximum daily time is two (2) hours per day without additional prior authorization.

(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.

- (c) Work Simulation is a program where an individual completes specific work-related tasks for a particular job and return to work. Use of this program is appropriate when modified duty can only be partially accommodated in the work place, when modified duty in the work place is unavailable, or when the patient requires more structured supervision. The need for work simulation should be based upon the results of a functional capacity evaluation and/or job analysis. Refer to Rule 17, Medical Treatment Guidelines.
- (d) For Work Conditioning, Work Hardening, or Work Simulation, the following apply.
  - (1) Prior authorization is required.
  - (2) Provider Restrictions: All procedures must be performed by or under the onsite supervision of a physician, physical therapist, occupational therapist, speech language pathologist or audiologist.
  - (3) Billing Codes: 97545 and 97546.

(I) Evaluation and Management Section (Codes range from 99201 – 99499)

- (1) E&M Service Medical Record Documentation to Determine Correct Billing/Reimbursement Code

Medical record documentation shall encompass the *RVP* "E&M Guideline" criteria to justify the billed Evaluation and Management service. If 50 percent of the time spent with an injured worker during an E&M visit is disability counseling, then time can determine the 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. Disability counseling shall include, but not be limited to, return to work, temporary and permanent work restrictions, self management of symptoms while working, correct posture/mechanics to perform work functions, job task exercises for muscle strengthening and stretching, and appropriate tool and equipment use to prevent re-injury and/or worsening of the existing injury.

(2) New or Established Patients

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

(3) Number of Office Visits

All providers, as defined in Rule 16-5.A-C, are limited to one office visit per patient per day per workers’ compensation claim unless prior authorization is obtained from the payer. The E&M Guideline criteria as specified in the *RVP* E&M Section shall be used in all office visits to determine the appropriate level.

(4) Case Management

(a) Case management codes 99361 - 99373 found in the evaluation and management section of the *RVP* may be billed if the services are performed on a separate day from an E&M office visit and when the medical records/documentation specifies all the following:

- (1) the amount of time and date;
- (2) the person or person(s) talked to; and
- (3) the discussion and/or decision made during the call to coordinate care for the injured worker.

(b) An interdisciplinary team conference, consisting of medical professionals caring for the injured worker, shall select a team member to perform the following duties:

- (1) Prepare the billing statement in accordance with Rule 16, Utilization Standards,
  - ◆ One conference charge per facility per patient per day.
  - ◆ Reimbursement for each interdisciplinary team conference shall be determined in 15-minute increments. Fifteen-minute conferences shall be reimbursed using code 99361 reducing the maximum allowance to 50 percent of the total value of the code.
- (2) Prepare and submit a written report for each conference including at least the following information:
  - ◆ Patient's identifying information;

- ◆ Diagnosis;
- ◆ Medical professionals attending the conference;
- ◆ A brief statement of conference recommendations and actions (no additional allowance shall be made for this statement); and
- ◆ Length of time of meeting.

18-6 DIVISION ESTABLISHED CODES AND VALUES

(A) Conferences Held at the Request of a Party

Telephonic or face-to-face conferences shall be related to the injured worker's treatment. All parties shall receive actual notification from the requesting party in advance and within 24 hours of scheduling.

99901 Maximum of \$225.00 per hour;

billed at \$56.25 per 15-minute increments.

(B) Cancellation Fees For Payer Made Appointments

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

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

\$150.00, whichever is less.

Cancellation Fee Billing Code: 99910

- (2) Missed Appointments:

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

(C) Copying Fees

The payer, payer's representative, injured worker and injured worker's representative shall pay a reasonable fee for the reproduction of the injured worker's medical record. Reasonable cost shall not exceed \$14.00 for the first 10 or fewer pages, \$0.50 per page for pages 11-40, and \$0.33 per page thereafter. Actual postage or shipping costs and

applicable sales tax, if any, also may be charged. The per-page fee for records copied from microfilm shall be \$1.50 per page.

Copying Fee Billing Code: 99911

(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 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:

(2) Deposition:

Payment for a physician's testimony at a deposition shall not exceed 35 RVU per hour times the medicine conversion factor (\$7.41) billed in 0.5-hour increments. Calculation of the physician's time shall be "portal to portal."

The physician may request a full hour deposit in advance in order to schedule the deposition.

By prior agreement with the deposing party, the physician may charge for preparation time or for reviewing and signing the deposition.

The physician shall refund to the deposing party, any portion of an advance payment in excess of time actually spent preparing and/or testifying when the physician is notified of the cancellation of the deposition at least three (3) business days prior to the scheduled deposition.

However, if the provider is not notified at least three (3) business days in advance of a cancellation, or the deposition is shorter than the time scheduled, the provider shall be paid the number of hours he or she has reasonably spent in preparation and has scheduled for the deposition.

Deposition Billing Code: 99075 at 35 units per hr.

Billed in half-hour increments

(3) Testimony:

Calculation of the physician's time shall be "portal to portal."

For testifying at a hearing, the physician may request a four (4) hour deposit in advance in order to schedule the testimony.

By prior agreement, the physician may charge for preparation time for testimony.

The physician shall refund any portion of an advance payment in excess of time actually spent preparing and/or testifying when the physician is notified of the cancellation of the hearing at least five (5) business days prior to the date of the hearing.

However, if the provider is not notified of a cancellation at least five (5) business days prior to the date of the hearing, or the hearing is shorter than the time scheduled, the provider shall be paid the number of hours he or she has reasonably spent in preparation and has scheduled for the hearing.

Testimony Billing Code: 99085

Maximum Rate of \$400.00 per hour

(E) Mileage Expenses

The payer shall reimburse an injured worker for reasonable and necessary mileage expenses for travel to and from medical appointments and reasonable mileage to obtain prescribed medications. The reimbursement rate shall be 30 cents per mile. The injured worker shall submit a statement to the payer showing the date(s) of travel and number of miles traveled, with receipts for any other reasonable and necessary travel expenses incurred.

Mileage Expense Billing Code: 99912

(F) Permanent Impairment Rating

(1) The payer is only required to pay for one combined whole-person permanent impairment rating per claim, except as otherwise provided in these Workers' Compensation Rules of Procedures. The authorized treating provider is required to submit in writing all permanent restrictions and future maintenance care related to the injury or occupational disease.

(2) Provider Restrictions

The permanent impairment rating shall be determined by the authorized treating physician, if Level II accredited, or by a Level II accredited physician selected by the authorized treating provider.

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

When physicians determine the injured worker is at MMI and has no permanent impairment, the physicians should be reimbursed an appropriate level of E&M service and the fee for completing the Physician's Report of Workers' Compensation Injury (Closing Report), WC164 (See Rule 18-6(G)(2)). Reimbursement for the appropriate level of E&M service is only applicable if the physician examines the injured worker and meets the criteria as defined in the *RVP*.

(4) MMI Determined with a Calculated Permanent Impairment Rating

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

(b) Billing Codes and Reimbursement for MMI with a Calculated Permanent Impairment Rating:

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

99455 Reimbursed for 1.5 hours with a maximum not to exceed \$309.27.

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

99456 Reimbursed for 2.5 hours with a maximum not to exceed \$594.75.

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

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

(G) Report Preparation

(1) Routine Reports

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

Diagnostic Testing

Procedure Reports

Progress notes

Office notes

Operative reports

Supply invoices, if requested by the payer

Requests for second copies of routine reports are reimbursable under the copying fee section of Rule 18.

(2) Completion of WC164 Form

(a) Initial Report

The completed "Physician's Report of Workers' Compensation Injury" (WC164) initial report is submitted to the payer after the first visit with the injured worker. 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 "Physician's Report of Workers' Compensation Injury" (WC164) closing report is required from the authorized treating physician when an injured worker is at maximum medical improvement and/or has a permanent impairment. A physician may bill for the completion of the WC164 if neither code 99455 nor 99456 (see Rule 18-6(F)(4)) are billed. The form requires the completion of items 1-5, 6 b-c, 7, 8 and 10. If the injured worker has sustained a permanent impairment, then Item 9 must be completed and the following additional information shall be attached to the bill at the time MMI is determined:

- (1) All necessary permanent impairment rating reports when the authorized treating physician is Level II Accredited, or
- (2) The name of the Level II Accredited physician designated to perform the permanent impairment rating when a rating is necessary and the authorized treating physician is not determining the permanent impairment rating.

(c) Payer Requested WC164 Form

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

(d) Provider Initiated WC164 Form

If the provider wants to use the WC164 Form as a progress report or for any purpose other than those designated here in Rule 18-6(G)(2)(a), (b)

or (c)), and seeks reimbursement for completion of the form, the provider shall get prior approval from the payer.

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

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

99960	\$42.00	Initial Report
99961	\$42.00	Progress Report (Payer Requested or Provider Initiated)
99962	\$42.00	Closing Report
99963	\$42.00	Initial report including closing report on the same date of service

(3) Special Reports

The term special reports includes reports falling outside the requirements set forth in Rule 16, Utilization Standards, Rule 17, Medical Treatment Guidelines and Rule 18 and includes any form, questionnaire or letter with variable content. Reimbursement for preparation of special reports or records shall require prior agreement with the requesting party. In special circumstances (e.g., when reviewing and/or editing is necessary) and when prior agreement is made with the requesting party, institutions, clinics or physicians' offices may charge additional sums.

Special Report Preparation Billing Code:

99080 not to exceed \$225.00-per hour.

Billed in half hour increments.

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.

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

(1) Payment for supplies shall reflect the provider's actual cost plus a 20 percent markup. Cost includes shipping and handling charges.

(2) Reimbursement for durable medical equipment (DME), orthotic and prosthetic devices may be based upon an appropriate CMS (Medicare) Healthcare

Common Procedure Coding System (HCPCS) Level II Code as a reasonable means for determining a fee unless CMS (Medicare) fees do not meet the provider's actual cost in which case the reimbursement would be cost plus 20 percent.

- (3) "Supply et al." means any single supply, durable medical equipment (DME), orthotic, prosthesis or single drug dose, that costs the provider an amount greater than \$300.00, and all implants regardless of their cost. Reimbursement shall have a maximum allowance of the provider's actual cost plus 20 percent.
- (4) 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 provisions outlined in the physical medicine and rehabilitation section of the *RVP*.

Supplies Billing Code: 99070

(I) Inpatient Hospital Facility Fees

(1) Provider Restrictions

All non-emergency, inpatient admissions require prior authorization for payment.

(2) Bills for Services

(a) Inpatient hospital facility fees shall be billed on the UB-92 and require summary level billing by revenue code. The provider must submit itemized bills along with the UB-92.

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

The hospital shall indicate the DRG code number in the remarks section (form locator 78) of the UB-92 billing form and maintain documentation on file showing how the DRG was determined. The hospital shall determine the DRG using the *DRGs Definition Manual*. The attending physician shall not be required to certify this documentation unless a dispute arises between the hospital and the payer regarding DRG assignment. The payer may deny payment for services until the appropriate DRG code is supplied.

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

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

(3) Inpatient Facility Reimbursement:

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

- (1) Children's hospital
- (2) Veterans' Administration hospital
- (3) State psychiatric hospital

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

- (1) Medicare certified Critical Access Hospital (CAH) (listed in Exhibit 3 of Rule 18)
- (2) Medicare certified long-term care hospital
- (3) Colorado Department of Public Health and Environment (CDPHE) licensed Rehabilitation, and,
- (4) CDPHE licensed psychiatric facilities that are privately owned.

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

Retrieve the relative weights for the assigned DRG from the DRG table in Exhibit 1 to Rule 18 and locate the hospital's base rate in Exhibit 2 to Rule 18.

The "Maximum Fee Allowance" is determined by calculating:

- (1)  $(\text{DRG Relative Wt} \times \text{Specific hospital base rate} \times 200\%) + (\text{cost plus } 20\% \text{ for all "supply et al."})$
- (2) "Supply et al." means any single supply, durable medical equipment (DME), orthotic, prosthesis or single drug dose, that costs the provider an amount greater than \$300.00, and all implants regardless of their cost.

Reimbursement shall be at cost to the provider plus 20%. The billing provider is responsible for identifying and itemizing all "Supply et al." items. If there is any question regarding the cost

of an item, the billing provider shall provide documentation of their cost for the billed "supply et al." item(s).

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

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

total billed charges (excluding any "supply et al." billed charges) times the hospital's cost-to-charge ratio.

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

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

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

"Difference" x .80 = additional fee allowance

(e) 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 DRG maximum value. The per diem value is calculated based upon the transferring hospital's DRG relative weight multiplied by the hospital's specific base rate (Exhibit 2 to Rule 18) divided by the DRG geometric mean length of stay. This per diem amount is multiplied times 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 DRG maximum value.

(J) Scheduled Outpatient Surgery Facility Fees

(1) Provider Restrictions

(a) All non-emergent outpatient surgeries require prior authorization from the payer.

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

(1) a hospital; or

(2) an Ambulatory Surgery Center (ASC).

(2) Bills for Services

- (a) Outpatient facility fees shall be billed on the UB-92 and require summary level billing by revenue code. The provider must submit itemized bills along with the UB-92.
- (b) All professional charges are subject to the RVP and Dental fee schedules as incorporated by Rule 18.
- (c) ASCs and hospitals shall bill using the surgical CPT code(s) as indicated by the surgeon's operative note up to a maximum of four surgery codes per surgical episode.

(3) Outpatient Surgery Facility Reimbursement:

- (a) The following types of inpatient facilities are reimbursed at 100% of billed inpatient charges:
  - (1) Children's hospital
  - (2) Veterans' Administration hospital
  - (3) State psychiatric hospital
- (b) CAHs, listed in Exhibit 3 of Rule 18, are to be reimbursed at 80% of billed charges.
- (c) All other outpatient surgery facilities are reimbursed based on the following:

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

- (1) The primary surgical code value plus 50% of any lesser-valued surgical code values. Surgical code values are in Exhibit 4.

Multiple procedures and bilateral procedures are to be indicated by the use of modifiers –51 and –50, respectively. The 50% reduction applies to all lower valued procedures.

Facility fee reimbursement is limited to a maximum of four surgical codes per surgical episode.

The following surgical codes not found in Exhibit 4 are to be billed using the appropriate radiological codes with a TC modifier:

23350	73040
25246	73115

62284	72240-72270
62290	72295 for each level
62291	72285 for each level

- (2) The provider's cost plus 20% of any "Supply et al." item(s). "Supply et al." means any single supply, durable medical equipment (DME), orthotic, prosthesis or single drug dose, that costs the provider an amount greater than \$300.00, and all implants regardless of their cost.

The billing provider is responsible for identifying and itemizing all "supply et al." items. If there is any question regarding the cost of an item, the billing provider shall provide documentation of their cost for the billed "supply et al." item(s).

- (3) Diagnostic testing and preoperative labs are reimbursed by applying the appropriate conversion factor to the unit values for the specific CPT code as listed in the RVP and Rule 18. and

- (4) Observation room maximum allowance shall not exceed a rate of \$50.00 an hour and is limited to a maximum of 6 hours without prior authorization. Documentation should support the medical necessity for observation.

- (d) The listed surgery code value in Exhibit 4 of this rule 18 includes reimbursement for:

- (1) nursing,
- (2) technician and related services,
- (3) use by the recipient of the facility including the operating room and recovery room,
- (4) drugs, biologics, surgical dressings, supplies, splints, cases and appliances,
- (5) equipment directly related to the provision of surgical procedures,
- (6) fluoroscopy and x-rays during the surgical episode,
- (7) administration, record keeping, housekeeping items and services,
- (8) intraocular lenses, and

- (9) materials for anesthesia.
- (e) Additional reimbursement is payable for code values not included in the surgery code value in Exhibit 4 of Rule 18:
  - (1) physicians,
  - (2) laboratory services,
  - (3) pre-operative diagnostic labs and x-rays, EKGs, etc.,
  - (4) ambulance services,
  - (5) blood, blood plasma, platelets,
  - (6) observation room,
  - (7) any "supply et al.,"
  - (8) all implants.
- (f) Prior authorization is required for any non-emergent outpatient surgery not listed in Exhibit 4 that warrants a separate facility fee in order to provide a safe environment for the procedure to be performed. Separate facility fees are only warranted when the procedure(s) performed produces a risk to the injured worker if the procedure is not performed in a facility where credentialed emergency equipment and personnel are maintained, including but not limited to, any procedure requiring the administration of regional or general anesthesia. Minor procedures, including but not limited to, laceration repairs and trigger point injections, do not routinely warrant a separate facility fee as a scheduled outpatient surgery.

If an outpatient surgery procedure not found in Exhibit 4 is warranted and the payer authorizes the surgery, the maximum fee is to be commensurate with other similar procedures that are found in Exhibit 4 (i.e., CMS, APC payment rate times 200%).

(K) Outpatient Diagnostic Testing and Clinic Facility Fees

- (1) Bills for Services
  - (a) All providers shall indicate whether they are billing for the total component of a diagnostic test on a UB-92.
  - (b) If the technical component only is being billed, the modifier "-TC" shall be appended to the respective CPT billing code(s).

- (c) If the professional component only is being billed, the provider shall bill on a CMS 1500 with the “-26” modifier appended to the CPT code(s).

(2) Reimbursement

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

- (1) Children’s hospitals,
- (2) Veterans’ Administration hospitals
- (3) State psychiatric hospitals

- (b) Primary rural health facilities are reimbursed at 80% of billed charges for clinic visits and diagnostic testing. Primary rural health facilities are listed in Exhibit 5.

- (c) All other facilities:

- (1) No allowance for clinic visit fees.
- (2) Clinic fees for diagnostic testing are considered part of the CPT code value’s technical component. Outpatient diagnostic testing is reimbursed using the RVP CPT code unit value times the applicable conversion factor.

(L) Outpatient Urgent Care Facility Fees

(1) Provider Restrictions:

- (a) Prior agreement or authorization is necessary for all facilities wishing to be allowed a separate Urgent Care fee.

- (b) Urgent care facility fees are only payable if the facility qualifies as an Urgent Care facility. The facility shall meet all of the following criteria to be eligible for a separate Urgent Care facility fee:

- (1) Separate facility dedicated to providing initial walk-in urgent care
- (2) Access without appointment during all operating hours.
- (3) State licensed physician on-site at all times exclusively to evaluate walk-in patients.
- (4) Support staff dedicated to urgent walk-in visits with certifications in Basic Life Support (BLS).

- (5) Advanced Cardiac Life Support (ACLS) certified life support capabilities to stabilize emergencies including, but not limited to, EKG, defibrillator, oxygen and respiratory support equipment (full crash cart), etc.
  - (6) Ambulance access
  - (7) Professional staff on-site at the facility certified in ACLS
  - (8) Extended hours including evening and some weekend hours
  - (9) Basic X-ray availability on-site during all operating hours
  - (10) Clinical Laboratory Improvement Amendments (CLIA) certified laboratory on-site for basic diagnostic labs or ability to obtain basic laboratory results within 1 hour
  - (11) Capabilities include, but are not limited to, suturing, minor procedures, splinting, IV medications and hydration
  - (12) Written procedures exist for the facility's stabilization and transport processes.
- (c) No separate facility fees are allowed for follow-up care. Subsequent care for an initial diagnosis does not qualify for a separate facility fee, unless the subsequent diagnosis is a new acute care situation and is entirely different from the initial diagnosis.
- (2) Bills for Services
- (a) Urgent care facility fees may be billed on a CMS 1500
  - (b) Urgent care facility fees shall be billed using HCPCS Level II code: S9088 – "Services provided in an Urgent care facility."
- (3) Urgent Care Reimbursement

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

- (a) An Urgent Care Facility fee maximum allowance of \$75.00,
- (b) "Supply et al." means any single supply, durable medical equipment (DME), orthotic, prosthesis or single drug dose, that costs the provider an amount greater than \$300.00, and all implants regardless of their cost or billed amount.

Reimbursement shall be at cost to the provider plus 20%. The billing provider is responsible for identifying and itemizing all "supply et al." items. If there is any question regarding the cost of an item, the billing

provider shall provide documentation of their cost for the billed "supply et al." item(s). Routine supplies, drugs and treatment rooms are included in the Urgent Care maximum fees.

- (c) All diagnostic testing, laboratory services and therapeutic services (including, but not limited to, radiology, pathology, respiratory therapy, physical therapy or occupational therapy) shall be reimbursed by multiplying the appropriate conversion factor times the unit value for the specific CPT code as listed in the RVP and Rule 18.
- (d) The Observation Room allowance shall not exceed a rate of \$50.00 per hour and is limited to a maximum of 3 hours without prior authorization.

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

(1) Provider Restrictions

All outpatient ERDs must be licensed by the CDPHE.

(2) Bills For Services

- (a) ERD facility fees shall be billed on the UB-92 and require summary level billing by revenue code. The provider must submit itemized bills along with the UB-92.
- (b) Documentation should support the "Level of Care" being billed.

(3) ERD Reimbursement

- (a) The following types of facilities are reimbursed at 100% of billed ERD charges:
  - (1) Children's hospitals
  - (2) Veterans' Administration hospitals
  - (3) State Psychiatric hospitals
- (b) Medicare certified Critical Access Hospitals (CAH) (listed in Exhibit 3 of Rule 18) are reimbursed at 80% of billed charges.
- (c) The ERD "Level of Care" is identified based upon one of five levels of care. The level of care is determined by the total number of points accumulated by assigning points to interventions completed by the ERD staff during an ERD visit. All levels of care include the following baseline level of care interventions:
  - (1) Registration,

- (2) Triage,
  - (3) Initial nursing assessment,
  - (4) Periodic vital signs (as appropriate),
  - (5) 1 limited intervention which utilizes minimal resources (e.g. administration of an oral medication, obtaining blood for CBC, visual acuity, rapid strep),
  - (6) Discharge instructions,
  - (7) Exam room set up and clean up.
  - (8) These activities are equivalent to “Zero” (0) points.
- (d) Additional ER staff interventions exceeding the baseline “Level of Care” have the following assigned points:

<u>Additional Interventions</u>	<u>Points</u>
Extended Triage	2
Extended Initial Nursing Assessment	3
Extended Nursing Discharge and arrangements	3
Nursing Reassessment (excluding vital signs) – each	3
Starting IV (with or without lab tests)	3
Other lab tests, obtaining specimen (each)	1
EKG – each	1
Patient transport (non-RN)	2
Accompany & remaining with patient to radiology, CT, etc. (RN)	7
All types of continuous Monitoring –each type (e.g., pulse ox – cardiac monitor)	1
Insertion of tubes – each (NG, Foley)	4
Administration of medications – oral	2
Administration of medications – IV, IM, suppository, SC	2
Initiation of oxygen therapy	1

Wound care dressing	
Simple	1
Intermediate	2
Complex	3
Assisting physician with complex exam or procedure	5
Chaperone exam or minimal assist	2
Other interventions – only if requiring more than 10 minutes staff time	3
Restraint application	4
Patient family Education – simple	1
Patient Education – complex	3
Consultation with other physicians/departments	1
Blood product administration –each unit	2

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

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

Code	Total Additional Intervention Points	Reimbursement
99281	0-10	\$ 120.00
99282	11-20	\$ 160.00
99283	21-30	\$ 250.00
99284	31-40	\$ 500.00
99285	41+	\$ 1,500.00

(2) All diagnostic testing, laboratory services and therapeutic services (including, but not limited to, radiology, pathology, any respiratory therapy, PT or OT) shall be reimbursed by the

appropriate conversion factor times the unit value for the specific CPT code as listed in the RVP and Rule 18.

- (3) The observation room allowance shall not exceed a rate of \$50.00 per hour and is limited to a maximum of 3 hours without prior authorization. The documentation should support the medical necessity for observation.
- (4) Routine supplies and treatment rooms are included in the ERD Level of Care maximum fees. However, any "supply et al." may be reimbursed separately at the provider's cost plus 20%.

"Supply et al." means any single supply, durable medical equipment (DME), orthotic, prosthesis or single drug dose, that costs the provider an amount greater than \$300.00, and all implants regardless of their cost.

The billing provider is responsible for identifying and itemizing all "supply et al." items. If there is any question regarding the cost of an item, the billing provider shall provide documentation of their cost for the billed "supply et al." items(s).

- (f) If the injured worker is admitted to the hospital, the ERD reimbursement is included in the inpatient reimbursement under 18-6(1)(3).
- (g) Trauma Center Fees are not paid for alerts. Activation fees are as follows:

Level I	\$3,000.00
Level II	\$2,500.00
Level III	\$1,000.00
Level IV	\$00.00

- (1) These fees are in addition to ER and inpatient fees.
- (2) Activation Fees mean a Trauma Team has been activated, not just alerted.

(N) Home Therapy

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

- (1) Home Infusion Therapy

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

- (a) Parenteral Nutrition:
  - 0 -1 liter                      \$140.00/day
  - 1.1 - 2.0 liter                \$200.00/day
  - 2.1 - 3.0 liter                \$260.00/day
  
- (b) Antibiotic Therapy:
  - \$105.00/day + AWP
  - (Average Wholesale Price)
  
- (c) Chemotherapy:
  - \$ 85.00/day + AWP
  
- (d) Enteral nutrition:
  - Category I                      \$ 43.00/day
  - Category II                     \$ 41.00/day
  - Category III                    \$ 52.00/day
  
- (e) Pain Management:        \$ 95.00/day + AWP
  
- (f) Fluid Replacement:       \$ 70.00/day + AWP
  
- (g) Multiple Therapies:
  - Highest cost therapy + AWP
  - only cost for remaining therapy

Medication/Drug Restrictions - the payment for drugs may be based upon the average wholesale price (AWP) of the drug as determined through the use of industry publications such as the monthly *Price Alert*, First Databank, Inc.

- (2) Nursing Services
  - 99970 Skilled Nursing (LPN & RN)

\$95.79 per hour

There is a limit of 2 hours without prior authorization.

99972 Certified Nurse Assistant (CNA):

\$31.67 per hour for the first hour;

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

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

(3) Physical Medicine

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

(4) Travel Allowances

Travel is typically included in the fees listed. Any extensive travel may need to be billed separately. Travel allowances should be agreed upon with the payer and should not exceed \$28.00 per visit, portal to portal. The \$28.00 allowance includes mileage.

Bill code: 99971

(O) Pharmacy Fees

- (1) Average Wholesale Price (AWP) + \$4.00
- (2) All bills shall reflect the National Drug Code (NDC)
- (3) All prescriptions shall be filled with bio-equivalent generic drugs unless the physician indicates "Dispense As Written" (DAW) on the prescription.
- (4) The above formula applies to both brand name and generic drugs.
- (5) The provider shall dispense no more than a 60-day supply per prescription.
- (6) A line-by-line itemization of each drug billed and the payment for that drug shall be made on the payment voucher by the payer.
- (7) AWP for brand name and generic pharmaceuticals may be determined through the use of such monthly publications as *Price Alert*, First Databank, Inc.

(8) Compounding Pharmacies

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

Bill Code:

99913 Materials, mailing, handling

99914 Pharmacist

(9) Injured Worker Reimbursement

The payer is responsible for timely payment of pharmaceutical costs (see Rule 16-11(A)(3)). In the event the injured worker has directly paid pharmaceutical costs, the payer shall reimburse the injured worker for actual costs incurred for authorized pharmacy services. If the actual costs exceed the maximum fee allowed by this rule, the payer may seek a refund from the dispensing provider for the difference between the amount charged to the injured worker and the maximum fee. Each request for a refund shall indicate the prescription number and the date of service involved.

(10) Dietary Supplements, Vitamins and Herbal Medicines

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

(11) Prescription Writing

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

(12) Provider Reimbursement

Provider offices that prescribe and dispense medications from their office have a maximum allowance of AWP plus \$4.00.

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

(13) Required Billing Forms

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

- (1) CMS 1500 (formerly HCFA 1500) – the dispensing provider shall bill by using the procedure code 99070 and shall include the

metric quantity and National Drug Code (NDC) number of the drug being dispensed; or

- (2) WC -M4 form or equivalent – each item on the form shall be completed, or
- (3) With the agreement of the payer, the National Council for Prescription Drug Programs (NCPDP) or ANSI ASC 837 (American National Standards Institute Accredited Standards Committee) electronic billing transaction containing the same information as in (1) or (2) in this sub-section.

- (b) Items prescribed for the work-related injury that do not have an NDC code shall be billed as a supply, using procedure code 99070 for the billed supply.
- (c) The payer may return any prescription billing form if the information is incomplete.
- (d) A signature shall be kept on file indicating the patient or his/her authorized representative has received the prescription.

(P) Complementary Alternative Medicine (CAM) (Requires prior authorization)

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

(Q) Acupuncture

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

(1) Provider Restrictions

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

(2) Billing Restrictions

- (a). For treatments of more than fourteen (14) sessions or for services beyond the following billing codes, the provider must obtain prior authorization from the payer.
- (b) Unless the provider's medical records reflect medical necessity and the provider obtains prior authorization for payment from the payer to exceed the one-hour limitation, the maximum amount of time allowed is one hour of procedures per day, per discipline for procedure codes 97110-97535 and 97810-97814.

(3) Billing Codes:

- (a) Code 97810 represents one or more needles, without electrical stimulation, for the initial 15 minutes of personal one-on-one contact with patient, full body;
- (b) Code 97811 represents each additional 15 minutes of personal one-on-one contact with the patient with re-insertion of needle(s) without electrical stimulation. No application of multiple procedure guidelines for reduction of value is used with this code.
- (c) Code 97813 represents acupuncture, one or more needles, with electrical stimulation, initial 15 minutes of personal one-on-one contact
- (d) Code 97814 represents each additional 15 minutes of personal one-on-one contact with the patient with electrical stimulation. No application of multiple procedure guidelines for reduction of value is used with this code.
- (e) Non-Physician evaluation services
  - (1) New or established patient services are reimbursable only if the medical record specifies the appropriate history, physical examination, treatment plan or evaluation of the treatment plan. Payers are only required to pay for evaluation services directly performed by an LAc. All evaluation notes or reports must be written and signed by the LAc.
  - (2) LAc new patient visit: 97041;  
Maximum value \$83.20.
  - (3) LAc established patient visit: 97044;  
Maximum value \$56.16.
- (f) Herbs require prior authorization and fee agreements as in this Rule 18-6(P)6);

- (g) See the appropriate physical medicine and rehabilitation section of the RVP for other billing codes and limitations (Rule 18-5.H).
- (h) The cost of disposable acupuncture needles is reimbursed at the provider's cost plus 20%.

#### 18-7 DENTAL FEE SCHEDULE

The dental schedule is adopted using the American Dental Association's *Current Dental Terminology*, Fourth Edition (CDT-4). However, surgical treatment for dental trauma and subsequent, related procedures shall be billed using codes from the *RVP*. Reimbursement shall be in accordance with the surgery/anesthesia section of the *RVP*, its corresponding conversion factors, the Division's Rule 16, Utilization Standards, and Rule 17, Medical Treatment Guidelines. See Exhibit 6 for the listing and maximum allowance for dental codes.