

# 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 2008 edition of the *Relative Values for Physicians (RVP®)*, developed by Relative Value Studies, Inc., published by Ingenix® St. Anthony Publishing, the *Current Procedural Terminology CPT® 2008*, Professional Edition, published by the American Medical Association (AMA) and *Medicare Severity Diagnosis Related Groups (MS-DRGs) Definitions Manual, Version 26.0* (DRGs Definitions Manual) developed and published by 3M Health Information Systems using MS-DRGs effective after October 1, 2008. The incorporation is limited to the specific editions named and does not include later revisions or additions. For information about inspecting or obtaining copies of the incorporated materials, contact the Medical Fee Schedule Administrator, 633 17th Street, Suite 400, Denver, Colorado 80202-3660. These materials may be examined at any state publications depository library. All guidelines and instructions are adopted as set forth in the RVP®, CPT® and MS-DRGs: Definitions Manual, unless otherwise specified in this rule.

This rule applies to all services rendered on or after January 1, 2009. 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® 2008*, copyrighted and distributed by the AMA and incorporated by reference in Rule 18-1.
- (B) DoWC – Colorado Division of Workers' Compensation created codes
- (C) MS-DRGs Definitions Manual – version 26.0 incorporated by reference in Rule 18-1.
- (D) RVP® – the 2008 edition incorporated by reference in Rule 18-1.
- (E) For other terms, see Rule 16, Utilization Standards.

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

All users are responsible for the timely purchase and use of Rule 18 and its supporting documentation as referenced herein. The Division shall make available for public review and inspection copies of all materials incorporated by reference in Rule 18. Copies of the RVP® may be purchased from Ingenix® St. Anthony Publishing, the *Current Procedural Terminology, 2008 Edition* may be purchased from the AMA, the MS-DRGs Definitions Manual may be purchased from 3M Health Information Systems, and the *Colorado Workers' Compensation Rules of Procedures with Treatment Guidelines, 7 CCR 1101-3*, may be purchased from LexisNexis

Matthew Bender & Co., Inc., Albany, NY. Interpretive Bulletins and unofficial copies of all rules, including Rule 18, are available on the Colorado Department of Labor and Employment web site at [www.coworkforce.com/DWC/](http://www.coworkforce.com/DWC/). An official copy of the rules is available on the Secretary of State's webpage <http://www.sos.state.co.us/CCR/Welcom.do>.

18-4 CONVERSION FACTORS (CF)

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

RVP© SECTION	CF
Anesthesia	\$ 49.87/RVU
Surgery	\$ 92.79/RVU
Surgery X Procedures (see Rule 18-5(D)(1)( d))	\$ 38.07/RVU
Radiology	\$ 17.43/RVU
Pathology	\$ 12.99 /RVU
Medicine	\$ 7.56 /RVU
Physical Medicine Physical Medicine and Rehabilitation, Medical Nutrition Therapy and Acupuncture	\$ 5.57 /RVU
Evaluation & Management (E&M)	\$ 8.81/RVU

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

- (A) Maximum allowance for all providers under Rule 16-5 is 100% of the RVP© value or as defined in this Rule 18.
- (B) Unless modified herein, the RVP© is adopted for RVUs and reimbursement. Interim relative value procedures (marked by an "I" in the left-hand margin of the RVP©) are accepted as a basis of payment for services; however deleted CPT© codes (marked by an "M" in the RVP©) are not, unless otherwise advised by this rule. The CPT© 2008 is adopted for codes, descriptions, parenthetical notes and coding guidelines, unless modified in this rule.
- (C) Temporary codes listed in the RVP© may be used for billing with agreement of the payer as to reimbursement. Payment shall be in compliance with Rule 16-6(C).
- (D) Surgery/Anesthesia
  - (1) Anesthesia Section:
    - (a) All anesthesia base values shall be established by the use of the codes as set forth in the RVP©, Anesthesia Section. Anesthesia services are

only reimbursable if the anesthesia is administered by a physician or Certified Registered Nurse Anesthetist (CRNA) who remains in constant attendance during the procedure for the sole purpose of rendering anesthesia.

When anesthesia is administered by a CRNA:

- (1) Not under the medical direction of an anesthesiologist, reimbursement shall be 90% of the maximum anesthesia value,
  - (2) Under the medical direction of an anesthesiologist, reimbursement shall be 50% of the maximum anesthesia value. The other 50% is payable to the anesthesiologist providing the medical direction to the CRNA,
  - (3) Medical direction for administering the anesthesia includes performing the following activities:
    - Performs a pre-anesthesia examination and evaluation,
    - Prescribes the anesthesia plan,
    - Personally participates in the most demanding procedures in the anesthesia plan including induction and emergence,
    - Ensures that any procedure in the anesthesia plan that s/he does not perform is performed by a qualified anesthetist,
    - Monitors the course of anesthesia administration at frequent intervals,
    - Remains physically present and available for immediate diagnosis and treatment of emergencies, and
    - Provides indicated post-anesthesia care.
- (b) Anesthesia add-on codes are reimbursed using the anesthesia CF and unit values found in the RVP©, Anesthesia section's Guidelines XII, "Qualifying Circumstances." (Not under the Medicine section.)
- (c) The following modifiers are to be used when billing for anesthesia services:  
AA – anesthesia services performed personally by the anesthesiologist  
QX – CRNA service; with medical direction by a physician  
QZ – CRNA service; without medical direction by a physician  
QY – Medical direction of one CRNA by an anesthesiologist
- (d) Surgery X Procedures
- (1) The surgery X procedures are limited to those listed below and found in the table under the RVP©, Anesthesia section's Guidelines XIII, "Anesthesia Services Where Time Units Are Not Allowed":

- Providing local anesthetic or other medications through a regional IV
- Daily drug management
- Endotracheal intubation
- Venipuncture, including cutdowns
- Arterial punctures
- Epidural or subarachnoid spine injections
- Somatic and Sympathetic Nerve Injections
- Paravertebral facet joint injections and rhizotomies

In addition, lumbar plexus spine anesthetic injection, posterior approach with daily administration = 7 RVUs.

- (2) The maximum reimbursement for these procedures shall be based upon the anesthesia value listed in the table in the RVP©, Anesthesia section's Guideline XIII multiplied by \$38.07 CF. No additional unit values are added for time when calculating the maximum values for reimbursement.
- (3) When performing more than one surgery X procedure in a single surgical setting, multiple surgery guidelines shall apply (100% of the listed value for the primary procedure and 50% of the listed value for additional procedures). Use modifier -51 to indicate multiple surgery X procedures performed on the same day during a single operative setting. The 50% reduction does not apply to procedures that are identified in the RVP© as "Add-on" procedures.
- (4) Bilateral injections: see 18-5(D)(2)(g).
- (5) Other procedures from Table XIII not described above may be found in another section of the RVP© (e.g., surgery). Any procedures found in the table under the RVP©, Anesthesia section's Guidelines XIII, "Anesthesia Services Where Time Units Are Not Allowed" but not contained in this list (Rule 18-5(D)(1)(d)(1)) are reimbursed in accordance with the assigned units from their respective sections multiplied by their respective CF.

(2) Surgical Section:

- (a) The use of assistant surgeons shall be limited according to the American College Of Surgeons' *Physicians as Assistants at Surgery: 2007 Study* (January 2007), available from the American College of Surgeons, Chicago, IL, or from their web page at <http://www.facs.org/ahp/pubs/2007physasstsurg.pdf> (accessed September 27, 2008). The incorporation is limited to the edition named and does not include later revisions or additions. Copies of the material

incorporated by reference may be inspected at any State publications depository library. For information about inspecting or obtaining copies of the incorporated material, contact the Medical Fee Schedule Administrator, 633 17th Street, Suite 400, Denver, Colorado, 80202-3660.

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 minimum assistant surgeon without prior authorization unless a trauma team was activated due to the emergency nature of the injury(ies).
- (d) The payer may use available billing information such as provider credential(s) and clinical record(s) to determine if an appropriate modifier should be used on the bill. To modify a billed code refer to Rule 16-11(B)(4).
- (e) Non-physician, minimum assistant surgeons used as surgical assistants shall be reimbursed at 10 % of the listed value.
- (f) Global Period
  - (1) The following services performed during a global period would warrant separate billing if documentation demonstrates significant identifiable services were involved, such as:
    - ◆ E&M services unrelated to the primary surgical procedure,
    - ◆ Services necessary to stabilize the patient for the primary surgical procedure,
    - ◆ Services not usually part of the surgical procedure, including an E&M visit by an authorized treating physician (ATP) for disability management,
    - ◆ Unusual circumstances, complications, exacerbations, or recurrences, or
    - ◆ Unrelated diseases or injuries.
  - (2) Separate identifiable services shall use an appropriate RVP© modifier in conjunction with the billed service.
- (g) Bilateral procedures are reimbursed the same as all multiple procedures: 100% for the first primary procedure and then 50% for all other procedures, including the 2nd "primary" procedure.
- (h) The "Services with Significant Direct Costs" section of the RVP© is not adopted. Supplies shall be reimbursed as set out in Rule 18-6(H).

(E) Radiology Section:

(1) General

- (a) The cost of dyes and contrast shall be reimbursed at 80 % of billed charges.
- (b) Copying charges for X-Rays and MRIs shall be \$15.00/film regardless of the size of the film.
- (c) The payer may use available billing information such as provider credential(s) and clinical record(s) to determine if an appropriate RVP© modifier should have been used on the bill. To modify a billed code, refer to Rule 16-11(B)(4).

(2) Thermography

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

American Academy of Thermology;

American Chiropractic College of Infrared Imaging.

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

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

Sympathetically Maintained Pain (SMP);

Autonomic neuropathy;

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

- (d) Thermography Billing Codes:

DoWC Z200 Upper body w/ Autonomic Stress Testing \$865.37

DoWC Z201 Lower body w/Autonomic Stress Testing \$865.37

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

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

(G) Medicine Section:



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 except where specifically addressed in the treatment guidelines.

(7) Hyperbaric Oxygen Therapy Services

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

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

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

(H) Physical Medicine and Rehabilitation:

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

(1) Prior authorization is required for medical nutrition therapy. See Rule 18-6(O)(10).

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

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

Prior authorization 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 Medical Treatment Guidelines,

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

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

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

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

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

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

- (6) Modalities

RVP© Timed and Non-timed Modalities

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

**NOTE:** Instruction and application of a TENS unit for the patient's independent use shall be billed using the timed e-stim RVP© code.

**Dry Needling of Trigger Points DoWC Codes:**

Bill only one of the dry needling modality codes. (see relevant treatment guidelines for limitations on frequency)

DoWC Z501	Single or multiple needles, one or two muscles,	5.4 RVUs
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DoWC Z502	three or more muscles,	5.8 RVUs
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- (7) Evaluation Services for Therapists: Physical Therapy (PT), Occupational Therapy (OT) and Athletic Trainers (cf. §12-36-106 C.R.S.)

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

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

- (b) Payers are only required to pay for evaluation services directly performed by a PT, OT, or athletic trainer as defined in §12-36-106 C.R.S. All evaluation notes or reports must be written and signed by the PT or OT. Physicians shall bill the appropriate E&M code from the E&M section of the RVP©.
- (c) A patient may be seen by more than one health care professional on the same day. An evaluation service with appropriate documentation may be charged for each professional per patient per day.
- (d) Reimbursement to PTs, OTs, speech language pathologists and audiologists for coordination of care with professionals shall be based upon the telephone codes for qualified non-physician providers found in the RVP© Medicine Section. Coordination of care reimbursement is limited to telephone calls made to professionals outside of the therapist's/pathologist's/ audiologist's employment facility(ies) and/or to the injured worker or their family.
- (e) All interdisciplinary team conferences shall be billed in compliance with Rule 18-5(1)(5).

(8) Special Tests

The following respective tests are considered special tests:

- Job Site Evaluation
- Functional Capacity Evaluation
- Assistive technology assessment
- Speech
- Computer Enhanced Evaluation (DoWC Z503)
- Work Tolerance Screening (DoWC Z504)

- (a) Billing Restrictions:

- (1) Job Site Evaluations require prior authorization if exceeding 2 hours. Computer-Enhanced Evaluations, and Work Tolerance Screenings require prior authorization for payment for more than 4 hours or more than 6 tests per claim. Functional Capacity Evaluations require prior authorization for payment for more than 4 hours or 2 tests per claim.
  - (2) The provider shall specify the time required to perform the test in 15-minute increments.
  - (3) The value for the analysis and the written report is included in the code's value.
  - (4) No E&M services or PT, OT, or acupuncture evaluations shall be charged separately for these tests.
  - (5) Data from computerized equipment shall always include the supporting analysis developed by the physical medicine professional before it is payable as a special test.
- (b) Provider Restrictions: all special tests must be fully supervised by a physician, a PT, an OT, a speech language pathologist/therapist or audiologist. Final reports must be written and signed by the physician, the PT, the OT, the speech language pathologist/therapist or the audiologist.
- (9) Speech Therapy/Evaluation and Treatment
- Reimbursement shall be according to the unit values as listed in the RVP© multiplied by their section's respective CF.
- (10) Supplies
- Physical medicine supplies are reimbursed in accordance with Rule 18-6(H).
- (11) Unattended Treatment
- When a patient uses a facility or its equipment but is performing unattended procedures, in either an individual or group setting, bill:
- |           |                   |         |
|-----------|-------------------|---------|
| DoWC Z505 | fixed fee per day | 1.5 RVU |
|-----------|-------------------|---------|
- (12) Non-Medical Facility
- Fees, such as gyms, pools, etc., and training or supervision by non-medical providers require prior authorization 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) The provider shall submit a treatment plan including expected frequency and duration of treatment. If requested by the provider, the payer will prior authorize payment for the treatment plan services or shall identify any concerns including those based on the reasonableness or necessity of care.
- (2) If the frequency and duration is expected to exceed the medical treatment guidelines' recommendation, prior authorization is required.
- (3) Provider Restrictions: All procedures must be performed by or under the onsite supervision of a physician, PT, OT, speech language pathologist or audiologist.

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

- (1) Medical record documentation shall encompass the RVP© "E&M Guideline" criteria to justify the billed E&M service. If 50% of the time spent for an E&M visit is disability counseling or coordination of care, then time can determine the level of E&M service. Documented telephonic or on-line communication time with the patient or other healthcare providers one day prior or seven days following the scheduled E&M visit may be included in the calculation of total time.

Disability counseling should be an integral part of managing workers' compensation injuries. The counseling shall be completely documented in the

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

(2) New or Established Patients

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

(3) Number of Office Visits

All providers, as defined in Rule 16-5 (A-B), are limited to one office visit per patient, per day, per workers’ compensation claim unless prior authorization 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) Treating Physician Telephone or On-line Services.

Telephone or on-line services may be billed if:

- (a) the service is performed more than one day prior to a related E&M office visit, or
- (b) the service is performed more than 7 days following a related E&M office visit, and
- (c) when the medical records/documentation specifies all the following:
  - (1) the amount of time and date;
  - (2) the patient, family member, or healthcare provider talked to, and
  - (3) the specifics of the discussion and/or decision made during the communication.

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

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

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

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

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

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

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

#### 18-6 DIVISION ESTABLISHED CODES AND VALUES

- (A) Face-to-face or telephonic meeting by a treating physician with the employer, claim representatives, or any attorney, and with or without the injured worker. Claim representatives may include physicians or qualified medical personnel performing payer-initiated medical treatment reviews.

Before the meeting is separately payable the following 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:
  - (1) Who was present at the meeting and their role at the meeting
  - (2) Purpose of meeting
  - (3) A brief statement of recommendations and actions at the conclusion of the meeting.
  - (4) Time documented ( both start and end times)
  - (5) Billing code DoWC Z701
    - ◆ \$75.00 per 15 minutes for time attending the meeting and preparing the report (no travel time or mileage is separately payable) The fee includes the cost of the report for all parties, including the injured worker.

#### (B) Cancellation Fees For Payer Made Appointments

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

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

\$150.00, whichever is less.

Cancellation Fee Billing Code: DoWC Z720

- (2) Missed Appointments:

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

(C) Copying Fees

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

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

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

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

Copying Fee Billing Code: DoWC Z721

(D) Deposition and Testimony Fees

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

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

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

Preparation Time:

Treating or Non-treating Physician:  
DoWC Z730 \$325.00 per hour

(3) Deposition:

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

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

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

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

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

Deposition:

Treating or Non-treating physician:

DoWC Z734

\$325.00 per hr.

Billed in half-hour increments

(4) Testimony:

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

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

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

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

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

Testimony:

Treating or Non-treating physician:

DoWC Z738

Maximum Rate of \$450.00 per hour

(E) Mileage Expenses

The payer shall reimburse an injured worker for reasonable and necessary mileage expenses for travel to and from medical appointments and reasonable mileage to obtain prescribed medications. The reimbursement rate shall be 55 cents per mile. The injured worker shall submit a statement to the payer showing the date(s) of travel and number of miles traveled, with receipts for any other reasonable and necessary travel expenses incurred.

Mileage Expense Billing Code: DoWC Z723

(F) Permanent Impairment Rating

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

(2) Provider Restrictions

The permanent impairment rating shall be determined by the authorized Level II accredited physician (see Rule 5-5(D)(1) and (2)).

(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) WC164.

(b) Use the appropriate RVP© code:

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

Reimbursed for 1.5 hours with a maximum not to exceed \$343.59.

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

Reimbursed for 2.5 hours with a maximum not to exceed \$660.75.

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

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

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

(G) Report Preparation

- (1) Routine Reports

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

Diagnostic Testing

Procedure Reports

Progress notes

Office notes

Operative reports

Supply invoices, if requested by the payer

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

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

- (a) Initial Report

The designated or selected authorized treating physician for this workers' compensation injury completes the initial WC 164 and submits it to the payer and to the injured worker 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 WC164 closing report is required from the authorized treating physician when an injured worker is at maximum medical improvement with or without a permanent impairment. A physician may bill for the completion of the WC164 if neither impairment rating code (see Rule 18-6(F)(4)) has been 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 Report

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 report.

(d) Provider Initiated WC164 Report

If the provider wants to use the WC164 report 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 report

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

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

- (3) Request for physicians to complete additional forms sent to them by a payer or employer shall be paid by the requesting party. A form requiring 15 minutes or less of a physician's time shall be billed pursuant to A & B below. Forms requiring more than 15 minutes shall be paid as a special report.
- a. Billing Code Z754
  - b. Maximum fee is \$42.00 per form completion

(4) Special Reports

Description: The term special reports includes reports not otherwise addressed under Rule 16, Utilization Standards, Rule 17, Medical Treatment Guidelines and Rule 18, including any form, questionnaire or letter with variable content. This includes, but is not limited to, independent medical evaluations or reviews performed outside C.R.S. §8-42-107.2 (the Division IME process), and treating or non-treating medical reviewers or evaluators producing written reports pertaining to injured workers not otherwise addressed. Special reports also include payment for meeting, reviewing another's written record, and amending or signing that record (see Rule 18-5(l)(7)). 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 time. Use the appropriate RVP© code.

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

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

Cancellation:

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

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.

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.

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.

Billing Codes: Billed in half hour increments

Written Report Only DoWC Code: Z755

IME/Report with patient exam DoWC Code: Z756

Lengthy Form Completion DoWC Code: Z757

Face-to-face/telephonic meeting with  
Non-treating Physician DoWC Code: Z758

Special Report Maximum Fees: \$325.00 per hour.  
Billed in half hour increments.

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

- (1) Unless otherwise indicated in this rule, minimum payment for supplies shall reflect the provider's actual cost plus a 20% markup. Cost includes shipping and handling charges.
- (2) Providers may bill supplies, including "Supply et al.," orthotics, prostheses, DMEs or drugs, including injectables, using Medicare's HCPCS Level II codes. The billing provider is responsible for identifying their cost for the items they wish to be paid at their cost plus 20% instead of Medicare's HCPCS Level II maximum fee. This may be done using an advance agreement between the payer and provider or may be done by furnishing an invoice or their supplier's published rate with their bill.
- (3) Payers may pay using Medicare's HCPCS Level II maximum fee values for the codes billed unless the provider has indicated that the item(s) is to be paid at cost plus 20%. The payer may request an invoice or published rate for any items to be paid at cost plus 20%.
- (4) If the provider failed to indicate that an item was to be paid at cost plus 20%, and their cost plus 20% is more than the Medicare HCPCS Level II value, the provider may submit cost information within 60 days following receipt of the Explanation of Benefits (EOB) and is entitled to at least their cost plus 20%.
- (5) Payment for professional services associated with the fabrication and/or modification of orthotics, custom splints, adaptive equipment, and/or adaptation and programming of communication systems and devices shall be paid in accordance with the RVP©.

(I) Inpatient Hospital Facility Fees

- (1) Provider Restrictions

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































































































































































