

BILLING and ADMINISTRATIVE PROCEDURES

Billing Information

Objectives:

- State the basis for the Colorado Workers' Compensation medical fee schedule.
- Explain procedures for prior authorization of payment.
- Describe restrictions on physical medicine billing and how time is used for E&M Codes.

Billing for Workers' Compensation

Introduction:

Workers' compensation medical providers must familiarize themselves with Rules 16 (Utilization Standards), 17 (Medical Treatment Guidelines [MTG]) and 18 (Medical Fee Schedule [MFS]). As we will discuss, the workers' compensation fee schedule consists of three parts: the actual Rule 18, *Relative Values for Physicians*® (RVP®) (copyright by Ingenix®) and the Director's Interpretive Bulletin.

In 2008, effective January 1, 2009, the Division of Workers' Compensation adopted revisions to 7 CCR 1101-3, Rule 18 (MFS) and incorporated the 2008 edition of the RVP® for payments of medical services, the Current Procedural Terminology CPT® 2008 for codes, descriptions, parenthetical notes and coding guidelines unless modified by rule and the Medicare Severity Diagnosis Related Groups (MS-DRGs) Definitions Manual for inpatient hospital stays. In addition, the Director's Interpretive Bulletin No. 13, available on the Division's webpage (www.coworkforce.com/DWC/), provides clarification of codes, a listing of the Division created codes with descriptors and relative value units (RVUs) for codes missing RVUs in the RVP® and further explanations relative to billing for medical services.

Each year the Division's Medical Cost Containment (MCC) unit conducts an evaluation of the fee schedule and the applicable conversion factors listed in Rule 18. The Division has been charged to create this fee schedule in an attempt to control the costs involved in workers' compensation cases. Therefore fees can change on an annual basis. You must reference Rule 18 each year to stay abreast of any changes. To evaluate the cost impact of updating or changing fee schedules, the MCC determines the budget neutral conversion factor for the several sections of Rule 18.

Budget Neutral Conversion Factor

A conversion factor (CF) is a dollar amount used to turn the RVUs listed in the fee schedule into a dollar amount for the service rendered. Since reimbursement amounts may be impacted by changes to the American Medical Association's (AMA) copyrighted Current Procedural Terminology (CPT®) system, the assigned RVUs, restrictions in the RVP®'s guidelines and the conversion factor, it is necessary to start by determining a "budget neutral" conversion factor. Changes to CPT® coding and the RVUs are outside the domain of the Division. A "budget neutral" conversion factor is a base-line calculation to determine the conversion factor needed to result in a zero percent change in cost between two fee schedules. The "cost" for the current fee schedule is relative to the frequency with which codes are billed and any modifiers associated with those codes. By using those frequencies and the cost generated, a comparison can be made to the new fee schedule. Because the various sections of the fee schedule have different conversion factors, the budget neutral conversion factor is calculated section by section.

A simplified formula for calculation of the current fee schedule costs:

$$\text{Frequency (of billing code)} \times \text{RVU} \times \text{current CF} = \text{Cost}$$

To determine a “budget neutral” CF, the equation becomes:

$$\text{Cost (from above)} / [\text{frequency} \times \text{new schedule's RVUs}] = \text{budget neutral CF}$$

Rule 16

Rule 16 defines the standard terminology, administrative procedures and dispute resolution procedures in workers' compensation. Rule 16-1 requires all providers and payers to use Rules 16, 17 (MTG) and 18 (MFS). Rule 16-2 gives standard terminology for Rules 16 and 18. To be eligible for reimbursement under Workers' Compensation, a medical provider must be an authorized treating provider as defined in Rule 16-2(B). Rule 16-3 prohibits payers from dictating the type or duration of medical treatment or imposing their own internal guidelines or standards for medical care that conflict with Rule 17. Rule 16-4 establishes that payers use the Medical Fee Schedule to determine maximum allowable fees. All non-physician providers must have a referral to establish their authorized classification for reimbursement. Rule 16-5 lists Division recognized health care providers. Any medical provider not listed in Rule 16-5 must have prior authorization from the payer before providing services.

Out-of-State Providers

In the event the injured worker moves out-of-state or is referred to an out-of-state provider, the explanation of the necessary procedures is outlined in Rule 16-5(B). Referrals to out-of-state providers must comply with Rule 16-5(B)(2). The referring physician must accept the responsibility for complying with the 5 requirements listed therein.

Out-of-state providers should be advised that the billing codes and reimbursement levels are limited to the Colorado workers' compensation fee schedule (Rule 16-5(B)(3)).

Billing Rates and Fees

Effective January 1, 2009, reimbursement for medical services shall not exceed the amount allowed by the 2008 edition of the RVP[®] or the billed amount whichever is less. Some codes in the RVP[®] have yet to be assigned RVUs, and in some cases the Division may have established different values. Check the Director's Interpretive Bulletin 13 to see if there are recommended values. If there are none or you are billing for a service not identified in the fee schedule, you must first get prior authorization from the payer. Since the payer is to establish a value for these services by considering the complexity, time, level of training and expertise required to perform the service, you have the right to request their methodology.

Required Billing Forms

All billed services shall be itemized on the appropriate billing form (professional services use CMS 1500 (08-05), (Rule 16-7(B)(1)), with the appropriate billing codes and modifiers from the fee schedule (Rule 16-7(C)). Any services not billed on the proper

forms or using the appropriate billing codes may be contested until the provider complies (Rule 16-7(D)).

In addition to the appropriate billing form, the provider shall submit accompanying documentation (Rule 16-7(E)). Initial contact with the patient is billed using the "Physician's Report of Workers' Compensation Injury" (WC164 – initial). This form requires completion of items 1-7 and item 10. Certain information, such as the insurer's claim number, may not be known and can be omitted. You are required to supply the injured worker with a legible copy of all WC164s at the time of completion and at no charge. In addition, the WC164 shall be submitted to the payer no later than fourteen (14) days from the date of service. All supporting documentation shall be submitted to the payer at the time of billing unless other agreements have been established. This documentation shall include copies of the examination, surgical, and/or treatment records.

When the patient reaches maximum medical improvement (MMI) for all injuries or diseases covered under this workers' compensation claim, the provider shall submit a WC164, specifying "closing" and completing items 1-5, 6 B and C, 7, 8 and 10. If the worker has sustained a permanent impairment, then item 9 must be completed as well and a Level II accredited physician must attach all necessary permanent impairment rating reports. Non-Level II accreditation physicians should complete the MMI data and notify the insurer they are not Level II accredited or provide the name of the Level II Accredited physician designated to perform the permanent impairment rating.

The payer may contest reimbursement for billed services until the provider completes and submits the required accompanying documentation.

Rule 16-8 sets forth the minimal requirements for medical record documentation.

Prior Authorization

The rules for obtaining prior authorization and how to proceed if authorization is contested are contained in Rule 16-9 and 16-10. In addition to procedures *not* listed in the Fee Schedule, Rule 17 (Treatment Guidelines) and Rule 18 (Fee Schedule) specifically identify some procedures *requiring* prior authorization.

In general, prior authorization for payment is requested when:

- (1) A prescribed service exceeds the recommended limitations set forth in the MTG
- (2) The MTG otherwise require prior authorization for that specific service
- (3) A prescribed service is identified in Rule 18 as requiring prior authorization or where the service will exceed a given limitation.
- (4) A prescribed service is not identified in the fee schedule (see Rule 16-9).

Authorization for a prescribed procedure may be granted immediately and without medical review. The payer shall respond to all requests for prior authorization within seven (7) business days from the receipt of the provider's completed request. The Division recommends payers confirm in writing to providers and all parties when a request for prior authorization is approved.

To complete a request, the provider shall concurrently explain the medical necessity of the service and provide relevant supporting medical documentation. Supporting medical documentation is defined as the documents used in the provider's decision-making process to substantiate the need for the requested service.

Hint: When you receive verbal prior authorization from the payer, send a form letter or e-mail addressed to the person who granted the prior authorization and state:

"As per our phone conversation of today (date), it is my understanding you have granted prior authorization for . . ." list the patient's name, workers' compensation number, carrier's claim identification code (if you know it or can get it from the person giving authorization), any approval authorization code provided and then specify the treatment approved (the procedures, frequency, etc.) and specify a time line for confirmation: "If I do not hear from you in writing within 7 days, I will assume my understanding is correct."

If the payer wishes to deny prior authorization they must comply with Rule 16-10.

Rule 16-9(H) Lack of prior authorization:

"If, after the service was provided, the payer agrees the service provided was reasonable and necessary, lack of prior authorization for payment does not warrant denial of payment."

Contest of Prior Authorization

If you have complied with the rules for prior authorization but the payer does not respond in a timely manner, Rule 16-10(E) states:

Failure of the payer to timely comply in full with the requirements of Rule 16-10(A) or Rule 16-10(B) shall be deemed authorization for payment of the requested treatment unless a hearing is requested within the time prescribed for responding as set forth in Rule 16-10(A) or (B) and the requesting party is notified that the request is being contested and the matter is going to hearing.

Payers may deny authorization for non-medical or medical reasons. Non-medical reasons could be because compensability of the claim has not been established; the billed services are not related to the admitted injury, the provider is not authorized to treat (referral), the employer may not have been covered by the carrier at the time of the

injury, or the billed code does not appear to be accurate based upon the information submitted.

When a payer wishes to deny prior authorization, the following, from Rule 16-10 must be followed:

- (A) If the payer contests a request for prior authorization for non-medical reasons as defined under this Rule 16-11(B)(1), the payer shall notify the provider and parties, in writing, of the basis for the contest within seven (7) business days. A certificate of mailing of the written contest must be sent to the provider and parties.

If an ATP requests prior authorization and indicates in writing, including their reasoning and relevant documentation, that they believe the requested treatment is related to the admitted workers' compensation (WC) claim, the insurer cannot deny based solely on relatedness without a medical review as under Rule 16-10(A).

- (B) If the payer is contesting a request for prior authorization for medical reasons, the payer shall, within seven (7) business days of the completed request:
 - (1) Have the request reviewed by a Physician or other health care professional, as defined in Rule 16-5(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review; and
 - (2) The reviewing provider may call the requesting provider to expedite communication and processing of prior authorization requests. However, the written contest or approval still needs to be completed within the specified seven (7) days under this Rule 16-10(B).
 - (3) Furnish the provider and the parties with either a verbal or written approval, or a written contest that sets forth the following information:
 - (a) An explanation of the specific medical reasons for the contest, including the name and professional credentials of the person performing the medical review and a copy of the medical reviewer's opinion;
 - (b) The specific cite from the division's MTG exhibits to Rule 17, when applicable;
 - (c) Identification of the information deemed most likely to influence the reconsideration of the contest when applicable; and
 - (d) A certificate of mailing to the provider and parties.

The Appeal of a Denial

Rule 16-10(C) Prior Authorization Disputes

- (1) The requesting party or provider shall have seven (7) business days from the date of the certificate of mailing on the written contest to provide a written response to the payer, including a certificate of mailing. The response is not considered a "special report" when prepared by the provider of the requested service.
- (2) The payer shall have seven (7) business days from the date of the certificate of mailing of the response to issue a final decision, including a certificate of mailing to the provider and parties.

If Continued Denial . . .

In some cases, the provider and the payer may not be able to come to an agreement. In such situations, the patient needs to rely on Rule 16-10(C) and approach the Division to request an expedited hearing:

(C) Prior Authorization . . .

- (3) In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts.

Hearings can take time, so keep in mind the following rules from Rule 16-10:

- (D) An urgent need for prior authorization of health care services, as recommended in writing by an authorized treating provider, shall be deemed good cause for an expedited hearing.
- (E) Failure of the payer to timely comply in full with the requirements of Rule 16-10(A) or Rule 16-10(B), shall be deemed authorization for payment of the requested treatment unless a hearing is requested within the time prescribed for responding as set forth in Rule 16-10(A) or Rule 16-10(B) and the requesting provider is notified that the request is being contested and the matter is going to hearing.
- (F) Unreasonable delay or denial of prior authorization, as determined by the Director or an administrative law judge, may subject the payer to penalties under the Workers' Compensation Act.

Payment of Medical Benefits

Rule 16-11(A)(1) requires medical providers to submit their bills within 120 days of the date of service. The payer has 30 days [Rule 16-11(A)(2)] from the date of receipt to

either pay the bill or give justification as to why they are not. The date of receipt can be determined by the payer's date stamp or electronic acknowledgement date. Otherwise, receipt is presumed to be 3 days after date the bill was mailed. Because of these timelines, providers should double-check the address to assure they are mailing to the correct office.

If the injured worker has paid the provider for authorized care, the payer shall reimburse the worker for the full amount s/he paid and may collect any over-payment difference between that amount and the allowable reimbursement under the fee schedule from the provider. [Rule 16-11(F)]

In cases where the payer is not in compliance with the timely payment rules, the provider should first attempt to resolve the issue with the payer. If the problem of timely payment persists, the provider may seek the assistance of the Division's Carrier Practice Unit.

Like prior authorization, contest of payment for a medical service may be for non-medical or medical reasons [Rule 16-11(B)]. In all cases where the payer is contesting the payment of billed services, the payer shall notify the billing party within 30 days of receipt of the bill. This notification should provide the provider with:

- Name of the injured worker,
- Date(s) of service in question,
- Any identifying numbers for the claim,
- Reference to the specific bill and each item being contested,
- Reason(s) for contesting the payment including:
 - Citing of appropriate statutes, rules and/or documents supporting Payer's reasons for contesting payment and
 - Notice that the billing party may resubmit the bill or corrected bill in sixty days.

If the problem is the use of an incorrect CPT® code, the payer may contact the provider and with the provider's agreement change the code [Rule 16-11(B)(4)]. The explanation of benefits (EOB) accompanying the check shall include the name of the person at the provider's office who made the agreement. If there is no agreement upon a code, the payer may deny payment in accordance with the rules for contesting bills. [Rule 16-11(B) and (C)]

When contesting payment for medical reasons, the payer shall have the contested item(s) reviewed, within 30 days of receipt of the bill, by a physician or other healthcare professional holding a license and in the same or similar specialty as would typically manage the item under review. The reviewer may call the provider to expedite the process, however, the written contest of payment is still due within the 30 day period.

Upon completion of the review, the payer shall provide the provider and all parties involved with the following information:

- (1) An explanation of the specific medical reason(s) for the decision,
- (2) The name and credentials of the professional performing the review and a written copy of the reviewer's opinion
- (3) Specific cites to any references to the Medical Treatment Guidelines (Rule 17)
- (4) The identification of information the reviewer believes most likely to influence the reconsideration of the contest, and
- (5) A certificate of mailing.

The medical provider has 60 days to appeal the contest of payment. Upon receipt of the resubmission, the payer has 30 days to process the appeal. If the contest of payment continues, the provider may approach the Division of Workers' Compensation, Medical Policy Unit for assistance. When approaching the Division, the provider should be prepared to submit a copy of the bill with the contested codes and dates of services in dispute, a copy of the payer's explanation as to why the billed services are being contested and a copy of any applicable medical record documentation.

Retroactive Adjustments of Medical Bills

Rule 16-11(E) limits the retroactive adjustment of payments. All medical bills are considered final unless such adjustments are made within twelve months after the date of the original EOB. In those cases where an adjustment is sought prior to the twelve month period, the written notice must contain a complete and specific explanation of the amounts being recovered, the specific reasons why these amounts are believed to be overpayments and evidence that these payments were in fact made to the provider. The provider has at least 60 days to respond to the written notice before any recovery is started.

Rule 16-11(G) requires contracts between providers and payers to comply with Rule 16-11.

Rule 18

Billing with the Fee Schedule

Once the diagnosis has been determined and the treatment protocol has been developed, the provider is faced with the gauntlet of seeking reimbursement for his/her services. This requires the submission of the CMS 1500 (08-05), adherence to the guidelines within the RVP[®], the Division's adopted fee schedule, and Rules 16, 17 and 18.

Modification to the RVP[®]

Rule 18-5 lists certain instructions and modifications made by the Division to the RVP[®]. Interim values, indicated by an "I" in the left-hand margin for the RVP[®], are accepted as a basis of payment; however deleted codes, marked by an "M", are not. Temporary codes listed in the RVP[®] may be used for billing if you have a prior agreement with the payer. Payment should be in compliance with Rule 16-6(B).

Fee Schedule Calculations

To properly bill for services, providers need to use the codes currently in effect for workers' compensation cases. The use of improper codes will result in the carriers returning the bills for re-coding. These codes and their RVUs are found in the RVP[®], Rule 18 itself (Division created codes), and the Director's Interpretive Bulletin (No. 13) for the respective year.

As stated at the beginning of this section, the RVP[®] is available from Ingenix[®] located in Salt Lake City, Utah. Official copies of the rules can be ordered from LexisNexis Matthew Bender & Co., Inc., in Albany, NY. Unofficial copies of the rules and the Director's Interpretive Bulletin are available on the Division's webpage at www.coworkforce.com/DWC/.

When billing for services rendered, the CPT[®] code must be related to one of the diagnostic codes (ICD-9) listed in *Item 21: Diagnosis or Nature of Illness or Injury* section of the CMS 1500 (08-05). The workers' compensation fee schedule is a "maximum fee schedule," meaning the carrier will reimburse the provider either the amount billed or the fee schedule amount, whichever is less. Providers should bill their usual and customary amount. To verify payments received, the provider must multiply the relative value units times the conversion factor for the respective code as established in Rule 18, taking into consideration any modification of the amount due to modifiers (to be discussed later). The codes from the RVP[®] and the respective CFs divide into the following sections for purposes of calculating reimbursement:

		<u>(Eff. 1/1/09 – per RVU)</u>
Anesthesia		\$49.87
Surgery		\$92.79
Surgery X Codes	see Rule 18-5(D)(1)(d)	\$38.07
Radiology		\$17.43
Pathology		\$12.99
Medicine		\$ 7.56
Physical Medicine		\$ 5.57
E&M		\$ 8.81

Thus the reimbursement for a new patient E&M code, as listed in RVP[®], 2008 edition, would be calculated by:

$$6.5 (RVUs) \times \$8.81 (E\&M \text{ CF from Rule 18-4.}) = \$57.27 (maximum \text{ allowed reimbursement})$$

Time Based Procedures

Certain codes are time based and require an additional step. For instance, a code listed as 8.0 units per 15 minutes must include under the Unit/Day column of the CMS 1500 (08-05) the number of 15 minute periods used. Treatment for 45 minutes with a 15-minute based unit value would show the number 3 in the “Unit/Day” column of the CMS 1500 (08-05) and be calculated by:

$$[8.0 (RVUs \text{ per } 15 \text{ minutes}) \times 3 (\text{number of } 15 \text{ minute periods})] \times \text{CF (respective area)} = \text{maximum reimbursement.}$$

Modifiers

Numeric modifiers may impact the reimbursement level. The RVP[®] contains a complete list of the modifiers on pp. 18-24. A modifier –26 indicates the provider is billing only for the professional component and requires the use of the RVUs listed for that modifier in the RVP[®]. The respective sections of the RVP[®] provide explanations of the professional and technical (modifier –TC) components of codes. Other common modifiers are:

- 51 indicates multiple procedures at the same session by the same provider. For surgery this will result in a reimbursement level of 50% of the fee schedule value for all multiple procedures. In other words, the primary surgical procedure should not be marked with a -51 modifier. Any other non add-on surgical procedures would be marked with it and the resulting payment for those procedures would be 50% of the fee schedule allowed amount. This is discussed in the RVP’s © surgery guidelines.

- 80 indicates the provider was the assistant surgeon on this code and is reimbursed 20% of the allowed fee schedule amount
- 81 indicates a minimum assistant surgeon's service and is reimbursed 10% of the fee schedule allowed amount.

As stated above, multiple surgery guidelines allow 100% of the allowed amount for the primary service and 50% for all others. For the assistant surgeon this would be 100% of the 20% allowed for the primary, and 50% of the 20% allowed for all other procedures.

Global Period

Global period is a term most commonly seen in surgery and refers to the pre- and post-operative time period. Once the decision for surgery has been made, all E&M (office) visits are considered to be included in the surgical fee. Thus a patient referred for care would entitle the surgeon to an initial new patient visit to establish records and determine surgery. After that, the office visits would not be billable. There are a few exceptions when an additional office visit may be warranted:

The E&M reason is unrelated to the primary surgical procedure.
Services are needed to stabilize the patient.
Services not usually associated with the type of surgery are required.
Unusual circumstances, complications, exacerbations or recurrences occur.
The patient complains of unrelated diseases or injuries.

In these instances, the E&M code occurring during the global period would need to have a modifier -24 (unrelated E&M service by the same physician during a postoperative period) or -25 (significant, separately identifiable E&M service by the same physician on the same day of the procedure or other service) attached to the respective E&M code.

Other Factors Impacting Reimbursement

The provider's billing office should familiarize themselves with the limitations and restrictions contained in Rule 17 (the medical treatment guidelines) and Rule 18. The rule is divided into sections corresponding to the conversion factor sections of the fee schedule listed above. These rule-generated limitations may involve time limits, level of training necessary to provide the service, limits to number of treatments (in tandem with the Treatment Guidelines), etc.

In addition, podiatrists' offices need to be familiar with the "Surgery Guidelines" as given in the surgical section of the RVP[®], giving particular attention to the use of modifiers to identify bilateral procedures, multiple surgical procedures on the same day in the same operative setting, use of two surgeons, a surgical team, and assistants at surgery.

Radiology and Pathology

These sections are relatively straightforward. Always indicate how much of a radiology or pathology procedure or lab was completed by billing the appropriate modifier. The appropriate modifiers are -26 (professional), -TC (technical component) and -00 (entire procedure).

The Relative Values for Physicians© defines the professional modifier (-26), technical modifier (-TC) and total component (-00) of a radiology, pathology or laboratory procedure or test. Modifier -26 indicates that the medical professional's interpretation and written report of the procedure or test, and/or the examination of the patient, was completed. The technical component modifier (-TC) applies only to the equipment, materials, space, technical personnel, and other overhead necessary to conduct and complete the test or procedure. The total procedure modifier (-00) indicates that both the technical and professional components were completed.

Note: when reviewing a report from a radiologist or pathologist, it is inappropriate to bill the radiology code with the -26 modifier.

Medicine –Biofeedback – Manipulation - Psychology

Biofeedback

Biofeedback is limited to the number of visits recommended in the MTGs. You must have prior authorization to exceed the guidelines. Unless provided or supervised by a physician or psychologist with evidence of biofeedback training, the person providing the biofeedback shall be certified by the Biofeedback Certification Institution of America.

Manipulation

Prior authorization from the payer is necessary before billing for more than four body regions in one visit. Manipulative therapy is limited to the maximum allowed in the relevant Rule 17 medical treatment guideline.

An E&M office visit may be billed on the same day as the manipulation if the provider can document that the patient's condition required a significant and separately identifiable E&M service that is unrelated to the pre- and post-manipulation assessments. A modifier -25 must be appended to the billed E&M code when manipulation is billed on the same date of services for the same patient.

Psychology

Physicians and licensed psychologists (PsyD, PhD, EdD) are reimbursed the maximum fee schedule allowed amount or the amount billed, whichever is less. Other non-

physician providers performing psychological psychiatric services shall be paid at 75% of the fee schedule allowed amount or the amount billed, whichever is less.

Providers should review Rule 18-5(G)(6)(b) for time limitations on evaluations, testing and psychotherapy sessions, keeping in mind that with documented prior authorization of the payer these limits may be extended.

Special attention should be paid to diagnostic interview codes, as some are based on a minute basis. In such cases, an hour would require 60 in the Days/Unit column of the CMS 1500 (08-05) to be reimbursed correctly.

Physical Medicine Billing Rules

The following restrictions are found in Rule 18-5(H):

Rule 18-5(H):

- (1) Prior authorization is required for medical nutrition therapy.
- (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 MTG 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 MTG 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) 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:

Because many physical medicine treatments include both timed and non-timed procedures, documentation must be sufficient to substantiate the time involved. For standard visits, the documentation must indicate to the payer how the services provided were administered to stay within the one-hour limitation. While a particular procedure may not be "timed," the total time of treatment should not exceed the one-hour limitation. The only exceptions are the modalities, whether attended or unattended, time or not timed, that are limited to two per visit per discipline by Rule 18-5(H)(6).

Keep in mind that several physical medicine procedures require prior authorization from the payer **BEFORE** they are performed. Examples include: work conditioning, pain management, etc.

Evaluation and Management

Disability Counseling Definitions

For the most part, time is not a factor when determining the level of E&M code to be billed. The criteria as outlined in the guidelines at the beginning of the E&M section are to be applied. However, if 50% of the physician's time is spent counseling the patient on disability related to the workers' compensation injury, time may become the overriding factor to the determination of the appropriate level of office visit.

Examples of billable, follow-up visits would be cases in which the patient is re-evaluated because of insufficient progress thus requiring a change in the treatment regimen, presentation of a new complaint or complications. These must be documented in the provider's notes.

Furthermore, since the Division stresses that the provider actively educate and counsel the patient, occasions when such services are provided would be billable. In these instances the specifics of the counseling and/or education and the time spent face-to-face with the patient must be clearly documented in the record to determine the proper level of office visit.

Rule 18-5(1)(2) defines a new injury as a New Patient even though the provider has seen the patient within the last three years. Any subsequent visit would then be an established patient code.

Without prior authorization, there is a limit of one office visit per patient, per day, per workers' compensation claim.

Particular attention should be paid to the new Division created codes effective January 1, 2009. A complete list of the Division created codes can be found in the Director's Interpretive Bulletin 13, effective January 1, 2009.

(PTs, OTs and Athletic Trainers, as defined in §12-36-106 C.R.S., should be referred to Rule 18-5(H)(7) for clarification of office visit billing.)

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 listed in the CPT® are met.

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. Bill Division Code Z601 at \$65.00 per 15 minutes to the requesting party.

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 is bill as a special report [Rule 18-6(G)(4)]

Face-to-face or Telephonic Meeting by a Treating Physician with the Employer, Claim Representatives or any Attorney, with or without the injured worker. Claim representatives may include physicians or qualified medical personnel performing payer-initiated medical treatment reviews. Bill Division Code Z701 at \$75.00 per 15 minutes for time attending the meeting and preparing the report. No travel time or mileage is separately payable and the fee includes the cost of the report for all parties, including the injured worker.

Patient Cancellation Rules

Rule 18-6(B) allows for the billing of appointments when the patient has not shown up. This allowance is permitted **only** when the **payer** has made the appointment. Reimbursement is one-half of the usual fee for the scheduled visit or \$150.00, whichever is less, and billed with Division Code Z720 (Rule 18-6(B)(1)). Since the payer needs to be kept abreast of the patient's behavior and active involvement in his/her recuperation, the provider should notify the payer within two (2) business days when a patient does not keep an appointment (Rule 18-6(B)(2)) and agree to reschedule only if the payer sets the next appointment.

Copying Fees

Copying fee rates (and copying of microfilm) can be found in Rule 18-6(C). In addition to the rates, the provider of the copies may charge actual postage and shipping costs, and any applicable sales tax.

Deposition and Testimony

A discussion of the rates, preparation time, scheduling fees and cancellation time-line rules are located in Rule 18-6(D) along with the respective Division created codes. All parties should consult and seek to abide by The Interprofessional Code prepared by the Colorado Bar Association, the Colorado Medical Society and the Denver Medical Society.

Routine Reports

Routine reports, such as diagnostic tests, procedure reports, progress notes, office notes, operative-reports, are considered to be part of the normal communication between provider and payer and are not specifically reimbursable. An exception to this is the WC164.

Report Preparation

Completion of the ‘Physician’s Report of Workers’ Compensation Injury’ (WC164)

After the initial contact with the patient, the physician should complete a WC164, marking it to indicate an initial report. This report is reimbursable under Z750 in the amount of \$42.00. When a patient reaches MMI and there is no permanent impairment, the physician is required to complete the WC164, closing, for which they may bill Z752 with a maximum reimbursement of \$42.00 pursuant to Rule 18-6(G)(2)(b) and (e). Effective January 1, 2009, a Division created code Z753 is established to represent those cases where the initial report including closing are reported on the same date of service.

The provider should review again the information on Rule 16-7(E)(1) regarding the required fields and timelines for the WC164.

When the physician is requested to complete additional forms sent to them by a payer or employer that require 15 minutes or less to complete, the physician should bill the requesting party with code Z754. Reimbursement is \$42.00 per completed form.

Special Reports

Special reports are any reports not otherwise addressed under Rule 16, 17 or 18, including any form, questionnaire or letter with variable content. This includes any independent medical evaluations or review (non-Division IMEs) and treating or non-treating medical reviewers or evaluators producing written reports pertaining to injured workers. Special reports also include payment for meeting, reviewing another’s written record and amending or signing that record. Reimbursement for preparation of special reports or records requires prior agreement with the requesting party. 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. 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. The time line for cancellations is found in Rule 18-6(G)(4). The maximum allowable fee is \$325.00 per hour billed in half-hour increments. For a written report only, use Division created code

Z755. For an IME or a report involving a patient exam use Z756. For the completion of a lengthy form use Z757. A face-to-face or telephonic meeting with a non-treating physician should be billed with Z758.

Supplies, Supplements, Herbs

Supplies are reimbursed at cost plus 20%. The use of supplements and herbs require prior authorization and agreement of the amount to be reimbursed. The provider should follow the requirements listed under Rule 16-9 to obtain the authorization necessary. References to herbs and supplements are found in Rule 18-6(O)(10) and 18-6(Q)(3)(c).

Acupuncture

Licensed Acupuncturist (LAc), or acupuncturists certified by an existing licensing board are limited to 14 sessions without prior authorization. The regulations concerning acupuncture are found in Rule 18-6(Q).

Use of an Interpreter

Rates and terms shall be negotiated with prior authorization except for emergency treatment. The billing code is Z722.