

## **DEPARTMENT OF LABOR AND EMPLOYMENT**

### **Division of Workers' Compensation**

## **WORKERS' COMPENSATION RULES OF PROCEDURE WITH TREATMENT GUIDELINES**

### **MEDICAL FEE SCHEDULE**

#### **7 CCR 1101-3 Rule 18 (no exhibits)**

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

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#### **18-1 STATEMENT OF PURPOSE**

Pursuant to § 8-42-101(3)(a)(I) C.R.S. and § 8-47-107, C.R.S., the Director promulgates this Medical Fee Schedule to review and establish maximum allowable fees for health care services falling within the purview of the Act. The Director adopts and hereby incorporates by reference as modified herein the 2013 edition of the Relative Values for Physicians (RVP©), developed by Relative Value Studies, Inc., published by OPTUMINSIGHT (Ingenix®), the Current Procedural Terminology CPT® 2013, Professional Edition, published by the American Medical Association (AMA) and Medicare Severity Diagnosis Related Groups (MS-DRGs) Definitions Manual, Version 31.0 developed and published by 3M Health Information Systems using MS-DRGs effective after October 1, 2013. The incorporation is limited to the specific editions named and does not include later revisions or additions. For information about inspecting or obtaining copies of the incorporated materials, contact the Medical Policy Unit Supervisor, 633 17th Street, Suite 400, Denver, Colorado 80202-3626. These materials may be examined at any state publications depository library. All guidelines and instructions are adopted as set forth in the RVP©, CPT® and MS-DRGs, unless otherwise specified in this Rule.

This Rule applies to all services rendered on or after January 1, 2014. 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® 2013, copyrighted and distributed by the AMA and incorporated by reference in 18-1.
- (B) DoWC Zxxxx – Colorado Division of Workers' Compensation created codes.
- (C) MS-DRGs – version 31.0 incorporated by reference in 18-1.
- (D) RVP© – the 2013 edition incorporated by reference in 18-1.
- (E) For other terms, see Rule 16, Utilization Standards.

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

All users are responsible for the timely purchase and use of Rule 18 and its supporting documentation as referenced herein. The Division shall make available for public review and inspection copies of all materials incorporated by reference in Rule 18. Copies of the RVP© may be purchased from Ingenix® OptumInsight, the Current Procedural Terminology, 2013 Edition may be purchased from the AMA, the MS-DRGs Definitions Manual may be purchased from 3M Health Information Systems, and the Colorado Workers' Compensation Rules of Procedures with Treatment Guidelines, 7 CCR 1101-3, may be purchased from LexisNexis Matthew Bender & Co., Inc., Albany, NY. Interpretive Bulletins and unofficial

copies of all rules, including Rule 18, are available on the Colorado Department of Labor and Employment web site. An official copy of the rules is available on the Secretary of State's webpage.

#### **18-4 CONVERSION FACTORS (CF)**

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

RVP© SECTION	CF
Anesthesia	\$ 53.20/RVU
Surgery	\$ 98.96/RVU
Radiology	\$ 18.23/RVU
Pathology	\$ 13.58/RVU
Medicine	\$ 7.91/RVU
Physical Medicine	\$ 6.17/RVU
(Physical Medicine and Rehabilitation, Medical Nutrition Therapy and Acupuncture)	
Evaluation & Management (E&M)	\$ 10.06/RVU

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

- (A) Maximum allowance for all providers under Rule 16-5 is 100% of the RVP© value or as defined in this Rule.
- (B) Unless modified herein, the RVP© is adopted for RVUs and reimbursement. Interim relative value procedures (marked by an "I" in the left-hand margin of the RVP©) are accepted as a basis of payment for services; however deleted CPT® codes (marked by an "M" in the RVP©) are not, unless otherwise advised by this Rule. Division created codes (Zxxxx) and values supersede CPT® or RVP© codes and reimbursement levels. Those codes listed with RVUs of "BR" (by report) and "RNE" (relativity not established) require prior authorization as explained in Rule 16. The CPT® 2013 is adopted for codes, descriptions, parenthetical notes and coding guidelines, unless modified in this Rule.
- (C) CPT® Category III codes listed in the RVP© may be used for billing with agreement of the payer as to reimbursement. Payment shall be in compliance with Rule 16-6(C).
- (D) Surgery/Anesthesia
  - (1) Anesthesia Section:
    - (a) All anesthesia base values shall be established by the use of the codes as set forth in the RVP©, Anesthesia Section. Anesthesia services are only reimbursable if the anesthesia is administered by a physician 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:
  - (a) Performs a pre-anesthesia examination and evaluation,
  - (b) Prescribes the anesthesia plan,
  - (c) Personally participates in the most demanding procedures in the anesthesia plan including induction and emergence,
  - (d) Ensures that any procedure in the anesthesia plan that s/he does not perform is performed by a qualified anesthetist,
  - (e) Monitors the course of anesthesia administration at frequent intervals,
  - (f) Remains physically present and available for immediate diagnosis and treatment of emergencies, and
  - (g) Provides indicated post-anesthesia care.
- (b) Anesthesia physical status modifiers and qualifying circumstances are reimbursed using the anesthesia CF and unit values found in the RVP®, Anesthesia section's Guidelines XI "Physical Status Modifiers" and XII, "Qualifying Circumstances."
- (c) The following modifiers are to be used when billing for anesthesia services:
  - AA – anesthesia services performed personally by the anesthesiologist
  - AD – greater than four (4) concurrent (occurring at the same time) anesthesia service cases being supervised by an anesthesiologist
  - QK – anesthesiologist providing direction to qualified individuals of two (2) to four (4) concurrent anesthesia cases
  - QX – CRNA 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
  - QS – Monitored anesthesia care service (MAC)
  - G8 – Monitored anesthesia care (MAC) for deep complex complicated, or markedly invasive surgical procedure

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

(d) Surgery X Procedures

(1) The relative value units in the Surgery X table of RVP© are no longer recognized. All Surgery X codes are reimbursed in accordance with the RVUs listed in the RVP© surgery section and the applicable conversion factor.

(2) The following relative value units listed in the 2013 RVP© Surgery Section for the following injections shall be replaced as follows:

(a) Epidural for blood or clot patch injection = 1.9

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

(1) Cervical or thoracic level = 2.0

(2) Lumbar or sacral (caudal) = 1.65

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

(1) Cervical or thoracic level = 1.85

(2) Lumbar or sacral (caudal) = 1.77

(d) Somatic nerve injections:

(1) Greater occipital nerve = 1.5

(2) Spinal accessory nerve = 1.5

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

(4) Regional block (intercostal) = 1.7

(5) Sciatic nerve, continuous infusion = 1.3

(6) Femoral nerve, single = 1.5

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

(8) Lumbar plexus, posterior approach, continuous infusion = 2.0

(9) Other peripheral nerve or branch = 1.25

(e) Paravertebral facet joint injections:

- (1) Single level cervical/thoracic levels = 2.0
- (2) Second levels at cervical/thoracic = 1.25
- (3) Third and any additional levels at cervical/thoracic = 1.10

(f) Paravertebral facet joint injections:

- (1) Single level lumbar/sacral levels = 1.75
- (2) Second levels at lumbar/sacral = 1.0
- (3) Third and any additional levels at lumbar/sacral = 1.0

(g) Autonomic nerve injection

- (1) Anesthetic agent, superior hypogastric plexus = 1.3
- (2) Anesthetic agent, lumbar or thoracic (paravertebral sympathetic) = 2.0

(h) Destruction of nerve by neurolytic agent:

- (1) Trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch, second and third division branches at foramen ovale = 5.5
- (2) Intercostal nerve = 3.0
- (3) Pudendal nerve = 3.0
- (4) Paravertebral facet joints at cervical and thoracic single level = 4.4
- (5) Paravertebral facet joints at cervical and thoracic each additional level = 2.0
- (6) Paravertebral facet joints at lumbar or sacral single level = 4.2
- (7) Paravertebral facet joints at lumbar or sacral single each additional level = 1.8
- (8) Other peripheral nerve or branch = 1.6
- (9) Celiac plexus = 2.9

(2) Surgical Section:

- (a) The use of assistant surgeons shall be limited according to the American College Of Surgeons' Physicians as Assistants at Surgery: 2011 Study (January 2011), available from the American College of Surgeons, Chicago, IL, or from their web page. The incorporation is limited to the edition named and does not include later

revisions or additions. Copies of the material incorporated by reference may be inspected at any State publications depository library. For information about inspecting or obtaining copies of the incorporated material, contact the Medical Policy Unit Supervisor, 633 17th Street, Suite 400, Denver, Colorado, 80202-3626.

Where the publication restricts use of such assistants to "almost never" or a procedure is not referenced in the publication, prior authorization for payment (see Rule 16-9 and 16-10) is required.

- (b) Incidental procedures are commonly performed as an integral part of a total service and do not warrant a separate benefit.
- (c) No payment shall be made for more than one (1) assistant surgeon or minimum assistant surgeon without prior authorization for payment (see Rule 16-9 and 16-10) 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:
    - (a) E&M services unrelated to the primary surgical procedure.
    - (b) Services necessary to stabilize the patient for the primary surgical procedure.
    - (c) Services not considered part of the surgical procedure, including an E&M visit by an authorized treating physician for disability management. The E&M service shall have an appropriate modifier appended to the E&M level of the service code when the surgeon is performing services during the global period. If at all possible, an appropriate identifying diagnosis code shall identify the E&M service as unrelated to the surgical global period. In addition, the reasonableness and necessity for an E&M service that is separate and identifiable from the surgical global period shall be clearly documented in the medical record.
    - (d) Disability management of an injured worker for the same diagnosis requires the managing physician to clearly identify in the medical record the specific disability management detail that was performed during that visit. The definitions of what is considered disability counseling can be located under 18-5(l)(1) and under Exhibit #7 of this Rule.

(e) Unusual circumstances, complications, exacerbations, or recurrences; or

(f) Unrelated diseases or injuries.

(g) If a patient is seen for the first time or an established patient is seen for a new problem and the "decision for surgery" is made the day of the procedure or the day before the procedure is performed, then the surgeon can bill both the procedure code and an E&M code, using a 57 modifier or 25 modifier on the E&M code.

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

(g) Bill each bilateral procedure on a separate line and append an "RT" modifier to one (1) procedure code and an "LT" modifier to the other bilateral procedure code. List one (1) unit for each separate bilateral procedure on the billed line. 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 18-6(H).

(i) If a surgical arthroscopic procedure is converted to the same surgical open procedure on the same joint, only the open procedure is payable. If an arthroscopic procedure and open procedure are performed on different joints, the two (2) procedures may be separately payable with anatomic modifiers or modifier 50.

(j) Use code G0289 to report any combination of surgical knee arthroscopies for removal of loose body, foreign body, and/or debridement/shaving of articular cartilage. G0289 is 11.8 RVUs and is paid using the surgical conversion factor.

G0289 shall not be paid when reported in conjunction with other knee arthroscopy codes in the same compartment of the same knee.

G0289 shall be paid when reported in conjunction with other knee arthroscopy codes in a different compartment of the knee. G0289 is subject to the 50% multiple surgical reduction guidelines.

#### (E) Radiology Section:

##### (1) General

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

(b) Copying charges for x-rays and MRIs shall be \$15.00/film regardless of the size of the film.

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

- (d) In billing radiology services, the applicable radiology procedure code shall be billed using the appropriate modifier to bill either the professional component (26) or the technical component (TC). Total component should be billed with the (00) modifier to facilitate processing. If a physician bills the total or professional component, a separate written interpretive report is required.

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

The time a physician spends reviewing and/or interpreting an existing radiological image is considered a part of the physician's evaluation and management service code.

## (2) Thermography

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

American Academy of Thermology;

American Chiropractic College of Infrared Imaging.

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

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

Sympathetically Maintained Pain (SMP);

Autonomic neuropathy;

- (c) General Protocols for Stress Testing

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

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

- (d) Thermography Billing Codes:

DoWC Z0200 Upper body w/ Autonomic Stress Testing \$865.37

DoWC Z0201 Lower body w/Autonomic Stress Testing \$865.37

- (e) Prior authorization for payment (see Rule 16-9 and 16-10) is required for thermography services only if the requested study does not meet the indicators for thermography as outlined in this radiology section. The billing shall include a report supplying the thermographic evaluation and reflecting compliance with 18-5(E)(2).



(F) Pathology Section:

- (1) Reimbursement for billed pathology procedures includes either a technical and professional component, or a total component. If an automated clinical lab procedure does not have a separate written interpretive report beyond the computer generated values, the biller may receive the total component value as long as no other provider seeks reimbursement for the professional component. The physician ordering the automated laboratory tests may seek verbal consultation with the pathologist in charge of the laboratory's policy, procedures and staff qualifications. The consultation with the ordering physician is not payable unless the ordering physician requested additional medical interpretation and judgment and requested a separate written report. Upon such a request, the pathologist may bill using the proper CPT® code and values from the RVP©, not DoWC Z0755.

(2) Drug Testing Codes and Values

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

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

- (b) Laboratories with a CLIA certificate of waiver may perform only those tests cleared by the Food and Drug Administration (FDA) as waived tests. Laboratories with a CLIA certificate of waiver shall bill using the QW modifier.

Laboratories with a CLIA certificate of compliance or accreditation may perform non-waived tests. Laboratories with a CLIA certificate of compliance or accreditation do not append the QW modifier to claim lines.

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

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

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

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

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

G0431 may only be reported once per patient encounter.

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

Reimbursement:

G0431 \$136.09

G0434 \$ 27.22

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

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

- (1) Concern regarding the functional status of the patient
- (2) Abnormal results on previous testing
- (3) Change in management of dosage or pain
- (4) Chronic daily opioid dosage above 150 mg of morphine or equivalent

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

- (1) The results of the qualitative screen are presumptively positive; or
- (2) Results of the qualitative screen are negative and this negative finding is inconsistent with the patient's medical history.

- (f) Codes G0431 and G0434 in this Rule 18-5(F)(2) are to be billed and used to determine maximum fee schedule dollars instead of the codes listed under the "Drug Testing" subsection in the "Pathology and Laboratory Section" of CPT® and RVP®. Specific quantitative drug testing codes listed under other sections of the "Pathology and Laboratory Section" of CPT® and RVP® are still recognized.

(G) Medicine Section:

- (1) Medicine home therapy services in the RVP® are not adopted. For appropriate codes see 18-6(L), Home Therapy.
- (2) Anesthesia qualifying circumstance values are reimbursed in accordance with the section 18-5(D)(1).
- (3) Biofeedback

Prior authorization for payment (see Rule 16-9 and 16-10) shall be required from the payer for any treatment exceeding the treatment guidelines. A licensed physician or psychologist shall prescribe all services and include the number of sessions. Session

notes shall be periodically reviewed by the prescribing physician or psychologist to determine the continued need for the service. All services shall be provided or supervised by an appropriate recognized provider as listed under Rule 16-5. Supervision shall be as defined in Rule 17, Medical Treatment Guidelines. Persons providing biofeedback shall be certified by the Biofeedback Certification 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) Appendix J of the 2013 CPT® identifies mixed, motor and sensory nerve conduction studies and their appropriate billing.

(5) Manipulation -- Chiropractic (DC), Medical (MD) and Osteopathic (DO):

(a) Prior authorization for payment (see Rule 16-9 and 16-10) shall be obtained before billing for more than four body regions in one (1) visit. Manipulative therapy is limited to the maximum allowed in Rule 17, Medical Treatment Guidelines. The provider's medical records shall reflect medical necessity and prior authorization for payment (see Rule 16-9 and 16-10) if treatment exceeds these limitations.

(b) An office visit may be billed on the same day as manipulation codes when the documentation meets the E&M requirement and an appropriate modifier is used.

(6) Psychiatric/Psychological Services:

(a) A licensed psychologist (PsyD, PhD, EdD) is reimbursed a maximum of 100% of the medical fee listed in the RVP®. Other non-physician providers performing psychological/psychiatric services shall be paid at 75% of the fee allowed for physicians.

(b) Prior authorization for payment (see Rule 16-9 and 16-10) is required any time the following limitations are exceeded on a single day:

Evaluation Procedures limit: 4 hours

Testing Procedures limit: 6 hours

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

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

Prior authorization for payment (see Rule 16-9 and 16-10) is required any time the 60 minutes per visit limitation is exceeded.

Psychotherapy for work-related conditions requiring more than 20 visits or continuing for more than three (3) months after the initiation of therapy, whichever comes first, requires prior authorization for payment (see Rule 16-9 and 16-10) except where specifically addressed in the Medical Treatment Guidelines.

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

(1) Both services must be separately identifiable;

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

- (3) Time may not be used as the basis for the E&M code selection; and
- (4) Add-on psychotherapy codes are to be used by psychiatrists to indicate both services were provided.

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

(7) Hyperbaric Oxygen Therapy Services

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

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

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

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

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

- (1) Resting Sweat Test
- (2) Stimulated Sweat Test
- (3) Resting Skin Temperature Test
- (4) Interpretation of clinical laboratory scores. Physician must evaluate the patient specific clinical information generated from the test and quantify it into a numerical scale. The data from the test and a separate report interpreting the results of the test must be documented.

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

QSART Billing Code

DoWC Z0401 QSART \$1,007.00

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

(10) Intra-Operative Monitoring (IOM)

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

- (a) Clinical Services for IOM: Technical and Professional

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

The American Society of Neurophysiologic Monitoring; or

The American Society of Electrodiagnostic Technologists

- (2) Professional/Supervisory /Interpretive

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

- (3) Technical Electronic Capacity for Real-time Communication requirements

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

- (b) Procedures and Time Reporting

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

- (11) Central Nervous System (CNS) Testing and Assessment

CNS tests and assessment services shall be billed using the appropriate code from the RVP©. All CNS tests and assessments requiring more than six (6) hours require prior authorization.

- (12) 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.

- (H) Physical Medicine and Rehabilitation:

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

- (1) Prior authorization for payment (see Rule 16-9 and 16-10) is required for medical nutrition therapy.
- (2) For recommendations on the use of the physical medicine and rehabilitation procedures, modalities, and testing, see Rule 17, Medical Treatment Guidelines.
- (3) Special Note to All Physical Medicine and Rehabilitation Providers:

The authorized treating provider shall obtain prior authorization for payment (see Rule 16-9 and 16-10) from the payer for any physical medicine or rehabilitation treatment not listed in or exceeding the frequency or duration recommendations in Rule 17, Medical Treatment Guidelines.

The injured worker shall be re-evaluated by the prescribing physician within 30 calendar days from the initiation of the prescribed treatment and at least once every month while that treatment continues to establish achievement of functional goals. Prior authorization for payment (see Rule 16-9 and 16-10) shall be required for treatment of a condition not covered under the Medical Treatment Guidelines and exceeding 60 calendar days from the initiation of treatment.

- (4) Interdisciplinary Rehabilitation Programs – Requires Prior Authorization for Payment (see Rule 16-9 and 16-10).

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

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

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

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

- (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)

The provider's medical records shall reflect the medical necessity and the provider shall obtain prior authorization for payment (see Rule 16-9 and 16-10) if the procedures are not recommended or the frequency and duration exceeds the recommendations of the Rule 17, Medical Treatment Guidelines. The maximum amount of time allowed is one (1) hour of procedures per day, per discipline; unless medical necessity is documented and prior authorization is obtained from the payer.

#### Aquatic Therapy Services

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

### (6) Modalities

#### RVP© Timed and Non-timed Modalities

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

NOTE: Instruction and application of a transcutaneous electric nerve stimulation (TENS) unit for the patient's independent use shall be billed using the education code in the Medicine section of the RVP©. Rental or purchase of a TENS unit requires prior authorization for payment (see Rule 16-9 and 16-10). For maximum fee allowance, see 18-6(H).

#### Dry Needling of Trigger Points

Bill only one (1) of the dry needling modality codes. See relevant Medical Treatment Guidelines for limitations on frequencies.

Single or multiple needles,

DoWC Z0501 one (1) or two (2) muscles, 5.4 RVUs

DoWC Z0502 three (3) or more muscles, 5.8 RVUs

### (7) Evaluation Services for Therapists: Physical Therapy (PT), Occupational Therapy (OT) and Athletic Trainers (ATC).

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

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

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

#### (8) Special Tests

The following respective tests are considered special tests:

- Job Site Evaluation
- Functional Capacity Evaluation
- Assistive Technology Assessment
- Speech
- Computer Enhanced Evaluation (DoWC Z0503)
- Work Tolerance Screening (DoWC Z0504)

#### (a) Billing Restrictions:

- (1) Job Site Evaluations require prior authorization for payment (see Rule 16-9 and 16-10) if exceeding 2 hours. Computer-Enhanced Evaluations and Work Tolerance Screenings require prior authorization for payment for more than 4 hours per test or more than 6 tests per claim. Functional Capacity Evaluations require prior authorization for payment for more than 4 hours per test 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 an audiologist. Final reports must be written and signed by the physician, the PT, the OT, the speech language pathologist/therapist or the audiologist.

(9) Supplies

Physical medicine supplies are reimbursed in accordance with 18-6(H).

(10) Unattended Treatment

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

DoWC Z0505 fixed fee per day 1.5 RVU

(11) Non-Medical Facility

Fees, such as gyms, pools, etc., and training or supervision by non-medical providers require prior authorization for payment (see Rule 16-9 and 16-10) and a written negotiated fee.

(12) Unlisted Service Physical Medicine

All unlisted services or procedures require a report.

(13) Work Conditioning, Work Hardening, Work Simulation

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

Restriction: Maximum daily time is two (2) hours per day without additional prior authorization for payment (see Rule 16-9 and 16-10).

(b) Work Hardening is an interdisciplinary program that uses a team of disciplines to meet the goal of employability and return to work. This type of program entails a progressive increase in the number of hours a day that an individual completes work tasks until they can tolerate a full workday. In order to do this, the program must address the medical, psychological, behavioral, physical, functional and vocational components of employability and return to work. Refer to Rule 17, Medical Treatment Guidelines.

Restriction: Maximum daily time is six (6) hours per day without additional prior authorization for payment (see Rule 16-9 and 16-10).

(c) Work Simulation is a program where an individual completes specific work-related tasks for a particular job and return to work. Use of this program

is appropriate when modified duty can only be partially accommodated in the work place, when modified duty in the work place is unavailable, or when the patient requires more structured supervision. The need for work simulation should be based upon the results of a functional capacity evaluation and/or job analysis. Refer to Rule 17, Medical Treatment Guidelines.

(d) For Work Conditioning, Work Hardening, or Work Simulation, the following apply:

- (1) The provider shall submit a treatment plan including expected frequency and duration of treatment. If requested by the provider, the payer will prior authorize payment for the treatment plan services or shall identify any concerns including those based on the reasonableness or necessity of care.
- (2) If the frequency and duration is expected to exceed the Medical Treatment Guidelines' recommendation, prior authorization for payment (see Rule 16-9 and 16-10) is required.
- (3) Provider Restrictions: All procedures must be performed by or under the onsite supervision of a physician, psychologist, PT, OT, speech language pathologist or audiologist.

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

- (1) Evaluation and management codes may be billed by medical providers as defined in Rule 16-5(A)(1)(a) and nurse practitioners (NP) and physician assistants (PA). Medical record documentation shall encompass the "E&M Documentation Guidelines" criteria as adopted in Exhibit #7 to this Rule to justify the billed level of E&M service. If 50% of the time spent for an E&M visit is shared decision making, disability counseling or coordination of care, then time can determine the level of E&M service. Documented telephonic or on-line communication time with the patient or other healthcare providers one (1) day prior or seven (7) days following the scheduled E&M visit may be included in the calculation of total time.

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

(2) New or Established Patients

An E&M visit shall be billed as a "new" patient service for each "new injury" even though the provider has seen the patient within the last three (3) years. Any subsequent E&M visits are to be billed as an "established patient" and reflect the level of service indicated by the documentation when addressing all of the current injuries.

(3) Number of Office Visits

All providers are limited to one (1) office visit per patient, per day, per workers' compensation claim unless prior authorization for payment (see Rule 16-9 and 16-10) is obtained. The E&M Guideline criteria as specified in the RVP© E&M Section shall be used in all office visits to determine the appropriate level.

(4) Treating Physician Telephone or On-line Services.

Telephone or on-line services may be billed if:

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

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

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

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

(6) Face -to-face or telephonic meeting by a non-treating physician with the employer, claim representatives or any attorney in order to provide a medical opinion on a specific workers' compensation case which is not accompanied by a specific report or written record.

Billing Code DoWC Z0601: \$65.00 per 15 minutes billed to the requesting party.

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

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

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

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

- (A) Face-to-face or telephonic meeting by a treating physician with the employer, claim representatives, or any attorney, and with or without the injured worker. Claim representatives may include physicians or qualified medical personnel performing payer-initiated medical treatment reviews, but this code does not apply to requests initiated by a provider for prior authorization for payment (see Rule 16-9 and 16-10).

Before the meeting is separately payable, the following must be met:

- (1) Each meeting shall be at a minimum 15 minutes.
- (2) A report or written record signed by the physician is required and shall include the following:
  - (a) Who was present at the meeting and their role at the meeting;
  - (b) Purpose of the meeting;
  - (c) A brief statement of recommendations and actions at the conclusion of the meeting;
  - (d) Documented time (both start and end times); and
  - (e) Billing code DoWC Z0701.

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

(B) Cancellation Fees for Payer Made Appointments

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

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

Cancellation Fee Billing Code: DoWC Z0720

- (2) Missed Appointments:

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

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

Copying Fee Billing Code: DoWC Z0721

#### (D) Deposition and Testimony Fees

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

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

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

Preparation Time:

Treating or Non-treating Provider:

DoWC Z0730 \$325.00 per hour

- (3) Deposition:

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

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

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

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

If the provider is notified less than five (5) business days in advance of a cancellation, or the deposition is shorter than the time scheduled, the provider shall be paid the number

of hours s/he has reasonably spent in preparation and has scheduled for the deposition. Bill using code DoWC Z0733.

Deposition:

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

Billed in half-hour increments

(4) Testimony:

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

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

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

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

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

Testimony:

Treating or Non-treating provider: DoWC Z0738

Maximum Rate of \$450.00 per hour

(E) Injured Worker Travel Expenses

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

Mileage Expense Billing Code: DoWC Z0723

Other Travel Expenses Billing Code: DoWC Z0724

(F) Permanent Impairment Rating

(1) The payer is only required to pay for one (1) combined whole-person permanent impairment rating per claim, except as otherwise provided in the Workers' Compensation Rules of

Procedures. Exceptions that may require payment for an additional impairment rating include, but are not limited to, reopened cases, as ordered by the Director or an administrative law judge, or a subsequent request to review apportionment. The authorized treating provider is required to submit in writing all permanent restrictions and future maintenance care related to the injury or occupational disease.

(2) Provider Restrictions

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

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

When physicians determine the injured worker is at MMI and has no permanent impairment, the physicians should be reimbursed an appropriate level of E&M service. The authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient should complete the Physician's Report of Workers' Compensation Injury (Closing Report), WC164 (see 18-6(G)(2)). Reimbursement for the appropriate level of E&M service is only applicable if the physician examines the injured worker and meets the criteria as defined in the RVP©.

(4) MMI Determined with a Calculated Permanent Impairment Rating

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

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

(b) Use the appropriate DoWC code:

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

Bill DoWC Z0759 \$355.00.

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

Bill DoWC Z0760 \$575.00.

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

(4) Fee for a Multiple Impairment Evaluation Requiring More Than One (1) Level II Accredited Physician:

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

(G) Report Preparation

(1) Routine Reports

Routine reports or records are incorporated in all fees for service. They 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 this Rule.

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

(a) Initial Report

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

(b) Closing Report

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



following additional information shall be attached to the bill at the time MMI is determined:

- (1) All necessary permanent impairment rating reports when the authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient is Level II Accredited, or
- (2) The name of the Level II Accredited Physician requested to perform the permanent impairment rating when a rating is necessary and the authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient is not determining the permanent impairment rating.

(c) Payer Requested WC164 Report

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

(d) Provider Initiated WC164 Report

If a provider wants to use the WC164 report as a progress report or for any purpose other than those designated in 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 Z0750	\$42.00	Initial Report
DoWC Z0751	\$42.00	Progress Report (Payer Requested or Provider Initiated)
DoWC Z0752	\$42.00	Closing Report
DoWC Z0753	\$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) and (b) below. Forms requiring more than 15 minutes shall be paid as a special report.

(a) Billing Code Z0754

(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 (Z0756) or reviews when the physician is requested to review files and examine the patient to provide an opinion for the requesting party, performed outside C.R.S. §8-42-107.2 (the Division IME process) and treating or non-treating medical reviewers or evaluators producing written reports pertaining to injured workers not otherwise addressed. Special reports also include payment for meeting, reviewing another's written record, and amending or signing that record (see 18-5(I)(7)). Reimbursement for preparation of special reports or records shall require prior agreement with the requesting party.

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

**Advance Payment:** If requested, the provider is entitled to a two (2) hour deposit in advance in order to schedule any patient exam associated with a special report.

**Cancellation:**

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

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

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

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

**Billing Codes:**

Written Report Only	DoWC Code:	Z0755
IME/Report with patient exam	DoWC Code:	Z0756
Lengthy Form Completion	DoWC Code:	Z0757
18-5(I)(7) meeting and report with Non-treating Physician	DoWC Code:	Z0758

Special Report Maximum Fees:	\$325.00 per hour billed in 15-minute increments.	
CRS 8-43-404 IME Audio Recording	DoWC Code:	Z0766
	\$30.00 per exam	
CRS 8-43-404 IME Audio copying fee	DoWC Code:	Z0767
	\$20.00 per copy	

(5) Chronic Opioid Management Report

- (a) When the authorized treating physician prescribes long-term opioid treatment, s/he shall use the Division of Workers' Compensation Chronic Pain Disorder Medical Treatment Guidelines and also review the Colorado State Board of Medical Examiners' Policy # 10-14, "Guidelines for the Use of Controlled Substances for the Treatment of Pain." Urine drug tests for chronic opioid management shall employ testing methodologies that meet or exceed industry standards for sensitivity, specificity and accuracy. The test methodology must be capable of identifying and quantifying the parent compound and relevant metabolites of the opioid prescribed. In-office screening tests designed to screen for drugs of abuse are not appropriate for chronic opioid compliance monitoring.
  - (1) Drug testing shall be done prior to the initial long-term drug prescription being implemented and randomly repeated at least annually.
  - (2) When drug screen tests are ordered, the authorized treating physician shall utilize the Colorado Prescription Drug Monitoring Program (PDMP).
  - (3) While the injured worker is receiving chronic opioid management, additional drug screens with documented justification may be conducted. Examples of documented justification include the following:
    - (i) Concern regarding the functional status of the patient
    - (ii) Abnormal results on previous testing
    - (iii) Change in management of dosage or pain
    - (iv) Chronic daily opioid dosage above 150 mg of morphine or equivalent
  - (4) The opioids prescribed for long-term treatment shall be provided through a pharmacy.
  - (5) The prescribing authorized treating physician shall review and integrate the screening results, PDMP, and the injured worker's past and current functional status on the prescribed levels of medications. A written report will document the treating physician's assessment of the patient's past and current functional status of work, leisure activities and activities of daily living competencies.

(b) Codes and maximum fees for the authorized treating physician for a written report with all the following review services completed and documented:

- (1) Ordering and reviewing drug tests
- (2) Ordering and reviewing PDMP results
- (3) Reviewing the medical records
- (4) Reviewing the injured workers' current functional status
- (5) Determining what actions, if any, need to be taken
- (6) Appropriate chronic pain diagnostic code (ICD)

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

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

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

- (1) Unless other limitations exist in this Rule, medical professionals may bill supplies, including "Supply et al.," orthotics, prostheses, DME or drugs, including injectables, using Medicare's HCPCS Level II codes, when one exists, as established in the most recent January Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) schedule. Otherwise, the billing provider is responsible for identifying their cost for the items, if they wish to be paid at their cost plus 20% instead of Medicare's Colorado 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 with their bill.
- (2) Payers may pay medical professionals using Medicare's most recent January DMEPOS Colorado HCPCS Level II maximum fee values listed for the codes billed unless the provider has indicated that the item(s) is to be paid at cost plus 20%. If no code exists, the payer shall pay 120% of the cost for the item as indicated on the provider's invoice.
- (3) Reimbursement of supplies to facilities shall be in compliance with Rule 18-6 (I) – (K). 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 Colorado 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%.
- (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 Colorado Medicare HCPCS Level II values.

(I) Inpatient Hospital Facility Fees

(1) Provider Restrictions

All non-emergency, inpatient admissions require prior authorization for payment (see Rule 16-9 and 16-10).

(2) Bills for Services

- (a) Inpatient hospital facility fees shall be billed on the UB-04 and require summary level billing by revenue code. The provider must submit itemized bills along with the UB-04.
- (b) The maximum inpatient facility fee is determined by applying the Center for Medicare and Medicaid Services (CMS) "Medicare Severity Diagnosis Related Groups" (MS-DRGs) classification system in effect at the time of discharge. Exhibit #1 to Rule 18 shows the relative weights per MS-DRGs that are used in calculating the maximum allowance.

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

- (c) Exhibit #1 to this Rule establishes the maximum length of stay (LOS) using the "arithmetic mean LOS". However, no additional allowance for exceeding this LOS, other than through the cost outlier criteria under 18-6(l)(3)(d) is allowed.
- (d) Any inpatient admission requiring the use of both an acute care hospital (admission/discharge) and its Medicare certified rehabilitation facility (admission/discharge) is considered as one (1) admission and MS-DRG. This does not apply to long term care and licensed rehabilitation facilities.

(3) Inpatient Facility Reimbursement:

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

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

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

- (1) Medicare certified Critical Access Hospitals (CAH) (listed in Exhibit #3 of this Rule)
- (2) Medicare certified long-term care hospitals
- (3) Colorado Department of Public Health and Environment (CDPHE) licensed rehabilitation facilities,
- (4) CDPHE licensed psychiatric facilities that are privately owned.
- (5) CDPHE licensed skilled nursing facilities (SNF).

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

Retrieve the relative weights for the assigned MS-DRG from the MS-DRG table in effect at the time of discharge in Exhibit #1 of this Rule and locate the hospital's base rate in Exhibit #2 of this Rule.

The "Maximum Fee Allowance" is determined by calculating:

- (1)  $(\text{MS-DRG Relative Wt} \times \text{Specific hospital base rate} \times 185\%) + (\text{trauma center activation allowance}) + (\text{organ acquisition, when appropriate})$ .
- 2) For trauma center activation allowance, (revenue codes 680-685) see 18-6(J)(6)(b)(5).
- (3) For organ acquisition allowance, (revenue codes 811-812) see 18-6(I)(3)(h).

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

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

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

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

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

- (4) If the "Difference" is greater than \$24,104.00, additional reimbursement is warranted. The additional reimbursement is determined by the following equation:

$$\text{"Difference"} \times .80 = \text{additional fee allowance}$$

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

- (1) If an injured worker is admitted to the hospital, the ERD reimbursement is included in the inpatient reimbursement under 18-6 (I)(3),
- (2) Trauma Center activation fees (see 18-6(J)(6)(b)(5)) and organ acquisition allowance (see 18-6(I)(3)(h)) are paid in addition to inpatient fees (18-6(I)(3)(c-d)).

(f) If an injured worker is admitted to one hospital and is subsequently transferred to another hospital, the payment to the transferring hospital will be based upon a per diem value of the MS-DRG maximum value. The per diem value is calculated based upon the transferring hospital's MS-DRG relative weight multiplied by the hospital's specific base rate (Exhibit #2 of this Rule) divided by the MS-DRG geometric mean length of stay (Exhibit #1 of this Rule). This per diem amount is multiplied by the actual LOS. If the patient is admitted and transferred on the same day, the actual LOS equals one (1). The receiving hospital shall receive the appropriate MS-DRG maximum value.

(g) To comply with Rule 16-6(B), the payer shall compare each billed charge type:

- The MS-DRG adjusted billed charges to the MS-DRG allowance (including any outlier allowance);
- The trauma center activation billed charge to the trauma center activation allowance; and
- The organ acquisition charges to the organ acquisition maximum fees under 18-6(l)(3)(h).

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

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

(J) Outpatient Hospital Facility Fees

(1) Provider Restrictions

- (a) All non-emergency outpatient surgeries require prior authorization for payment (see Rule 16-9 and 16-10).
- (b) A separate facility fee is only payable if the facility is licensed as a hospital by the Colorado Department of Public Health and Environment (CDPHE) or applicable out of state governing agency and statute.

(2) Types of Bills for Service

- (a) Outpatient facility fees shall be billed on the UB-04 and require summary level billing by revenue code. The provider must submit itemized bills along with the UB-04.
- (b) All professional charges are subject to the RVP© and Dental Fee Schedules as incorporated by this Rule and applicable to all facilities regardless of whether the facility fees are based upon Exhibit #4 or a percentage of billed charges.
- (c) Outpatient hospital facility bills include all outpatient surgery, Emergency Room Department (ERD), Clinics, Urgent Care (UC) and diagnostic testing.

(3) Outpatient Facility Reimbursement:

- (a) The following types of outpatient facilities are reimbursed at 100% of billed outpatient charges, except for any associated professional fees:
  - (1) Children's hospitals
  - (2) Veterans' Administration hospitals
  - (3) State psychiatric hospitals

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

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

(2) Primary Rural Health clinics, listed in Exhibit # 5 of this Rule.

(c) Exhibit #4 to this Rule

Hospital reimbursement is based upon Medicare's 2013 Outpatient Prospective Payment System (OPPS) as modified in Exhibit #4 of this Rule. Exhibit #4 lists Medicare's Outpatient Hospital Ambulatory Prospective Payment (APC) Codes and the Division's established rates for hospitals and other types of providers as follows:

- Column 1 lists the APC code number.
- Column 2 lists APC code description.
- Column 3 is used to determine maximum fees for all Outpatient Hospital Emergency Room Departments (ERDs).
- Column 4 is used to determine maximum fees for all hospital facilities not listed under 18-6(J)(3)(a) and (b).
- Column 5 is used to determine maximum fees for all Ambulatory Surgery Centers (ASC) when outpatient surgery is performed in an ASC.

To identify which APC grouper is aligned with an Exhibit #4 APC code # and dollar value, use Medicare's 2013 Addendum B. Grouper code 210 in Exhibit #4 was created by the Division to reimburse RVP© spinal fusion codes not listed in Medicare's Hospital Outpatient Prospective Payment System, Addendum B.

(4) The APC Exhibit #4 values include the following packaged revenue codes inclusive of the following services (all surgical implants are separately payable at cost to the facility):

- (a) nursing, technician, and related services;
- (b) use of the facility where the surgical procedure(s) was performed;
- (c) drugs and biologicals for which separate payment is not allowed;
- (d) medical and surgical supplies, durable medical equipment and orthotics not listed as a "pass through";
- (e) surgical dressings;
- (f) equipment;
- (g) splints, casts and related devices;
- (h) radiology services when not allowed under Exhibit #4;
- (i) administrative, record keeping and housekeeping items and services;



- (j) materials, including supplies and equipment for the administration and monitoring of anesthesia;
- (k) supervision of the services of an anesthetist by the operating surgeon; and
- (l) post-operative pain blocks.

Revenue Code	Packaged Services Description
0250	Pharmacy; General Classification
0251	Pharmacy; Generic Drugs
0252	Pharmacy; Non-Generic Drugs
0254	Pharmacy; Drugs Incident to Other Diagnostic Services
0255	Pharmacy; Drugs Incident to Radiology
0257	Pharmacy; Non-Prescription
0258	Pharmacy; IV Solutions
0259	Pharmacy; Other Pharmacy
0260	IV Therapy; General Classification
0261	IV Therapy; Infusion Pump
0262	IV Therapy; IV Therapy/Pharmacy Services
0263	IV Therapy; IV Therapy/Drug/Supply Delivery
0264	IV Therapy; IV Therapy/Supplies
0269	IV Therapy; Other IV Therapy
0270	Medical/Surgical Supplies and Devices; General Classification
0271	Medical/Surgical Supplies and Devices; Non-sterile Supply
0272	Medical/Surgical Supplies and Devices; Sterile Supply
0275	Medical/Surgical Supplies and Devices; Pacemaker
0276	Medical/Surgical Supplies and Devices; Intraocular Lens
0278	Medical/Surgical Supplies and Devices; except surgically implanted devices
0279	Medical/Surgical Supplies and Devices; except surgically implanted devices
0280	Oncology; General Classification
0289	Oncology; Other Oncology
0343	Nuclear Medicine; Diagnostic Radiopharmaceuticals
0344	Nuclear Medicine; Therapeutic Radiopharmaceuticals
0370	Anesthesia; General Classification
0371	Anesthesia; Anesthesia Incident to Radiology
0372	Anesthesia; Anesthesia Incident to Other DX Services
0379	Anesthesia; Other Anesthesia
0390	Administration, Processing and Storage for Blood and Blood Components; General Classification
0392	Administration, Processing and Storage for Blood and Blood Components; Processing and Storage
0399	Administration, Processing and Storage for Blood and Blood Components; Other Blood Handling
0621	Medical Surgical Supplies - Extension of 027X; Supplies Incident to Radiology
0622	Medical Surgical Supplies - Extension of 027X; Supplies Incident to Other DX Services
0623	Medical Supplies - Extension of 027X, Surgical Dressings
0624	Medical Surgical Supplies - Extension of 027X; FDA Investigational Devices
0630	Pharmacy - Extension of 025X; Reserved
0631	Pharmacy - Extension of 025X; Single Source Drug
0632	Pharmacy - Extension of 025X; Multiple Source Drug

0633	Pharmacy - Extension of 025X; Restrictive Prescription
0700	Cast Room; General Classification
0710	Recovery Room; General Classification
0720	Labor Room/Delivery; General Classification
0721	Labor Room/Delivery; Labor
0732	EKG/ECG (Electrocardiogram); Telemetry
0801	Inpatient Renal Dialysis; Inpatient Hemodialysis
0802	Inpatient Renal Dialysis; Inpatient Peritoneal Dialysis (Non-CAPD)
0803	Inpatient Renal Dialysis; Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)
0804	Inpatient Renal Dialysis; Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)
0809	Inpatient Renal Dialysis; Other Inpatient Dialysis
0810	Acquisition of Body Components; General Classification
0819	Inpatient Renal Dialysis; Other Donor
0821	Hemodialysis-Outpatient or Home; Hemodialysis Composite or Other Rate
0824	Hemodialysis-Outpatient or Home; Maintenance - 100%
0825	Hemodialysis-Outpatient or Home; Support Services
0829	Hemodialysis-Outpatient or Home; Other OP Hemodialysis
0942	Other Therapeutic Services (also see 095X, an extension of 094x); Education/Training
0943	Other Therapeutic Services (also see 095X, an extension of 094X), Cardiac Rehabilitation
0948	Other Therapeutic Services (also see 095X, an extension of 094X), Pulmonary Rehabilitation

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

- (a) "A" means use another fee schedule instead of Exhibit #4, i.e., 18-4 Conversion Factors or 18-6(Q) Ambulance Fee Schedule.
- (b) "B" means it is not recognized by Medicare for Outpatient Hospital services Part B bill type (12x and 130x) and therefore is not separately payable unless separate fees are applicable under another section of this Rule 18, such as home health.
- (c) "C" means recognized by Medicare as inpatient only procedures; however, the DWC does recognize these procedures can be done outpatient if prior authorization is obtained per Rule 16-6(C).
- (d) "G" means it is a separate "Pass-Through Drugs and Biologicals" that is separately payable under Exhibit #4.
- (e) "H" means it is a separate "Pass-Through Device" that is separately payable under Exhibit #4.
- (f) "K" means it is not a separately payable "Pass-Through Drug or Biological or Device," with this code.
- (g) "L" represents Influenza Vaccine and therefore, is generally not considered workers compensation related.
- (h) Any "Packaged Codes" with Q1, Q2, Q3, or STVX combinations are not recognized unless the payer and provider make a prior agreement.
- (i) "M" means not separately payable unless separate fees are applicable under another section of this Rule 18, such as home health.

- (j) "N" means the service is bundled and is not separately payable.
- (k) "R" means separate payment for blood and blood products.
- (l) "S" and "T" means there are multiple procedures, the highest valued code allowed at 100% of the Exhibit #4 value and up to three (3) additional codes allowed at 50% of the Exhibit #4 value, per episode of care.
- (m) "U" means Brachytherapy is separately payable.
- (n) "V" represents a clinic or Emergency Department Visit and is separately payable for hospitals.
- (o) "X" represents Ancillary Services and is separately payable.
- (p) "Y" represents non-implantable Durable Medical Equipment and is paid according to Medicare's Durable Medical Equipment Regional Carrier (DMERC) fee schedule for Colorado.

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

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

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

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

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

- (1) Outpatient ERDs within Colorado must be physically located within a hospital licensed by the CDPHE as a general hospital; or
- (2) Free-standing ERD, must have equivalent operations as a licensed ERD; or
- (3) Meet the out-of-state facility's state's licensure requirements.
- (4) The ERD "Level of Care" is identified based upon one (1) of five (5) levels of care. The level of care is defined by CPT® E&M definitions and internal level of care guidelines developed by the hospital in compliance with Medicare regulations. The hospital's guidelines should establish an appropriate graduation of hospital resources (ERD staff and other resources) as the level of service increases. Upon request the provider shall supply a copy of their level of care guidelines to the payer. (Only the higher one (1) of any ERD Levels or critical care codes shall be paid).

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

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

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

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

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

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

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

(7) For the purposes of Rule 16-6 (B), the sum of all outpatient ERD fees charged, less any amounts charged for professional fees found on the same bill, is to be compared to the maximum reimbursement allowed by the calculated value of 18-6(J)(6)(b). The lesser of the two (2) amounts shall be the maximum facility allowance for the ERD episode of care. A line by line comparison is not appropriate.

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

(c) Multiple APCs identified by multiple CPT® codes are to be indicated by the use of modifiers –51 and –50, respectively. The 50% reduction applies to all lower valued procedures, even if they are identified in the RVP® as modifier -51 exempt. The reduction also applies to the second "primary" procedure of bilateral procedures.

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

- (2) If an arthroscopic procedure is converted to an open procedure on the same joint, only the open procedure is payable. If an arthroscopic procedure and open procedure are performed on different joints, the two (2) procedures may be separately payable with anatomic modifiers.
  - (3) When reported in conjunction with other knee arthroscopy codes, any combination of surgical knee arthroscopies for removal of loose body, foreign body, and/or debridement/shaving of articular cartilage shall be paid only if performed in a different compartment of the knee using G0289.
  - (4) Discontinued surgeries require the use of modifier -73 (discontinued prior to administration of anesthesia) or modifier -74 (discontinued after administration of anesthesia). Modifier -73 results in a reimbursement of 50% of the APC value for the primary procedure only. Modifier -74 allows reimbursement of 100% of the primary procedure value only.
  - (5) In compliance with Rule 16-6(B), the sum of 18-6(J)(3)(c) Columns 1-5 is compared to the total facility fee billed charges. The lesser of the two amounts shall be the maximum facility allowance for the surgical episode of care. A line by line comparison of billed charges to the calculated maximum fee schedule allowance of 18-6(J)(3)(c) is not appropriate.
- (d) Any diagnostic testing clinical labs or therapies with a status indicator (SI) of "A" may be reimbursed using the appropriate CF to the unit values for the specific CPT® code as listed in the RVP®.
- (e) Observation room maximum allowance is limited to six (6) hours without prior authorization for payment (see Rule 16-9 and 16-10). Documentation should support the medical necessity for observation or convalescent care. Observation time begins when the patient is placed in a bed for the purpose of initiating observation care in accordance with the physician's order. Observation or daily outpatient convalescence time ends when the patient is actually discharged from the hospital or ASC or admitted into a licensed facility for an inpatient stay. Observation time would not include the time patients remain in the observation area after treatment is finished for reasons such as waiting for transportation home. Hospital or convalescence licensure is required for billing observation or convalescence time beyond 23 hours.

**Billing Codes:**

G0378 Observation/Convalescence rate: \$45.00 per hour

round to the nearest hour.

- (f) Professional fees are reimbursed according to the fee schedule times the appropriate conversion factor regardless of the facility type. Additional reimbursement is payable for the following services not included in the values found in Exhibit #4 of this Rule:
- ambulance services (Revenue Code 540), See 18-6(Q)
  - blood, blood plasma, platelets (Revenue Codes 380X)
  - Physician or physician assistant services

- Nurse practitioner services
- Licensed clinical psychologist
- Licensed social workers
- Rehabilitation services (PT, OT, Respiratory or Speech/Language, Revenue Codes 420, 430, 440) are paid based upon the RVP unit value multiplied by the applicable conversion factor.

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

(h) All the clinics revenue codes are reimbursed in accordance with Exhibit #4 to this Rule.

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

(1) Types of facilities

- (a) Ambulatory Surgery Centers licensed by the CDPHE
- (b) Physician offices
- (c) Freestanding Radiology Imaging Cardiovascular Testing and procedure Centers
- (d) Freestanding Clinical Laboratory Centers
- (e) Urgent Care facility fees are only payable if the facility qualifies as an Urgent Care facility. Facilities licensed by the CDPHE as a Community Clinic (CC) or a Community Clinic and Emergency Center (CCEC) under 6 CCR 1011-1, Chapter IX should still provide evidence of these qualifications to be reimbursed as an Urgent Care facility. The facility shall meet all of the following criteria to be eligible for a separate Urgent Care facility fee:
  - (1) Separate facility dedicated to providing initial walk-in urgent care;
  - (2) Access without appointment during all operating hours;
  - (3) State licensed physician on-site at all times exclusively to evaluate walk-in patients;
  - (4) Support staff dedicated to urgent walk-in visits with certifications in Basic Life Support (BLS);
  - (5) Advanced Cardiac Life Support (ACLS) certified life support capabilities to stabilize emergencies including, but not limited to, EKG, defibrillator, oxygen and respiratory support equipment (full crash cart), etc.;
  - (6) Ambulance access;
  - (7) Professional staff on-site at the facility certified in ACLS;
  - (8) Extended hours including evening and some weekend hours;

- (9) Basic x-ray availability on-site during all operating hours;
- (10) Clinical Laboratory Improvement Amendments (CLIA) certified laboratory on-site for basic diagnostic labs or ability to obtain basic laboratory results within 1 hour;
- (11) Capabilities include, but are not limited to, suturing, minor procedures, splinting, IV medications and hydration; and
- (12) Written procedures exist for the facility's stabilization and transport processes.

(2) Billing and Maximum Fees

- (a) ASCs are reimbursed in accordance with 18-6(J) and Column 5 from Exhibit #4.
- (b) Maximum reimbursement for physicians performing diagnostic testing in their offices during the course of their care shall be based upon the appropriate RVP© unit value multiplied by the applicable 18-4 conversion factor.
- (c) Maximum Fees for all Freestanding Diagnostic Testing Facilities:
  - (1) All providers should indicate whether they are billing for the total component (00 modifier), professional component only (26 modifier) or technical component only (TC modifier) for any diagnostic test or procedure by listing the appropriate RVP© modifier on the required billing form CMS-1500.
  - (2) Shall be based upon the appropriate RVP© unit value multiplied by the applicable 18-4 conversion factor.
  - (3) All radiology and cardiovascular codes are reimbursed at 90% of the modified or not modified RVP© unit value multiplied by the radiology 18-4 conversion factor. A maximum of four (4) radiology codes may be used in one (1) episode of outpatient diagnostic testing. The highest valued radiology code is allowed at 100% of the maximum value and the remaining three lower valued codes are allowed at 50% of the maximum radiology value.
  - (4) Diagnostic testing dyes, contrasts, supplies and drugs are not separately payable.
  - (5) Fluoroscopy is generally considered incidental when used for guidance when performing a higher valued radiology tests. Refer to CPT® for specific billing instructions.
  - (6) The maximum fees for all clinical laboratory testing shall be reimbursed according the fees as outlined under the Pathology section in 18-5(F).
  - (7) All observation services must be prior approved by the payer if time is greater than 3 hours.

G0378 Observation rate: \$45.00 per hour

(d) Urgent Care Facility Reimbursement

- (1) The total maximum value for an urgent care episode of care includes:
  - (a) An Urgent Care facility fee maximum allowance of \$75.00; and
  - (b) Prior agreement or authorization is recommended for all facilities billing a separate Urgent Care fee. Facilities must provide documentation of the required Urgent Care facility criteria as listed in this Rule 18-6(K) if requested by the payer.
  - (c) All other services/procedures provided in an Urgent Care are reimbursed according the appropriate CPT® code relative weight from RVP® multiplied by the appropriate 18-4 conversion factor.
  - (d) The Observation Room allowance shall not exceed a rate of \$45.00 per hour and is limited to a maximum of three (3) hours without prior authorization for payment (see Rule 16-9 and 16-10).
 

G0378 Observation rate: \$45.00 per hour
  - (e) All supplies are included in the facility fee for Urgent Care facilities.
  - (g) Any prescription for a drug supply to be used longer than a 24 hour period, filled at any clinic, shall fall under the requirements of and be reimbursed as a pharmacy fee. See 18-6(M).
- (2) No separate facility fees are allowed for follow-up care. Subsequent care for an initial diagnosis does not qualify for a separate facility fee. To receive another facility fee any subsequent diagnosis shall be a new acute care situation entirely different from the initial diagnosis.
- (3) No facility fee is appropriate when the injured worker is sent to the employer's designated provider for a non-urgent episode of care during regular business hours of 8 am to 5 pm, Monday through Friday.

#### (L) Home Therapy

Prior authorization for payment (see Rule 16-9 and 16-10) 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, IV administration sets, supplies, supply management, and delivery services. Nursing fees should be billed as indicated in 18-6(L)(2).

##### (a) Parenteral Nutrition:

S9364 <1 Liter	\$160.00/day
S9365 1 liter	\$174.00/day
S9366 1.1 - 2.0 liter	\$200.00/day



S9367 2.1 - 3.0 liter \$227.00/day

S9368 > 3.0 liter \$254.00/day

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

(b) Antibiotic Therapy Dosage Rate:

(See 18-6(M)(3))

S9494 hourly \$158.00/day

S9497 once every 3 hours \$152.00/day

S9500 every 24 hours \$ 97.00/day

S9501 once every 12 hours \$110.00/day

S9502 once every 8 hours \$122.00/day

S9503 once every 6 hours \$134.00/day

S9504 once every 4 hours \$146.00/day

(c) Chemotherapy Dosage Rate:

Per diem + AWP (See 18-6(M)(3))

S9329 Administrative Services \$ 0.00/day

S9330 Continuous (24 hrs. or more) chemotherapy \$91.00/day

S9331 Intermittent (less than 24 hrs.) \$103.00/day

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

S9341 Via Gravity \$44.09/day

S9342 Via Pump \$24.23/day

S9343 Via Bolus \$24.23/day

(e) Pain Management: Per diem + AWP (See 18-6(M)(3))

S9326 Continuous (24 hrs. or more) \$ 79.00/day

S9327 Intermittent (less than 24 hrs.) \$103.00/day

S9328 Implanted pump \$116.00/day

(f) Fluid Replacement: Per diem + AWP (See 18-6(M)(3))

S9373 <1 liter per day \$61.00/day

S9374 1 liter per day \$85.00/day

S9375 >1 but <2 liters per day \$85.00/day

S9376 >2 liters but <3 liters \$85.00/day

S9377 >3 liters per day \$85.00/day

(g) Multiple Therapies:

Rate per day for highest cost therapy only + AWP (see 18-6(M)(3)) for all drugs

Medication/Drug Restrictions - the payment for drugs may be based upon the AWP (see 18-6(M)) of the drug as determined through the use of industry publications such as the monthly Price Alert, First Databank, Inc.

## (2) Nursing Services

(a) Skilled Nursing (LPN & RN)

S9123 RN \$111.00/hr.

S9124 LPN \$ 89.00/hr.

There is a limit of two (2) hours without prior authorization for payment (see Rule 16-9 and 16-10).

(b) Certified Nurse Assistant (CNA):

S9122 CNA \$ 25.00/hr.

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

## (3) Physical Medicine

Physical medicine procedures are payable at the same rate as provided in the physical medicine and rehabilitation services section (see 18-5(H)).

## (4) Mileage

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

DoWC code: Z0772

## (5) Travel Time

Travel is typically included in the fees listed. Travel time greater than one (1) hour, one-way shall be reimbursed. The fee shall be agreed upon at the time of prior authorization for payment (see Rule 16-9 and 16-10) and shall not exceed \$30.00 per hour.

DoWC code: Z0773

(M) Drugs and Medications

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

(2) Average Wholesale Price (AWP)

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

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

(3) Reimbursement for Drugs & Medications (Except Compounded Drugs)

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

(b) For prescriptions written after 30 days from the date of injury, reimbursement shall be AWP + \$4.00. If drugs have been repackaged, use the original AWP and NDC that was assigned by the source of the repackaged drugs to determine reimbursement.

(c) Drugs administered in the course of the provider's direct care shall be reimbursed at the provider's actual cost incurred.

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

(4) Compounded Drugs

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

Category I Z0790 Fee \$ 75.00 per 30 day supply

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

Category II Z0791 Fee \$150.00 per 30 day supply

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

Category III Z0792 Fee \$250.00 per 30 day supply

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

Category IV Z0793 Fee \$350.00 per 30 day supply

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

All ingredient materials must be listed by quantity used per prescription. Category fees include materials, shipping and handling and time. Regardless of how many ingredients or what type, compounded drugs cannot be reimbursed higher than the Category IV fee.

(5) Injured Worker Reimbursement

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

(6) Dietary Supplements, Vitamins and Herbal Medicines

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

(7) Prescription Writing

- (a) Physicians shall indicate on the prescription form that the medication is related to a workers' compensation claim.
- (b) All prescriptions shall be filled with bio-equivalent generic drugs unless the physician indicates "Dispense As Written" (DAW) on the prescription.
- (c) The provider shall prescribe no more than a 60-day supply per prescription.

(8) Required Billing Forms

- (a) All parties shall use one (1) of the following forms:
    - (1) CMS-1500 – the dispensing provider shall bill by using the metric quantity and NDC number of the drug being dispensed; or, if one does not exist, the RVP® supply code; or
    - (2) WC-M4 form or equivalent – each item on the form shall be completed; or
    - (3) With the agreement of the payer, the National Council for Prescription Drug Programs (NCPDP) or ANSI ASC 837 (American National Standards Institute Accredited Standards Committee) electronic billing transaction containing the same information as in (1) or (2) in this sub-section may be used for billing.
- NCPDP Workers' Compensation/Property and Casualty (P&C) Universal Claim Form, version 1.1, for prescription drugs billed on paper shall be used by dispensing pharmacies and pharmacy benefit managers

(PBMs). Physicians may use the CMS- 1500 billing form as described in Rule 16-7(B)(1).

(b) Items prescribed for the work-related injury that do not have an NDC code shall be billed as a supply, using the RVP© supply code (see 18-6(H)).

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

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

(9) A line-by-line itemization of each drug billed and the payment for that drug shall be made on the payment voucher by the payer.

#### (N) Complementary Alternative Medicine (CAM)

CAM is a term used to describe a broad range of treatment modalities, some of which are generally accepted in the medical community and others that remain outside the accepted practice of conventional western medicine. Non-physician providers of CAM may be both licensed and non-licensed health practitioners with training in one (1) or more forms of therapy and certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in acupuncture and/or Chinese herbology. CAM requires prior authorization for payment (see Rule 16-9 and 16-10). Refer to Rule 17, Medical Treatment Guidelines for the specific types of CAM modalities.

#### (O) Acupuncture

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

##### (1) Provider Restrictions

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

##### (2) Billing Restrictions

(a) For treatment frequencies exceeding the maximum allowed in Rule 17, Medical Treatment Guidelines, the provider must obtain prior authorization for payment (see Rule 16-9 and 16-10).

(b) Unless the provider's medical records reflect medical necessity and the provider obtains prior authorization for payment (see Rule 16-9 and 16-10), the maximum amount of time allowed for acupuncture and procedures is one (1) hour of procedures, per day, per discipline.

##### (3) Billing Codes:

(a) Reimburse acupuncture, including or not including electrical stimulation, as listed in the RVP©.

(b) Non-Physician evaluation services

(1) New or established patient services are reimbursable only if the medical record specifies the appropriate history, physical examination, treatment plan or evaluation of the treatment plan. Payers are only required to pay for evaluation services directly performed by an LAc. All evaluation notes or reports must be written and signed by the LAc. Without appropriate supporting documentation, the payer may deny payment. (See Rule 16-11)

(2) LAc new patient visit: DOWC Z0800 Maximum value \$98.72

(3) LAc established patient visit: DOWC Z0801 Maximum value \$66.64

(c) Herbs require prior authorization for payment (see Rule 16-9 and 16-10) and fee agreements as in 18-6(M)(6).

(d) See the appropriate physical medicine and rehabilitation section of the RVP© for other billing codes and limitations (18-5(H)).

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

(P) Use of an Interpreter

Rates and terms shall be negotiated. Prior authorization for payment (see Rule 16-9 and 16-10) is required except for emergency treatment. Use DoWC Z0722 to bill.

(Q) Ambulance Fee Schedule

(1) Billing Requirements:

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

(2) General Claims Submission:

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

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

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

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

(3) Ground and Air Ambulance Vehicle and Crew Requirements

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

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

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

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

		Urban	Rural (R = Zip Code) First 17 miles or > if not a Super Rural	Super Rural (B = Zip code)
Ground Ambulance	HCPCS Code Description	Medicare Rate *250%	Medicare Rate *250%	Medicare Rate *250%
A0425	Ground mileage, per statute mile	\$ 17.72	\$ 17.90	No change
A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1- Non-Emergency)	\$ 663.40	\$ 669.90	\$ 821.30
A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS1- Emergency)	\$1,050.38	\$1,060.68	\$1,300.38
A0428	Ambulance service, basic life support, non-emergency transport (BLS)	\$ 552.83	\$ 558.25	\$ 684.40
A0429	Ambulance service, basic life support, emergency transport (BLS-Emergency)	\$ 884.53	\$ 893.20	\$1,095.05
A0433	Advanced life support, level 2 (ALS2)	\$1,520.28	\$1,535.18	\$1,882.13
A0434	Specialty care transport (SCT)	\$1,796.70	\$1,814.30	\$2,224.35
A0432	Paramedic intercept (PI), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers.	\$ 967.45	\$ 976.93	No change

The "urban" base rate(s) and mileage rate(s) as indicated in 18-6(Q) shall be applied to all relevant/applicable ambulance services unless the zip code range area is "Rural" or "Super Rural." Medicare MSA zip code grouping is listed on Medicare's webpage with an "R" indicator for "Rural" and "B" indicator for "Super Rural." Zip Code to Carrier Locality File- Updated 5/22/12 [ZIP,3MB]

## (5) Modifiers

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

### Code Description

D Diagnostic or therapeutic site other than "P" or "H"

E Residential, domiciliary, custodial facility, nursing home other than SNF (other than 1819 facility)

G Hospital-based dialysis facility (hospital or hospital-related) which includes:

- Hospital administered/Hospital located
- Non-Hospital administered/Hospital located

H Hospital

I Site of transfer (e.g., airport, ferry, or helicopter pad) between modes of ambulance transport

J Non-hospital-based dialysis facility

- Non-Hospital administered/Non-Hospital located
- Hospital administered/Non-Hospital located

N Skilled Nursing Facility (SNF) (1819 Facility)

P Physician's Office (includes HMO non-hospital facility, clinic, etc.)

R Residence

S Scene of Accident or Acute Event

X Destination Code Only (Intermediate stop at physician's office enroute to the hospital, includes HMO non-hospital facility, clinic, etc.)

## (6) Mileage

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



## **18-7 DENTAL FEE SCHEDULE**

The dental fee schedule is adopted using the American Dental Association's Current Dental Terminology, 2009-2010 (CDT-2009-2010). However, surgical treatment for dental trauma and subsequent, related procedures may be billed using medical codes from the RVP©. If billed using medical codes as listed in the RVP©, reimbursement shall be in accordance with the Surgery/Anesthesia section of the RVP© and its corresponding conversion factor. All dental billing and reimbursement shall be in accordance with the Division's Rule 16, Utilization Standards, and Rule 17, Medical Treatment Guidelines. See Exhibit #6 for the listing and maximum allowance for CDT-2013 dental codes.

Regarding prosthetic appliances, the provider may bill and be reimbursed for 50% of the allowed fee at the time the master casts are prepared for removable prosthodontics or the final impressions are taken for fixed prosthodontics. The remaining 50% may be billed on insertion of the final prosthesis.

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### **Editor's Notes**

7 CCR 1101-3 has been divided into smaller sections for ease of use. Versions prior to 01/01/2011, and rule history, are located in the first section, 7 CCR 1101-3. Prior versions can be accessed from the History link that appears above the text in 7 CCR 1101-3. To view versions effective after 01/01/2011, select the desired part of the rule, for example 7 CCR 1101-3 Rules 1-17, or 7 CCR 1101-3 Rule 18: Exhibit 1.

### **History**

*[For history of this section, see Editor's Notes in the first section, 7 CCR 1101-3]*