Director's Interpretations of Issues Impacting the Colorado Workers' Compensation System

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The Division publishes Interpretive Bulletins in an effort to provide guidance on practical applications and interpretations of the Colorado Workers' Compensation Act and Division Rules. The purpose is to provide greater levels of consistency and predictability as to how the Colorado system is intended to operate. While the opinions do not have the force and effect of a rule, they are offered as navigational tools to clarify and simplify processes, create efficiencies, and reduce litigation. This interpretive bulletin includes some of the amendments to Division Rules 16 and 18 that will go into effect on January 1, 2016.

If you have questions regarding the information contained in this bulletin or would like to see additional issues addressed in future bulletins, please direct your inquiries to Paul Tauriello, Director of the Division of Workers' Compensation, 633 17th St., Suite 400, Denver, CO 80202-3660, fax 303.318.8049, or email at paul.tauriello@state.co.us.

Services Performed by Physician Assistants and Nurse Practitioners

The typical maximum value for the medical services performed by Physician Assistants (PAs) and Nurse Practitioners (NPs) is 85 percent of the Medical Fee Schedule. The maximum value for services performed by physicians, on the other hand, is 100 percent of the Medical Fee Schedule. These different reimbursement levels recognize the different expertise levels among these types of providers.

However, Rule 18-5(A) lists two exceptions to this general rule, where PAs and NPs may be paid 100 percent of the Medical Fee Schedule. First, these mid-level providers may be paid 100 percent of the Medical Fee Schedule when a service is provided in a rural area, as defined in Rule. Second, PAs and NPs may be paid 100 percent for their services if they meet "incident to"

criteria. This part of Rule 18-5(A) incorporates by reference the Medicare "incident to" criteria found in 42 CFR §§ 410.26(a) and (b), 410.27, and 410.32(b)(3), as these federal rules existed on August 14, 2015 when the Division adopted the latest revision to Rule 18-5(A). Click here to see the federal regulations. The Division attaches these incorporated federal rules to this interpretive bulletin.

It is important to note that Medicare and affiliated entities may have adopted additional "incident to" rules or interpretations and they may revise these rules and interpretations in the future. The Division is not adopting any present or future rules or interpretations that are not specifically listed in Rule 18-5(A). For example, some publications may state that "incident to" services must be part of a course of treatment where a physician personally performed an initial service. However, this qualification is not listed in 42 CFR §§ 410.26(a) and (b), 410.27, and 410.32(b)(3), as published on August 14, 2015. Therefore, the Division is not requiring a physician to personally perform an initial service in order for any subsequent services performed by PAs and NPs to qualify as "incident to" services. The Division only requires that all claims have an authorized treating physician responsible for all services rendered by any PA or NP and that the physician evaluates the injured worker within his or her first three visits to the office. Rule 16-5(A)(6)(a) and (e). (Notably, this is required for both "incident to" and "non-incident to" services.) The Division also requires that the "incident to" services meet all other applicable conditions listed in 42 CFR §§ 410.26(b) and 410.27.

While Rule 16-5(A)(6)(b) permits physicians to be immediately available *by telephone or in person* when a PA or NP provides services to an injured worker, the "incident to" rules usually require direct supervision. This means that the physician must be present in the office suite (not necessarily in the same room) and must be immediately available to assist and direct the PA or

the NP throughout the performance of the procedure. Thus, a situation where a physician is only available by telephone would comply with Rule 16-5(A)(6)(b), but the PA or NP would be paid 85 percent of the medical fee schedule, not 100 percent (unless the service is provided in a rural area).

Finally, in accordance with Rule 16-5(A)(6)(d), the authorized treating physician (ATP) must counter-sign patient records related to inability to work resulting from the work injury or disease, ability to return to regular or modified employment, maximum medical improvement, as well as permanent impairment. The ATP also must counter sign Form WC 164. The purpose of Rule 16-5(A)(6)(d) is to comply with §§ 8-42-105(2)(b), -105(3)(c), and -107(8), C.R.S., which require statements from an attending or authorized *physician* regarding these matters (emphasis added). *See*, Interpretive Bulletin 10. This rule applies to both "incident to" services and "non-incident to" services performed by PAs and NPs.

Transition to International Classification of Diseases (ICD) 10 Coding System

The October 1, 2015 compliance date for implementation of ICD-10 applies to all Health Insurance Portability and Accountability Act (HIPAA)-covered entities. Workers' compensation companies are considered non-covered entities. However, because ICD-9 will not be maintained after ICD-10 is implemented, it is in non-covered entities' best interest to use the new ICD-10 coding system. The increased level of detail in ICD-10 is of significant value to non-covered entities as well. Rule 18, which establishes the Colorado Workers' Compensation fee schedule, enables the transition to ICD-10 CM and PCS coding systems once CMS adopts them. Given that CMS 1500 form, version 02/012, carries both ICD-9 and 10, both providers and payers have the flexibility to work together in implementing the ICD-10 as it is rolled out in other insurance

and healthcare systems. Medical providers must bill using only ICD-9 or ICD-10 and cannot mix coding systems in a single bill.

One exception to the discussion above is hospital inpatient billing. Rule 18 incorporates by reference the Medicare Severity Diagnosis Related Groups (MS-DRGs) Definitions Manual, Version 33.0 effective after October 1, 2015, which in turn incorporates the ICD-10 PCS coding system applicable to hospital inpatient billing. Therefore, the ICD-10 PCS coding system will be required for hospital inpatient billing after October 1, 2015.

The Division recommends that insurers and bill review companies clearly identify on the Explanation of Benefits or Reviews a contact person who could assist providers with conversion to ICD-10. In addition, payers should not deny reimbursement solely because a provider billed using either ICD-9 or ICD-10. The Division does not believe these coding differences meet the "clear and persuasive" standard for denying payment.

Medical Providers Billing Separately for Documenting Functional Progress Made By The Injured Worker

New Rule 18-6(G)(6)(c) permits medical providers who are Level I or II accredited, or who have completed the Division-sponsored Level I or II accreditation program and have successfully completed the Quality Performance and Outcomes Payment training to bill separately for documenting functional progress made by the injured worker. The medical providers must use Division codes Z0815, Z0816, and Z0817 to accomplish this billing. Rule 18-6(G)(6)(c) lists documentation and other requirements that must be met before the medical providers may bill these codes. The payers will be able to verify whether a provider is qualified to bill these codes on the Division website's Physician Accreditation page and are encouraged to contact the Division if there are auditing concerns.

Current Procedural Terminology (CPT®) and Other References

Rule 18 includes numerous references to medical services and procedures. The previous interpretive bulletin, adopted on September 12, 2014, identifies CPT® codes for many of those services or procedures. This interpretive bulletin incorporates the CPT® code references listed in the previous interpretive bulletin, unless inconsistent with the discussion below or the version of Rule 18 effective January 1, 2016 (which adopts and incorporates by reference as modified and published by Medicare in January 2015, National Physician Fee Schedule Relative Value file (RBRVS-Resource Based Relative Value Scale) instead of the Relative Values for Physicians scale).

The previous interpretive bulletin contains a transposed CPT® code. The code is listed under Vaccines and Toxoids as **90467**, but the correct code is **90476**.

Rule 16:

To receive an NPI number, providers can go to:

https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart (last checked September 23, 2015).

Rule 18:

The fee schedules for the 2016 dates of service, including RBRVS-professional Relative Value Units (RVUs) (non-facility and facility); Exhibit Nos. 4, 6, and 8; Average Sale Price fees, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fees, Outpatient Hospital and Ambulatory Surgical Center (ASC) fees, Home health fees, and Ambulance fees may be found here.

Rule 18-6-(H), Supplies:

A list of HCPCS codes related to Complex Rehabilitation Technology (CRT) can be found here.

Rule 18-6(J), Outpatient Hospital Facility Fees:

The updated link to Medicare's Revised Addendum B, found on Medicare's Hospital Outpatient Prospective Pay Systems website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates-Items/2015-Jan-Addendum-B.html (last checked September 23, 2015).

The link to the APC offset file for implants and biologicals, last checked September 23, 2015, is:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files-Items/2015-Annual-Policy-Files.html?DLPage=1&DLSort=0&DLSortDir=ascending (last checked September 23, 2015).

Division Referenced Fee Schedule sources (RBRVS, DMEPOS, ASP, Outpatient Hospital APCs and etc) and Division Established Zxxxx Codes and Values:

Click here for a link to an Excel® spreadsheet of Division fee schedule(s) with Division established codes and values (Z codes) and RBRVS relative values and 2015 APC crosswalk of Rule 18, Exhibit 4