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

In an effort to provide guidance on the practical applications of the Colorado Workers' Compensation Act, we are publishing Director's interpretations of statutes and other factors affecting the system, in the form of *Interpretive Bulletins*. 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 rule, they are offered as navigational tools to clarify and simplify processes, create efficiencies and to reduce litigation.

If you have questions regarding this information or issues you would like to see addressed in future bulletins, please direct your inquiries to Paul Tauriello, Director of the Division of Workers' Compensation, at 633 17<sup>th</sup> St., Suite 400, Denver, CO 80202-3660, fax 303.318.8632, or e-mail at [paul.tauriello@state.co.us](mailto:paul.tauriello@state.co.us).

### **Colorado Workers' Compensation Fee Schedule Implementation Data (CWCFSID) Rule 18 Medical Fee Schedule, Effective January 1, 2012**

**Release Date: November 22, 2011**  
**Revision Date:**

For medical services rendered after January 1, 2012, Rule 18 makes a number of references to medical procedures. This interpretive bulletin identifies *Current Procedural Terminology* (CPT®) codes for many of those procedures and identifies the citations within Rule 18 where these CPT® codes logically fit into that language. There are a few instances in *Relative Values for Physicians* (RVP©) with no assigned relative value units (RVU) where the Division believes it would be appropriate to provide reasonable values. These codes are referenced in the paragraphs below under their respective sections of the RVP©. The full text of Rule 18 can be found on the Division's webpage under "Rules of Procedure."

The five character codes included in the *Colorado Workers' Compensation Fee Schedule Implementation Data* are obtained from CPT®, copyright 2010 by the American Medical Association (AMA). CPT® is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physicians.

The responsibility for the content of *Colorado Workers' Compensation Fee Schedule Implementation Data* is with the Colorado Division of Workers' Compensation (DWC) and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in *Colorado Workers' Compensation Fee Schedule Implementation Data*. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT® and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT® outside of *Colorado Workers' Compensation Fee Schedule Implementation Data* should refer to the most current *Current Procedural Terminology* manual which contains the complete and most current listing of CPT® codes and descriptive terms. Applicable Federal Acquisition Regulations Supplement/Defense Federal Acquisition Regulations Supplement (FARS/DFARS) apply.

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**Rule 16, effective January 1, 2012**

To receive a NPI number, providers can go to

<https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart> . (accessed September 29, 2011).

**Rule 18, effective January 1, 2012**

In some instances of high frequency services, the 2011 RVP© has not established RVUs. In other cases, RVP© RVUs have not been adopted. The Division considers the following RVU values would be appropriate:

**Table 1**

CPT® / DoWC Code	DOWC Recommended Relative Value Unit or fee	Identifier
64449	7	Surgery-X Code, Lumbar plexus spine anesthetic injection
64490	10	Surgery-X Code, Cervical/thoracic zygapophyseal, single level
64491	5	Surgery X Code, Cervical/thoracic zygapophyseal, second level
64492	5	Surgery X Code, Cervical/thoracic zygapophyseal, third or more
64493	8	Surgery X Code, Lumbar/sacral zygapophyseal, single level
64494	4	Surgery X Code, Lumbar/sacral zygapophyseal, second level
64495	4	Surgery X Code, Lumbar/sacral zygapophyseal, third or more
99053	4	Medicine: Service between 10:00 PM and 8:00 AM, 24-hr facility
99183	24	Medicine: Hyperbaric Oxygen Therapy Services
Z759	\$355.00	For Impairment rating max fee by authorized treating Level II physician. Do not use 99455.
Z760	\$575.00	For Impairment rating max fee by non-treating authorized Level II physician. Do not use 99456.
Z500	negotiated	PM&R: Mutually agreed upon per diem rate
Z503	9.5 RVU/15-min	PM&R: Computer Enhanced Evaluation
Z504	9.5 RVU/15-min	PM&R: Work Tolerance Screening

**Table 2****HCPCS Level II Codes**

Code	DoWC Recommended Value	Identifier
G0289	RVP© value 11.8 RVUs	Arthroscopy multiple add on
G0378	\$45.00/hr observation	Observation Room
G0431	\$138.28	Drug screen, qualitative, multiple drug classes by high complexity test method
G0434	\$27.66	Drug screen, other than chromatographic any number of drug classes
S9088	\$75.00	Urgent Care Facility Fee

### Rule 18-4

The conversion factors (CF) found in Rule 18-4 are listed here with their applicable code ranges for your convenience. Maximum reimbursement is calculated by multiplying the respective CF by the RVU from the RVP©.

**Table 3**

<b>RVP©</b>	<b>Code Range</b>	<b>CONVERSION FACTOR</b>
Anesthesia	(CPT® 00100 –01999 and 99100-99140)	\$51.89 /RVU
Surgery	(CPT® 10021-69990)	\$96.53 /RVU
Surgery X Codes	(See Rule 18-5(D)(1)(d)) and below	\$38.83 /RVU
Radiology	(CPT® 70010-79999)	\$17.78 /RVU
Pathology	(CPT® 80047-89358)	\$13.25 /RVU
Medicine	(CPT® 90281 - 96999 and 98925 – 99199 and 99500-99607)	\$ 7.71 /RVU
Physical Medicine	(CPT® 97001-97814)	\$ 6.02 /RVU
Evaluation & Management	(CPT® 99201 – 99499)	\$ 9.81 /RVU

### Rule 18-5(D)(1)

Anesthesia add-on codes 99100-99140 found in the Medicine section of the RVP© are reimbursed using the anesthesia CF and unit values found in the RVP©, Anesthesia Guidelines XII, “Qualifying Circumstances”.

The surgery-X codes, referred to in section 18-5(D)(1)(d)(1) are:

01996 31500 36400 36425 36600 36620 36625 36660 62273 62280 62281 62282  
62310 62311 62318 62319 64400 64402 64405 64408 64410 64412 64413 64415  
64416 64417 64418 64420 64421 64425 64430 64435 64445 64446 64447 64448  
64449 64450 64479 64480 64483 64484 64490 64491 64492 64493 64494 64495  
64505 64508 64510 64520 64530 64600 64605 64610 64620 64622 64623 64626  
64627 64630 64640 64680

64490, -91, -92, -93, -94, -95 replace 64470, -72, -75, -76. The 64490-64495 series includes fluoroscopy or CT guidance. If no imaging is used, they should bill the surgery non-X codes 20550-20553, CPT® says ultrasound guidance should bill 64999.

### Rule 18-5(G)

The Medicine section of the RVP©:

- Home therapy codes 99500-99602 are not adopted.

- Biofeedback training codes are 90901 and 90911.
- Electro-diagnostic study codes are 95860-95937.
- Osteopathic manipulation codes are 98925-98929.
- Chiropractic manipulation codes are 98940-98943.
- Psychological diagnostic interview procedures are 90801-90802.
- Psychotherapy services are 90804-90829, 90845-90857, and 90875-90876, 90882.
  - NOTE: 90882 environmental intervention for medical management on a psychiatric patient's behalf with agencies, employers or institutions.
- Hyperbaric oxygen therapy service code is 99183.
- Qualified non-physician provider telephone services are 98966-98968.
- Qualified non-physician provider on-line service is 98969.
- Medical team conference non-physician codes are:
  - When the patient/family is present, bill code 99366.
  - When the patient/family is not present, bill code 99367-99368.
- CNS testing procedures are 96101-96125.

○

#### **Rule 18-5(H)**

##### Physical Medicine and Rehabilitation:

- Medical nutrition therapy codes are 97802-97804 (prior authorization required).
- Procedure codes are 97110-97535 and 97542.
- Unattended, non-timed modality codes are 97010-97028.
- Attended, timed modality codes are 97032-97039.
- Physical therapist evaluation codes are 97001, evaluation, and 97002, reevaluation.
- Occupational therapist evaluation codes are 97003, evaluation, and 97004, re-evaluation.
- Athletic training evaluation codes are 97005, evaluation, and 97006, re-evaluation.
- Interdisciplinary rehabilitation programs use DoWC Z500.
- Special Tests

- Job site evaluation is 97537.
- Functional capacity evaluation is 97750
- Computer enhanced evaluation code is DoWC Z503
- Work tolerance screening code is DoWC Z504
- Assistive technology assessment code is 97755.
- Speech therapy codes are 92506, evaluation, 92507-92508, treatment, and 96105-96111 CNS and aphasia evaluation.
- Work conditioning, work hardening, and work simulation codes are 97545 and 97546.
- Telephone assessment services are Medicine codes 98966, 98967, 98968
- Non-physician on-line and management code is Medicine code 98969

### **Rule 18-5(l)**

#### Evaluation and Management (E&M):

- Office or other outpatient visit codes are 99201-99350.
- Treating physician telephone or on-line medical management service codes are 99366-99368.
- Medical team conference physician codes are:
  - When the patient/family is present, physicians may bill an E&M code;
  - When the patient/family is not present, the physician should bill 99367.
  - Face-to-face or telephonic meeting by a non-treating physician without a specific report or written record should bill DoWC Z601.
  - Face-to-face or telephonic meeting by a non-treating physician with a report or written record should bill as a special report (Rule 18-6(G) (4)).
  - Face-to-face or telephonic meeting by a treating physician should be billed in accordance with Rule 18-6(A).
  - Rule 18, Exhibit 7 “Evaluation and Management (E&M) Guidelines for Colorado”.

### **Rule 18-6**

#### **Division Established Codes and Values (Z codes)**

**Table 4**

<b>Cite Rule18</b>	<b>Code</b>	<b>New Rate</b>	<b>RVUs</b>	<b>Time</b>	<b>Description</b>
18-5(E)(2)(d)	Z200	\$865.37			Upper body w/Autonomic Stress Testing
	Z201	\$865.37			Lower Body w/autonomic Stress Testing
18-5(G)(9)	Z401	\$1,007.00			<b>QSART</b>
18-5(H)(4)	Z500	per diem			Interdisciplinary Team
18-5(H)(6)	Z501	\$32.51	5.4		Single or multiple needles - dry needling
	Z502	\$34.92	5.8		Three or more needles - dry needling
18-5(H)(8)	Z503	\$57.19	9.5	per 15 min	Computer Enhanced Evaluation
	Z504	\$57.19	9.5	per 15 min	Work Tolerance Screening
18-6(H)(11)	Z505	\$9.03	1.5	per day	Unattended Treatment fixed fee per day
18-5(I)(6)	Z601	\$65.00		per 15 min	Face-to-face or telephonic meeting
18-6(A)	Z701	\$75.00		per 15 min	Face-to-face or telephone meeting treating with emp (SAMS)
18-6(B)	Z720	see 18-6(B)	1/2 fee		Cancellation Fee 1/2 usual fee or rate whichever is less
18-6(C)	Z721	see 18-6(C)			Copying Fee
	Z722	see 18-6(R)			Interpreter
18-6(E)	Z723	\$0.47			Mileage
18-6(D)(2)	Z730	\$325.00		hr	Prep Time Deposition and Testimony
18-6(D)(3)	Z731	\$325.00		hr	Deposition cancellation 7+
	Z732	\$325.00		hr	Deposition cancellation >5 but <7
	Z733	\$325.00		hr	Deposition cancellation <5
	Z734	\$325.00		hr	Deposition fee per hr
18-6(D)(4)	Z735	\$450.00		hr	Testimony cancellation 7+
	Z736	\$450.00		hr	Testimony cancellation >5 but <7
	Z737	\$450.00		hr	Testimony cancellation <5
	Z738	\$450.00		hr	Testimony Fee \$450.00/hr
18-6(G)(2)(e)	Z750	\$42.00			Initial WC 164
	Z751	\$42.00			Progress Report
	Z752	\$42.00			Closing Report
	Z753	\$42.00			Initial and Closing on same report
18-6(G)(3)	Z754	\$42.00			Completion add'l forms
18-6(G)(4)	Z755	\$325.00		hr	Special Report - Written Report only
	Z756	\$325.00		hr	Special Report - IME/Report W Patient Exam
	Z757	\$325.00		hr	Special Report - Lengthy Form Completion
	Z758	\$325.00		hr	18-5(I)(7) Meeting & Report with Non-treating Physician
	Z759	\$355.00			Impairment Rating Treating Physician
	Z760	\$575.00			Impairment Rating Referral
	Z761	\$325.00		hr	Special Report - cancellation not requiring patient exam

Cite Rule18	Code	New Rate	RVUs	Time	Description
	Z762	\$325.00		hr	Special Report - IME/Report W Patient Exam Cancellation +7 days
	Z763	\$325.00		hr	Special Report - IME/Report W Patient Exam Cancellation >5 but <7 days
	Z764	\$325.00		hr	Special Report - IME/Report W Patient Exam Cancellation <5 days
18-6(G)(5)(b)	Z765	\$75.00		per 15 min	Opioid Management
18-6(G)(4)	Z766	\$30.00		per exam	CRS 8-43-404 IME Audio Recording
	Z767	\$20.00		per copy	CRS 8-43-404 IME Audio Copying Fee
Rule 11	Z768	\$675.00			DIME Division Independent Medical Exam
Rule 11	Z769	\$100.00			DIME Late Payment adjustment
18-6(N)(2)	Z770	\$95.79		hr	Skilled Nursing
	Z771	\$31.67		first hr	Certified Nurse Assistant
18-6(N)(4)	Z772	\$0.47		mile	Mileage
18-6(N)(5)	Z773	\$30.00		hr	Travel Time
	Z774	\$9.46		addtl 1/2 hr	Certified Nurse Assistant
18-6(O)(4)	Z790	\$75.00			Compounded Drugs -- Category I
	Z791	\$150.00		hr	Compounded Drugs -- Category II
	Z792	\$250.00			Compounded Drugs -- Category III
	Z793	\$350.00			Compounded Drugs -- Category IV
18-6(Q)(3)(b)(2)	Z800	\$96.32			LAc new patient
	Z801	\$65.02			LAc established patient
Rule 18-5(D)(2)(j)	G0289	\$1,081.14	11.2		See description of use in Rule 18-6(D)(2)(j)
18-6(J)(3)(c)(4)	G0378	\$45.00		hr	Observation/convalescence
	G0431	\$138.28			Drug screen qualitative, multiple drug classes by high complexity test method
	G0434	\$27.66			Drug screen, other than chromatographic any number of drug classes by CLIA waived test/moderate complexity test per patient encounter
18-6(L)(2)(b) & (3)(a)	S9088	\$75.00			Urgent Care Facility Fee

### Rule 18-6(J)

Outpatient surgery facility fees for both hospitals and ASCs are based upon Medicare's APC system. To assist in the determination of the appropriate APC Grouper under Rule 18-6(J)(3)(c), a list of CPT® codes and their respective APC Grouper is given in the "Exhibit for Outpatient Surgery Facility Codes and Fees" to this interpretive bulletin. Grouper code 210, found in that exhibit, was created by DOWC to reimburse CPT® spinal fusion codes not listed in Medicare's Addendum B. For CPT® codes not contained in that Exhibit, refer to Rule 18-6(J)(3)(c).

The Revised Addendum B can be found on Medicare's Hospital Outpatient Prospective Pay Systems (PPS) website. The address as of September 23, 2011 was:

<https://www.cms.gov/HospitalOutpatientPPS/AU/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1243097&intNumPerPage=10>

In addition, Medicare's "2011 Offset Amount by APC" table was used identify separately payable implants and biologics for outpatient and ASC services. The address as of October 15, 2010 was:

Facility fees for the following outpatient surgery arthrogram and myelogram injection codes are best billed by using the corresponding radiology code with an appropriate modifier [see Rule 18-6(J)(3)(c)(3)]:

**APC Facility fees for Arthrography in hospitals or ASCs are determined based upon the Radiology Code, not the Surgical Injection Code**

Fluoroscopy is always included in facility fees when done in hospital or ASC.

<b>CPT surgical injection code</b>	<b>X-ray Arthrography code has fluoroscopy included</b>	<b>APC # for X-Ray Arthrography APC #</b>	<b>Or enhanced Arthrography Upper or Lower Extremity with CT</b>	<b>APC # for CT enhanced Arthrography</b>	<b>Or enhanced Arthrography any joint with MRI</b>	<b>APC # for MRI enhanced Arthrography</b>
21116	70332	275			70336	336
23350	73040	275	73201 or 73202	283 or 333	73222 or 73223	284 or 337
24220	73085	275	73201 or 73202	283 or 333	73222 or 73223	284 or 337
25246	73115	275	73201 or 73202	283 or 333	73222 or 73223	284 or 337
27093	73525	275	73701 or 73702	283 or 333	73722 or 73723	284 or 337
27095	73525	275	73701 or 73702	283 or 333	73722 or 73723	284 pr 337
27096	73542	275	normally not done		normally not done	
27370	73580	275	73701 or 73702	283 or 333	73722 or 73723	284 or 337
27648	73615	275	73701 or 73702	283 or 333	73722 or 73723	284 or 337

**Spine Injection Diagnostic Testing done in Hospital or ASC**

<b>CPT surgical injection code</b>	<b>X-ray Arthrography code has fluoroscopy included</b>	<b>APC # for X-Ray Arthrography APC #</b>
62284	72240-72270	274
62290	72295	388
62291	72285	388

**Rule 18-6(M)(3)(d)**

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All hospital outpatient emergency room facility fees, including the ERD level, are reimbursed based on Exhibit 4 of this Rule 18. Exhibit 4 lists Medicare's outpatient hospital ambulatory prospective payment codes (APC) and rates. The Division's "Outpatient Hospital ERD Rate" is equal to Medicare's APC payment rate, as listed in Column #3 in Exhibit #4. See Medicare's January 2010 revision of Addendum B to reflect the Affordable Care Act 05/18/2010:

<https://www.cms.gov/HospitalOutpatientPPS/AU/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1243097&intNumPerPage=10>

(Only the higher one of any ERD Levels or critical care codes Outpatient emergency room department (ERD) facility fees, ERD levels 1-5 are billed using E&M codes 99281-99285 as required by Medicare. When billed on a UB-92, the billing of these codes should not be confused with the professional services of the physician.

**Rule 18-6(O)(13)(b)**

Pharmacy fees for pharmaceuticals that have no NDC code are appropriately billed as a supply using the *RVP*© supply code 99070.

**Rule 18-6(Q)**

Acupuncture codes are the physical medicine codes 97810-97814.

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**Colorado Division of Workers' Compensation**  
**Rule 18 Interpretive Bulletin: Exhibit for Outpatient Surgery Facility Codes & Fees**  
**For CPT® codes not contained in this Exhibit, refer to Rule 18-6(J)(3)(c)**  
**Effective January 1, 2012**