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 17th St., Suite 400, Denver, CO 80202-3660, fax 303.318.8632, or e-mail at paul.tauriello@state.co.us.

Colorado Workers' Compensation Fee Schedule Implementation Data (CWCFSID)
Rule 18 Medical Fee Schedule, Effective January 1, 2013.

Release Date:
Revision Date: October 23, 2012

For medical services rendered after January 1, 2013, 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 of *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 CWCFSID are obtained from CPT®, copyright 2011 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.

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CPT is a registered trademark of the AMA.

Rule 16, effective January 1, 2013

To receive an NPI number, providers can go to https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart (accessed September 28, 2012).

Rule 18, effective January 1, 2013

In some instances of high frequency services, the 2012 RVP© has not established RVUs. In other cases, RVP© RVUs have not been adopted. The Division considers the following RVU values to be appropriate:

Table 1

CPT® / DoWC Code	DOWC Recommended Relative Value Unit or fee	Identifer
64449	7	Surgery-X Code, anesthetic agent; lumbar plexus posterior approach, continuous infusion by catheter (including catheter placement)
64490	10	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
64491	5	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure) an add-on code
64492	5	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any addition level(s) (List separately in addition to code for primary procedure) an add-on code
64493	8	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
64494	4	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure) an add-on code
64495	4	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any addition level(s) (List separately in addition to code for primary procedure) an add-on code
64633	12	Destruction by neurolytic agent, paravertebral facet joint nerve(s), w imaging guidance (fluroscopy or CT); cervical or thoracic, single facet
64634	6	Cervical or thoracic, each additional facet joint (Lisdt in addition to code for primary procedure) add-on code
64635	12	Destruction by neurolytic agent, paravertebral facet joint nerve(s),

CPT® / DoWC Code	DOWC Recommended Relative Value Unit or fee	Identifer
		w imaging guidance (fluroscopy or CT); lumbar or sacral, single facet
64636	6	Lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure) add-on code
99053	4	Medicine: Service between 10:00 PM and 8:00 AM, 24-hr facility
99100	Anesthesia 1	Anesthesia Qualifying Circumstance, cf. RVP© Anesthesia Guidelines
99116	Anesthesia 5	Anesthesia Qualifying Circumstance, cf. RVP© Anesthesia Guidelines
99135	Anesthesia 5	Anesthesia Qualifying Circumstance, cf. RVP© Anesthesia Guidelines
99140	Anesthesia 2	Anesthesia Qualifying Circumstance, cf. RVP© Anesthesia Guidelines
99183	24	Medicine: Hyperbaric Oxygen Therapy Services
Z0759	$355.00	For Impairment rating max fee by authorized treating Level II physician. Do not use 99455.
Z0760	$575.00	For Impairment rating max fee by non-treating authorized Level II physician. Do not use 99456.
Z0500	negotiated	PM&R: Mutually agreed upon per diem rate
Z0503	9.5 RVU/15-min	PM&R: Computer Enhanced Evaluation
Z0504	9.5 RVU/15-min	PM&R: Work Tolerance Screening; refer to Rule 17 Exhibits
Rev681	$3,000.00	Trauma Activation fee
Rev682	$2,500.00	Trauma Activation fee
Rev683	$1,000.00	Trauma Activation fee
Rev684	$0.00	Trauma Activation fee

Table 2

HCPCS Level II Codes

Ground Ambulance	Urban Medicare*250%	Rural Medicare*250%	Super Rural Medicare*250%	Description
A0425	$17.57	$17.74	No change	Ground mileage, per statue mile
A0426	$658.12	$664.57	$814.76	ALS 1-Non-Emergency
A0427	$1,042.02	$1,052.23	$1,290.04	ALS 1-Emergency
A0428	$548.43	$553.81	$678.97	BLS
A0429	$877.49	$886.09	$1,086.35	BLS-Emergency
A0432	$959.75	$969.16	No change	PI, Paramedic intercept
A0433	$1,508.18	$1.522.97	$1,867.16	ALS2
A0434	$1,782.40	$1,799.87	$2,206.64	SCT
Fixed Wing Air				
A0430	$7,290.80	$10,936.20	No change	FW, one way
A0435	$20.63	$30.94	No change	FW mileage, per statue mile
Rotary Air				
A0431	$8,476.64	$12,714.97	No change	RW, one way, per statue mile
A0436	$55.08	$82.61	No change	RW mileage
Code		DoWC Recommended Value		Identifier

G0289	RVP© value 11.2 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

S9364	$160.00	Parenteral Nutrition	<1 Liter
S9365	$174.00	Parenteral Nutrition	1 Liter
S9366	$200.00	Parenteral Nutrition	1.1-2.0 Liter
S9367	$227.00	Parenteral Nutrition	2.1-3.0 Liter
S9368	$254.00	Parenteral Nutrition	>3 Liter
S9494	$158.00	Antibiotic Therapy	
S9497	$152.00	Antibiotic Therapy	once every 3 hours
S9500	$97.00	Antibiotic Therapy	every 24 hours
S9501	$110.00	Antibiotic Therapy	once every 12 hours
S9502	$122.00	Antibiotic Therapy	once every 8 hours
S9503	$134.00	Antibiotic Therapy	once every 6 hours
S9504	$146.00	Antibiotic Therapy	once every 4 hours
S9329	$0.00	Chemotherapy	Administrative Services
S9330	$91.00	Chemotherapy	Continuous (24 hrs or more) chemotherapy
S9331	$103.00	Chemotherapy	Intermittent (less than 24 hours)
S9341	$44.09	Enteral nutrition	Via Gravity
S9342	$24.23	Enteral nutrition	Via Pump
S9343	$24.23	Enteral nutrition	Via Bolus
S9326	$79.00	Pain Management	Continuous (24 hrs or more) chemotherapy
S9327	$103.00	Pain Management	Intermittent (less than 24 hours)
S9328	$116.00	Pain Management	Implanted pump
S9373	$61.00	Fluid Replacement	<1 Liter
S9374	$85.00	Fluid Replacement	1 Liter per day
S9375	$85.00	Fluid Replacement	>1 but <2 Liters per day
S9376	$85.00	Fluid Replacement	>2 but <3 Liters
S9377	$85.00	Fluid Replacement	>3 Liters
S9123	$111.00	Skilled Nursing	RN
S9124	$89.00	Skilled Nursing	LPN
S9122	$25.00	Certified N Asst	CAN

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

RVP©	Code Range	CONVERSION FACTOR
Anesthesia	(CPT® 00100 –01999 and 99100-99140)	$52.67 /RVU
Surgery	(CPT® 10021-69990)	$97.98 /RVU
Surgery X Codes	(*See* Rule 18-5(D)(1)(d)) and below	$39.41 /RVU
Radiology	(CPT® 70010-79999)	$18.05 /RVU
Pathology	(CPT® 80047-89398)	$13.45 /RVU
Medicine	(CPT® 90281 - 96999 and 98925 – 99199 and 99500-99607)	$ 7.83 /RVU
Physical Medicine	(CPT® 97001-97814)	$ 6.11 /RVU
Evaluation & Management	(CPT® 99201 – 99499)	$ 9.96 /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	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	64630	64633	64634	64635	64636	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 (requires prior authorization).

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 is 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 code is 97001, evaluation; and 97002 is re-evaluation.
- Occupational therapist evaluation code is 97003, evaluation, and 97004 is re-evaluation.
- Athletic training evaluation code is 97005, evaluation, and 97006 is re-evaluation.
- Interdisciplinary rehabilitation programs use DoWC Z0500.
- Special Tests
    - Job site evaluation is 97537.
    - Functional capacity evaluation is 97750
    - Computer enhanced evaluation code is DoWC Z0503

- Work tolerance screening code is DoWC Z0504
- 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(I)

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 Z0601.
  - 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 18-6

Division Established Codes and Values

Click here for a link to Excel® spreadsheet of Division established codes and values (Z codes)

Table 4

Cite Rule18	Code	New Rate	RVUs	Time	Description
18-5(E)(2)(d)	Z0200	$865.37			Upper body w/Autonomic Stress Testing
	Z0201	$865.37			Lower Body w/autonomic Stress Testing
18-5(G)(9)	Z0401	$1,007.00			QSART
18-5(H)(4)	Z0500	per diem			Interdisciplinary Team
18-5(H)(6)	Z0501	$32.99	5.4		Single or multiple needles - dry needling
	Z0502	$35.44	5.8		Three or more needles - dry needling
18-5(H)(8)	Z0503	$58.05	9.5	per 15 min	Computer Enhanced Evaluation
	Z0504	$58.05	9.5	per 15 min	Work Tolerance Screening
18-6(H)(11)	Z0505	$9.17	1.5	per day	Unattended Treatment fixed fee per day
18-5(I)(6)	Z0601	$65.00		per 15 min	Face-to-face or telephonic meeting
18-6(A)	Z0701	$75.00		per 15 min	Face-to-face or telephone meeting treating with emp (SAMS)
18-6(B)	Z0720	see 18-6(B)	$150 or 1/2 fee		Cancellation Fee 1/2 usual fee or rate whichever is less
18-6(C)	Z0721	see 18-6(C)			Copying Fee
	Z0722	see 18-6(S)			Interpreter
18-6(E)	Z0723	$0.52			Mileage
18-6(D)(2)	Z0730	$325.00		hr	Prep Time Deposition and Testimony
18-6(D)(3)	Z0731	$325.00		hr	Deposition cancellation 7+
	Z0732	$325.00		hr	Deposition cancellation >5 but <7
	Z0733	$325.00		hr	Deposition cancellation <5
	Z0734	$325.00		hr	Deposition fee per hr
18-6(D)(4)	Z0735	$450.00		hr	Testimony cancellation 7+
	Z0736	$450.00		hr	Testimony cancellation >5 but <7
	Z0737	$450.00		hr	Testimony cancellation <5
	Z0738	$450.00		hr	Testimony Fee $450.00/hr
18-6(G)(2)(e)	Z0750	$42.00			Initial WC 164
	Z0751	$42.00			Progress Report
	Z0752	$42.00			Closing Report
	Z0753	$42.00			Initial and Closing on same report
18-6(G)(3)	Z0754	$42.00			Completion addt'l forms
18-6(G)(4)	Z0755	$325.00		hr	Special Report - Written Report only
	Z0756	$325.00		hr	Special Report - IME/Report W Patient Exam
	Z0757	$325.00		hr	Special Report - Lengthy Form Completion
	Z0758	$325.00		hr	18-5(I)(7) Meeting & Report with Non-treating Physician
18-6(F)(4)(b)(1)	Z0759	$355.00			Impairment Rating Treating Physician
18-6(F)(4)(b)(2)	Z0760	$575.00			Impairment Rating Referral

Cite Rule18	Code	New Rate	RVUs	Time	Description
18-6(G)(4)	Z0761	$325.00		hr	Special Report - cancellation not requiring patient exam
18-6(G)(4)	Z0762	$325.00		hr	Special Report - IME/Report W Patient Exam Cancellation +7 days
18-6(G)(4)	Z0763	$325.00		hr	Special Report - IME/Report W Patient Exam Cancellation >5 but <7 days
18-6(G)(4)	Z0764	$325.00		hr	Special Report - IME/Report W Patient Exam Cancellation <5 days
18-6(G)(5)(b)	Z0765	$75.00		per 15 min	Opioid Management
18-6(G)(4)	Z0766	$30.00		per exam	CRS 8-43-404 IME Audio Recording
	Z0767	$20.00		per copy	CRS 8-43-404 IME Audio Copying Fee
Rule 11	Z0768	$675.00			DIME Division Independent Medical Exam
Rule 11	Z0769	$100.00			DIME Late Payment adjustment
18-6(O)(4)	Z0772	$0.52		mile	Mileage
18-6(N)(5)	Z0773	$30.00		hr	Travel Time
18-6(P)(4)	Z0790	$75.00			Compounded Drugs -- Category I
	Z0791	$150.00		hr	Compounded Drugs -- Category II
	Z0792	$250.00			Compounded Drugs -- Category III
	Z0793	$350.00			Compounded Drugs -- Category IV
18-6(R)(3)(b)(2)	Z0800	$97.76			LAc new patient
	Z0801	$65.99			LAc established patient

Rule 18-6(J)

Outpatient surgery facility fees for both hospitals and ambulatory surgery centers (ASCs) are based upon Medicare's Ambulatory Payment Classification (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 (July) can be found on Medicare's Hospital Outpatient Prospective Pay Systems (PPS) website. The address as of September 28, 2012 was:

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html

In addition, Medicare's "2011 Offset Amount by APC" table was used to identify separately payable implants and biologics for outpatient and ASC services. The address as of October 23, 2012 was:

http://www.cms.gov/apps/ama/license.asp?file=/HospitalOutpatientPPS/Downloads/2012-Final-OFFSET-AMOUNTS-BY-APC.zip If this link does not work because it is the specific file and zipped use the following:

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files-Items/CMS1253695.html click on the following icon: 2012 Offset Amounts by APC

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.

CPT surgical injection code	*X-ray Arthrography code has fluoroscopy included*	*APC # for X-Ray Arthrography APC #*	*Or enhanced Arthrography Upper or Lower Extremity with CT*	*APC # for CT enhanced Arthrography*	*Or enhanced Arthrography any joint with MRI*	*APC # for MRI enhanced Arthrography*
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 or333	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

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

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

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 July 2012 revision of Addendum:

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

(Only the higher value of an ERD Level or critical care code (outpatient emergency room department (ERD) facility fees [ERD levels 1-5 are billed using E&M codes 99281-99285 as required by Medicare]) is reimbursable. 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(P)(8)(b)

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

Rule 18-6(R)

Acupuncture codes are the physical medicine codes 97810-97814.

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Click here for link the APC crosswalk of Rule 18, Exhibit 4

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, 2013