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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, 2015.**

**Adoption Date: 09/12/2014**

For medical services rendered after January 1, 2015, 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 2013 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 CWCFSID 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 CWCFSID. 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 CWCFSID 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 FARS/DFARS regulations apply.

CPT is a registered trademark of the AMA.

## Rule 16, effective January 1, 2015

To receive an NPI number, providers can go to <https://nppes.cms.hhs.gov/NPPE/StaticForward.do?forward=static.npistart> (last checked October 15, 2014).

## 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©.

<b>RVP©</b>	<b>Code Range</b>	<b>CONVERSION FACTOR</b>
Anesthesia	(CPT® 00100 –01999 and 99100-99140)	\$53.73/RVU
Surgery	(CPT® 10021-69990)	\$99.83/RVU
Radiology	(CPT® 70010-79999)	\$18.41/RVU
Pathology	(CPT® 80047-89398)	\$13.72/RVU
Medicine	(CPT® 90281 - 96999 and 98925 – 99199 and 99500-99607)	\$ 8.33/RVU
Physical Medicine	(CPT® 97001-97814)	\$ 6.23/RVU
Evaluation & Management	(CPT® 99201 – 99499)	\$10.16/RVU

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

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

## 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.
- Speech therapy codes are 92507-92508 treatment, and 96105-96111 CNS and aphasia evaluation.
- Electro-diagnostic study codes are 95860, 95861, 95863, 95864, 95865, 95866, 95867, 95868, 95869, 95870, 95872, 95873, 95874, 95875, 95885, 95886, 95887, 95905, 95907, 95908, 95909, 95910, 95911, 95912, 95913

- Intraoperative neuro-monitoring 95940-95941.
- Osteopathic manipulation codes are 98925-98929.
- Chiropractic manipulation codes are 98940-98943.
- Add-on code for psychiatric procedures with interactive complexity is 90785. CPT© specifies what is required to report this code.
- Psychological diagnostic evaluation procedures are 90791-90792 and may be paid up to 2 times per episode.
- Psychotherapy services are 90832-90838, 90845-90853, and 90875-90876, 90882.
- Crisis psychotherapy procedures are 90839-90840.
- Hyperbaric oxygen therapy service code is 99183 and code C1300 is the technical portion for hyperbaric therapy.
- Qualified non-physician, healthcare provider telephone services are 98966-98968.
- Qualified non-physician, healthcare provider on-line service is 98969.
- CNS assessments and test procedures are 96101-96125 and prior authorization is required after 6 hours of testing.
- Vaccine and Toxoids Codes 90281-90399, and 90467-90749 or Medicare's J code's as covered under Medicare's ASP fee schedule.
  - Administration codes 90460-90474.
  - IV Infusions performed in physician's office are 96360-96361, and 96365-96549.

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

#### Physical Medicine and Rehabilitation:

- Medical nutrition therapy codes are 97802-97804 (prior authorization required).
- Procedure codes are 97110-97533, 97542, and dry needling is DoWC Z0501 and DoWC Z0502.
- Unattended, non-timed modality codes are 97010-97028.
- Attended, timed modality codes are 97032-97039.
- Physical therapist evaluation code is 97001, and 97002 is re-evaluation.
- Occupational therapist evaluation code is 97003, and 97004 is re-evaluation.

- Athletic training evaluation code is 97005, 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.
- Work conditioning, work hardening, and work simulation codes are 97545 and 97546.
- Orthotic management and training code is 97760.
- Prosthetic training code is 97761.
- Checkout of orthotic/prosthetic devices code is 97762.
- Telephone assessment services are Medicine codes 98966, 98967, 98968.
- Non-physician on-line medical evaluation code is Medicine code 98969.

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

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

- Office or other outpatient visit codes are 99201-99350.
- Medical team conference codes are 99366-99368.
- Non-face-to-face telephone or on-line E&M service by a treating physician, PA or NP to an injured worker or family member is coded under 99441-99444. Criteria for medical/record documentation and CPT© criteria need to be met.
- Face-to-face or telephonic meeting by a treating physician with an employer, claims representative or any attorney to provide a medical opinion on a specific workers compensation case, with a written report is billed under Rule 18-6(A), DoWC code Z0701.
- Non-treating physician telephone or on-line service with employer, claims representative or any attorney to provide a medical opinion on a specific workers' compensation case
  - Without a report is coded: DoWC Z0601 \$65.00/15 minutes;
  - With a report is coded: DoWC Z0758 (Special Report) \$325.00/hr.

## **Rule 18-6(F)**

Permanent impairment ratings are billed using codes Z0759 (treating physician) and Z0760 (non-treating physician).

## **Rule 18-6(H) Supplies**

Supplies included in the practice expense under Medicare's RBRVS are not separately billable. DMEPOS suppliers must be licensed by the state of Colorado per Rule 16. Examples include: needles/syringes for injections or aspirations, electrodes and supplies used for EKG's, ultrasound, nerve conduction studies, EMG's, drug/supplies used for iontophoresis, and needles used to perform acupuncture.

[A list of HCPCS codes related to Complex Rehabilitation Technology \(CRT\) can be found here.](#) If no Medicare fee schedule exists, payers shall reimburse CRT accredited suppliers at MSRP less 20%.

## **Rule 18-6(J) Hospital Out-Patient Facility Fees**

All professional services billed by hospitals, such as PT/OT, MD, etc., regardless of the type of hospital (VA, Children's, etc.), are payable according to the applicable section(s) of Rule 18. All maximum hospital outpatient facility fees are determined by Rule 18-6(J).

Most outpatient hospital facility fees, except facilities listed under Rule 18-6(J)(3)(a)&(b), are based upon Medicare's Ambulatory Payment Classification (APC) system as listed in Exhibit #4. To assist in the determination of the appropriate APC Grouper under Rule 18-6(J)(3), 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. Medicare's Status Indicators (SI) are applicable according to Rule 18-6(J)(5) directives. Medicare's Status Indicators (SI) are applicable according to Rule 18-6(J)(5) directives; however, some pathology CPT codes with "N" status indicators may turn to an "A" status indicator if the code is billed with modifier "L1" appended to the CPT code. The L1 modifier is applicable to outpatient hospital facility bills covered under 013x or 014x "Type of Bill" (TOB) in Form locator (FL) field 4 on the UB04.

Only surgical implants are separately payable at the facility's cost, please refer to Rule 18-6(J)(4) for directives on what is "packaged" and not separately payable.

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 Medicare's Revised Addendum B (January) 2014. Addendum B can be found on Medicare's Hospital Outpatient Prospective Pay Systems (PPS) website. The address as of October 15, 2014 was:

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates-Items/2014-July-Addendum-B.html?DLPage=1&DLSort=2&DLSortDir=descending>

Status indicators S and T with listed values are paid in accordance with Rule 18-6(J)(6)(a).

Hospital clinic visit fees are limited for all facilities in accordance with the following:

1) No separate facility fees are allowed for follow-up care visits. 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.

2) 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.

3) Any specialty care clinic (wound/infections) that require expensive drugs/supplies that are typically not provided by a physician's office may be allowed a separate clinic fee with prior approval from the payer as outlined in Exhibit #4.

The link to the APC offset file for implants and biologicals, last checked October 15, 2014, is:

[2015 OPPS APC Offset File](#)

### **Rule 18-6(K) Freestanding (Not Affiliated with a Hospital) Outpatient Diagnostic Testing or Treatment Facilities**

The types of facilities and their fees include:

- ASC — 5<sup>th</sup> column of Exhibit #4 (plus cost of implants only, + observation fees + pre-operative testing) in and applied per hospital Rules under Rule 18-6(J).
- Physician's Offices — 100% of appropriately modified RVP x the applicable conversion factor.
- Freestanding Radiology Imaging and Cardiovascular Testing and procedure Centers (includes arteriograms and arthrography) — 90% of RVP x applicable conversion factors — maximum of 4 CPT codes the highest allowed at 100% of maximum fees and 50% the subsequent 3 additional codes.
- Urgent Care — non hospital \$75.00 facility fee if criteria is met in this Rule 18-6(K).
- The maximum fees for all clinical laboratory testing shall be reimbursed according to the fees as outlined under the Pathology section in 18-5(F).

Dyes, contrast and supplies are included and not separately payable for Freestanding Urgent Care, Radiology or Cardiovascular facilities.

All observation services must be prior approved by the payer if time is greater than 3 hours at an Urgent Care Facility or 6 hours if at an ASC -- G0378 at \$45.00/hour

### **Rule 18-6(M)(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(O)**

Acupuncture service codes are the physical medicine codes 97810-97814.

### **Division Established Zxxxx Codes and Values**

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

[Click here for link the 2015 APC crosswalk of Rule 18, Exhibit 4](#)