**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 of the Colorado Workers' Compensation Act and Division Rules. Even though this Interpretive Bulletin does not have the force and effect of Division Rules, it offers clarifications and interpretations to assist the stakeholders, create efficiency, and reduce litigation.

This interpretive bulletin focuses on the new Notification Rule (16-9) and amendments to the Prior Authorization Rule (16-10) that will go into effect on January 1, 2017. If you have any questions regarding the contents of this bulletin or would like to see additional issues addressed in the future, 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.

## Notification Pointers

Rule 16-9(C)(1)(a) requires the provider submitting the notification form to certify the proposed service or treatment is medically necessary and consistent with the Medical Treatment Guidelines. The payer reviewing a notification submission is entitled to rely on that certification and the provider who incorrectly applies the Guidelines may be subject to penalties. Therefore, providers should use the notification process only for medical treatment that clearly falls within the Guidelines given the medical condition(s) of the injured worker. If it is arguable whether or not a particular medical treatment falls within the Guidelines, the provider should utilize the prior authorization process instead.

It is also important to remember the self-insured employers and insurers must follow the Colorado Workers' Compensation Act and Division Rules, even with respect to claims that have

not been adjudicated or admitted as compensable. Therefore, the payers must timely respond to notifications and prior authorization requests even when the claim has been denied, preferably in writing. One-sentence response that "the compensability of this claim is denied" is sufficient in that circumstance. The Director also recommends providers check the status of the claim with the payer or the Division before relying on the lack of response from the payer and providing medical service or treatment.

**Medical Reviews of Prior Authorization Requests**

Rule 16-11(B)(2) now explicitly requires the payer responding to a prior authorization request to review not only the documentation submitted by the requesting provider, but also the documentation that is referenced in the request and available to the payer. In the past, payers sometimes failed to provide all relevant medical records in their possession to their reviewers. The reviewers would then recommend denials of prior authorization solely because they were unable to review all relevant documentation to evaluate the reasonableness and necessity of the proposed medical treatment. These denials unnecessarily delayed the decision on whether the proposed medical treatment was reasonable and necessary. For example, the payer may fail to forward an MRI relevant to a prior authorization request to its medical reviewer, even though the payer previously received this record when the performing provider submitted its bill. Yet, the requesting provider may not have the MRI record in its possession, only a summary of its results. The requesting provider would be forced to spend time obtaining the MRI from the performing provider even though the payer already had this record in its possession.

The intent of new Rule 16-11(B)(2) is to avoid such delays, yet assist an adjuster tasked with responding to a prior authorization request and retaining a medical reviewer. The Division understands the payer may have voluminous medical records in its possession. The requirements

(1) for the requesting provider to reference any relevant medical records not submitted with the request itself and (2) for the payer to supply these records (if available) to the medical reviewer balances the work load of the parties and avoids unnecessary delays in the determining whether the proposed treatment is reasonable and necessary.

**International Classification of Diseases (ICD) 10 Coding System**

Rule 16-7(C) now requires all provider bills, including outpatient hospital bills, to list the appropriate diagnosis code(s) using the current ICD-10-Clinical Modification (CM) code set. If ICD-10-CM requires a seventh character, it must be applied in accordance with the ICD-10-CM Chapter Guidelines provided by the Centers for Medicare and Medicaid Services. Because most diagnoses for work-related injuries are found in Chapter XIX of ICD-10-CM, the providers may wish to consult the coding guidelines found at the beginning of that chapter (page 1075 of the 2016 Edition).

The payers may deny payment based on incorrect or incomplete ICD-10 code(s), even though they cannot use these codes to establish the work relatedness of an injury or treatment (Rule 16-6(E)). However, the Division recommends the payer give the provider an opportunity to correct the ICD-10 code(s) prior to denying a bill.

**Current Procedural Terminology (CPT®) and Other References**

Rule 18 includes numerous references to medical services and procedures. The previous interpretive bulletin, adopted October 5, 2015, 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, 2017 (which adopts and incorporates by reference as modified and

published by Medicare in January 2016, National Physician Fee Schedule Relative Value file (RBRVS-Resource Based Relative Value Scale).

**Professional Component of Certain Radiology Services**

Rule 18-5(E)(2)(b) now states that professional component for MRIs, CTs, and nuclear medicine scans is reimbursable at 130% of the fee schedule. Providers billing *both* professional and technical components would need to bill these components on two separate lines to claim the 130% reimbursement for the professional component *only*.

**The Fee Schedules**

Click here for an Excel spreadsheet of the fee schedules for the 2017 dates of service, including RBRVS-professional Relative Value Units (RVUs) (non-facility and facility); 2016 Medicare Addendum B crosswalk for Exhibit # 4 for outpatient hospital facility fees; Exhibits #6; Exhibit #8; Medicare's January 2016 Average Sale Price (ASP) fees; and Medicare's January 2016 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fees, Home Health fees, and Ambulance fees.