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. If you have 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.

Services Performed by Physician Assistants and Nurse Practitioners (Rule 18-5(A))

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. However PAs and NPs may be paid 100 percent of the fee schedule under two circumstances. Beginning in 2018, Level I accreditation will be one of these circumstances. The Division recognizes that NPs, pursuant to §8-42-101(3.5), C.R.S., cannot become Level I accredited (although they are welcome to attend the Level I seminar). However, should that statute change in the future, the NPs also will be eligible to receive 100% of the fee schedule for services performed in non-rural areas.

Surgical Implant Reimbursement For Outpatient Facilities (Rule 18-6(J)(4))

Surgical implants typically are not separately payable to outpatient facilities. *See*, Rule 18-6(J)(4). However, a new exception in that rule states that "the maximum allowable fee in

Exhibit #4 may be exceeded in the rare case a more expensive implant is medically necessary. The facility must request prior authorization for additional payment with a separate report documenting medical reasonableness and necessity and submit an invoice showing cost of the implant(s) to the facility. Payers must report authorized exceptions to the Division's Medical Policy Unit on a monthly basis." The payers should email information regarding these additional payments, if any has been made during a given month, to cdle_medicalpolicy@state.co.us. The payers should attach to their email the prior authorization request (including documentation of medical reasonableness and necessity), medical reviews, if any, and the invoice.

Current Procedural Terminology (CPT®) and Other References

Rule 18 includes numerous references to medical services and procedures. This interpretive bulletin incorporates the CPT® code references listed in the previous interpretive bulletin, unless inconsistent with the version of Rule 18 effective January 1, 2018 (which adopts and incorporates by reference as modified and published by Medicare in January 2017, National Physician Fee Schedule Relative Value file (RBRVS-Resource Based Relative Value Scale).

The Fee Schedules

Click here for an Excel spreadsheet of the fee schedules for the 2018 dates of service, including RBRVS-professional Relative Value Units (RVUs) (non-facility and facility); 2017 Medicare Addendum B crosswalk for Exhibit # 4 for outpatient hospital facility fees; Exhibits #6; Exhibit #8; Medicare's January 2017 Average Sale Price (ASP) fees; and Medicare's January 2017 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fees, Home Health fees, and Ambulance fees.

The Definition of Referral Level II Accredited Physician

The 2018 revisions to Rule 18-6(F)(4)(b) increased the maximum fee for a permanent impairment rating performed by a Level II accredited authorized treating physician providing primary care, DOWC Z0759, to $575.00. The revisions also increased the maximum fee for a permanent impairment rating by a referral Level II accredited physician, DOWC Z0760, to $775.00, and clarified the injured worker may not be "a previously established patient to that physician." The maximum fee for a permanent impairment rating performed by a referral Level II accredited physician is higher because that physician will require additional time to examine the injured worker and review the medical records.

Quality impairment ratings are essential because they form the basis for permanent disability benefits to which injured workers may be entitled. The Division understands the impairment rating process requires an in-depth, current knowledge of the revised third edition of the "American Medical Association Guides to the Evaluation of Permanent Impairment" and the Division's Level II accreditation curriculum. The authorized treating physician may refer the injured worker for an impairment rating to another Level II accredited physician who specializes in the type of injury involved in the claim.

In the context of Rule 18-6(F)(4)(b), an injured worker is a previously established patient if the rating physician has met all of the following conditions:

- Evaluated or treated or consulted regarding the injured worker;
- That evaluation, treatment, or consultation was related to the claim where the impairment rating is being determined;
- The evaluation, treatment, or consultation occurred within three years of the impairment rating;

For purposes of distinguishing between DOWC Z0759 and DOWC Z0760, the relevant inquiry is whether the injured worker is a previously established patient as to the rating physician, not as to the group or facility where the rating physician practices. If the authorized treating physician and the rating physician practice in the same group or facility, the Division recommends that the group or facility have a written policy addressing such referrals.