DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation
7 CCR 1101-3
WORKERS' COMPENSATION RULES OF PROCEDURE

Rule 18 MEDICAL FEE SCHEDULE

18-1 STATEMENT OF PURPOSE

Pursuant to § 8-42-101(3)(a)(I) C.R.S. and Section 8-47-107, C.R.S., the Director promulgates this medical fee schedule to review and establish maximum allowable fees for health care services falling within the purview of the Act. The Director adopts and hereby incorporates by reference as modified herein the 2006 edition of the R*elative Values for Physicians* (RVP©), developed by Relative Value Studies, Inc., published by Ingenix® St. Anthony Publishing, and version 23.0 of *DRGs: Diagnosis Related Groups, Definitions Manual*, (DRGs Definitions Manual) developed and published by 3M Health Information Systems using DRGs effective after October 1, 2005. The incorporation is limited to the specific editions named and does not include later revisions or additions. For information about inspecting or obtaining copies of the incorporated materials, contact the Medical Fee Schedule Administrator, 633 17th Street, Suite 400, Denver, Colorado 80202-3660. These materials may be examined at any state publications depository library. All guidelines and instructions are adopted as set forth in the RVP© or DRG*s*: Definitions Manual, unless otherwise specified in this rule.

This rule applies to all services rendered on or after January 1, 2007. All other bills shall be reimbursed in accordance with the fee schedule in effect at the time service was rendered.

18-2 STANDARD TERMINOLOGY FOR THIS RULE

(A) CPT® - CPT® *2006 Current Procedural Terminology*, copyrighted and distributed by the American Medical Association (AMA).

(B) DoWC – Colorado Division of Workers' Compensation created codes

(C) DRGs Definitions Manual – version 23.0 incorporated by reference in Rule 18-1.

(D) RVP© – the 2006 edition incorporated by reference in Rule 18-1.

(E) For other terms, see Rule 16-2, Utilization Standards.

18-3 HOW TO OBTAIN COPIES

All users are responsible for the timely purchase and use of Rule 18 and its supporting documentation as referenced herein. The Division shall make available for public review and inspection copies of all materials incorporated by reference in Rule 18. Copies of the RVP© may be purchased from Ingenix® St. Anthony Publishing, the DRGs Definitions Manual may be purchased from 3M Health Information Systems, and the *Colorado Workers' Compensation Rules*

of Procedures with Treatment Guidelines, 7 CCR 1101-3, may be purchased from LexisNexis Matthew Bender & Co., Inc., Albany, NY Unofficial copies of all rules, including Rule 18, are available on the Colorado Department of Labor and Employment web site at www.coworkforce.com/DWC/ .

18-4 CONVERSION FACTORS (CF)

The following CFs shall be used to determine the maximum allowed fee. The maximum fee is determined by multiplying the following section CFs by the established relative value unit(s) (RVU) found in the corresponding RVP© sections:

RVP© SECTION	CF
Anesthesia	$47.96/RVU
Surgery	$90.97/RVU
Surgery X Procedures (see Rule 18-5(D)(1)(d))	$37.69/RVU
Radiology	$17.26/RVU
Pathology	$12.99/RVU
Medicine	$ 7.56/RVU
Physical Medicine Physical Medicine and Rehabilitation, Medical Nutrition Therapy and Acupuncture	$ 5.41/RVU
Evaluation & Management (E&M)	$ 8.22/RVU

18-5 INSTRUCTIONS AND/OR MODIFICATIONS TO THE RVP©

(A) Maximum allowance for all providers under Rule 16-5 is 100% of the RVP© value or as defined in this Rule 18.

(B) Interim relative value procedures (marked by an "I" in the left-hand margin of the RVP©) are accepted as a basis of payment for services; however deleted CPT® codes (marked by an "M" in the RVP©) are not, unless otherwise advised by this rule. The CPT® 2006 may be referenced for further clarification of descriptions and billing, but if conflicts arise between the RVP© and the CPT® 2006, the RVP© should control.

(C) Temporary codes listed in the RVP© may be used for billing with agreement of the payer as to reimbursement. Payment shall be in compliance with Rule 16-6(B).

(D) Surgery/Anesthesia

(1) Anesthesia Section:

(a) All anesthesia base values shall be established by the use of the codes as set forth in the RVP©, Anesthesia Section. Anesthesia services are only reimbursable if the anesthesia is administered by a physician or Certified Registered Nurse Anesthetist (CRNA) who remains in constant attendance during the procedure for the sole purpose of rendering anesthesia.

When anesthesia is administered by a CRNA:

(1) Not under the medical direction of an anesthesiologist, reimbursement shall be 90% of the maximum anesthesia value,

(2) Under the medical direction of an anesthesiologist, reimbursement shall be 50% of the maximum anesthesia value. The other 50% is payable to the anesthesiologist providing the medical direction to the CRNA,

(3) Medical direction for administering the anesthesia includes performing the following activities:

- Performs a pre-anesthesia examination and evaluation,
- Prescribes the anesthesia plan,
- Personally participates in the most demanding procedures in the anesthesia plan including induction and emergence,
- Ensures that any procedure in the anesthesia plan that s/he does not perform are performed by a qualified anesthetist,
- Monitors the course of anesthesia administration at frequent intervals,
- Remains physically present and available for immediate diagnosis and treatment of emergencies, and
- Provides indicated post-anesthesia care.

(b) Anesthesia add-on codes are reimbursed using the anesthesia CF and unit values found in the RVP©, Anesthesia section's Guidelines ~~I~~X, "Qualifying Circumstances." (Not under the Medicine section.)

(c) The following modifiers are to be used when billing for anesthesia services:

AA – anesthesia services performed personally by the anesthesiologist

QX – CRNA service; with medical direction by a physician

QZ – CRNA service; without medical direction by a physician

QY – Medical direction of one CRNA by an anesthesiologist

(d) Surgery X Procedures

(1) The Surgery X procedures are limited to those listed below and found in the table under the RVP©, Anesthesia section's Guidelines XI, "Anesthesia Services Where Time Units Are Not Allowed":

- Providing local anesthetic or other medications through a regional IV
- Daily drug management
- Endotracheal intubation
- Venipuncture, including cutdowns
- Arterial punctures
- Epidural or subarachnoid spine injections
- Somatic and Sympathetic Nerve Injections
- Paravertebral facet joint injections and rhizotomies

In addition, lumbar plexus spine anesthetic injection, posterior approach with daily administration = 7 RVUs.

(2) The maximum reimbursement for these procedures shall be based upon the anesthesia value listed in the table in the RVP©, Anesthesia section's Guideline XI multiplied by $37.69 CF. No additional unit values are added for time when calculating the maximum values for reimbursement.

(3) When performing more than one surgery X procedure in a single surgical setting, multiple surgery guidelines shall apply (100% of the listed value for the primary procedure and 50% of the listed value for additional procedures). Use modifier -51 to indicate multiple Surgery X procedures performed on the same day during a single operative setting. The 50% reduction does not apply to procedures that are identified in the RVP© as "Add-on" procedures.

(4) Other procedures from Table XI not described above may be found in another section of the RVP© (e.g., surgery). Any procedures found in the table under the RVP©, Anesthesia section's Guidelines XI, "Anesthesia Services Where Time Units Are Not Allowed" but not contained in this list (Rule 18-

5(D)(1)(d)(1)) are reimbursed in accordance with the assigned units from their respective sections multiplied by their respective CF.

(2) Surgical Section:

(a) The use of assistant surgeons shall be limited according to the American College Of Surgeons' *2002 Study: Physicians as Assistants at Surgery* (April 2002), available from the American College of Surgeons, Chicago, IL, or from their web page at http://www.facs.org/ahp/pubs/2002physasstsurg.pdf, (accessed June 29, 2006). The incorporation is limited to the edition named and does not include later revisions or additions. Copies of the material incorporated by reference may be inspected at any State publications depository library. For information about inspecting or obtaining copies of the incorporated material, contact the Medical Fee Schedule Administrator, 633 17th Street, Suite 400, Denver, Colorado, 80202-3660.

Where the publication restricts use of such assistants to "almost never" or a procedure is not referenced in the publication, prior authorization for payment shall be obtained from the payer.

(b) Incidental procedures are commonly performed as an integral part of a total service and do not warrant a separate benefit.

(c) No payment shall be made for more than one assistant surgeon or minimum assistant surgeon without prior authorization unless a trauma team was activated due to the emergency nature of the injury(ies).

(d) The payer may use available billing information such as provider credential(s) and clinical record(s) to determine if an appropriate modifier should be used on the bill. To modify a billed code refer to Rule 16-11(B)(3).

(e) Non-physician, minimum assistant surgeons used as surgical assistants shall be reimbursed at 10 % of the listed value.

(f) Global Period

(1) The following services performed during a global period would warrant separate billing if documentation demonstrates significant identifiable services were involved, such as:

- ♦ E&M services unrelated to the primary surgical procedure,
- ♦ Services necessary to stabilize the patient for the primary surgical procedure,
- ♦ Services not usually part of the surgical procedure, including an E&M VISIT by an authorized treating physician (ATP) for disability management,

- ♦ Unusual circumstances, complications, exacerbations, or recurrences, or

- ♦ Unrelated diseases or injuries.

(2) Separate identifiable services shall use an appropriate RVP© modifier in conjunction with the billed service.

(g) Intradiscal Electrothermal Annuloplasty (IDEA) -

Prior authorization is required. A physician well-trained in the procedure must perform it. Please refer to the applicable Rule 17 medical treatment guideline for the required surgical indications for this procedure.

First level, uni- or bilateral including fluoroscopic guidance	$1,690.26
one or more additional levels	$ 657.33

CT or MRI may be billed separately in addition to the IDEA procedure.

(h) Lumbar Artificial Disc

Lumbar disc arthroplasty is reimbursed using the following RVUs multiplied by the surgery CF:

one interspace	67.5 RVUs
Per additional interspace	25 RVUs

(E) Radiology Section:

(1) General

(a) The cost of dyes and contrast shall be reimbursed at 80 % of billed charges.

(b) Copying charges for X-Rays and MRIs shall be $15.00/film regardless of the size of the film.

(c) The payer may use available billing information such as provider credential(s) and clinical record(s) to determine if an appropriate RVP© modifier should have been used on the bill. To modify a billed code, refer to Rule 16-11(B)(3).

(2) Thermography

(a) The physician supervising and interpreting the thermographic evaluation shall be board certified by the examining board of one of the following national organizations and follow their recognized protocols:

American Academy of Thermology;

American Chiropractic College of Infrared Imaging.

(b) Indications for thermographic evaluation must be one of the following:

Complex Regional Pain Syndrome/Reflex Sympathetic Dystrophy (CRPS/RSD);

Sympathetically Maintained Pain (SMP);

Autonomic neuropathy;

Chronic Neuropathic Pain (involving small caliber sensory fiber neuropathy).

(c) Protocol for stress testing is outlined in the Medical Treatment Guidelines found in Rule 17.

(d) Thermography Billing Codes:

DoWC 79993 Upper body w/ Autonomic Stress Testing $856.80

DoWC 79995 Lower body w/Autonomic Stress Testing $856.80

DoWC 79997 Whole Body w/Autonomic Stress Testing $1,285.20

When whole body thermography is performed, only "whole body" billing codes can be used. Do not use separate upper and lower body billing codes and fees.

(e) Prior authorization for payment is required for thermography services only if the requested study does not meet the indicators for thermography as outlined in this radiology section. The billing shall include a report supplying the thermographic evaluation and reflecting compliance with Rule 18-5(E)(2).

(F) Pathology Section:

The payer may use available billing information such as provider credential(s) and clinical record(s) to determine if an appropriate modifier should have been used on the bill. To modify a billed code refer to Rule 16-11(B)(3).

(G) Medicine Section:

(1) Medicine home therapy services in the RVP© are not adopted. For appropriate codes see Rule 18-6(N), Home Therapy.

(2) Anesthesia add-on values are reimbursed in accordance with the anesthesia section of Rule 18.

(3) Biofeedback

Prior authorization for payment shall be required from the payer after 12 visits. A licensed physician or psychologist shall prescribe all services and include the number of sessions**.** Session notes shall be periodically reviewed by the prescribing physician to determine the continued need for the service. All services shall be provided or supervised by an appropriate recognized provider as listed under Rule 16-5. Supervision shall be as defined in an applicable Rule 17 medical treatment guidelines. Persons providing biofeedback shall be certified by the Biofeedback Certification Institution of America, or be a licensed physician or psychologist, as listed under Rule 16-5(A)(1)(a) and (b) with evidence of equivalent biofeedback training.

(4) Appendix J of the *2006* CPT® lists the maximum number of nerves per type of electrodiagnostic study.

(5) Manipulation -- Chiropractic (DC), Medical (MD) and Osteopathic (DO):

(a) Prior authorization from the payer shall be obtained before billing for more than four body regions in one visit. Manipulative therapy is limited to no more than 34 visits or the maximum allowed in the relevant Rule 17 medical treatment guidelines. The provider's medical records shall reflect medical necessity and prior authorization for payment if treatment exceeds these limitations.

(b) An office visit may be billed on the same day as manipulation codes when the documentation meets the E&M requirement and an appropriate modifier is used.

(6) Psychiatric/Psychological CNS Tests and Assessment Services:

(a) A licensed clinical psychologist is reimbursed a maximum of 90 % of the medical fee listed in the RVP©. Other non-physician providers performing psychological/psychiatric services shall be paid at 75 % of the fee allowed for physicians.

(b) Most initial evaluations for delayed recovery can be completed in two (2) hours. Prior authorization for payment is required any time the following limitations are exceeded:

Evaluation Procedures	limit: 4 hours
Testing Procedures	limit: 6 hours
Psychotherapy services	limit: 50 mins per visit

Psychotherapy for work-related conditions requiring more than 20 visits or continuing for more than three (3) months after the initiation of therapy, whichever comes first, requires prior authorization from the payer.

(7) Hyperbaric Oxygen Therapy Services

The maximum unit value shall be 24 units, instead of 14 units as listed in the RVP©.

(H) Physical Medicine and Rehabilitation:

Restorative services are an integral part of the healing process for a variety of injured workers.

(1) Prior authorization is required for medical nutrition therapy. See Rule 18-6(O)(10).

(2) For recommendations on the use of the physical medicine and rehabilitation procedures, modalities, and testing, see Rule 17, Medical Treatment Guidelines Exhibits.

(3) Special Note to All Physical Medicine and Rehabilitation Providers:

Prior authorization shall be obtained from the payer for any physical medicine treatment exceeding the recommendations of the Medical Treatment Guidelines as set forth in Rule 17.

The injured worker shall be re-evaluated by the prescribing physician within thirty (30) calendar days from the initiation of the prescribed treatment and at least once every month while that treatment continues. Prior authorization for payment shall be required for treatment of a condition not covered under the medical treatment guidelines and exceeding sixty (60) days from the initiation of treatment.

(4) Interdisciplinary Rehabilitation Programs – (Requires Prior Authorization)

An interdisciplinary rehabilitation program is one that provides focused, coordinated, and goal-oriented services using a team of professionals from varying disciplines to deliver care. These programs can benefit persons who have limitations that interfere with their physical, psychological, social, and/or vocational functioning. As defined in Rule 17, rehabilitation programs may include, but are not limited to: chronic pain, spinal cord, or brain injury programs.

Billing Restrictions: The billing provider shall detail to the payer the services, frequency of services, duration of the program and their proposed fees for the entire program, inclusive for all professionals. The billing provider and payer shall attempt to mutually agree upon billing code(s) and fee(s) for each interdisciplinary rehabilitation program.

(5) For orthotic and prosthetic management, apply the 2005 RVP© RVUs to the renumbered 2006 RVP© instead of the “RNE” value.

(6) Procedures (therapeutic exercises, neuromuscular re-education, aquatic therapy, gait training, massage, acupuncture and any unlisted physical medicine procedures)

Unless the provider’s medical records reflect medical necessity and the provider obtains prior authorization for payment from the payer, the maximum amount of time allowed is one hour of procedures per day, per discipline.

(7) Modalities

RVP© Timed and Non-timed Modalities

Billing Restrictions: There is a total limit of two (2) modalities (whether timed or non-timed) per visit, per discipline, per day.

NOTE: Instruction and application of a TENS unit for the patient's independent use shall be billed using the timed e-stim RVP© CODE.

(8) Evaluation Services for Therapists: Physical Therapy (PT), Occupational Therapy (OT) and Athletic Trainers (cf. §12-36-106 C.R.S.)

(a) All evaluation services must be supported by the appropriate history, physical examination documentation, treatment goals and treatment plan or re-evaluation of the treatment plan. The provider shall clearly state the reason for the evaluation, the nature and results of the physical examination of the patient, and the reasoning for recommending the continuation or adjustment of the treatment protocol. Without appropriate supporting documentation, the payer may deny payment. These codes shall not be billed for pre-treatment patient assessment.

If a new problem or abnormality is encountered that requires a new evaluation and treatment plan, the professional may perform and bill for another initial evaluation. a new problem or abnormality may be caused by a surgical procedure being performed after the initial evaluation has been completed.

(b) Payers are only required to pay for evaluation services directly performed by a PT, OT or athletic trainer, as defined in §12-36-106 C.R.S. All evaluation notes or reports must be written and signed by the PT or OT. Physicians shall bill the appropriate E&M code from the E&M section of the RVP©.

(c) A patient may be seen by more than one health care professional on the same day. An evaluation service with appropriate documentation may be charged for each professional per patient per day.

(d) Reimbursement to PTs, OTs, speech language pathologists and audiologists for coordination of care with professionals shall be based upon RVP© telephone case management codes. Coordination of care reimbursement is limited to telephone calls made to professionals outside of the therapist's/pathologist's/audiologist's employment facility(ies) and/or to the injured worker or their family and the prescribing physician.

(e) All interdisciplinary team conferences shall be billed under the case management services section in the RVP© using medical conference codes.

(9) Special Tests

The following respective tests are considered special tests:

- Job Site Evaluation
- Computer- Enhanced Evaluation

  Functional Capacity Evaluation

  Work Tolerance Screening
- Assistive technology assessment
- Speech

(a) Billing Restrictions:

(1) Job Site Evaluations requires prior authorization if exceeding 2 hours. Computer-Enhanced Evaluations, Functional Capacity Evaluations and Work Tolerance Screenings requires prior authorization for payment for more than 4 hours.

(2) The provider shall specify the time required to perform the test in 15-minute increments.

(3) The value for the analysis and the written report is included in the code's value.

(4) No E&M services or PT, OT, or acupuncture evaluations shall be charged separately for these tests.

(5) Data from computerized equipment shall always include the supporting analysis developed by the physical medicine professional before it is payable as a special test.

(b) Provider Restrictions: all special tests must be fully supervised by a physician, a PT, an OT, a speech language pathologist/therapist or audiologist. Final reports must be written and signed by the physician, the PT, the OT, the speech language pathologist/therapist or the audiologist.

(10) Speech Therapy/Evaluation and Treatment

Reimbursement shall be according to the unit values as listed in the RVP© multiplied by their section's respective CF.

(11) Supplies

Physical medicine supplies are reimbursed in accordance with Rule 18-6(H).

(12) Unattended Treatment

When a patient uses a facility or its equipment but is performing unattended procedures, in either an individual or group setting, bill:

DoWC 97152 fixed fee per day 1.5 RVU

(13) Non-Medical Facility

Fees, such as gyms, pools, etc., and training or supervision by non-medical providers require prior authorization from the payer and a written negotiated fee.

(14) Unlisted Service Physical Medicine

All unlisted services or procedures require a report.

(15) Work Conditioning, Work Hardening, Work Simulation

(a) Work conditioning is a non-interdisciplinary program that is focused on the individual needs of the patient to return to work. Usually one discipline oversees the patient in meeting goals to return to work. Refer to Rule 17, Medical Treatment Guidelines.

Restriction: Maximum daily time is two (2) hours per day without additional prior authorization.

(b) Work Hardening is an interdisciplinary program that uses a team of disciplines to meet the goal of employability and return to work. This type of program entails a progressive increase in the number of hours a day that an individual completes work tasks until they can tolerate a full workday. In order to do this, the program must address the medical, psychological, behavioral, physical, functional and vocational components of employability and return to work. Refer to Rule 17, Medical Treatment Guidelines.

Restriction: Maximum daily time is six (6) hours per day without additional prior authorization.

(c) Work Simulation is a program where an individual completes specific work-related tasks for a particular job and return to work. Use of this program is appropriate when modified duty can only be partially accommodated in the work place, when modified duty in the work place is unavailable, or when the patient requires more structured supervision. The need for work simulation should be based upon the results of a functional capacity evaluation and/or job analysis. Refer to Rule 17, Medical Treatment Guidelines.

(d) For Work Conditioning, Work Hardening, or Work Simulation, the following apply.

(1) Prior authorization is required.

(2) Provider Restrictions: All procedures must be performed by or under the onsite supervision of a physician, PT, OT, speech language pathologist or audiologist.

(I) Evaluation and Management Section (E&M)

(1) Medical record documentation shall encompass the RVP© "E&M Guideline" criteria to justify the billed E&M service. If 50 % of the time spent with an injured worker during an E&M visit is disability counseling, then time can determine the level of E&M service.

Disability counseling should be an integral part of managing workers' compensation injuries. The counseling shall be completely documented in the medical records, including, but not limited to, the amount of time spent with the injured worker. Disability counseling shall include, but not be limited to, return to work, temporary and permanent work restrictions, self management of symptoms while working, correct posture/mechanics to perform work functions, job task exercises for muscle strengthening and stretching, and appropriate tool and equipment use to prevent re-injury and/or worsening of the existing injury.

(2) New or Established Patients

An E&M visit shall be billed as a "new" patient service for each "new injury" even though the provider has seen the patient within the last three years. Any subsequent E&M visits are to be billed as an "established patient" and reflect the level of service indicated by the documentation when addressing all of the current injuries.

(3) Number of Office Visits

All providers, as defined in Rule 16-5 (A-C), are limited to one office visit per patient, per day, per workers' compensation claim unless prior authorization is obtained from the payer. The E&M Guideline criteria as specified in the RVP© E&M Section shall be used in all office visits to determine the appropriate level.

(4) Case Management

(a) Telephone case management services may be billed if the services are performed on a separate day from an E&M office visit and when the medical records/documentation specifies all the following:

(1) the amount of time and date;

(2) the person or person(s) talked to; and

(3) the discussion and/or decision made during the call to coordinate care for the injured worker.

(b) An interdisciplinary team conference, consisting of medical professionals caring for the injured worker, shall select a team member to perform the following duties:

(1) Prepare the billing statement in accordance with Rule 16, Utilization Standards,

- ♦ One conference charge per facility, per patient, per day.

- Reimbursement for each interdisciplinary team conference shall be billed in 15-minute increments. Fifteen-minute conferences shall be reimbursed by reducing the maximum allowance to 50% of the total 30 minute value found in the RVP©.

(2) Prepare and submit a written report for each conference that includes at least the following information:

- Patient's identifying information;
- Diagnosis**;**
- Medical professionals attending the conference;
- A brief statement of conference recommendations and actions (no additional allowance shall be made for this statement); and
- Length of time of meeting.

18-6 DIVISION ESTABLISHED CODES AND VALUES

(A) Conferences Held at the Request of a Party

Telephonic or face-to-face conferences shall be related to the injured worker's treatment. All parties shall receive actual notification from the requesting party in advance and within 24 hours of scheduling.

DoWC 99901 Maximum ~~of~~ $225.00 per hour; billed at $56.25 per 15-minute increments.

(B) Cancellation Fees For Payer Made Appointments

(1) A cancellation fee is payable only when a payer schedules an appointment the injured worker fails to keep, and the payer has not canceled three (3) business days prior to the appointment. The payer shall pay:

One-half of the usual fee for the scheduled services, or

$150.00, whichever is less.

Cancellation Fee Billing Code: DoWC 99910

(2) Missed Appointments:

When claimants fail to keep scheduled appointments, the provider should contact the payer within two (2) business days. Upon reporting the missed appointment, the provider may request whether the payer wishes to reschedule the appointment for the claimant. If the claimant fails to keep the payer’s rescheduled appointment, the provider may bill for a cancellation fee according to this Rule 18-6(B).

(C) Copying Fees

The payer, payer's representative, injured worker and injured worker's representative shall pay a reasonable fee for the reproduction of the injured worker's medical record. Reasonable cost shall not exceed $14.00 for the first 10 or fewer pages, $0.50 per page for pages 11-40, and $0.33 per page thereafter. Actual postage or shipping costs and applicable sales tax, if any, may also be charged. The per-page fee for records copied from microfilm shall be $1.50 per page.

Copying Fee Billing Code: DoWC 99911

(D) Deposition and Testimony Fees

(1) When requesting deposition or testimony from physicians or any other type of provider, guidance should be obtained from the *Interprofessional Code*, as prepared by the Colorado Bar Association, the Denver Bar Association, the Colorado Medical Society and the Denver Medical Society. If the parties cannot agree upon fees for the deposition or testimony services, or cancellation time frames and/or fees, the following Deposition and Testimony rules and fees shall be used:

(2) Deposition:

Payment for a physician's testimony at a deposition shall not exceed 35 RVU per hour multiplied by the medicine CF ($7.56) billed in half-hour increments. Calculation of the physician's time shall be "portal to portal."

The physician may request a full hour deposit in advance in order to schedule the deposition.

By prior agreement with the deposing party, the physician may charge for preparation time or for reviewing and signing the deposition.

The physician shall refund to the deposing party, any portion of an advance payment in excess of time actually spent preparing and/or testifying when the physician is notified of the cancellation of the deposition at least three (3) business days prior to the scheduled deposition.

However, if the provider is not notified at least three (3) business days in advance of a cancellation, or the deposition is shorter than the time scheduled, the provider shall be paid the number of hours he or she has reasonably spent in preparation and has scheduled for the deposition.

Deposition	units per hr. Billed in half-hour increments

(3) Testimony**:**

Calculation of the physician's time shall be "portal to portal."

For testifying at a hearing, the physician may request a four (4) hour deposit in advance in order to schedule the testimony.

By prior agreement, the physician may charge for preparation time for testimony.

The physician shall refund any portion of an advance payment in excess of time actually spent preparing and/or testifying when the physician is notified of the cancellation of the hearing at least five (5) business days prior to the date of the hearing.

However, if the provider is not notified of a cancellation at least five (5) business days prior to the date of the hearing, or the hearing is shorter than the time scheduled, the provider shall be paid the number of hours he or she has reasonably spent in preparation and has scheduled for the hearing.

Testimony Billing Code: DoWC 99085

Maximum Rate of $400.00 per hour

(E) Mileage Expenses

The payer shall reimburse an injured worker for reasonable and necessary mileage expenses for travel to and from medical appointments and reasonable mileage to obtain prescribed medications. The reimbursement rate shall be 37 cents per mile. The injured worker shall submit a statement to the payer showing the date(s) of travel and number of miles traveled, with receipts for any other reasonable and necessary travel expenses incurred.

Mileage Expense Billing Code: DoWC 99912

(F) Permanent Impairment Rating

(1) The payer is only required to pay for one combined whole-person permanent impairment rating per claim, except as otherwise provided in these Workers' Compensation Rules of Procedures. Exceptions that may require payment for an additional impairment rating include, but are not limited to, reopened cases, as ordered by the Director or an administrative law judge, or a subsequent request to review apportionment. The authorized treating provider is required to submit in writing all permanent restrictions and future maintenance care related to the injury or occupational disease.

(2) Provider Restrictions

The permanent impairment rating shall be determined by the authorized treating physician, if Level II accredited, or by a Level II accredited physician selected by the authorized treating provider.

(3) Maximum Medical Improvement (MMI) Determined Without any Permanent Impairment

When physicians determine the injured worker is at MMI and has no permanent impairment, the physicians should be reimbursed an appropriate level of E&M service and the fee for completing the Physician’s Report of Workers’ Compensation Injury (Closing Report), WC164 (See Rule 18-6(G)(2)). Reimbursement for the appropriate level of E&M service is only applicable if the

physician examines the injured worker and meets the criteria as defined in the RVP©.

(4) MMI Determined with a Calculated Permanent Impairment Rating

(a) Calculated Impairment: The total fee includes the office visit, a complete physical examination, complete history, review of all medical records, determining MMI, completing all required measurements, referencing all tables used to determine the rating, using all report forms from the AMA's *Guide to the Evaluation of Permanent Impairment*, Third Edition (Revised), (AMA *Guides*), and completing the Division form, titled Physician's Report of Workers' Compensation Injury (Closing Report) WC164.

(b) USE THE APPROPRIATE RVP© CODE*:*

(1) Fee for the Level II Accredited Authorized Treating Physician Providing Primary Care:

Reimbursed for 1.5 hours with a maximum not to exceed $320.58.

(2) Fee for the Referral, Level II Accredited Authorized Physician:

Reimbursed for 2.5 hours with a maximum not to exceed $616.50.

(3) Fee for a Multiple Impairment Evaluation Requiring More Than One Level II Accredited Physician:

All physicians providing consulting services for the completion of a whole person impairment rating shall bill using the appropriate E&M consultation code and shall forward their portion of the rating to the authorized physician determining the combined whole person rating.

(G) Report Preparation

(1) Routine Reports

Completion of routine reports or records are incorporated in all fees for service and include:

Diagnostic Testing

Procedure Reports

Progress notes

Office notes

Operative reports

Supply invoices, if requested by the payer

Requests for second copies of routine reports are reimbursable under the copying fee section of Rule 18.

(2) Completion of the Physician's Report of Workers' Compensation Injury (WC164)

(a) Initial Report

The completed WC164 initial report is submitted to the payer after the first visit with the injured worker. This form shall include completion of items 1-7 and 10. Note that certain information in Item 2 (such as Insurer Claim #) may be omitted if not known by the provider.

(b) Closing Report

The WC164 closing report is required from the authorized treating physician when an injured worker is at maximum medical improvement with or without a permanent impairment. A physician may bill for the completion of the WC164 if neither impairment rating code (see Rule 18-6(F)(4)) has been billed. The form requires the completion of items 1-5, 6 b-c, 7, 8 and 10. If the injured worker has sustained a permanent impairment, then Item 9 must be completed and the following additional information shall be attached to the bill at the time MMI is determined:

(1) All necessary permanent impairment rating reports when the authorized treating physician is Level II Accredited, or

(2) The name of the Level II Accredited physician designated to perform the permanent impairment rating when a rating is necessary and the authorized treating physician is not determining the permanent impairment rating.

(c) Payer Requested WC164 Report

If the payer requests the provider complete the WC164 report, the payer shall pay the provider for the completion and submission of the completed WC164 report.

(d) Provider Initiated WC164 REPORT ~~Form~~

If the provider wants to use the WC164 report as a progress report or for any purpose other than those designated here in Rule 18-6(G)(2)(a), (b) or (c)), and seeks reimbursement for completion of the form, the provider shall get prior approval from the payer.

(e) Billing Codes and Maximum Allowance for completion and submission of WC164 report

Maximum allowance for the completion and submission of the WC164 Report is:

DoWC 99960	$42.00	Initial Report
DoWC 99961	$42.00	Progress Report (Payer Requested or Provider Initiated)
DoWC 99962	$42.00	Closing Report
DoWC 99963	$42.00	Initial and Closing Reports are completed on the same form for the same date of service

(3) Special Reports

The term special reports includes reports falling outside the requirements set forth in Rule 16, Utilization Standards, Rule 17, Medical Treatment Guidelines and Rule 18 and includes any form, questionnaire or letter with variable content. Reimbursement for preparation of special reports or records shall require prior agreement with the requesting party. In special circumstances (e.g., when reviewing and/or editing is necessary) and when prior agreement is made with the requesting party, institutions, clinics or physicians' offices may charge additional sums. Use the appropriate RVP© code.

Special Report Preparation:	not to exceed $225.00 per hour. Billed in half hour increments.

Because narrative reports may have variable content, the content and total payment shall be agreed upon by the provider and the report's requester before the provider begins the report.

(H) Supplies, Durable Medical Equipment (DME), Orthotics and Prosthesis

(1) Unless otherwise indicated, payment for supplies shall reflect the provider's actual cost plus a 20% markup. Cost includes shipping and handling charges.

(2) "Supply et al." is defined in Rule 16-2. Reimbursement shall be the provider's cost plus 20%. The provider shall furnish an invoice or their supplier's published rate, either with their bill for services or by previous agreement, to substantiate their cost. The billing provider is responsible for identifying and itemizing all "Supply et al." items.

(3) Payment for professional services associated with the fabrication and/or modification of orthotics, custom splints, adaptive equipment, and/or adaptation and programming of communication systems and devices shall be paid in accordance with RULE 18-5(H)(5).

(I) Inpatient Hospital Facility Fees

(1) Provider Restrictions

All non-emergency, inpatient admissions require prior authorization for payment.

(2) Bills for Services

(a) Inpatient hospital facility fees shall be billed on the UB-92 and require summary level billing by revenue code. The provider must submit itemized bills along with the UB-92.

(b) The maximum inpatient facility fee is determined by applying the Center for Medicare and Medicaid Services (CMS) "Diagnosis Related Group" (DRG) classification system. Exhibit 1 to Rule 18 shows the relative weights per DRG that are used in calculating the maximum allowance.

The hospital shall indicate the DRG code number in the remarks section (form locator 78) of the UB-92 billing form and maintain documentation on file showing how the DRG was determined. The hospital shall determine the DRG using the DRG*s Definitions Manual*. The attending physician shall not be required to certify this documentation unless a dispute arises between the hospital and the payer regarding DRG assignment. The payer may deny payment for services until the appropriate DRG code is supplied.

(c) Exhibit 1 to Rule 18 establishes the maximum length of stay (LOS) using the "arithmetic mean LOS". However, no additional allowance for exceeding this LOS, other than through the cost outlier criteria under Rule 18-6(I)(3)(d) is allowed.

(d) Any inpatient admission requiring the use of both an acute care hospital and its Medicare certified rehabilitation facility is considered as one admission and DRG. This does not apply to long term care and licensed rehabilitation facilities.

(3) Inpatient Facility Reimbursement:

(a) The following types of inpatient facilities are reimbursed at 100% of billed inpatient charges:

(1) Children's hospital

(2) Veterans' Administration hospital

(3) State psychiatric hospital

(b) The following types of inpatient facilities are reimbursed at 80% of billed inpatient charges:

(1) Medicare certified Critical Access Hospital (CAH) (listed in Exhibit 3 of Rule 18)

(2) Medicare certified long-term care hospital

(3) Colorado Department of Public Health and Environment (CDPHE) licensed rehabilitation facility, and,

(4) CDPHE licensed psychiatric facilities that are privately owned.

(c) All other inpatient facilities are reimbursed as follows:

Retrieve the relative weights for the assigned DRG from the DRG table in Exhibit 1 to Rule 18 and locate the hospital's base rate in Exhibit 2 to Rule 18.

The "Maximum Fee Allowance" is determined by calculating:

(1) (DRG Relative Wt x Specific hospital base rate x 200%) + (reimbursement for all "Supply et al.")

(2) "Supply et al." is defined in Rule 16-2. Reimbursement shall be consistent with Rule 18-6(H). The billing provider is responsible for identifying and itemizing all "Supply et al." items.

(d) Outliers are admissions with extraordinary cost warranting additional reimbursement beyond the maximum allowance under (3) (c) of Rule 18-6(I). To calculate the additional reimbursement, if any:

(1) Determine the "Hospital's Cost":

total billed charges (excluding any "Supply et al." billed charges) multiplied by the hospital's cost-to-charge ratio.

(2) Each hospital's cost-to-charge ratio is given in Exhibit 2 of Rule 18.

(3) The "Difference" = "Hospital's Cost" – "Maximum Fee Allowance" excluding any "Supply et al." allowance (see (c) above)

(4) If the "Difference" is greater than $25,800.00, additional reimbursement is warranted. The additional reimbursement is determined by the following equation:

"Difference" x .80 = additional fee allowance

(e) Inpatient combined with ERD or Trauma Center reimbursement

(1) If an injured worker is admitted to the hospital, the ERD reimbursement is included in the inpatient reimbursement under 18-6 (I)(3),

(2) Except, Trauma Center activation fees (see 18-6(M)(3)(g)) are paid in addition to inpatient fees (18-6(I)(3)(c-d).

(f) If an injured worker is admitted to one hospital and is subsequently transferred to another hospital, the payment to the transferring hospital will be based upon a per diem value of the DRG maximum value. The per diem value is calculated based upon the transferring hospital's DRG relative weight multiplied by the hospital's specific base rate (Exhibit 2 to Rule 18) divided by the DRG geometric mean length of stay. This per diem amount is multiplied by the actual LOS. If the patient is admitted

and transferred on the same day, the actual LOS equals one (1). The receiving hospital shall receive the appropriate DRG maximum value.

(J) Scheduled Outpatient Surgery Facility Fees

(1) Provider Restrictions

(a) All non-emergency outpatient surgeries require prior authorization from the payer.

(b) A separate facility fee is only payable if the facility is licensed by the Colorado Department of Public Health and Environment (CDPHE) as:

(1) a hospital; or

(2) an Ambulatory Surgery Center (ASC).

(2) Bills for Services

(a) Outpatient facility fees shall be billed on the UB-92 and require summary level billing by revenue code. The provider must submit itemized bills along with the UB-92.

(b) All professional charges are subject to the RVP© and Dental Fee Schedules as incorporated by Rule 18.

(c) ASCs and hospitals shall bill using the surgical RVP© code(s) as indicated by the surgeon's operative note up to a maximum of four surgery codes per surgical episode.

(3) Outpatient Surgery Facility Reimbursement:

(a) The following types of outpatient facilities are reimbursed at 100% of billed outpatient charges:

(1) Children's hospital

(2) Veterans' Administration hospital

(3) State psychiatric hospital

(b) CAHs, listed in Exhibit 3 of Rule 18, are to be reimbursed at 80% of billed charges.

(c) All other outpatient surgery facilities are reimbursed based on Exhibit 4 of this Rule 18. Exhibit 4 lists Medicare's Outpatient Hospital Ambulatory Prospective Payment Codes (APC) with the Division's values for each APC code.

The surgical procedure codes are classified by APC code in Medicare's April 2006 Addendum B. This Addendum B should be used to determine the APC code payable under the Division's Exhibit 4. However, not

every surgical code listed under Addendum B warrants a separate facility fee. A separate facility fee may be warranted if there is a significant health risk to the injured worker if the procedure is not performed in a facility where credentialed emergency equipment and personnel are maintained, including but not limited to, any procedure requiring the administration of regional or general anesthesia. Minor procedures, including but not limited to, laceration repairs and trigger point injections, do not routinely warrant a separate facility fee as a scheduled outpatient surgery.

The APC values listed in Exhibit 4 include reimbursement for the following even if they are billed as line item charges:

- nursing,
- technician and related services,
- use by the recipient of the facility including the operating room and recovery room,
- equipment directly related to the provision of surgical procedures,
- fluoroscopy and x-rays during the surgical episode,
- supplies, drugs, biologics, surgical dressings, splints, cases and appliances that do not meet the "Supply et al." threshold,
- administration, record keeping, housekeeping items and services, and
- materials and trained observer for anesthesia.

The April 2006 Addendum B can be accessed at Medicare's Hospital Outpatient PPS website.

Total maximum facility value for an outpatient surgical episode of care includes the sum of:

(1) The highest valued APC code per Exhibit 4 plus 50% of any lesser-valued APC code values.

Multiple procedures and bilateral procedures are to be indicated by the use of modifiers –51 and –50, respectively. The 50% reduction applies to all lower valued procedures, even if they are identified in the RVP© as modifier -51 exempt.

The surgery discogram procedure(s) (APC 388) value is for each level and includes conscious sedation and the technical component of the radiological procedure.

Facility fee reimbursement is limited to a maximum of four surgical procedures per surgical episode; and

(2) "Supply et al." is defined in Rule 16-2. Reimbursement shall be consistent with Rule 18-6(H). The billing provider is responsible for identifying and itemizing all "Supply et al." items; and

(3) Diagnostic testing and preoperative labs are reimbursed by applying the appropriate CF to the unit values for the specific CPT® code as listed in the RVP.

RVP© radiological procedure codes (not the injection codes) with an appropriate modifier are to be used for all arthrograms and myelograms; and

(4) Observation room maximum allowance shall not exceed a rate of $50.00 an hour and is limited to a maximum of 6 hours without prior authorization. Documentation should support the medical necessity for observation.

(5) Additional reimbursement is payable for the following services not included in the values found in Exhibit 4 of Rule 18:

- ambulance services
- blood, blood plasma, platelets

(d) Discontinued surgeries require the use of modifier -73 (discontinued prior to administration of anesthesia) or modifier -74 (discontinued after administration of anesthesia). Modifier -73 results in a reimbursement of 50% of the APC value for the primary procedure only. Modifier -74 allows reimbursement of 100% of the primary procedure value only.

(e) All surgical procedures performed in one operating room, regardless of the number of surgeons, are considered one outpatient surgical episode of care for purposes of facility fee reimbursement.

(f) In compliance with rule 16-6(A), the sum of Rule 18-6(J)(3)(c)(1-5) is compared to the total facility fee billed charges. The lesser of the two amounts shall be the maximum facility allowance for the surgical episode of care. A line by line comparison of billed charges to the calculated maximum fee schedule allowance of 18-6(J)(3)(c) is not appropriate.

(K) Outpatient Diagnostic Testing and Clinic Facility Fees

(1) Bills for Services

All providers shall indicate whether they are billing for the total, professional only or technical only component of a diagnostic test by listing the appropriate RVP© modifier on the UB-92 or CMS 1500.

(2) Reimbursement

(a) The following types of outpatient diagnostic testing and clinic facilities are reimbursed at 100% of billed charges:

(1) Children's hospitals,

(2) Veterans' Administration hospitals

(3) State psychiatric hospitals

(b) Rural health facilities listed in Exhibit 5 are reimbursed at 80% of billed charges for clinic visits, diagnostic testing, and supplies and drugs that do not meet the "Supply et al." threshold.

"Supply et al." is defined in Rule 16-2 and reimbursement shall be consistent with Rule 18-6(H). The billing provider is responsible for identifying and itemizing all "Supply et al." items.

(c) All other facilities:

(1) No separate allowance for clinic visit fees. Supplies are reimbursed in accordance with Rule 18-6(H).

(2) No separate facility fee allowance for diagnostic testing. Facility fees for diagnostic testing are considered part of the procedure's technical component value. Outpatient diagnostic testing is reimbursed using the RVP© code unit value. Dyes and contrasts may be reimbursed at 80% of billed charges.

(3) "Supply et al." is defined in Rule 16-2 and reimbursement shall be consistent with Rule 18-6(H). The billing provider is responsible for identifying and itemizing all "Supply et al." items.

(L) Outpatient Urgent Care Facility Fees

(1) Provider Restrictions:

(a) Prior agreement or authorization is recommended for all facilities billing a separate Urgent Care fee. Facilities must provide documentation of the required urgent care facility criteria if requested by the payer.

(b) Urgent care facility fees are only payable if the facility qualifies as an Urgent Care facility. Facilities licensed by the CDPHE as a Community Clinic (CC) or a Community Clinic and Emergency Center (CCEC) under 6 CCR 1011-1, Chapter IX, should still provide evidence of these qualifications to be reimbursed as an Urgent Care facility. The facility shall meet all of the following criteria to be eligible for a separate Urgent Care facility fee:

(1) Separate facility dedicated to providing initial walk-in urgent care;

(2) Access without appointment during all operating hours;

(3) State licensed physician on-site at all times exclusively to evaluate walk-in patients;

(4) Support staff dedicated to urgent walk-in visits with certifications in Basic Life Support (BLS);

(5) Advanced Cardiac Life Support (ACLS) certified life support capabilities to stabilize emergencies including, but not limited to, EKG, defibrillator, oxygen and respiratory support equipment (full crash cart), etc.;

(6) Ambulance access;

(7) Professional staff on-site at the facility certified in ACLS;

(8) Extended hours including evening and some weekend hours;

(9) Basic X-ray availability on-site during all operating hours;

(10) Clinical Laboratory Improvement Amendments (CLIA) certified laboratory on-site for basic diagnostic labs or ability to obtain basic laboratory results within 1 hour;

(11) Capabilities include, but are not limited to, suturing, minor procedures, splinting, IV medications and hydration;

(12) Written procedures exist for the facility's stabilization and transport processes.

(c) No separate facility fees are allowed for follow-up care. 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) Bills for Services

(a) Urgent care facility fees may be billed on a CMS 1500

(b) Urgent care facility fees shall be billed using HCPCS Level II code: S9088 – "Services provided in an Urgent care facility."

(3) Urgent Care Reimbursement

The total maximum value for an urgent care episode of care includes the sum of:

(a) An Urgent Care Facility fee maximum allowance of $75.00; and

(b) "Supply et al." is defined in Rule 16-2 and reimbursement shall be consistent with Rule 18-6(H). The billing provider is responsible for identifying and itemizing all "Supply et al." items.

Supplies and drugs that do not meet the "Supply et al." threshold and treatment rooms are included in the Urgent Care maximum fees; and

(c) All diagnostic testing, laboratory services and therapeutic services (including, but not limited to, radiology, pathology, respiratory therapy, physical therapy or occupational therapy) shall be reimbursed by multiplying the appropriate CF by the unit value for the specific CPT® code as listed in the RVP© and Rule 18; and

(d) The Observation Room allowance shall not exceed a rate of $50.00 per hour and is limited to a maximum of 3 hours without prior authorization.

(e) In compliance with Rule 16-6 (A), the sum of all Urgent Care fees charged, less any amounts charged for professional fees or dispensed prescriptions per Rule 18-6(L)(4) found on the same bill, is to be compared to the maximum reimbursement allowed by the calculated value of Rule 18-6(L)(3)(a-d). The lesser of the two amounts shall be the maximum facility allowance for the episode of urgent care. A line by line comparison is not appropriate.

(4) Any prescription for a drug supply to be used longer than a 24 hour period, filled at any Urgent Care facility, shall fall under the requirements and be reimbursed as a pharmacy fee. See Rule 18-6(O).

(M) Outpatient Emergency Room Department (ERD) Facility Fees

(1) Provider Restrictions

To be reimbursed under this section (M), all outpatient ERDs within Colorado must be physically located within a hospital licensed by the CDPHE as a general hospital, or if free-standing ERD, must have equivalent operations as a licensed ERD. To be paid as an ERD, out-of-state facilities shall meet that state's licensure requirements.

(2) Bills For Services

(a) ERD facility fees shall be billed on the UB-92 and require summary level billing by revenue code. The provider must submit itemized bills along with the UB-92.

(b) Documentation should support the "Level of Care" being billed.

(3) ERD Reimbursement

(a) The following types of facilities are reimbursed at 100% of billed ERD charges:

(1) Children's hospitals

(2) Veterans' Administration hospitals

(3) State Psychiatric hospitals

(b) Medicare certified Critical Access Hospitals (CAH) (listed in Exhibit 3 of Rule 18) are reimbursed at 80% of billed charges.

(c) The ERD "Level of Care" is identified based upon one of five levels of care. The level of care is defined by the point system developed by the hospital in compliance with Medicare regulations and determined by the total number of points accumulated by assigning points to interventions completed by the ERD staff during an ERD visit. Upon request the provider shall supply a copy of their point system to the payer.

(d) Total maximum value for an ERD episode of care includes the sum of the following:

(1) ERD reimbursement amount for "Level of Care" points:

ERD LEVEL	Reimbursement
1	$ 120.00
2	$ 160.00
3	$ 250.00
4	$ 500.00
5	$ 1,500.00

and

(2) All diagnostic testing, laboratory services and therapeutic services not included in the hospital's point system (including, but not limited to, radiology, pathology, any respiratory therapy, PT or OT) shall be reimbursed by the appropriate CF multiplied by the unit value for the specific code as listed in the RVP© and Rule 18; and

(3) The observation room allowance shall not exceed a rate of $50.00 per hour and is limited to a maximum of 3 hours without prior authorization. The documentation should support the medical necessity for observation; and

(4) ERD level of care maximum fees include supplies and drugs that do not meet the "Supply et al." threshold and treatment rooms. "Supply et al." is defined in Rule 16-2 and reimbursement shall be consistent with Rule 18-6(H). The billing provider is responsible for identifying and itemizing all "Supply et al." items

(e) For the purposes of Rule 16-6 (A), the sum of all outpatient ERD fees charged, less any amounts charged for professional fees found on the same bill, is to be compared to the maximum reimbursement allowed by the calculated value of Rule 18-6(M)(3)(d). The lesser of the two

amounts shall be the maximum facility allowance for the ERD episode of care. A line by line comparison is not appropriate.

(f) If an injured worker is admitted to the hospital through that hospital's ERD, the ERD reimbursement is included in the inpatient reimbursement under 18-6(I)(3).

(g) Trauma Center Fees are not paid for alerts. Activation fees are as follows:

Level I	$3,000.00
Level II	$2,500.00
Level III	$1,000.00
Level IV	$00.00

(1) These fees are in addition to ERD and inpatient fees.

(2) Activation Fees mean a Trauma Team has been activated, not just alerted.

(N) Home Therapy

Prior authorization is required for all home therapy. The payer and the home health entity should agree in writing on the type of care, skill level of provider, frequency of care and duration of care at each visit, and any financial arrangements to prevent disputes.

(1) Home Infusion Therapy

The per diem rates for home infusion therapy shall include the initial patient evaluation, education, coordination of care, products, equipment, IV administration sets, supplies, supply management, and delivery services. Nursing fees should be billed as indicated in Rule 18-6(N)(2).

(a) Parenteral Nutrition:

0 -1 liter	$140.00/day
1.1 - 2.0 liter	$200.00/day
2.1 - 3.0 liter	$260.00/day

(b) Antibiotic Therapy:

$105.00/day + Average Wholesale Price (AWP)

(c) Chemotherapy:

$ 85.00/day + AWP

(d) Enteral nutrition:

Category I	$ 43.00/day
Category II	$ 41.00/day
Category III	$ 52.00/day

(e) Pain Management: $ 95.00/day + AWP

(f) Fluid Replacement: $ 70.00/day + AWP

(g) Multiple Therapies:

Only highest cost therapy + AWP for any remaining therapy

Medication/Drug Restrictions - the payment for drugs may be based upon the AWP of the drug as determined through the use of industry publications such as the monthly *Price Alert*, First Databank, Inc.

(2) Nursing Services

DoWC 99970 Skilled Nursing (LPN & RN)

$95.79 per hour

There is a limit of 2 hours without prior authorization.

DoWC 99972 Certified Nurse Assistant (CNA):

$31.67 per hour for the first hour;

$9.46 for each additional half hour. Service must be at least 15 minutes

to bill an additional half hour charge.

The amount of time spent with the injured worker must be specified in the medical records and on the bill.

(3) Physical Medicine

Physical medicine procedures are payable at the same rate as provided in the physical medicine and rehabilitation services section of Rule 18.

(4) Travel Allowances

Travel is typically included in the fees listed. Any extensive travel may need to be billed separately. Travel allowances should be agreed upon with the payer and should not exceed $28.00 per visit, portal to portal. The $28.00 allowance includes mileage.

DoWC code: 99971

(O) Pharmacy Fees

(1) AWP + $4.00

(2) All bills shall reflect the National Drug Code (NDC)

(3) All prescriptions shall be filled with bio-equivalent generic drugs unless the physician indicates "Dispense As Written" (DAW) on the prescription

(4) The above formula applies to both brand name and generic drugs

(5) The provider shall dispense no more than a 60-day supply per prescription

(6) A line-by-line itemization of each drug billed and the payment for that drug shall be made on the payment voucher by the payer

(7) AWP for brand name and generic pharmaceuticals may be determined through the use of such monthly publications as *Price Alert*, First Databank, Inc.

(8) Compounding Pharmacies

Reimbursement for compounding pharmacies shall be based on the cost of the materials plus 20%, $50.00 per hour for the pharmacist's documented time, and actual cost of any mailing & handling.

Bill Code:

DoWC 99913 Materials, mailing, handling

DoWC 99914 Pharmacist

(9) Injured Worker Reimbursement

The payer is responsible for timely payment of pharmaceutical costs (see Rule 16-11(A)(3)). In the event the injured worker has directly paid pharmaceutical costs, the payer shall reimburse the injured worker for actual costs incurred for authorized pharmacy services. If the actual costs exceed the maximum fee allowed by this rule, the payer may seek a refund from the dispensing provider for the difference between the amount charged to the injured worker and the maximum fee. Each request for a refund shall indicate the prescription number and the date of service involved.

(10) Dietary Supplements, Vitamins and Herbal Medicines

Reimbursement for outpatient dietary supplements, vitamins and herbal medicines dispensed in conjunction with acupuncture and complementary alternative medicine are authorized only by prior agreement of the payer, except for specific vitamins supported by Rule 17.

(11) Prescription Writing

Physicians shall indicate on the prescription form that the medication is related to a workers' compensation claim.

(12) Provider Reimbursement

Provider offices that prescribe and dispense medications from their office have a maximum allowance of AWP plus $4.00.

All medications administered in the course of the provider's care shall be reimbursed at actual cost incurred.

(13) Required Billing Forms

(a) All parties shall use one of the following forms:

(1) CMS 1500 (formerly HCFA 1500) – the dispensing provider shall bill by using the RVP© supply code and shall include the metric quantity and NDC number of the drug being dispensed; or

(2) WC -M4 form or equivalent – each item on the form shall be completed, or

(3) With the agreement of the payer, the National Council for Prescription Drug Programs (NCPDP) or ANSI ASC 837 (American National Standards Institute Accredited Standards Committee) electronic billing transaction containing the same information as in (1) or (2) in this sub-section may be used for billing.

(b) Items prescribed for the work-related injury that do not have an NDC code shall be billed as a supply, using the RVP© supply code.

(c) The payer may return any prescription billing form if the information is incomplete.

(d) A signature shall be kept on file indicating that the patient or his/her authorized representative has received the prescription.

(P) Complementary Alternative Medicine (CAM) (Requires prior authorization)

CAM is a term used to describe a broad range of treatment modalities, some of which are generally accepted in the medical community and others that remain outside the accepted practice of conventional western medicine. Providers of CAM may be both licensed and non-licensed health practitioners with training in one or more forms of therapy. Refer to Rule 17, Medical Treatment Guidelines for the specific types of CAM modalities.

(Q) Acupuncture

Acupuncture is an accepted procedure for the relief of pain and tissue inflammation. While commonly used for treatment of pain, it may also be used as an adjunct to physical rehabilitation and/or surgery to hasten return of functional recovery. Acupuncture may be

performed with or without the use of electrical current on the needles at the acupuncture site.

(1) Provider Restrictions

All providers must be Registered Acupuncturists (LAc) or certified by an existing licensing board as provided in Rule 16, Utilization Standards, and must provide evidence of training, registration and/or certification upon request of the payer.

(2) Billing Restrictions

(a). For treatments of more than fourteen (14) sessions, the provider must obtain prior authorization from the payer.

(b) Unless the provider's medical records reflect medical necessity and the provider obtains prior authorization for payment from the payer, the maximum amount of time allowed for acupuncture and procedures is one hour of procedures, per day, per discipline.

(3) Billing Codes:

(a) Reimburse acupuncture, including or not including electrical stimulation, as listed in the RVP©.

(b) Non-Physician evaluation services

(1) New or established patient services are reimbursable only if the medical record specifies the appropriate history, physical examination, treatment plan or evaluation of the treatment plan. Payers are only required to pay for evaluation services directly performed by an LAc. All evaluation notes or reports must be written and signed by the LAc.

(2) LAc new patient visit:

DoWC 97041	Maximum value	$86.56

(3) LAc established patient visit:

DoWC 97044	Maximum value	$58.43

(c~~)~~ Herbs require prior authorization and fee agreements as in this Rule 18-6(O)(10);

(d) See the appropriate physical medicine and rehabilitation section of the RVP© for other billing codes and limitations (see also Rule 18-5.H).

(e) Acupuncture supplies are reimbursed in accordance with Rule 18-6(H).

The dental schedule is adopted using the American Dental Association's *Current Dental Terminology*, Fourth Edition (CDT-4). However, surgical treatment for dental trauma and subsequent, related procedures shall be billed using codes from the RVP©. Reimbursement shall be in accordance with the surgery/anesthesia section of the RVP©, its corresponding CFs, the Division's Rule 16, Utilization Standards, and Rule 17, Medical Treatment Guidelines. See Exhibit 6 for the listing and maximum allowance for dental codes.