DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation
CCR 1101-3
RULE XVIII

MEDICAL FEE SCHEDULE

A. STATEMENT OF PURPOSE

Pursuant to § 8-42-101(3)(a)(I), 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 2004, edition of the R*elative Values for Physicians* (*RVP*), developed by Relative Value Studies, Inc., published by Ingenix® St. Anthony Publishing. The incorporation is limited to the specific edition named and does not include later revisions or additions. For information about inspecting or obtaining copies of the incorporated material, contact the Medical Fee Schedule Administrator, 1515 Arapahoe, Tower 2, Suite 610, Denver, Colorado 80202-2117. These materials may be examined at any state publications depository library. All guidelines and instructions are adopted as set forth in the *Relative Values for Physicians*, unless otherwise specified in this rule.

This rule applies to all services rendered on or after January 1, 2005. All other bills shall be reimbursed in accordance with the fee schedule in effect at the time service was rendered.

B. STANDARD TERMINOLOGY FOR THIS RULE

1. *RVP* – the 2004 edition of *Relative Values for Physicians*, incorporated by reference in Rule XVIII.A.

2. For other terms, see Rule XVI.B, Utilization Standards.

C. HOW TO OBTAIN COPIES

All users are responsible for the timely purchase and use of this Rule XVIII 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 this Rule XVIII. Copies of the *RVP* may be purchased from St. Anthony Press, and the *Workers' Compensation Rules of Procedures*, 7 CCR 1101-3, may be purchased from Weil Publishing, Augusta, ME. Unofficial copies of all rules, including Rule XVIII, are available on the Colorado Department of Labor and Employment web site at www.coworkforce.com/DWC/ .

D. CONVERSION FACTORS

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

RVP SECTION	CONVERSION FACTOR
Medicine	$7.34/RVU
Evaluation & Management (E&M)	$7.70/RVU
Physical Medicine	$4.98/RVU
(Codes 97000-97804)	
Anesthesia	$40.00/RVU
Surgery X Codes	$36.95/RVU
(see Rule XVIII.E.1.a.4)	
Surgery	$86.04/RVU
Radiology	$16.93/RVU
Pathology	$12.65/RVU

E. INSTRUCTIONS AND/OR MODIFICATIONS TO THE *RVP*

1. Maximum allowance for all providers under Rule XVI.E is 100 percent of the fees as defined in this Rule XVIII.

2. 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 Current Procedural Terminology codes (CPT codes marked by an "M" in the *RVP*) are not, unless otherwise advised by this rule. The American Medical Association's *Current Procedural Terminology* (*CPT*) 2004 may be referenced for further clarification of descriptions and billing, but if conflicts arise between the *RVP* and the *CPT* 2004, the *RVP* shall prevail.

3. *CPT* Category III, temporary codes, may be used for billing with agreement of the payer as to reimbursement. Payment shall be in compliance with Rule XVI.F.2.

4. Surgery/Anesthesia

   a. Anesthesia Section:(Codes range from 00100 – 01999, and 99100-99140)

      1) All anesthesia base values shall be established by the use of the codes 00100 - 01999 as set forth in the *RVP*.

      2) CPT codes 99100-99140, anesthesia add-on codes, are reimbursed using the anesthesia conversion factor (CF) and unit values found in the RVP, Anesthesia Guidelines IX, "Qualifying Circumstances."

3) Justifying documentation shall be submitted with the billing for all stand-by anesthesia.

4) When justified by a report, a second anesthesiologist can be reimbursed as recommended by the anesthesia guidelines in the *RVP*.

5) Surgery X Codes

(1) The following codes limit the list found in the table under the "Anesthesia Value Guidelines" of the *RVP* Section X, “Anesthesia Services Where Time Units Are Not Allowed”.

01995	01996	31500	36400	36420	36425
36600	36620	36625	36660	62273	62280
62281	62282	62310	62311	62318	62319
64400	64402	64405	64408	64410	64412
64413	64415	64416	64417	64418	64420
64421	64425	64430	64435	64445	64446
64447	64448	64450	64470	64472	64475
64476	64479	64480	64483	64484	64505
64508	64510	64520	64530	64600	64605
64610	64620	64622	64623	64626	64627
64630	64640	64680			

(2) The maximum reimbursement for these codes shall be based upon the anesthesia value listed in the table in Section X multiplied by $36.95 conversion factor. No additional unit values are added for time when calculating the maximum values for reimbursement.

(3) When performing more than one surgery x code 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 x code procedures performed on the same day during a single operative setting.

(4) Codes from Table X not found above may be found in another section of the *RVP* (e.g., surgery). Any codes found in the table under the “Anesthesia Value Guidelines” of the *RVP*, Section X, “Anesthesia Services Where Time Units Are Not Allowed” but not contained in this list (Rule XVIII.E.4.a.5)(1)) are reimbursed in accordance with the assigned units from their respective sections times their respective conversion factor.

b. Surgical Section: (Codes range from 10000-69999)

1) 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 April 22, 2004). 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, 1515 Arapahoe, Tower 2, Suite 610, Denver, Colorado, 80202-2117. 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.

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

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

4) 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 XVI.K.2.c.

5) Non-physician providers, used as surgical assistants, shall use the modifier –81 and shall be reimbursed at 10 percent of the listed value.

6) Starred (*) surgical procedures have been deleted from the CPT coding nomenclature.

7) Global period

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

(i) Evaluation and management services unrelated to the primary surgical procedure,

(ii) Services necessary to stabilize the patient for the primary surgical procedure,

(iii) Services not usually part of the surgical procedure,

(iv) Unusual circumstances, complications, exacerbations, or recurrences,

(v) Unrelated diseases or injuries.

(2) Separate identifiable services shall use the –25 modifier in conjunction with the billed service.

8) Intradiscal Electrothermal Annuloplasty (IDEA) -

This is a new procedure and prior authorization is required. A wire is guided into the identified painful disc using fluoroscopy. The wire is then heated within the disc. The goal of the procedure is to burn the nerves and to tighten the injured tissue within the disc. A physician well trained in the procedure must perform this procedure. Please refer to Rule XVII, Exhibit A, Section F.8 for the required surgical indications for this procedure.

Billing code and maximum fees are as follows:

Billing Code: S2370 $2,127.72

Fees are inclusive of all levels and all professional services except, fluoroscopy guidance; see code 76005.

9) The following surgery code relative value units, anesthesia base units and global days replace those existing in the 2004 *RVP*. All surgery code descriptors are based upon the 2004 *RVP*.

Code	Unit Value	Anes Base Units	Global Days
11771	7.2	5	090
11772	8.8	5	090
11971	3.6	3	090
13160	4.2	3	090
14000	7.2	3	090
14001	8.3	3	090
14040	10.5	5	090

Code	Unit Value	Anes Base Units	Global Days
14041	13.2	5	090
14060	14.3	5	090
14350	8.8	3	090
15050	4.2	3	090
15100	7.0	3	090
15120	12.7	5	090
15200	5.5	3	090

Code	Unit Value	Anes Base Units	Global Days
15220	7.2	5	090
15240	10.9	5	090
15260	13.8	5	090
15600	5.8	3	090
15610	5.8	5	090
15620	6.3	5	090
15630	7.5	5	090

Code	Unit Value	Anes Base Units	Global Days
15650	9.2	3	090
15760	10.4	5	090
15770	13.2	5	090
15783	2.2	3	090
15788	7.7	5	090
15789	9.9	5	090
15792	5.5	3	090
15793	7.7	3	090
15810	1.0	3	090
15811	2.4	3	090
15819	20.6	5	090
15820	11.0	5	090
15821	11.6	5	090
15822	10.2	5	090
15823	9.9	5	090
15831	22.0	5	090
15832	18.3	3	090
15833	18.3	3	090
15834	18.3	3	090
15835	18.3	3	090
15836	11.0	3	090
15837	9.1	3	090

Code	Unit Value	Anes Base Units	Global Days
15838	8.8	5	090
15950	2.3	5	090
15951	6.6	6	090
19110	5.2	3	090
19112	5.0	3	090
19120	6.0	3	090
19125	8.4	3	090
19140	7.7	3	090
19160	6.6	3	090
19162	18.7	5	090
19180	11.4	3	090
19182	11.0	3	090
19240	20.9	5	090
20661	4.4	5	090
20662	6.2	6	090
20663	6.2	4	090
20664	10.5	5	090
20680	4.9	5	090
20690	6.2	3	090
20692	11.1	3	090
20693	5.5	3	090
20694	2.5	3	090

Code	Unit Value	Anes Base Units	Global Days
21110	7.8	5	090
21440	15.6	7	090
21445	19.2	7	090
21501	5.5	5	090
21502	7.6	6	090
21510	4.9	10	090
21600	6.1	6	090
21610	22.0	6	090
21615	17.6	6	090
21616	22.4	6	090
21620	22.0	6	090
21627	8.8	10	090
21630	27.5	13	090
21632	44.0	13	090
21700	7.2	5	090
21705	13.8	6	090
21720	7.2	5	090
21725	9.4	5	090
21800	1.2	6	090
21805	11.0	6	090
21810	26.4	10	090
21820	3.0	6	090

Code	Unit Value	Anes Base Units	Global Days
21825	11.0	10	090
21925	3.3	5	090
21930	3.3	5	090
23000	6.8	5	090
23020	12.5	5	090
23035	14.4	5	090
23040	12.5	5	090
23044	8.1	5	090
23100	12.5	5	090
23101	12.5	5	090
23120	8.8	5	090
23125	17.6	6	090
23130	8.8	5	090
23140	6.8	5	090
23150	14.4	5	090
23172	7.2	5	090
23182	7.2	5	090
23184	12.0	5	090
23190	7.2	5	090
23195	18.0	5	090
23200	14.4	6	090
23210	19.2	6	090

Code	Unit Value	Anes Base Units	Global Days
23220	19.2	6	090
23395	11.6	5	090
23397	13.8	5	090
23400	16.5	5	090
23405	9.4	5	090
23406	12.9	5	090
23412	16.7	5	090
23415	11.0	5	090
23545	2.6	4	090
23550	12.7	5	090
23650	3.2	0	090
23655	4.7	4	090
24000	12.1	4	090
24006	15.6	4	090
24075	3.7	3	090
24076	6.0	3	090
24100	7.6	4	090
24101	12.1	4	090
24105	5.5	3	090
24110	11.0	5	090
24120	9.0	4	090
24130	9.4	3	090

Code	Unit Value	Anes Base Units	Global Days
24134	14.4	4	090
24136	14.4	3	090
24138	14.4	3	090
24140	13.2	4	090
24145	9.6	3	090
24147	8.3	3	090
24155	13.6	4	090
24160	10.7	4	090
24164	10.2	4	090
24201	4.7	3	090
24301	16.8	3	090
24305	6.4	3	090
24310	6.0	5	090
24350	6.0	3	090
24351	7.2	3	090
24352	9.6	3	090
24354	8.4	3	090
24365	11.0	4	090
24366	12.1	4	090
24495	13.2	3	090
24576	1.4	3	090
24577	4.4	3	090

Code	Unit Value	Anes Base Units	Global Days
24600	2.8	0	090
24605	3.5	3	090
24650	2.2	3	090
24670	2.2	3	090
24925	3.7	6	090
25000	5.4	3	090
25020	6.6	3	090
25023	7.2	3	090
25028	4.8	3	090
25031	2.4	3	090
25035	5.5	3	090
25040	6.1	3	090
25075	3.6	3	090
25076	5.5	3	090
25085	5.9	3	090
25100	5.5	3	090
25101	6.5	3	090
25105	8.8	3	090
25107	7.7	3	090
25110	4.2	3	090
25111	5.4	3	090
25112	6.8	3	090

Code	Unit Value	Anes Base Units	Global Days
25115	11.0	3	090
25116	11.0	3	090
25118	7.7	3	090
25119	11.0	3	090
25120	9.1	3	090
25130	6.6	3	090
25150	7.0	3	090
25151	8.3	3	090
25170	16.5	3	090
25210	7.7	3	090
25215	11.0	3	090
25230	5.9	3	090
25240	5.9	3	090
25248	5.5	3	090
25250	12.0	3	090
25251	18.0	6	090
25260	8.8	3	090
25263	9.4	3	090
25270	5.5	3	090
25272	6.6	3	090
25280	7.9	3	090
25290	4.7	3	090

Code	Unit Value	Anes Base Units	Global Days
25295	5.8	3	090
25500	2.4	3	090
25530	3.6	3	090
25560	3.2	3	090
25565	6.5	3	090
25600	3.3	3	090
25622	3.9	3	090
25630	3.9	3	090
25635	4.6	3	090
25675	3.4	3	090
25680	3.3	3	090
25695	11.0	3	090
25907	3.7	3	090
25915	11.6	3	090
25922	3.8	3	090
25929	3.7	3	090
26020	6.1	3	090
26025	6.6	3	090
26030	10.8	3	090
26034	7.2	3	090
26035	16.0	3	090
26037	14.4	3	090

Code	Unit Value	Anes Base Units	Global Days
26040	3.6	3	090
26045	5.5	3	090
26055	5.4	3	090
26070	6.1	3	090
26075	6.0	3	090
26080	5.4	3	090
26100	6.1	3	090
26105	6.0	3	090
26110	5.4	3	090
26115	3.6	3	090
26116	6.0	3	090
26160	4.8	3	090
26170	5.4	3	090
26180	6.0	3	090
26200	6.8	3	090
26210	5.9	3	090
26230	6.1	3	090
26235	5.5	3	090
26236	5.5	3	090
26320	6.0	3	090
26370	8.8	3	090
26372	12.4	3	090

Code	Unit Value	Anes Base Units	Global Days
26392	12.1	3	090
26410	5.1	3	090
26412	7.7	3	090
26415	9.4	3	090
26416	11.0	3	090
26432	7.2	3	090
26433	7.2	3	090
26437	6.6	3	090
26440	6.4	3	090
26442	7.7	3	090
26445	6.6	3	090
26449	8.8	3	090
26450	4.8	3	090
26455	6.0	3	090
26460	4.2	3	090
26560	11.5	3	090
26561	16.3	3	090
26600	1.7	3	090
26605	2.8	3	090
26607	5.5	3	090
26608	8.1	3	090
26615	7.7	3	090

Code	Unit Value	Anes Base Units	Global Days
26641	2.2	3	090
26645	4.6	3	090
26650	8.6	3	090
26665	11.6	3	090
26670	1.8	0	090
26675	2.9	3	090
26676	2.9	3	090
26685	6.6	3	090
26686	8.8	3	090
26700	2.3	0	090
26705	2.5	3	090
26706	4.6	3	090
26715	8.1	3	090
26720	1.7	3	090
26725	2.4	3	090
26727	3.7	3	090
26735	6.6	3	090
26740	2.8	3	090
26742	3.9	3	090
26746	6.6	3	090
26750	0.9	3	090
26755	1.2	3	090

Code	Unit Value	Anes Base Units	Global Days
26756	1.8	3	090
26765	4.4	3	090
26770	1.2	0	090
26775	1.7	3	090
26776	1.8	3	090
26785	3.3	3	090
26951	6.3	3	090
26952	8.1	3	090
26990	4.8	6	090
26991	1.3	6	090
26992	6.0	6	090
27000	2.4	4	090
27001	3.6	4	090
27003	8.1	4	090
27005	6.6	4	090
27006	7.7	4	090
27060	6.1	4	090
27062	4.4	4	090
27065	5.5	6	090
27070	6.6	8	090
27071	13.2	6	090
27087	2.8	6	090
27200	1.8	6	090
27250	3.9	0	090
27301	3.6	4	090
27303	6.6	6	090
27305	6.9	4	090
27306	2.9	4	090
27307	3.6	4	090
27315	13.2	4	090
27320	13.2	4	090
27340	8.8	4	090
27345	9.9	4	090
27350	13.2	4	090
27355	12.1	5	090
27372	6.2	4	090
27390	7.2	4	090
27391	9.2	4	090
27392	13.8	4	090
27393	8.4	4	090
27394	10.8	4	090
27395	15.6	4	090
27520	2.9	3	090
27550	2.6	0	090
27552	3.8	3	090
27560	2.6	0	090
27562	4.0	3	090
27600	7.2	3	090
27601	9.6	3	090
27602	13.2	3	090
27603	5.5	3	090
27604	1.3	3	090
27607	4.8	3	090
27610	10.0	3	090
27612	11.0	3	090
27618	3.7	3	090
27619	6.0	3	090
27620	10.0	3	090
27630	4.6	3	090
27635	11.6	3	090
27656	6.9	3	090
27675	6.6	3	090
27676	7.2	3	090
27680	5.5	3	090
27681	6.6	3	090
27704	13.2	3	090

Code	Unit Value	Anes Base Units	Global Days
27831	3.6	3	090
27840	2.1	0	090
27842	3.1	3	090
28003	2.5	3	090
28005	5.8	3	090
28008	3.5	3	090
28010	1.2	3	090
28011	1.8	3	090
28020	6.8	3	090
28022	4.4	3	090
28024	3.3	3	090
28030	13.2	3	090
28035	12.0	3	090
28043	3.7	3	090
28045	6.2	3	090
28050	6.8	3	090
28052	4.4	3	090
28054	3.3	3	090
28060	6.1	3	090
28080	5.4	3	090
28086	11.0	3	090
28088	7.2	3	090

Code	Unit Value	Anes Base Units	Global Days
28090	4.6	3	090
28092	3.0	3	090
28100	6.8	3	090
28104	5.4	3	090
28108	4.4	3	090
28110	3.3	3	090
28111	5.4	3	090
28112	4.4	3	090
28113	6.0	3	090
28114	13.2	3	090
28116	7.7	3	090
28118	7.7	3	090
28119	5.5	3	090
28120	6.6	3	090
28122	5.3	3	090
28124	4.0	3	090
28126	3.9	3	090
28140	6.6	3	090
28150	4.2	3	090
28153	4.8	3	090
28160	4.8	3	090
28192	3.6	3	090

Code	Unit Value	Anes Base Units	Global Days
28193	5.4	3	090
28220	5.5	3	090
28222	6.6	3	090
28225	3.1	3	090
28226	4.0	3	090
28230	3.6	3	090
28232	1.7	3	090
28234	1.2	3	090
28238	7.6	3	090
28240	4.0	3	090
28250	6.6	3	090
28260	10.3	3	090
28261	11.8	3	090
28270	2.6	3	090
28272	1.9	3	090
28280	3.9	3	090
28285	5.3	3	090
28286	5.3	3	090
28288	5.3	3	090
28309	7.7	3	090
28470	2.4	3	090
28475	2.8	3	090

Code	Unit Value	Anes Base Units	Global Days
28476	3.5	3	090
28490	1.2	3	090
28495	1.3	3	090
28496	2.2	3	090
28505	4.6	3	090
28510	0.8	3	090
28515	1.3	3	090
28525	3.6	3	090
28530	2.2	3	090
28531	3.2	3	090
28540	3.5	0	090
28545	5.2	3	090
28546	6.3	3	090
28570	2.8	0	090
28575	4.5	3	090
28576	6.2	3	090
28600	2.3	0	090
28605	3.0	3	090
28606	4.1	3	090
28675	4.6	3	090
28820	3.6	3	090
28825	2.8	3	090

Code	Unit Value	Anes Base Units	Global Days
29804	14.3	5	090
29819	13.2	4	090
29820	14.3	4	090
29821	17.6	4	090
29822	16.5	4	090
29823	17.1	4	090
29825	7.7	4	090
29826	15.4	4	090
29834	11.0	3	090
29835	13.2	3	090
29836	17.6	3	090
29837	11.0	3	090
29838	11.6	3	090
29843	8.3	3	090
29844	8.4	3	090
29845	9.9	3	090
29846	10.8	3	090
29847	10.8	3	090
29871	8.3	3	090
29874	11.0	3	090
29875	15.4	3	090
29876	17.6	3	090

Code	Unit Value	Anes Base Units	Global Days
29877	15.4	3	090
29879	15.4	3	090
29880	19.9	3	090
29881	15.4	3	090
29882	19.3	3	090
29883	23.1	3	090
29884	17.6	3	090
29885	17.6	3	090
29886	17.6	3	090
29887	19.3	3	090
29888	34.1	3	090
29889	34.1	3	090
29894	9.9	3	090
29895	9.9	3	090
29897	9.9	3	090
29898	11.0	3	090
30118	9.0	5	090
30120	9.9	5	090
30124	2.0	5	090
30125	10.2	5	090
30130	2.4	5	090
30320	7.4	5	090

Code	Unit Value	Anes Base Units	Global Days
30430	7.5	5	090
30435	14.4	5	090
30450	18.4	5	090
30460	15.8	5	090
30462	28.8	5	090
30540	15.1	5	090
30545	19.1	5	090
30915	15.0	5	090
30920	18.0	5	090
31320	8.8	6	090
31613	5.3	6	090
31614	11.9	6	090
31800	24.0	6	090
32800	14.4	13	090
32810	22.0	13	090
32820	33.0	10	090
34001	11.0	10	090
34051	22.0	15	090
34101	8.8	6	090
34111	8.8	6	090
34151	16.5	15	090
34201	13.2	6	090

Code	Unit Value	Anes Base Units	Global Days
34203	13.2	6	090
35201	23.1	10	090
35206	23.1	4	090
35207	23.1	6	090
35301	22.0	10	090
35321	19.8	6	090
36261	7.5	4	090
36819	16.8	6	090
36821	15.6	6	090
36822	13.2	6	090
36823	13.2	6	090
36825	17.4	6	090
36830	15.6	6	090
36834	17.4	6	090
36835	15.6	6	090
37565	12	5	090
37600	9.0	5	090
37605	9.6	5	090
37606	11.0	5	090
37607	9.6	5	090
37615	9.6	5	090
37616	22.0	15	090

Code	Unit Value	Anes Base Units	Global Days
37617	16.5	15	090
37618	12.0	4	090
37650	8.4	3	090
37700	4.8	3	090
37720	8.4	3	090
37730	12.0	3	090
37735	19.3	3	090
37780	2.4	3	090
37785	1.4	3	090
38100	18.4	7	090
38101	18.4	7	090
38115	18.4	7	090
38305	2.4	6	090
38308	6.0	5	090
38380	5.8	6	090
38381	15.4	13	090
38382	15.4	6	090
38542	6.6	6	090
38550	6.6	6	090
38555	11.0	6	090
38564	13.2	6	090
38700	13.2	6	090

Code	Unit Value	Anes Base Units	Global Days
38720	23.1	6	090
38724	23.1	6	090
38740	8.8	5	090
38745	15.4	5	090
38760	8.8	3	090
38765	19.8	6	090
38770	19.8	6	090
38780	29.7	6	090
40500	9.8	5	090
40510	9.0	9	090
40520	8.3	5	090
40525	9.5	5	090
40530	8.6	5	090
40650	3.6	5	090
40652	4.8	5	090
40654	7.2	5	090
40814	2.4	5	090
40816	3.3	5	090
40818	2.2	5	090
41500	6.0	5	090
41510	12.0	5	090
41520	2.4	5	090

Code	Unit Value	Anes Base Units	Global Days
42325	1.2	5	090
42326	1.4	5	090
42335	2.9	5	090
42340	7.2	5	090
42410	6.8	5	090
42415	18.2	5	090
42420	22.4	5	090
42425	15.0	5	090
42426	30.8	6	090
42440	11.6	5	090
42450	11.6	5	090
42500	7.8	5	090
42505	11.6	5	090
42507	14.3	5	090
42508	14.3	5	090
42509	24.2	5	090
42510	14.9	5	090
42600	11.0	5	090
42810	4.6	5	090
42815	12.4	5	090
42820	6.1	5	090
42821	6.6	5	090

Code	Unit Value	Anes Base Units	Global Days
42825	5.9	5	090
42826	6.4	5	090
42830	3.5	5	090
42831	3.8	5	090
42835	3.2	5	090
42836	3.5	5	090
42842	18.2	7	090
42844	21.8	7	090
42845	21.8	7	090
42860	3.6	5	090
42870	6.2	5	090
42890	13.2	7	090
42892	17.6	7	090
42894	20.9	7	090
42950	13.8	5	090
42953	13.8	7	090
43500	15.5	7	090
43501	19.0	7	090
43502	21.9	7	090
43510	16.1	7	090
43520	13.2	7	090
43605	15.5	7	090

Code	Unit Value	Anes Base Units	Global Days
43610	17.3	7	090
43638	30.8	7	090
43639	31.9	7	090
43640	20.4	7	090
43641	22.0	7	090
43800	16.7	7	090
43810	17.5	7	090
43820	17.5	7	090
43825	21.0	7	090
43830	13.2	7	090
43831	10.7	7	090
43832	18.4	7	090
43840	16.1	7	090
43850	22.0	7	090
43855	25.3	7	090
43860	22.0	7	090
43865	25.3	7	090
43870	11.5	7	090
43880	18.4	7	090
44010	16.4	7	090
44020	16.1	6	090
44021	15.4	6	090
44025	17.2	6	090
44055	15.4	7	090
44110	16.6	6	090
44111	18.7	6	090
44120	19.4	7	090
44125	19.4	6	090
44130	16.5	6	090
44160	20.9	7	090
44300	9.9	6	090
44310	16.0	6	090
44312	3.1	6	090
44314	17.6	6	090
44316	24.2	6	090
44320	12.7	6	090
44322	13.2	6	090
44340	2.8	6	090
44345	13.2	6	090
44346	13.8	6	090
44602	14.9	6	090
44603	19.3	6	090
44604	19.3	6	090
44605	17.3	6	090
44615	19.5	6	090
44620	11.0	6	090
44625	16.0	6	090
44626	28.6	6	090
44640	14.3	6	090
44650	15.4	6	090
44660	15.4	6	090
44661	24.2	6	090
44680	19.8	6	090
44800	13.8	6	090
44820	11.5	6	090
44850	12.1	6	090
44900	11.5	6	090
44950	11.5	6	090
44960	12.7	6	090
45020	5.4	5	090
45170	3.6	5	090
46200	4.4	5	090
46210	1.8	5	090
46285	2.4	5	090
46288	12.6	5	090
47010	17.6	7	090

Code	Unit Value	Anes Base Units	Global Days
47015	15.4	7	090
47100	11.5	7	090
47120	33.4	13	090
47122	44.9	13	090
47125	44.9	13	090
47130	44.9	13	090
47135	180.0	30	090
47136	156.0	30	090
47400	24.2	7	090
47420	21.9	7	090
47425	25.9	7	090
47460	24.2	7	090
47480	14.4	7	090
47510	8.1	4	090
47600	16.3	7	090
47605	18.4	7	090
47610	23.0	7	090
47612	24.2	7	090
47620	25.3	7	090
47700	20.7	7	090
47701	48.3	7	090
47711	27.5	7	090
47712	38.5	7	090
47715	22.0	7	090
47716	18.7	7	090
47720	16.5	7	090
47721	20.9	7	090
47740	18.7	7	090
47741	27.5	7	090
47760	23.1	7	090
47765	22.0	7	090
47780	26.4	7	090
47785	39.6	7	090
47800	24.2	7	090
47801	12.1	7	090
47802	19.8	7	090
47900	25.3	7	090
48000	18.7	7	090
48001	20.9	7	090
48005	18.7	7	090
48020	22.0	7	090
48100	16.5	7	090
48120	19.3	7	090
48140	22.0	8	090
48145	26.4	8	090
48146	33.0	8	090
48148	19.8	7	090
48150	38.5	8	090
48152	36.3	8	090
48153	38.5	8	090
48154	36.3	8	090
48155	26.4	8	090
48180	27.5	7	090
48500	16.5	7	090
48510	22.0	7	090
48520	18.7	7	090
48540	22.0	7	090
48545	20.4	7	090
48547	28.1	7	090
49200	15.4	6	090
49201	23.1	6	090
49215	18.2	10	090
49220	24.2	7	090
49250	8.8	6	090
49255	11.0	7	090
49425	15.0	7	090

Code	Unit Value	Anes Base Units	Global Days
49426	24.0	7	090
49505	9.8	4	090
49507	13.0	4	090
49520	12.7	4	090
49521	15.9	4	090
49525	10.4	4	090
49540	11.8	6	090
49550	10.2	4	090
49553	13.5	4	090
49555	12.1	4	090
49557	15.3	4	090
49560	13.2	6	090
49561	16.4	6	090
49565	15.0	6	090
49566	18.2	6	090
49570	4.6	4	090
49572	7.8	4	090
49580	8.1	4	090
49582	11.3	4	090
49585	9.2	4	090
49587	12.4	4	090
49590	10.4	4	090

Code	Unit Value	Anes Base Units	Global Days
49600	12.1	7	090
49605	29.9	7	090
49606	24.2	7	090
49610	13.2	7	090
49611	13.2	7	090
49900	7.4	6	090
50205	9.6	7	090
51580	42.7	8	090
52700	8.8	3	090
53010	7.2	3	090
53040	3.6	3	090
53210	15.4	3	090
53215	20.1	3	090
53220	11.0	3	090
53230	14.3	3	090
53235	14.3	3	090
53400	11.0	3	090
53405	16.0	3	090
53410	17.6	3	090
53415	26.4	3	090
53420	22.0	3	090
53442	5.5	3	090

Code	Unit Value	Anes Base Units	Global Days
53450	4.8	3	090
53460	6.0	3	090
53502	12.2	3	090
53505	12.2	3	090
54110	10.0	3	090
54111	22.2	3	090
54112	24.6	3	090
54115	6.6	3	090
54120	12.0	3	090
54300	9.6	3	090
54380	9.6	3	090
54385	12.0	3	090
54390	12.0	6	090
54400	14.4	4	090
54401	16.8	4	090
54420	15.0	3	090
54430	15.0	3	090
54435	3.6	3	090
54520	7.6	3	090
54530	11.4	4	090
54535	14.4	6	090
54550	10.0	4	090

Code	Unit Value	Anes Base Units	Global Days
54560	13.8	6	090
54640	13.2	4	090
54660	4.6	3	090
54670	9.2	3	090
54680	11.5	3	090
54820	6.7	3	090
54830	7.2	3	090
54840	9.2	3	090
54860	9.2	3	090
54861	13.8	3	090
55040	9.2	3	090
55041	13.8	3	090
55060	7.0	3	090
55150	3.6	3	090
55175	9.6	3	090
55180	14.4	3	090
55200	4.3	3	090
55250	5.4	3	090
55530	9.2	3	090
55535	10.9	6	090
55540	10.9	4	090
55600	7.7	6	090

Code	Unit Value	Anes Base Units	Global Days
55650	23.0	6	090
55680	23.0	6	090
56620	12.1	4	090
56625	17.1	4	090
57010	6.6	4	090
57120	13.5	4	090
57240	9.5	4	090
57250	8.8	4	090
57260	14.3	4	090
57265	16.0	4	090
57268	11.0	4	090
57270	13.8	6	090
57280	15.4	6	090
57282	15.4	6	090
57289	13.8	4	090
57330	18.7	6	090
57520	5.8	3	090
57522	5.2	3	090
57530	5.8	3	090
57540	13.8	6	090
57545	17.3	6	090
57550	13.8	6	090

Code	Unit Value	Anes Base Units	Global Days
57555	17.3	6	090
57556	17.3	6	090
57700	10.9	4	090
57720	5.8	4	090
58140	13.8	6	090
58150	19.6	6	090
58152	26.5	6	090
58180	17.3	6	090
58260	21.9	6	090
58262	23.0	6	090
58263	25.3	6	090
58267	25.3	6	090
58270	23.0	6	090
58275	23.0	6	090
58280	23.0	6	090
58400	13.9	6	090
58410	19.0	6	090
58520	12.7	6	090
58540	20.7	6	090
58600	11.5	6	090
58605	8.6	6	090
58740	19.0	6	090

Code	Unit Value	Anes Base Units	Global Days
58750	24.2	6	090
58752	19.0	6	090
58760	19.6	6	090
58770	19.6	6	090
58805	13.8	6	090
58822	11.5	6	090
58825	13.8	6	090
58900	12.1	6	090
58920	12.7	6	090
58925	12.7	6	090
58940	12.7	6	090
58943	23.0	6	090
58950	17.6	6	090
58951	27.5	8	090
58952	25.9	8	090
59100	18.4	6	090
59120	16.1	6	090
59121	16.1	6	090
59130	16.7	6	090
59135	20.1	6	090
59136	23.0	6	090
59140	16.1	3	090

Code	Unit Value	Anes Base Units	Global Days
59150	12.7	6	090
59151	20.7	6	090
59870	6.0	3	090
60200	12.0	6	090
60210	15.0	6	090
60212	21.0	6	090
60220	18.4	6	090
60225	21.6	6	090
60240	25.2	6	090
60252	31.2	6	090
60254	34.8	6	090
60260	20.4	6	090
60270	27.6	13	090
60280	14.4	6	090
60281	14.4	6	090
60500	21.0	6	090
60502	20.7	6	090
60505	27.6	13	090
60540	23.4	10	090
60545	27.0	10	090
60600	24.0	6	090
60605	29.4	10	090

Code	Unit Value	Anes Base Units	Global Days
61120	12.0	9	090
61140	26.4	9	090
61150	26.4	9	090
61151	27.0	9	090
64732	8.4	5	090
64734	8.4	5	090
64736	12.0	5	090
64738	12.0	5	090
64740	6.0	5	090
64742	12.0	5	090
64744	9.0	5	090
64746	6.0	5	090
64752	16.7	13	090
64755	25.3	7	090
64760	16.1	7	090
64761	5.8	3	090
64763	6.9	3	090
64766	11.5	4	090
64771	13.2	11	090
64772	7.2	10	090
64774	4.8	5	090
64776	4.8	3	090

Code	Unit Value	Anes Base Units	Global Days
64782	7.2	3	090
64784	10.8	4	090
64786	12.6	4	090
64788	7.6	5	090
64790	9.9	5	090
64792	12.1	5	090
64802	16.0	10	090
64804	22.0	10	090
64809	22.0	13	090
64818	13.2	7	090
65091	12.0	5	090
65093	15.0	5	090
65101	15.0	5	090
65103	16.8	5	090
65105	20.4	5	090
65110	24.0	5	090
65112	27.0	5	090
65114	31.2	5	090
65125	7.2	5	090
65130	13.8	5	090
65135	15.0	5	090
65140	18.0	5	090

Code	Unit Value	Anes Base Units	Global Days
65150	13.2	5	090
65155	14.4	5	090
65175	9.0	5	090
65235	17.3	5	090
65260	23.0	5	090
65265	23.0	5	090
65275	8.6	5	090
65280	15.4	5	090
65285	16.5	5	090
65286	12.0	5	090
65290	12.0	5	090
65400	9.6	5	090
65420	6.0	5	090
65426	8.4	5	090
65600	7.2	5	090
65820	12.6	4	090
65850	18.4	5	090
65860	5.9	5	090
65865	12.6	5	090
65870	11.4	5	090
65875	12.0	5	090
65880	12.6	5	090

Code	Unit Value	Anes Base Units	Global Days
65900	15.6	5	090
65920	24.0	5	090
65930	12.0	5	090
66130	4.6	5	090
66150	16.7	5	090
66155	16.1	5	090
66160	16.1	5	090
66165	17.3	5	090
66170	17.3	5	090
66172	20.7	5	090
66180	16.7	5	090
66185	12.1	5	090
66500	8.4	5	090
66505	8.4	5	090
66600	16.1	6	090
66605	25.3	6	090
66625	11.5	6	090
66630	11.5	6	090
66635	11.5	6	090
66680	13.8	5	090
66682	17.3	5	090
66700	10.4	5	090

Code	Unit Value	Anes Base Units	Global Days
66710	10.4	5	090
66720	10.4	5	090
66740	10.4	5	090
66761	11.5	6	090
66762	7.2	6	090
66770	9.0	5	090
66820	6.3	6	090
66821	6.3	6	090
66825	12.9	6	090
67015	12.1	6	090
67025	12.1	6	090
67027	5.5	6	090
67030	17.3	6	090
67031	12.7	6	090
67036	38.5	6	090
67038	44.0	6	090
67039	35.2	6	090
67040	37.4	6	090
67115	10.8	5	090
67120	10.8	5	090
67121	14.4	6	090
67141	10.8	6	090

Code	Unit Value	Anes Base Units	Global Days
67145	14.4	6	090
67311	18.0	5	090
67312	21.6	5	090
67314	18.0	5	090
67316	22.8	5	090
67318	19.2	5	090
67343	17.4	5	090
67400	16.8	5	090
67405	16.8	5	090
67412	22.0	5	090
67413	24.0	5	090
67414	25.2	5	090
67420	27.6	5	090
67430	25.2	5	090
67440	24.0	5	090
67445	26.4	5	090
67450	24.0	5	090
67550	14.4	5	090
67560	12.0	5	090
67570	10.8	5	090
67835	15.6	5	090
67880	5.4	5	090

Code	Unit Value	Anes Base Units	Global Days
67882	7.8	5	090
67900	6.8	5	090
67901	15.4	5	090
67902	17.6	5	090
67903	18.7	5	090
67904	18.7	5	090
67906	17.6	5	090
67908	14.4	5	090
67909	14.4	5	090
67911	21.6	5	090
67916	10.8	5	090
67917	14.4	5	090
67923	10.8	5	090
67924	13.8	5	090
67935	9.6	5	090
67950	13.8	5	090
67961	16.0	5	090
67966	17.6	5	090
67971	18.7	5	090
67973	19.8	5	090
67974	22.0	5	090
67975	8.8	5	090

Code	Unit Value	Anes Base Units	Global Days
68320	15.6	5	090
68325	16.8	5	090
68326	16.8	5	090
68328	19.2	5	090
68330	12.0	5	090
68335	16.8	5	090
68360	7.2	5	090

Code	Unit Value	Anes Base Units	Global Days
68362	13.2	5	090
68500	14.4	5	090
68505	13.8	5	090
68520	15.0	5	090
68540	17.3	5	090
68550	19.6	5	090
68700	14.4	5	090

Code	Unit Value	Anes Base Units	Global Days
68720	16.5	5	090
68770	9.0	5	090
69110	7.2	5	090
69440	13.2	5	090
69450	13.8	5	090

5. Radiology Section: (Codes range from 70000 - 79999)

   a. General

      1) The cost of dyes and contrast shall be reimbursed at 80 percent of billed charges.

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

   b. Modifiers

      1) The five-digit CPT code without a modifier indicates the provider performed both the professional and technical components of the radiological procedure.

      2) If the provider supplies only the professional component, as defined in the Radiology Guidelines section of the *RVP* then the five-digit CPT code must carry a modifier –26.

      3) Modifier –27 is not recognized for the technical component of a radiological procedure. If the provider supplies only the technical component, as defined in the Radiology Guidelines section of the *RVP* the five-digit CPT code must carry a modifier TC.

      4) 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 XVI.K.2.c.

c. Thermography

1) 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.

2) 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).

3) Protocol for stress testing is outlined in the Medical Treatment Guidelines found in Rule XVII.

4) Thermography Billing Codes:

79993 Upper body w/ Autonomic Stress Testing $840.00

79995 Lower body w/Autonomic Stress Testing $840.00

79997 Whole Body w/Autonomic Stress Testing $1,260.00

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.

5) 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 this Rule XVIII.E.4.c.

6. Pathology Section: (Codes range from 80000 - 89999)

a. Modifiers

1) The five-digit CPT code without a modifier indicates the provider performed both the professional and technical components of the pathological procedure.

2) If the provider supplies only the professional component, as defined in the Pathology and laboratory Guidelines section of the *RVP*, then the five-digit CPT code must carry a modifier –26.

3) Modifier –27 is not recognized for the technical component of a pathology procedure. If the provider supplies only the technical component, as defined in the Pathology and laboratory Guidelines section of the *RVP*, the five-digit CPT code must carry a modifier -TC.

4) 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 XVI.K.2.c.

7. Medicine Section: (Codes range from 90000 - 96999 and 98925 - 99199)

a. Medicine codes 99500-99602 in the *RVP* are not adopted. For appropriate codes see Rule XVIII.F.11.

b. Codes 99100-99140 are reimbursed in accordance with the anesthesia section of this Rule XVIII.

c. Biofeedback (Codes: 90901, 90911)

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 XVI.E. Supervision shall be as defined in an applicable Rule XVII medical treatment guideline. Persons providing biofeedback shall be certified by the Biofeedback Certification Institution of America, or be a licensed physician or psychologist, as listed under Rule XVI.E.1.a.1) and 2) with evidence of equivalent biofeedback training.

d. Osteopathic (DO) and Medical (MD) Manipulation: (Codes range from 98925 - 98929)

Evaluation and management (E&M) services can be billed separately when the provider's records document significant and identifiable services that are above and

beyond the usual services required to perform manipulation. A modifier –25 on the E&M service is required when manipulation is also billed at the same visit for the same patient.

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. The provider's medical records shall reflect medical necessity and prior authorization for payment if treatment needs to exceed 34 visits.

For purposes of DO and MD manipulation, body regions referred to are: head region; cervical region; thoracic region; lumbar region; sacral region; pelvic region; lower extremities; upper extremities; rib cage region; abdomen and viscera region.

e. Chiropractic (DC) Manipulation: (Codes range from 98940 - 98943)

E&M services can be billed separately when the provider's records document significant and identifiable services that are above and beyond the services required to perform manipulation. A modifier –25 on the E&M service is required when manipulation is also billed at the same visit for the same patient.

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. The provider's medical records shall reflect medical necessity and prior authorization for payment if treatment needs to exceed 34 visits.

For purposes of DC manipulation, the five spinal regions referred to are: cervical regions (includes atlanto-occipital joint); thoracic region (includes costovertebral and costotransverse joints); lumbar region; sacral region; and pelvic (sacro-iliac joint) region. The five extraspinal regions referred to are: head region (including temporomandibular joint, excluding atlanto-occipital); lower extremities; upper extremities; rib cage (excluding costotransvers and costovertebral joints) and abdomen.

f. Psychiatric/Psychological Services: (Codes range from 90801-90899 and 96100-96117)

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

2) 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 Code:	90801-90802	limit: 4 hours
Testing Code:	96100-96117	limit: 6 hours

Psychotherapy Codes: 90804-90829 maximum allowance of 50 minutes 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.

g. Hyperbaric Oxygen Therapy Services (Code 99183)

The maximum unit value shall be 24 units, instead of 14 units as listed in the *RVP* for code 99183.

8. Physical Medicine and Rehabilitation: (Codes range from 97001 – 97804**)**

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

a. Prior authorization is required for codes 97802-97804. See Rule XVIII.F.12.g.

b. Recommendations

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

c. 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 XVII.

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.

d. 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 XVII, 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.

e. Procedures 97110 – 97535, 97542

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

f. Modalities

Codes 97010 – 97028, unattended

Codes 97032 – 97039, attended

Billing Restrictions: There is a total limit of two (2) modalities (whether attended or unattended) per visit per discipline.

NOTE: Instruction and application of a TENS unit for the patient's independent use shall be billed using attended therapy 97032.

g. Evaluation Services for Therapists: Physical Therapy (PT), Occupational Therapy (OT) (97001 – 97004) and Athletic Trainers (cf. §12-36-106 C.R.S.) (97005-97006)

1) 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.

2) Payers are only required to pay for evaluation services directly performed by a physical therapist (97001-97002), occupational therapist (97003-97004) or athletic trainer, as defined in §12-36-106 C.R.S., (97005-97006). 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 (99201-99499) of the *RVP*.

3) 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.

4) Reimbursement to physical therapists, occupational therapists, speech language pathologists and audiologists for coordination of care with professionals shall be based upon codes 99371-99373. 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.

5) All interdisciplinary team conferences shall be billed under the case management services section in the *RVP* using codes 99361 or 99362.

h. Special Tests

The following codes should be used for the respective tests:

97537	Job Site Evaluation
97750	Computer- Enhanced Evaluation
	Functional Capacity Evaluation
	Work Tolerance Screening
96105 - 96115	Speech

1) Billing Restrictions:

(1) 97537 requires prior authorization if exceeding 2 hours. 97750 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 billing rate codes.

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

(5) Reports from computerized equipment include a supporting analysis developed by the physical medicine professional performing the evaluation.

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

i. Speech Therapy/Evaluation and Treatment

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

j. Supplies

See Rule XVIII.F.8

k. Unattended Treatment

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

97152 fixed fee per day 1.5 RVU

l. 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.

m. Unlisted Service Physical Medicine

All unlisted services or procedures require a report.

n. Work Conditioning, Work Hardening, Work Simulation

1) 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 XVII, Medical Treatment Guidelines.

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

2) 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 XVII, Medical Treatment Guidelines.

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

3) 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 XVII, Medical Treatment Guidelines.

4) 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, physical therapist, occupational therapist, speech language pathologist or audiologist.

(3) Billing Codes: 97545 and 97546.

9. Evaluation and Management Section (Codes range from 99201 – 99499)

a. E&M Service Medical Record Documentation to Determine Correct Billing/Reimbursement Code

Medical record documentation shall encompass the *RVP* "E&M Guideline" criteria to justify the billed Evaluation and Management service. If 50 percent 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.

b. 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.

c. Number of Office Visits

All providers, as defined in Rule XVI.E.1-4, 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.

d. Case Management

1) Case management codes 99361 - 99373 found in the evaluation and management section of the *RVP* 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.

2) 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 XVI, Utilization Standards,

(i) One conference charge per facility per patient per day.

(ii) Reimbursement for each interdisciplinary team conference shall be determined in 15-minute increments. Fifteen-minute conferences shall be reimbursed using code 99361 reducing the maximum allowance to 50 percent of the total value of the code.

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

(i) Patient's identifying information;

(ii) Diagnosis**;**

(iii) Medical professionals attending the conference;

(iv) A brief statement of conference recommendations and actions (no additional allowance shall be made for this statement); and

(v) Length of time of meeting.

F. DIVISION ESTABLISHED CODES AND VALUES

1. 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.

99901 Maximum of $225.00 per hour;

billed at $56.25 per 15-minute increments.

2. Cancellation Fees For Payer Made Appointments

a. 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: 99910

b. 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 XVIII.F.2.

3. 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, also may be charged. The per-page fee for records copied from microfilm shall be $1.50 per page.

Copying Fee Billing Code: 99911

4. Deposition and Testimony Fees

a. 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:

b. Deposition:

Payment for a physician's testimony at a deposition shall not exceed 35 RVU per hour times the medicine conversion factor ($7.34) billed in 0.5-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 Billing Code:	99075 at 35 units per hr.
	Billed in half-hour increments

c. 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: 99085

Maximum Rate of $400.00 per hour

5. 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 30 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: 99912

6. Permanent Impairment Rating

a. 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. The authorized treating provider is required to submit in writing all permanent restrictions and future maintenance care related to the injury or occupational disease.

b. 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.

c. 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 XVIII F.7.b.). 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*.

d. MMI Determined with a Calculated Permanent Impairment Rating

1) 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)" (Form WC164).

2) Billing Codes and Reimbursement for MMI with a Calculated Permanent Impairment Rating:

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

99455 Reimbursed for 1.5 hours with a maximum not to exceed $300.30.

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

99456 Reimbursed for 2.5 hours with a maximum not to exceed $577.50.

(c) 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.

7. Report Preparation

a. 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 this Rule XVIII.

b. Completion of WC164 Form

1) Initial Report

The completed “Physician’s Report of Workers’ Compensation Injury” (WC164) initial report is submitted to the payer after the first visit with the injured worker.

2) Closing Report

The “Physician’s Report of Workers’ Compensation Injury” (WC164) closing report is required from the authorized treating physician when an injured worker is at maximum medical improvement and/or has a permanent impairment. A physician may bill for the completion of the WC164 if neither code 99455 nor 99456 (see Rule XVIII.F.6.d.) are billed.

3) Payer Requested WC164 Form

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

4) Provider Initiated WC164 Form

If the provider wants to use the WC164 Form as a progress report or for any purpose other than those designated here in Rule XVIII.F.7.b.1), 2) or 3), and seeks reimbursement for completion of the form, the provider shall get prior approval from the payer.

5) Billing Codes and Maximum Allowance for completion and submission of WC164 Form

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

99960	$42.00	Initial Report
99961	$42.00	Progress Report (Payer Requested or Provider Initiated)
99962	$42.00	Closing Report
99963	$42.00	Initial report including closing report on the same date of service

c. Special Reports

The term special reports includes reports falling outside the requirements set forth in Rule XVI, Utilization Standards, Rule XVII, Medical Treatment Guidelines and this Rule XVIII 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.

Special Report Preparation Billing Code:

99080 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.

8. Supplies, Durable Medical Equipment (DME), Orthotics and Prosthesis

a. Payment for supplies shall reflect the provider's actual cost plus a 20 percent markup. Cost includes shipping and handling charges.

b. Reimbursement for DMEs, orthotic and prosthetic devices may be based upon an appropriate CMS (Medicare) HCPC Level II Code as a reasonable means for determining a fee unless CMS (Medicare) fees do not meet the provider's actual cost in which case the reimbursement would be cost plus 20 percent.

c. Any single supply, durable medical equipment (DME), orthotic, prosthesis, or implantable device exceeding a billed amount of $500.00 per item shall have a maximum allowance of the provider's actual cost plus 20 percent.

d. 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 the provisions outlined in the physical medicine and rehabilitation section of the *RVP*.

Supplies Billing Code: 99070

9. In-Patient Hospital Services

a. Provider Restrictions

Determination of in-patient status shall be made by applying the CMS (Medicare) "Diagnosis Related Group" (DRG) classification system, medical or surgical, to the discharge diagnosis.

The CMS (Medicare) DRG classification system, hereby incorporated by reference, is published in THE *FEDERAL REGISTER,* VOLUME 65, NUMBER 148, PAGE 47160 (August 1, 2000), and is also available on the U.S. Government website (U.S. Department of Health of Human Services) at www.gpoaccess.gov/fr/index.html (accessed May 24, 2004). 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, 1515 Arapahoe, Tower 2, Suite 610, Denver, Colorado 80202-2117.

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 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.

b. Bills for Services

Required Billing Form - See Rule XVI.G, Utilization Standards.

All services billed on the UB-92 do not require itemization but do require summary level billing by revenue code. Providers may be required to submit itemized bills along with the UB-92 when requested to do so by the insurer.

In calculating the length of stay, do not count the discharge day.

Non-emergency, in-patient admissions require prior authorization for payment.

c. In-Patient Billing Per Diem Billing Rates:

Acute Care Hospital

99940	Medical DRG	$1,332.53 per day
99941	Surgical DRG	$2,422.78 per day

Per diem includes all charges made by the hospital except for television, long distance telephone and personal item charges; these are the responsibility of the injured worker when agreed to in writing at the time of admission.

d. Exceptions to Per Diem System

Hospitals shall be paid 80 percent of billed charges:

1) When the hospital charges for a medical DRG exceed the following medical per diem amount (it includes a 3.0 outlier factor):

99950 - $3,997.59 per day

2) When the hospital charges for a surgical DRG exceed the following surgical per diem amount (it includes a 3.0 outlier):

99951- $7,268.35 per day

3) 99952 When the length-of-stay is no more than two (2) days

4) 99953 When the services are provided by a psychiatric unit of an acute care hospital, or

5) 99954 When the services are provided by a free-standing psychiatric hospital (licensed), or

6) 99955 When the services are provided by a free-standing rehabilitation hospital (licensed).

It shall be the responsibility of the hospital to notify the payer these exceptions to the per diem system are being applied. Such notification shall be sent with the discharge billing.

e. Agreements

Nothing in this section precludes the payer from entering into payment agreements for lower reimbursement rates with hospitals to promote the continuity of care and the reduction of hospital costs.

f. Bill Review

Nothing in this rule precludes the payer's right to review the hospital bill.

g. Supplies and Implantable Hardware

1) Any single supply, durable medical equipment (DME), orthotic, prosthesis, or implantable device (“supply et al.”) exceeding a billed amount of $500.00 per item shall have a separate maximum allowance of the provider’s actual cost plus 20 percent. See Rule XVIII F.8.b. for DME, orthotics, and prosthetic devices.

2) To determine the remaining inpatient maximum allowance, the amount billed for the “supply et al.” is subtracted from the total billed charges. Then, the provider’s actual cost plus 20 percent is added back into the balance of the billed charges to determine whether the per diem amount or 80 percent of billed charges is the maximum allowance for the

remaining billed charges of the inpatient hospital bill. For total payment to be made in a timely manner, the provider should send a copy of the "supply et al." invoice with the initial bill.

3) The total maximum allowance for the inpatient, billed charges is the sum of the allowance for the "supply et al." plus the per diem or 80 percent of the remaining billed charges.

10. Outpatient Facility Services

a. Provider Restrictions

All non-emergency, outpatient surgery requires prior authorization for payment by the payer. All professional charges are subject to the *RVP* and dental fee schedule as incorporated in this Rule XVIII. Outpatient facility fees are only reimbursable if the facility is credentialed at the appropriate level for the service provided. Such credentials include:

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation for hospitals; or

Colorado Department of Public Health and Environment licensure as an ambulatory surgery center; or

The facility has the same or equivalent level of safety, monitoring and quality of care as the JCAHO or Colorado Department of Public Health and Environment licensure requires and has documented use showing these processes and procedures are in practice.

In all other cases, a facility fee is not reimbursable without prior agreement of the payer regardless of location of service.

b. Bills for Services:

A qualifying "outpatient facility" shall use the CMS 1500 (formerly HCFA 1500) for professional services and the UB-92 billing form for facility services. Outpatient hospital services are to be billed on the UB-92 and the following revenue codes require CPT coding:

030X – Laboratory

031X – Laboratory, Pathological

032X – Radiology, Diagnostic

033X – Radiology - Therapeutic

034X – Nuclear Medicine

035X – CT Scan

040X – Other Imaging Services

042X – Physical Therapy

043X – Occupational Therapy

044X – Speech Language Pathology

051X – Clinic

052X – Freestanding Clinic

053X – Osteopathic Services

057X – Home Health – Home Health Aide

058X – Home Health – Other Visits

059X – Home Health – Units of Service

061X – Magnetic Resonance Technology (MRI)

064X – Home IV Therapy Services

073X – EKG/ECGT

074X – EEG

090X – Psychiatric/Psychological Treatments

091X – Psychiatric/Psychological Services

092X – Other Diagnostic Services

094X – Other Therapeutic Services

096X – Professional Fees

097X – Professional Fees

098X – Professional Fees

c. Billing Restrictions

1) Examples of reimbursable facility fees, such as, but not limited to:

(1) After hours/weekend urgent follow-up care in an emergency room facility of a JCAHO accredited hospital (e.g., weekend or holiday burn); or

(2) Anesthesia - when any procedure requires regional or general anesthesia; or

(3) Emergency Room Visits - initial visits to a JCAHO accredited hospital; or

(4) Spinal blocks requiring fluoroscopic guidance; or

(5) Stellate ganglion blocks.

2) Examples of non-reimbursable facility fees, such as, but not limited to:

(1) When a fluoroscopic fee is charged for procedures other than spinal blocks or IDEA, a facility fee would not be appropriate; or

(2) When billing a routine clinical visit; or

(3) When the visit is to an urgent care facility or is an urgent physician office visit, unless ambulatory surgery is performed requiring regional or general anesthesia.

3) Fees for authorized outpatient facilities shall be reimbursed at 80 percent of billed charges. The following billing codes shall be used:

Emergency Room (ER)	99956
Ambulatory Surgical Centers	99957
Other Out-Patient Facilities	99958

(1) Outpatient charges requiring itemization by CPT code (see Rule XVIII.F.10.b) will be reimbursed at the current fee schedule rate. No separate facility fee may be billed when services are CPT code itemized for a routine clinical visit, such as PT or routine follow-up visits with physicians.

(2) Any single supply, durable medical equipment (DME), orthotic, prosthesis, or implantable device ("supply et al.") exceeding a billed amount of $500.00 per item shall have a maximum allowance of the provider's actual cost plus 20 percent.

To determine the remaining outpatient facility fee maximum allowance, the amount billed for the "supply et al." is subtracted from the total billed charges. Then, the maximum allowance for the remainder is 80 percent of the remaining balance of billed charges.

(3) The total maximum allowance for the outpatient billed charges is the sum of the allowance for any CPT itemized services, the

allowance for the “supply et al.,” and the allowance for the remaining balance of billed charges.

11. 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.

a. Home Infusion Therapy

The per diem rates for home infusion therapy shall include the initial patient evaluation, education, coordination of care, products, equipment, administration sets, supplies, supply management, and delivery services. Nursing fees should be billed as indicated in Rule XVIII.F.11.b.

1) Parenteral Nutrition:

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

2) Antibiotic Therapy:

$105.00/day + AWP

(Average Wholesale Price)

3) Chemotherapy:

$ 85.00/day + AWP

4) Enteral nutrition:

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

5) Pain Management: $ 95.00/day + AWP

6) Fluid Replacement: $ 70.00/day + AWP

7) Multiple Therapies:

Highest cost therapy + AWP

only for remaining therapy

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

b. Nursing Services

99970 Skilled Nursing (LPN & RN)

$95.79 per hour

There is a limit of 2 hours without prior authorization.

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.

c. Physical Medicine

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

d. 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.

Bill code: 99971

12. Pharmacy Fees

a. Average Wholesale Price (AWP) + $6.00

b. All bills shall reflect the National Drug Code (NDC)

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

1) The above formula applies to both brand name and generic drugs.

2) The provider shall dispense no more than a 60-day supply per prescription.

3) 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.

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

d. Compounding Pharmacies

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

Bill Code:

99913 Materials, mailing, handling

99914 Pharmacist

e. Hospital Reimbursement

Medications dispensed to a hospitalized patient shall be exempt from this Rule XVIII.F.12.a-c and shall be reimbursed in accordance with Rule XVIII.F.9.

Chart orders:

A chart order is defined as an order for inpatient or outpatient medications entered on a patient's chart or medical record to be dispensed by a pharmacist, pharmacy intern under the direct supervision of a pharmacist, or withdrawn from a medicine storage unit by, or on the order of, a physician. The medication is to be administered by an authorized person only during the patient's stay in a hospital facility. In addition, on the specific order of a physician, a quantity dose, not to exceed a 72-hour supply, may be dispensed to a registered emergency room patient and such quantity dose shall be compensated in accordance with hospital supplies.

Other prescriptions filled in a hospital or non-hospital pharmacy shall have a maximum allowance in accordance with this Rule XVIII.E.12.a-d.

f. Injured Worker Reimbursement

The payer is responsible for timely payment of pharmaceutical costs (see Rule XVI.K). 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.

g. 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 XVII.

h. Prescription Writing

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

i. Provider Reimbursement

Provider offices that prescribe and dispense medications from their office have a maximum allowance of AWP plus $6.00.

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

j. Required Billing Forms

1) All parties shall use one of the following forms:

(1) CMS 1500 (formerly HCFA 1500) – the dispensing provider shall bill by using the procedure code 99070 and shall include the metric quantity and National Drug Code (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 (a) or (b) in this sub-section.

2) Items prescribed for the work-related injury that do not have an NDC code shall be billed as a supply, using procedure code 99070 for the billed supply.

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

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

13. Complementary Alternative Medicine (CAM) (Requires prior authorization)

Complementary Alternative Medicine (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 XVII, Medical Treatment Guidelines for the specific types of CAM modalities.

14. 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.

a. Provider Restrictions

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

b. Billing Restrictions

For treatments of more than fourteen (14) sessions or for services beyond the following billing codes, the provider must obtain prior authorization from the payer.

c. Billing Codes:

1) Acupuncture (represents whole body): 97780;

2) Acupuncture with electrical stimulation (represents whole body): 97781;

3) 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: 97041;

Maximum value $79.68.

(3) LAc established patient visit: 97044;

Maximum value $53.78.

4) Herbs require prior authorization and fee agreements as in this Rule XVIII.F.12;

5) See the appropriate physical medicine and rehabilitation section of the *RVP* for other billing codes and limitations (Rule XVIII.E.7).

G. DENTAL FEE SCHEDULE

The following 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 conversion factors, the Division's Rule XVI, Utilization Standards, and Rule XVII, Medical Treatment Guidelines. The following dental billing codes begin with the letter "D":

CODE	DESCRIPTOR	VALUE
	Clinical Oral Evaluations	
D0120	Periodic oral evaluation	$37.13
D0140	Limited oral evaluation - problem focused	$50.92
D0150	Comprehensive oral evaluation - new or established patient	$70.02
D0160	Detailed and extensive oral evaluation - problem focused, by report	$90.18
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$44.56
D0180	Comprehensive periodontal evaluation - new or established patient	BR
	Radiographs/Diagnostic Imaging (including interpretation)	
D0210	Intraoral - complete series (including bitewings)	$90.18

D0220	Intraoral - periapical first film	$19.10
D0230	Intraoral - periapical each additional film	$15.91
D0240	Intraoral - occlusal film	$31.83
D0250	Extraoral - first film	$43.50
D0260	Extraoral - each additional film	$42.44
D0270	Bitewing - single film	$23.34
D0272	Bitewing - two films	$29.71
D0274	Bitewing - four films	$45.62
D0277	Vertical Bitewings-7-8 Films	$76.38
D0290	Posterior - anterior or lateral skull and facial bone survey film	$146.40
D0310	Sialography	$373.44
D0320	Temporomandibular joint arthrogram, including injection	$639.72
D0321	Other temporomandibular joint films	BR
D0322	Tomographic Survey	$513.48
D0330	Panoramic Film	$79.57
D0340	Cephalometric film	$108.21
D0350	Oral/Facial Images (Incl. Intra and extra-oral images)	$47.74
Tests and Examinations		
D0415	Bacteriologic studies for determination of pathologic agents	$42.44
D0425	Caries susceptibility tests	$27.58
D0460	Pulp vitality tests	$47.74
D0470	Diagnostic casts	$79.57
Oral Pathology Laboratory		

D0472	Accession Tissue-Gross Exam, Prep & Trans report	$72.14
D0473	Accession Tissue-Gross & Micro exam, prep & trans report	$140.04
D0474	Accession tissue-Gross & micro exam, Assess surgical margins, prep & trans report	$168.68
D0480	Process & interpret cytologica smears-Prep report	$101.85
D0502	Other oral pathology procedures	BR
D0999	Unspecified diagnostic procedure	BR
	Dental Prophylaxis	
D1110	Prophylaxis - adult	$68.96
D1120	Prophylaxis - child	$47.74
	Topical Fluoride Treatment	
D1201	Topical application of fluoride (including prophylaxis)- child	$64.71
D1203	Topical application of fluoride (prophylaxis not included)- child	$31.83
D1204	Topical application of fluoride (prophylaxis not included) - adult	$31.83
D1205	Topical application of fluoride (including prophylaxis) - adult	$79.57
	Other Preventive Services	
D1310	Nutritional counseling for the control of dental disease	$40.31
D1320	Tobacco counseling for the control and prevention of oral dis-ease	$42.44
D1330	Oral hygiene instruction	$54.11
D1351	Sealant - per tooth	$37.13
	Space Maintenance (Passive Appliances)	
D1510	Space maintainer - fixed (unilateral)	$238.70
D1515	Space maintainer - fixed (bilateral)	$306.60

D1520	Space maintainer - removable (unilateral)	$325.70
D1525	Space maintainer - removable (bilateral)	$446.64
D1550	Re-cementation of space maintainer	$57.29
	Amalgam Restorations (Including Polishing)	
D2140	Amalgam - one surface, primary or permanent	$90.18
D2150	Amalgam - two surface, primary or permanent	$116.70
D2160	Amalgam - three surfaces, primary or permanent	$150.65
D2161	Amalgam - four or more surfaces, primary or permanent	$175.05
	Resin-Based Composite Restorations - Direct	
D2330	Resin – based composite -one surface, anterior	$106.09
D2331	Resin – based composite - two surfaces, anterior	$146.40
D2332	Resin – based composite - three surfaces, anterior	$184.60
D2335	Resin - four or more surfaces or involving incisal angle, anterior	$217.48
D2390	Resin-based composite crown, anterior	$276.89
D2391	Resin-based composite - one surface, posterior	$144.28
D2392	Resin-based composite - two surfaces, posterior	$167.62
D2393	Resin-based composite - three surfaces, posterior	$230.22
D2394	Resin-based composite - four or more surfaces, posterior	$291.75
	Gold Foil Restorations	
D2410	Gold foil - one surface	$230.22
D2420	Gold foil - two surfaces	$384.05
D2430	Gold foil - three surfaces	$665.18
	Inlay/Onlay Restorations	

D2510	Inlay - metallic - one surface	$636.54
D2520	Inlay - metallic - two surfaces	$649.27
D2530	Inlay - metallic - three or more surfaces	$796.74
D2542	On-lay-metallic-2 surfaces	$780.82
D2543	On-lay - metallic - three surfaces	$751.12
D2544	On-lay - metallic - four or more surfaces	$849.78
D2610	Inlay - porcelain/ceramic - one surface	$717.17
D2620	Inlay - porcelain/ceramic - two surfaces	$663.06
D2630	Inlay - porcelain/ceramic -three or more surfaces	$756.42
D2642	On-lay - porcelain/ceramic - two surfaces	$828.56
D2643	On-lay - porcelain/ceramic - three surfaces	$828.56
D2644	On-lay - porcelain/ceramic - four or more surfaces	$896.46
D2650	Inlay – resin-based composite/resin - one surface (indirect tech)	$695.95
D2651	Inlay – resin-based composite/resin - two surfaces (indirect tech)	$695.95
D2652	Inlay – resin-based composite/resin - three or more surfaces (indirect tech)	$589.86
D2662	On-lay – resin-based composite/resin - two surfaces (indirect tech)	$512.41
D2663	On-lay – resin-based composite/resin - three surfaces (indirect tech)	$602.59
D2664	On-lay – resin-based composite/resin - four or more surfaces (indirect tech)	$645.03
Crowns - Single Restorations Only		
D2710	Crown - resin (indirect)	$363.89
D2720	Crown - resin with high noble metal	$896.46
D2721	Crown - resin with predominantly base metal	$839.17
D2722	Crown - resin with noble metal	$858.27

D2740	Crown - porcelain/ceramic substrate	$828.56
D2750	Crown - porcelain fused to high noble metal	$835.99
D2751	Crown - porcelain fused to predominantly base metal	$668.37
D2752	Crown - porcelain fused to noble metal	$716.11
D2780	Crown-3/4 cast high noble metal	$869.94
D2781	Crown-3/4 cast predominantly base metal	$819.01
D2782	Crown-3/4 cast noble metal	$845.54
D2783	Crown-3/4 Porcelain/ceramic (without facial veneers)	$895.40
D2790	Crown - full cast high noble metal	$751.12
D2791	Crown - full cast predominantly base metal	$829.62
D2792	Crown - full cast noble metal	$844.48
D2799	Provisional crown	$363.89
Other Restorative Services		
D2910	Recement inlay	$89.12
D2920	Recement crown	$79.57
D2930	Prefabricated stainless steel crown - primary tooth	$213.24
D2931	Prefabricated stainless steel crown - permanent tooth	$251.43
D2932	Prefabricated resin crown	$312.97
D2933	Prefabricated stainless steel crown with resin window	$351.16
D2940	Sedative filling	$95.48
D2950	Core buildup, including any pins	$196.27
D2951	Pin retention - per tooth, in addition to restoration	$50.92
D2952	Cast post & core in addition to crown	$358.58

D2953	Each add cast post-same tooth	$184.60
D2954	Prefabricated post and core in addition to crown	$306.60
D2955	Post removal (not in conjunction with endodontic therapy)	$230.22
D2957	Each additional prefabricated post-same tooth	$152.77
D2960	Labial veneer (resin laminate) - chairside	$567.58
D2961	Labial veneer (resin laminate) - laboratory	$840.23
D2962	Labial veneer (porcelain laminate) - laboratory	$716.11
D2970	Temporary crown (fractured tooth)	$217.48
D2980	Crown repair, by report	BR
D2999	Unspecified restorative procedure, by report	BR
Pulp Capping		
D3110	Pulp cap - direct (excluding final restoration)	$76.38
D3120	Pulp cap - indirect (excluding final restoration)	$73.20
Pulpotomy		
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$157.01
D3221	Pulpal debridement, primary & permanent teeth	$158.07
Endodontic Therapy or Primary Teeth		
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$151.71
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$163.38
Endodontic Therapy (Including Treatment Plan, Clinical Procedures and Follow-up Care)		
D3310	Anterior (excluding final restoration)	$477.41

D3320	Bicuspid (excluding final restoration)	$571.83
D3330	Molar (excluding final restoration)	$689.59
D3331	Treatment root canal obstruction -non-surgical access	$204.75
D3332	Incomplete endodontic therapy-inoperable or fractured tooth	$526.21
D3333	Internal Root Repair of perforation defects	$175.05
	Endodontic Retreatment	
D3346	Retreatment of previous root canal therapy - anterior	$819.01
D3347	Retreatment of previous root canal therapy - bicuspid	$965.42
D3348	Retreatment of previous root canal therapy - molar	$1,160.62
	Apexification/Recalcification Procedures	
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$344.79
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	$150.65
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair or perforations, root resorption, etc.)	$509.23
	Apicoectomy/Periradicular Services	
D3410	Apicoectomy/periradicular surgery - anterior	$429.66
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$760.67
D3425	Apicoectomy/periradicular surgery - molar (first root)	$860.39
D3426	Apicoectomy/periradicular surgery - (each additional root)	$286.44
D3430	Retrograde filling - per root	$211.12
D3450	Root amputation - per root	$427.54
D3460	Endodontic endosseous implant	$2,050.72

D3470	Intentional re-implantation (including necessary splinting)	$851.90
	Other Endodontic Procedures	
D3910	Surgical procedure for isolation of tooth with rubber dam	$111.39
D3920	Hemisection (including any root removal,) not including root canal therapy	$333.12
D3950	Canal preparation and fitting of performed dowel or post	$151.71
D3999	Unspecific endodontic procedure, by report	BR
	Surgical Services (Including Usual Postoperative Care)	
D4210	Gingivectomy or gingivoplasty - four or more contiquous teeth or bounded teeth spaces per quadrant	$437.09
D4211	Gingivectomy or gingivoplasty one to three teeth, per quadrant	$159.14
D4240	Gingival flap procedure, including root planing - per quadrant	$800.98
D4241	Gingival flap procedure, including root planing - one to three teeth, per quadrant	$800.98
D4245	Apically positioned flap	$576.07
D4249	Clinical crown lengthening - hard tissue	$913.43
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	$848.72
D4261	Osseous surgery (including flap entry and closure)- one to three teeth, per quadrant	$848.72
D4263	Bone replacement graft - first site in quadrant	$390.41
D4264	Bone replacement graft - each additional site in quadrant	$195.21
D4265	Biologic materials to aid in soft and osseous tissue regeneration	BR
D4266	Guided tissue regeneration - resorbable barrier, per site	$471.04
D4267	Guided tissue regeneration - nonresorbable barrier, per site, (includes membrane removal)	$605.77

D4268	Surgical revision procedure per tooth	BR
D4270	Pedicle soft tissue graft procedure	$955.87
D4271	Free soft tissue graft procedure (including donor site surgery)	$982.39
D4273	Subepithelial connective tissue graft procedures	$1,048.17
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$295.99
D4275	Soft tissue allograft	BR
D4276	Combined connective tissue and double pedicle graft	BR
Non-Surgical Periodontal Service		
D4320	Provisional splinting - intracoronal	$382.98
D4321	Provisional splinting - extracoronal	$473.16
D4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$196.27
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant	$196.27
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$137.92
D4381	Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	BR
Other Periodontal Services		
D4910	Periodontal maintenance	$124.13
D4920	Unscheduled dressing change (by someone other than treating dentist)	$106.09
D4999	Unspecified periodontal procedure, by report	BR
Complete Dentures (Including Routine Post-Delivery Care)		
D5110	Complete denture - maxillary	$1,273.08
D5120	Complete denture - mandibular	$1,273.08

D5130	Immediate denture - maxillary	$1,214.73
D5140	Immediate denture - mandibular	$1,214.73
Partial Dentures (Including Routine Post-Delivery Care)		
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$1,039.68
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$1,039.68
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$1,273.08
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$1,273.08
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	$823.26
Adjustments to Dentures		
D5410	Adjust complete denture - maxillary	$70.02
D5411	Adjust complete denture - mandibular	$70.02
D5421	Adjust partial denture - maxillary	$70.02
D5422	Adjust partial denture - mandibular	$70.02
Repairs to Complete Dentures		
D5510	Repair broken complete denture base	$201.57
D5520	Replace missing or broken teeth - complete denture (each tooth)	$111.39
Repairs to Partial Dentures		
D5610	Repair resin denture base	$159.14
D5620	Repair cast framework	$212.18
D5630	Repair replace broken clasp	$196.27

D5640	Replace broken teeth - per tooth	$111.39
D5650	Add tooth to existing partial denture	$159.14
D5660	Add clasp to existing partial denture	$206.88
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	BR
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	BR
Denture Rebase Procedures		
D5710	Rebase complete maxillary denture	$387.23
D5711	Rebase complete mandibular denture	$495.44
D5720	Rebase maxillary partial denture	$489.07
D5721	Rebase mandibular partial denture	$489.07
Denture Reline Procedures		
D5730	Reline complete maxillary denture (chairside)	$265.23
D5731	Reline complete mandibular denture (chairside)	$265.23
D5740	Reline maxillary partial denture (chairside)	$268.41
D5741	Reline mandibular partial denture (chairside)	$268.41
D5750	Reline complete maxillary denture (laboratory)	$318.27
D5751	Reline complete mandibular denture (laboratory)	$318.27
D5760	Reline maxillary partial denture (laboratory)	$385.11
D5761	Reline mandibular partial denture (laboratory)	$385.11
Interim Prosthesis		
D5810	Interim complete denture (maxillary)	$617.44
D5811	Interim complete denture (mandibular)	$664.12
D5820	Interim partial denture (maxillary) (includes any necessary clasps and rests)	$477.41

D5821	Interim partial denture (mandibular) (includes any necessary clasps and rests)	$507.11
	Other Removable Prosthetic Services	
D5850	Tissue conditioning, maxillary	$122.00
D5851	Tissue conditioning, mandibular	$122.00
D5860	Overdenture - complete, by report	BR
D5861	Overdenture - partial, by report	BR
D5862	Precision attachment, by report	BR
D5867	Replacement of replaceable part of semi-precision or precision attachment (male or female component)	BR
D5875	Modification of removable prosthesis following implant surgery	BR
D5899	Unspecified removable prosthodontic procedure, by report	BR
	Maxillofacial Prosthetics	
D5911	Facial moulage (sectional)	$323.57
D5912	Facial moulage (complete)	$323.57
D5913	Nasal prosthesis	$6,823.71
D5914	Auricular prosthesis	$6,823.71
D5915	Orbital prosthesis	$9,234.07
D5916	Ocular prosthesis	$2,461.94
D5919	Facial prosthesis	BR
D5922	Nasal spetal prosthesis	BR
D5923	Ocular prosthesis, interim	$2,415.67
D5924	Cranial prosthesis	BR
D5925	Facial augmentation implant prosthesis	BR

D5926	Nasal prosthesis, replacement	BR
D5927	Auricular prosthesis, replacement	BR
D5928	Orbital prosthesis, replacement	BR
D5929	Facial prosthesis, replacement	BR
D5931	Obturator prosthesis, surgical	$3,673.90
D5932	Obturator prosthesis, definitive	$6,871.45
D5933	Obturator prosthesis, modification	BR
D5934	Mandibular resection prosthesis with guide flange	$6,262.49
D5935	Mandibular resection prosthesis without guide flange	$5,448.78
D5936	Obturator prosthesis, interim	$6,120.33
D5937	Trismus appliance (not for TMD treatment)	$769.15
D5951	Feeding aid	$1,000.43
D5952	Speech aid prosthesis, pediatric	$3,247.41
D5953	Speech aid prosthesis, adult	$6,167.01
D5954	Palatal augmentation prosthesis	$5,715.07
D5955	Palatal lift prosthesis, definitive	$5,285.40
D5958	Palatal lift prosthesis, interim	BR
D5959	Palatal lift prosthesis, modification	BR
D5960	Speech aid prosthesis, modification	BR
D5982	Surgical stent	$635.48
D5983	Radiation carrier	$1,538.31
D5984	Radiation shield	$1,538.31
D5985	Radiation cone locator	$1,538.31

D5986	Fluoride gel carrier	$130.49
D5987	Commissure splint	$2,308.52
D5988	Surgical splint	RNE
D5999	Unspecified maxillofacial prosthesis	BR
Implant Services (Local anesthesia is considered to be part of implant service procedures)		
D6010	Surgical placement of implant body: endosteal implant	$2,134.53
D6020	Abutment placement or substitution: endosteal implant	$302.36
D6040	Surgical placement: eposteal implant	$9,816.51
D6050	Surgical placement: transosteal implant	$6,092.75
Implant Supported Prosthetics		
D6053	Implant/abutment supported removable denture for complete edentulous arch	BR
D6054	Implant/abutment supported removable denture for partially edentuous arch	BR
D6055	Dental implant supported connecting bar	$542.12
D6056	Prefabricated abutment	BR
D6057	Custom Abutment	BR
D6058	Abutment supported porcelain/ceramic crown	$1,228.52
D6059	Abutment support porcelain fused to metal crown (high noble metal)	$1,212.61
D6060	Abutment support porcelain fused metal crown (predominantly base metal)	$1,145.77
D6061	Abutment support porcelain fused to metal crown (noble metal)	$1,169.11
D6062	Abutment supported cast metal crown (high noble metal)	$1,164.87
D6063	Abutment supported cast metal crown (predominantly base metal)	$994.06
D6064	Abutment supported cast metal crown (noble metal)	$1,059.84

D6065	Implant supported porcelain/ceramic crown	$1,208.37
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$1,177.60
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$1,142.59
D6068	Abutment supported retainer for porcelain/ceramic FPD	$1,228.52
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal))	$1,212.61
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$1,145.77
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal	$1,169.11
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$1,193.51
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$1,080.00
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$1,164.87
D6075	Implant supported retainer for ceramic FPD	$1,208.37
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, high noble metal)	$1,177.60
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, high noble metal)	$1,142.59
D6078	Implant/abutment supported fixed denture for completely edentulous arch	BR
D6079	Implant/abut supported fixed denture for partially edentulous arch	BR
	Other Implant Services	
D6080	Implant maintenance procedures, including: removal of prosthesis, cleansing of prosthesis and abutments, reinsertion of prosthesis	BR
D6090	Repair implant supported prosthesis, by report	BR
D6095	Repair implant abutment, by report	BR

D6100	Implant removal, by report	BR
D6199	Unspecified implant procedure, by report	BR
	Prosthodontics, fixed	
D6210	Pontic - cast high noble metal	$751.12
D6211	Pontic - cast predominantly base metal	$806.28
D6212	Pontic - cast noble metal	$839.17
D6240	Pontic - porcelain fused to high noble metal	$769.15
D6241	Pontic - porcelain fused to predominantly base metal	$689.59
D6242	Pontic - porcelain fused to noble metal	$828.56
D6245	Pontic-porcelain/ceramic	$877.36
D6250	Pontic - resin with high noble metal	$839.17
D6251	Pontic - resin with predominantly base metal	$774.46
D6252	Pontic - resin with noble metal	$799.17
D6253	Provisional pontic	BR
	Fixed Partial Denture Retainers - Inlays/Onlays	
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$769.15
D6548	Retainer-porcelain/ceramic for resin bonded fixed prosthesis	$392.53
D6600	Inlay - procelain/ceramic for resin bonded fixed prosthesis	$795.68
D6601	Inlay - porcelain/ceramic, three or more surfaces	$849.78
D6602	Inlay - cast high noble metal, two surfaces	$741.57
D6603	Inlay - cast high noble metal, three or more surfaces	$909.19
D6604	Inlay - cast predominantly base metal, two surfaces	$741.57
D6605	Inlay - cast predominantly base metal, three or more surfaces	$849.78

D6606	Inlay - cast noble metal, two surfaces	$741.57
D6607	Inlay - cast noble metal, three or more surfaces	$909.19
D6608	Onlay - porcelain/Ceramic, two surfaces	$795.68
D6609	Only - porcelain/ceramic, three or more surfaces	$909.19
D6610	Onlay - cast high noble metal, two surfaces	$741.57
D6611	Onlay - cast high noble metal, three or more surfaces	$849.78
D6612	Onlay - cast predominantly base metal, two surfaces	$741.57
D6613	Onlay - cast predominantly base metal, three or more surfaces	$849.78
D6614	Onlay - cast noble metal, two surfaces	$871.00
D6615	Onlay - cast noble metal, three or more surfaces	$871.00
Fixed Partial Denture Retainers - Crowns		
D6720	Crown - resin with high noble metal	$721.41
D6721	Crown - resin with predominantly base metal	$898.58
D6722	Crown - resin with noble metal	$914.50
D6740	Crown-porcelain/ceramic	$996.19
D6750	Crown - porcelain fused to high noble metal	$769.15
D6751	Crown - porcelain fused to predominantly base metal	$716.11
D6752	Crown - porcelain fused to noble metal	$927.23
D6780	Crown - 3/4 cast high noble metal	$716.11
D6781	Crown - ¾ cast predominately base metal	$914.50
D6782	Crown - ¾ cast noble metal	$849.78
D6783	Crown - 3/4 porcelain/ceramic	$942.08
D6790	Crown - full cast high noble metal	$732.02

D6791	Crown - full cast predominantly base metal	$887.97
D6792	Crown - full cast noble metal	$919.80
D6793	Provisional retainer crown	BR
Other Fixed Partial Denture Services		
D6920	Connector bar	$162.32
D6930	Recement fixed partial denture	$132.61
D6940	Stress breaker	$257.80
D6950	Precision attachment	$503.93
D6970	Cast post and core in addition to fixed partial denture retainer	$314.03
D6971	Cast post as part of fixed partial denture retainer	$275.83
D6972	Prefabricated post and core in addition to fixed partial denture retainer	$255.68
D6973	Core build up for retainer, including any pins	$205.81
D6975	Coping - metal	$563.34
D6976	Each additional cast post - same tooth	$133.67
D6977	Each additional prefabricated post - same tooth	$127.31
D6980	Fixed partial denture repair, by report	BR
D6985	Pediatric partial denture, fixed	BR
D6999	Unspecified fixed prosthodontic procedure, by report	BR
Oral and Maxillofacial Surgery		
Extractions (Includes Local Anesthesia, Suturing, If Needed, and Routine Postoperative Care)		
D7111	Coronal remnants, deciduous tooth	BR
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	BR

Surgical Extractions (Includes Local Anesthesia, Suturing, If Needed, and Routine Postoperative Care)		
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$190.96
D7220	Removal of impacted tooth - soft tissue	$213.24
D7230	Removal of impacted tooth - partially bony	$250.37
D7240	Removal of impacted tooth - completely bony	$294.93
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$413.75
D7250	Surgical removal of residual tooth roots (cutting procedure)	$212.18
Other Surgical Procedures		
D7260	Oroantral fistual closure	$2,134.53
D7261	Primary closure of a sinus perforation	BR
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$442.40
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	$629.11
D7280	Surgical access of an unerupted tooth	$484.83
D7281	Surgical exposure of impacted or unerupted tooth to aid eruption	$219.61
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	BR
D7285	Biopsy of oral tissue – hard (bone, tooth)	$858.27
D7286	Biopsy of oral tissue – soft (all others)	$352.22
D7287	Cytoloy sample collection	BR
D7290	Surgical repositioning of teeth	$399.96
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$60.47

Alveoloplasty - Surgical Preparation of Ridge For Dentures		
D7310	Alveoloplasty in conjunction with extractions - per quadrant	$233.40
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	$318.27
Vestibuloplasty		
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	$1,912.80
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$5,998.33
Surgical Excision of Soft Tissue Lesions		
D7410	Excision or benign lesion up to 1.25 cm	$1,333.55
D7411	Excision of benign lesion greater than 1.25 cm	BR
D7412	Excision of benign lesion, complicated	BR
D7413	Excision of malignant lesion up to 1.25 cm	BR
D7414	Excision of malignant lesion greater than 1.25 cm	BR
D7415	Excision of malignant lesion, complicated	BR
Surgical Excision of Intra-Osseous Lesions		
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	$1,350.53
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	$2,098.46
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$764.91
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$1,200.94
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$764.91
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$1,231.70

Excision of Bone Tissue		
D7471	Removal of exostosis (maxilla or mandible)	$792.49
D7472	Removal of torus palatinus	BR
D7473	Removal of torus mandibularis	BR
D7485	Surgical reduction of osseous tuberosity	BR
D7490	Radical resection of mandible with bone graft	$6,398.29
Surgical Incision		
D7510	Incision and drainage of abscess - intraoral soft tissue	$229.15
D7520	Incision and drainage of abscess - extraoral soft tissue	$1,091.67
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$393.59
D7540	Removal of reaction-producing foreign bodies - musculoskeletal system	$436.03
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$271.59
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$2,159.99
Treatment of Fractures - Simple		
D7610	Maxilla - open reduction (teeth immobilized, if present)	$3,492.48
D7620	Maxilla - closed reduction (teeth immobilized, if present)	$2,619.36
D7630	Mandible - open reduction (teeth immobilized, if present)	$4,540.65
D7640	Mandible - closed reduction (teeth immobilized, if present)	$2,881.40
D7650	Malar and/or zygomatic arch - open reduction	$2,183.33
D7660	Malar and/or zygomatic arch - closed reduction	$1,286.87
D7670	Alveolus -closed reduction may include stabilization of teeth	$1,004.67
D7671	Alveolus - open reduction, may include stabilization of teeth	BR

D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	$6,548.94
Treatment of Fractures - Compound		
D7710	Maxilla - open reduction	$4,104.62
D7720	Maxilla - closed reduction	$2,881.40
D7730	Mandible - open reduction	$5,937.86
D7740	Mandible - closed reduction	$2,937.63
D7750	Malar and/or zygomatic arch - open reduction	$3,736.49
D7760	Malar and/or zygomatic arch - closed reduction	$1,499.05
D7770	Alveolus - open reduction stabilization of teeth	$2,031.62
D7771	Alveolus - closed reduction stabilization of teeth	BR
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches	$8,732.27
Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions		
D7810	Open reduction of dislocation	$3,841.52
D7820	Closed reduction of dislocation	$629.11
D7830	Manipulation under anesthesia	$360.71
D7840	Condylectomy	$5,236.60
D7850	Surgical discectomy, with/without implant	$4,521.56
D7852	Disc repair	$5,177.19
D7854	Synovectomy	$5,342.69
D7856	Myotomy	$3,791.66
D7858	Joint reconstruction	$10,806.33

D7860	Arthrotomy	$4,606.43
D7865	Arthroplasty	$7,422.06
D7870	Arthrocentesis	$245.07
D7871	Non-arthroscopic lysis & lavage	$490.14
D7872	Arthroscopy - diagnosis, with or without biopsy	$2,618.30
D7873	Arthroscopy - surgical: lavage & lysis of adhesions	$3,151.93
D7874	Arthroscopy - surgical: disc repositioning and stabilization	$4,521.56
D7875	Arthroscopy - surgical: synovectomy	$4,953.34
D7876	Arthroscopy - surgical: discectomy	$5,340.57
D7877	Arthroscopy - surgical: debridement	$4,713.58
D7880	Occlusal orthotic device, by report	$1,485.26
D7899	Unspecified TMD therapy, by report	BR
Repair of Traumatic Wounds		
D7910	Suture of recent small wounds up to 5 cm	$212.18
Complicated Suturing (Reconstruction Requiring Delicate Handling of Tissues and Wide Undermining for Meticulous Closure)		
D7911	Complicated suture - up to 5 cm	$873.12
D7912	Complicated suture - greater than 5 cm	$1,572.25
Other Repair Procedures		
D7920	Skin graft (identify defect covered, location, and type of graft)	$2,575.87
D7940	Osteoplasty - for orthognathic deformities	$7,710.62
D7941	Osteotomy – mandibular rami	$7,710.62
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	$8,029.95

D7944	Osteotomy - segmented or subapical - per sextant or quadrant	$7,160.01
D7945	Osteotomy - body of mandible	$7,945.08
D7946	LeFort I (maxilla - total)	$9,817.57
D7947	LeFort I (maxilla - segmented)	$8,270.78
D7948	LeFort II or LeFort III (osteoplasty of facial bone for midface hypoplasia or retrusion) - without bone graft	$12,879.33
D7949	LeFort II or LeFort III - with bone graft	$18,119.11
D7950	Osseous, osteoperiosteal or cartilage graft of the mandible or facial bones - autogenous or nonautogenous, by report	BR
D7955	Repair of maxillofacial soft and hard tissue defect	BR
D7960	Frenulectomy (frenectomy or frenotomy), separate procedure	$293.87
D7970	Excision of hyperplastic tissue - per arch	$437.09
D7971	Excision of pericoronal gingiva	$165.50
D7972	Surgical reduction of fibrous tuberosity	BR
D7980	Sialolithotomy	$741.57
D7981	Excision of salivary gland, by report	BR
D7982	Sialodochoplasty	$1,994.49
D7983	Closure of salivary fistula	$1,903.25
D7990	Emergency tracheotomy	$1,746.24
D7991	Coronoidectomy	$4,322.11
D7995	Synthetic graft - mandible or facial bones, by report	BR
D7996	Implant - mandible for augmentation purposes (excluding alveolar ridge), by report	BR
D7997	Appliance Removal (not by dentist who placed appliance), includes removal	$267.35

	of archbar	
D7999	Unspecified oral surgery procedure, by report	BR
	Orthodontics	
	Limited Orthodontic Treatment	
D8010	Limited orthodontic treatment of the primary dentition	BR
D8020	Limited orthodontic treatment of the transitional dentition	BR
D8030	Limited orthodontic treatment of the adolescent dentition	BR
D8040	Limited orthodontic treatment of the adult dentition	BR
	Interceptive Orthodontic Treatment	
D8050	Interceptive orthodontic treatment of the primary dentition	BR
D8060	Interceptive orthodontic treatment of the transitional dentition	BR
	Comprehensive Orthodontic Treatment	
D8070	Comprehensive orthodontic treatment of the transitional dentition	BR
D8080	Comprehensive orthodontic treatment of the adolescent dentition	BR
D8090	Comprehensive orthodontic treatment of the adult dentition	BR
	Minor Treatment to Control Harmful Habits	
D8210	Removable appliance therapy	BR
D8220	Fixed appliance therapy	BR
	Other Orthodontic Services	
D8660	Pre-orthodontic treatment visit	$73.20
D8670	Periodic orthodontic treatment visit (as part of contract)	$352.22
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$774.46

D8690	Orthodontic treatment (alternative billing to a contract fee)	$366.01
D8691	Repair of orthodontic appliance	$192.02
D8692	Replacement of lost or broken retainer	$382.98
D8999	Unspecified orthodontic procedure, by report	BR
Adjunctive General Services		
Unclassified Treatment		
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$117.76
Anesthesia		
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$58.35
D9211	Regional block anesthesia	$47.74
D9212	Trigeminal division block anesthesia	$88.05
D9215	Local anesthesia	$47.74
D9220	Deep sedation/general anesthesia - first 30 minutes	$390.41
D9221	Deep sedation/general anesthesia - each additional 15 minutes	$164.44
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$76.38
D9241	Intravenous conscious sedation/analgesia - first 30 min	$307.66
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	$128.37
D9248	Non-intravenous conscious sedation	$65.78
Professional Consultation		
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	$205.81
Professional Visits		
D9410	House/extended care facility call	$271.59

D9420	Hospital call	$373.44
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$68.96
D9440	Office visit - after regularly scheduled hours	$106.09
D9450	Case presentation, detailed and extensive treatment planning	BR
Drugs		
D9610	Therapeutic drug injection, by report	BR
D9630	Other drugs and/or medicaments, by report	BR
Miscellaneous Services		
D9910	Application of desensitizing medicament	$44.56
D9911	Applic desenzt resin-cerv &/or root surf/tooth	$68.96
D9920	Behavior management, by report	BR
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	BR
D9940	Occlusal guard, by report	$631.24
D9941	Fabrication of athletic mouthguard	$291.75
D9950	Occlusion analysis - mounted case	$272.65
D9951	Occlusal adjustment - limited	$212.18
D9952	Occlusal adjustment - complete	$750.06
D9970	Enamel microabrasion	$47.74
D9971	Odontoplasty 1-2 Teeth-includes removal of enamel projections	$66.84
D9972	External Bleaching – Per Arch	$306.60
D9973	External Bleaching-Per Tooth	$33.95
D9974	Internal Bleaching-Per Tooth	$260.98

D9999	Unspecified adjunctive procedure, by report	BR