COLORADO
Department of Labor and Employment

Meeting Title: Stakeholder Meeting for Annual Review of Rules 16 and 18

Meeting Date and Time: January 24, 2019

Meeting Location: Colorado Department of Labor and Employment, 633 17th Street, 2nd Floor Conference Room, Denver, CO 80202

Meeting Facilitator: Christy Culkin

Attendees (in person): Hank Hahne, Colorado Springs School District 11 and Colorado Self-Insured Association; Lisa Anne Bickford, Coventry; Rachel Wendt, Colorado Chiropractic Association; Alan Hutchins, City and County of Denver and Colorado Self-Insured Association; Katelyn Palazzolo, American Physical Therapy Association; William Sterck, Esq., and Lee & Brown, P.C., and AIG; Brett deMooy, Injury Care Associates, Katie Metcalf, Chris Snelgrove, and Dr. Tom Denberg, Pinnacol Assurance; Daniela Gosselova, citizen; James Becker, Dr. Ethan Moses, Marisa Cordova, Tara York-Winkler, Janell Cobb, Blair Ilsley, David Indovina, Gina Johannesman, Colleena Blakeman, Nina Fresquez, and Mariya Cassin, Division of Workers' Compensation.

Attendees (by telephone or webinar): Holly Pappas, Kelly Bowland, Chris Gross, Lisa Hamko, Kristin Mulhollen, and Mary Schmid, Pinnacol Assurance; Rhonda Koehn, Colorado Pain and Rehabilitation; Jordan Fritz, Ascent Medical Consultants; Jen Bean and Tom Coccia, Automated Healthcare Solutions; Marilyn Rissmiller, Colorado Medical Society; Marvel Hammer, MJH Consulting; Monica Sanchez, HealtheSystems; Betty Osborn, CorVel; Luv Dobbins, Denver Back Pain Specialists; Sharon McManus and Mike Strong, Equian; Karol Larrabee, Optum; Paul Krueger, Esq., Ritsema & Lyon, P.C.; Tom Dauphinee, The University of New Mexico; Debra Northrup, citizen; Roy Foster and Kari Gomes, Division of Workers' Compensation.

I. Introduction:

- Ms. Culkin welcomed everyone to the meeting and asked each in-person attendee to state his or her name. She also provided a brief overview of the stakeholder process.

II. Supervision of NPs and PAs, Aligning Rule 16-3(A)(5) With Other Laws:

- Ms. Cassin discussed whether the Division should continue to require that a physician be immediately available while a physician assistant (PA) or a nurse practitioner (NP) is providing services to an injured worker or defer to the scope of practice statutes and rules. The requirements for the physician counter-signature of patient records related to inability to work, ability to return to regular or modified employment, and Form WC 164 would not change.

- Ms. Cassin overviewed the Colorado Medical Practice Act, the Colorado Nurse Practice Act, as well as the rules adopted by the Colorado Medical Board and the Colorado Board of Nursing (scope of practice laws). The term "immediately available" is not in the scope of practice laws. In regards to PAs, a supervising physician must be "readily available" on site or by a telecommunications device anytime a PA is working. The NPs, as advanced practical nurses, do not require physician supervision.

- Ms. Culkin added that, whenever possible, the Division tries to keep its rules consistent with the rules adopted by the Division of Regulatory Agencies (DORA) and other agencies. By deleting the "immediately available" language, the Division would be following the Colorado Medical Practice Act while maintaining the requirement that a physician see an injured worker within the first three visits.

- Ms. Gosselova stated the requirements for a physician to be immediately available and to see an injured worker within the first three visits are not followed in rural areas. She argued the Division should continue to require immediate availability, either in person or by telehealth, as opposed to by telephone. She argued mere telephonic availability is hard to prove and enforce.

III. Required Use of the Medical Treatment Guidelines, Rule 16-4:

- Ms. Culkin introduced two proposed language revisions to Rule 16-4, to emphasize that the "time to produce effect" and "functional gains" parameters of the Medical Treatment Guidelines apply to all treatment recommendations.

- Dr. Denberg argued the rules should clarify that payers may deny payment for services that are outside these two parameters. Ms. Cassin stated that Rule 16-11(C)) already allows payers to deny payment for medical reasons (with a medical review).

- In response to a comment by Ms. Gosselova, Ms. Culkin clarified that the intent is not to require a prior authorization for every proposed treatment. Rather, all initial treatment recommendations should comply with the "time to produce effect" and "functional gains" parameters. In addition, so long as the providers see functional gains, they may continue with treatment without worrying that payment may be denied.

- Ms. Palazzolo stated she preferred the second proposed revision. Ms. Culkin also invited the stakeholders to submit other proposed language that would accomplish the same goal.

- Mr. Hutchins asked about the interplay between the "functional gain" and "time to produce effect" concepts and the QPOP program. Ms. Culkin stated that the "functional gain" and "time to produce effect" concepts apply to a variety of treatment modalities, while QPOP is an overall psychological and functional assessment of the injured worker.

- Ms. Wendt asked whether the Division defined the term "functional gain." Ms. Culkin responded the definition is in the general principles of the Medical Treatment Guidelines.

IV. Referrals by Non-Physicians:

- Ms. Cassin discussed whether mid-level providers (for example, physical therapists) may refer injured workers for additional treatment, imaging, or surgery or whether all referrals must come from a physician. Ms. Cassin pointed to an ambiguity in Rule 16-3(A)(4) on that point. She added that, by statute, a payer is not liable for physical therapy treatment unless an authorized treating physician has prescribed it. There is no such requirement with respect to other treatment.

- Mr. Hahne asked for the definition of physician. Ms. Culkin stated that Rule 16-3(A)(1)(a) defined "physician providers" as MD/DOs, chiropractors, podiatrists, and dentists.

- Ms. Palazzolo was not sure where her organization stands regarding the ability of physical therapists to refer patients, given the upcoming requirement for PTs to have a doctoral level education. She stated PTs operate in a direct access model in general health and in many states, but that is not true in the Colorado workers' compensation system. The PTs are not practicing in a silo by themselves. Ms. Culkin asked Ms. Palazzolo to bring the issue before the APTA so that the Division could consider that input in drafting rules.

- Ms. Culkin discussed the need to keep the authorized treating physician in the loop. For example, if the physician has already ordered an MRI there is no need for the PT to order it and duplicate the service. Dr. Denberg agreed with the need to keep the physician in the loop. He also considers a referral for an imaging test to be different from a referral to a specialist, arguing the latter definitely should come from a physician.

- Dr. Moses noted that PAs and NPs do not fall within the statutory definition of physician and the Division does not wish to limit the ability of these providers to make referrals. So, the proposed language could be problematic from that perspective and would need to be amended to include PAs and NPs.

- Ms. Koehn and Ms. Gosselova argued the primary physician managing the claim should be kept in the loop, because there can be more than one authorized physician involved in a claim. On the other hand, Ms. Fritz argued for the need to keep the referring physician in the loop, who may be a specialist and not necessarily the primary physician.

- The stakeholders discussed the possibility of requiring a physician to "verify" or "adopt" the referrals made by a mid-level provider. However, such a requirement may be difficult to administer and enforce.

- Ms. Johannesman noted that allowing PTs to make referrals implies they will be familiar with the Medical Treatment Guidelines. However, currently PTs cannot become Level I or II accredited.

V. Payment for Services Without an Established Fee:

- Ms. Culkin discussed a potential amendment to Rule 16-8(C). Currently, that rule requires prior authorization for services that do not have an established value in the Medical Fee

Schedule, even if the service is otherwise within the Medical Treatment Guidelines. She proposed changing this prior authorization to prior negotiation and asked what should be the outcome if no prior negotiation occurs.

- Ms. Bickford stated that, in her experience, parties typically look at similarly priced codes. Ms. Pappas agreed, but expressed a concern about prior negotiations delaying care. The parties also may try to value an unlisted code that is included in other procedures.

- Mr. Hahne proposed using Medicare as default if there is no prior negotiations.

- Mr. Strong stated that, similarly to prior authorization, prior negotiation should not be a guarantee of payment if the provider cannot document the service actually was performed.

- Dr. Denberg noted that prior authorization is a clinical process, so prior negotiation that focuses on pricing would involve a different set of professionals. He asked about a scenario where there is only one or very few providers offering some novel treatment.

- The stakeholders noted that a prior negotiation requirement may be abused by both payers and providers. In addition, prior negotiation is not possible in exigent circumstances.

- Ms. Cassin noted that prior negotiation process may need to include timelines like the prior authorization process.

- Ms. Koehn asked how such disputes are resolved currently. She expressed a concern that the prior negotiation requirement could delay care, arguing that pricing disputes should be resolved after the fact.

- Ms. Culkin said she was fine with leaving the language as is for the outlier scenarios, but perhaps the Rules can encourage (not require) prior negotiation for unvalued services. In response to a stakeholder question, Ms. Culkin said the Division can offer only mediation where there are no pricing benchmarks whatsoever.

VI. *Timely Filing*

- Ms. Fresquez reviewed the requirements for timely claim filings and appeals. Ms. Culkin requested that the stakeholders comment on what evidence they would accept as proof of timely filing or appeal for both mailed and electronic claims. For example, screenshots or logs generated by provider's billing system.

- Mr. Snelgrove and Ms. Metcalf argued the providers have a responsibility to follow up if they do not receive a timely response to their claims. Mr. Snelgrove also noted that most of these disputes involve mailed claims. For electronic claims, the provider gets acceptance reports from both the clearinghouse and the payer. Ms. Culkin discussed the proposed language that proof of timely filing for electronic claims means an acceptance report from the payer, not just the clearinghouse.

- Mr. Hahne noted his office only accepts paper claims, which receive a date stamp. Dr. Moses asked Mr. Hahne what he would accept as proof the provider timely mailed a claim. Mr. Hahne said his files reflect all timely claims.

- Ms. Culkin noted that requiring providers to submit all claims via certified mail would be overly burdensome, so what are alternative ways to prove timely filing? Sometimes, mail gets lost, even with the best intentions. In general health, the providers do not have 100% of the burden to follow up. Ms. Culkin noted the provider has performed the service, so payment should not be denied on a technicality.

- Mr. Snelgrove and Ms. Metcalf opined that proof of timely mailing would be the provider following up if there is no payment in 30 days. They pointed out the policy reasons for timely filing requirements.

- Ms. Koehn noted that following up is a burden that is 100% on the providers. She stated that a screenshot should be an acceptable proof of mailing for a paper claim.

- Ms. Culkin noted the Division cannot require electronic billing for all payers and providers. She agreed that a hard deadline for follow-ups, such as twelve months, is reasonable.

- Ms. Metcalf noted that generating a bill and printing a screenshot does not prove mailing, because the claim could have been mailed elsewhere. The screenshot should state where that bill was mailed.

- Mr. Hahne questioned how a potential rule regarding proof of timely filing would interact with the rule regarding eight percent interest on untimely paid claims.

VII. Timeline for Appeals

- Ms. Fresquez noted that Rule 16-11 states the provider has 60 days to appeal the payer's adjudication. However, it is not clear whether the 60 days start to run from the date on the Explanation of Benefits (EOB) or from the date the provider receives the EOB. Ms. Fresquez invited the stakeholders to comment on whether the Division should clarify this issue and, if so, how.

- Mr. Snelgrove said he interprets the 60 days as beginning to run from the date of the EOB. Ms. Pappas added this applies to the original bill, if the provider rebills and rebills without new information the time for appeal does not start over. Ms. Culkin noted stakeholder agreement to use the date EOB has been generated.

VIII. Next Steps:

- The next meeting will be held on February 21, 2019. Ms. Culkin projected a slide with issues scheduled for discussion at that meeting.

The meeting was adjourned at approximately 6:00 p.m.

COLORADO
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Meeting Title: Stakeholder Meeting for Annual Review of Rules 16 and 18

Meeting Date and Time: February 21, 2019

Meeting Location: Colorado Department of Labor and Employment, 633 17th Street, 2nd Floor Conference Room, Denver, CO 80202

Meeting Facilitator: Christy Culkin

Attendees (in person): Hank Hahne, Colorado Springs School District 11 and Colorado Self-Insured Association; Chris Gross, Holly Pappas, and Kelly Bowland, Pinnacol Assurance; Brett DeMooy, Injury Care Associates, Daniela Gosselova, citizen; James Becker, Dr. Ethan Moses, Dr. Kathryn Mueller, Tara York-Winkler, Janell Cobb, Blair Ilsley, Gina Johannesman, Colleena Blakeman, Nina Fresquez, and Mariya Cassin, Division of Workers' Compensation.

Attendees (by telephone or webinar): Katie Metcalf, Lisa Hamko, Chris Snelgrove, Dana Held, and Mary Schmid, Pinnacol Assurance; Rhonda Koehn, Colorado Pain and Rehabilitation; Jen Bean and Tom Coccia, Automated Healthcare Solutions; Marilyn Rissmiller, Colorado Medical Society; Marvel Hammer, MJH Consulting; Betty Osborn, CorVel; Luv Dobbins, Denver Back Pain Specialists; Mike Strong, Equian; Paul Krueger, Esq., Ritsema & Lyon, P.C.; Fred Scherr, M.D.; Lisa Anne Bickford, Aetna; Cindy Gallagher, Coventry; Tom Dauphinee, The University of New Mexico; Debra Northrup, citizen; Roy Foster, Division of Workers' Compensation; Jeannette Hrubes, Peak Form Clinic; Steve Orr, AIG; Stephen Pottenger, WorkWell; Matt Rose, H-Wave.

I. Introduction:

- Ms. Culkin welcomed everyone to the meeting and asked each in-person attendee to state his or her name.

II. Deposition and Testimony Fees:

- Ms. Cassin reviewed Rules 18-6(D)(3) and (4), which establish the fees paid to providers in the event of a cancelled deposition or testimony. If the provider receives notice at least 7 business days prior to the scheduled deposition or testimony, the provider is paid for the time reasonably spent in preparation. If the provider receives notice of at least 5 but less than 7 business days, the provider is paid the time reasonably spent in preparation plus ½ of the time scheduled. If the provider receives notice of less than 5 business days or if the deposition/testimony is shorter than the time scheduled, the provider is paid for the time reasonably spent in preparation and the time scheduled.

- The Division staff received some feedback that providers have difficulties refilling their calendars in these timeframes. The parties often cancel and reschedule depositions and hearings. In addition, the recently amended DIME rule increased both cancellation *and* rescheduling timeframes and payments.

- The Division staff received a proposal by Dr. Scherr to increase these timeframes to 14 business days and 10 business days, which would be in line with recent changes to Rule 11 for Division Independent Medical Examinations. That proposal also contemplates the same payments for reschedulings as for cancellations (even if a hearing or a deposition would occur later, the provider still must refill the original time slot). The Division is not taking a position on this proposal, at this time, but is inviting other stakeholders to comment.

- Ms. Gosselova recommended the Rule have a single tier of payments for cancellations or reschedulings, such as 14 business days. She stated that multiple tiers are complicated and 2 additional days of notice do not make enough difference to justify a different payment.

- Mr. DeMooy agreed with adding rescheduled depositions and hearings as events triggering fees to providers.

- Mr. Hahne suggested 10 business days as the timeframe. He also suggested a provision where providers who successfully filled the original time slots would refund cancellation or rescheduling fees to the parties.

- Mr. Becker, Mr. DeMooy, Dr. Moses, and Ms. Koehn spoke against the refund proposal. The proposal would be difficult to enforce and would lead to accounting difficulties. Dr. Moses also questioned how the rule would apply if the provider only partially refilled the time slot.

- Mr. Krueger said that doubling the cancellation timeframes would have a chilling effect on settlements. In response, Dr. Scherr stated that 10 business days would be a reasonable middle ground.

- Ms. Culkin confirmed the consensus to establish a single timeframe of 10 business days, to include rescheduled depositions and hearings as events triggering payments to providers, and to not adopt the refund proposal.

- Ms. Hammer asked for a clarification regarding consequences of providing a notice of 10 business days vs. a shorter notice. Ms. Culkin clarified that a notice of 10 business days or more would result in a payment of reasonable preparation time to the provider, while a notice of less than 10 business days would result in payment of reasonable preparation time plus time scheduled for deposition or testimony.

III. Services Provided in Rural Areas:

- Ms. Culkin discussed the concept of differential payments to rural providers. She noted that 47 out of 64 counties in Colorado are rural, 12 do not have a mental health provider,

and 2 do not have a single physician. The Division does allow telemedicine, but not all services can be provided in this way. One possible way to incentivize physicians to provide services in rural areas (counties outside a Metropolitan Statistical Area (MSA) or Health Professional Shortage Areas, as determined by the U.S. Department of Health and Human Services) is to pay a premium above the fee schedule, such as 115%. The reimbursement for transportation to rural areas is another possibility, although the Division must be careful not to penalize providers who are already there.

- Ms. Gross asked for a clarification whether the provider has to be physically present in a rural area or merely serve a rural patient by telehealth. Ms. Culkin clarified this proposal would not include telehealth, as telehealth has separate codes and modifiers that result in additional payments.

- Ms. Pappas inquired whether current rules already reimburse providers for traveling. Ms. Culkin noted that rule is limited to home health providers and only pays for mileage expenses, not travel time.

- Mr. Hahne said paying for transportation would be complicated and difficult to audit. Dr. Moses added this would not help providers who live in rural areas.

- In response to Dr. Moses, Ms. Koehn and Mr. Strong, Ms. Culkin clarified the proposal would apply only to professional services of physicians not affiliated with a Critical Access Hospital (CAH) because these physicians are already paid to be in rural areas.

- Mr. Strong noted that the Division already pays more than Medicare, including in rural areas, which raises cost concerns. He suggested there should be a telemedicine visit or a teleconference before a physician travels to a rural area, to avoid unnecessary expense.

- Ms. Culkin also noted that rural claims are a small percentage of all claims. She also stated access to healthcare in rural areas is not unique to workers' compensation.

- Mr. DeMooy noted that a 15% increase is unlikely to incentivize service in rural areas. He explained travel time is not the only expense of providing service in a rural area, there are infrastructure expenses too (setting up a business, office space, and support staff). Some rural areas may not have enough population to support the business. Ms. Gosselova agreed.

- Dr. Scherr stated he has been providing services in the Steamboat Springs area for 2.5 days every three weeks for 12 years. Dr. Scherr is also available to NPs by telephone or email when he is not there. Dr. Scherr is paid $150 per hour for travel time and while he is in the area. The medical center collects what Dr. Scherr would have billed at each visit to offset the expense of his contract. Dr. Scherr is also paid this hourly fee whenever he consults remotely. He is not sure 115% would incentivize physicians who are already in rural areas to accept workers' compensation, but it may incent someone to travel with no providers currently. Dr. Scherr opined rural physicians need support and education the most.

- Ms. Culkin then proposed amending the rule to allow payers discretion to negotiate with providers if there is shortage in a particular area. Ms. Pappas agreed.

- Ms. Koehn noted physicians do not travel just to see one acute patient. In response to Mr. Strong, she also stated that reimbursing at just Medicare rates is not realistic in Colorado.

IV. Reimbursements to Physical Therapy Assistants and Occupational Therapy Assistants:

- The Division will table this issue while Medicare develops additional guidance.

V. Payer-Requested WC164 Reports:

- Ms. Culkin stated the Division received feedback from several large providers that spent significant administrative time answering calls from payers requesting work restrictions updates. The calls can add up to 6 hours per week of office time, but they are not payable. Ms. Culkin asked how the providers should handle these calls, given that Form WC164 lists the same information. Rule 18-6(G)(2)(c) states that, if the payer requests WC164 report (other than initial and closing reports), the payer shall pay the provider for the completion and submission of the report. The current fee for the report is $49.

- Mr. Hahne stated he prefers to see WC164 report from every visit. He suggested amending the rule to require providers to complete (and be paid for) this report after every visit, unless the payer previously notified the provider otherwise.

- Mr. DeMooy also agreed with the proposal, adding that it is inefficient for the provider to have to fill out the form or provide information after the fact. Mr. Hahne and Dr. Mueller agreed with that point.

- Mr. Snelgrove stated this would add a cost of $49 to the system for every time an injured worker visits the physician. Dr. Mueller, Ms. Koehn, and Mr. DeMooy responded by mentioning the benefits to the system, including timely communication of functional gains and other return to work information, improved quality of care, and avoiding inefficiencies.

- Dr. Moses also agreed with the proposal, but stated that the provider must fully complete the form before he or she can be paid. Mr. DeMooy agreed. He also noted that the payer that opts out of interim WC164 reports should educate its policyholders accordingly, as many phone calls requesting work restrictions updates come from employers.

- Ms. Pappas noted that filling out Form WC164 should not substitute for the requirement to submit medical records with the claim.

- Mr. Hahne and Ms. Gosselova noted that only the authorized treating physician managing the claim should be filling out Form WC164, not any other provider.

- Mr. Bowland added the rule should specify which portions of the form the provider must complete and require the provider to send the form within the next business day. He also stated the medical fee schedule accounts for administrative expenses incurred by providers.

- Mr. Snelgrove and Ms. Gross opined the solution is for the providers to charge for a WC 164 report whenever they receive these calls, instead of a presumption that the report will be filled out after every visit. Mr. Hahne replied that the form is harder to complete after the fact. Mr. Hahne added the revised rule should except visits that occur after MMI unless the claim is reopened or the payer requests a WC164 report for a post-MMI visit.

VI. Medicare Long Term Care Hospitals:

- Mr. Becker introduced a proposal to add language to Rule 18-6(I)(3)(c) to calculate the length of stay in Medicare Long Term Care Hospitals (MLTCHs). The proposal would count the date of discharge but not the date of admission. The bed hold days or temporary leaves typically are not subtracted from the length of stay.

- Ms. Cassin noted that stays spanning multiple calendar years can involve more than one per-diem rate. She asked whether the rule also should clarify which rate would apply to the stay or if multiple rates would apply in that scenario.

- Ms. Culkin invited the payers to look at their payment systems to see what would make the most sense.

- Ms. Metcalf noted that date of admission is the industry standard, but Pinnacol interprets the Division Rule as stating the date of discharge controls the per-diem rate. Ms. Bickford stated the date of discharge would be preferable, but sometimes the parties agree to interim billing. If so, the discharge date and the per-diem rate is unknown at the time of the interim bill.

VII. Home Care Services:

- Ms. Culkin discussed the inconsistencies within Rule 18-6(M) regarding the requirement for prior authorization for home care services. She asked the stakeholders to comment on resolving these inconsistencies.

- Mr. Hahne suggested requiring prior authorization for all home care services. Ms. Bickford agreed, adding this is also the case in California.

- Ms. Pappas suggested the Division adopt fees for Medicare's S and G codes for home health.

- Mr. Hahne asked about including travel time in the prior authorization. Ms. Culkin agreed.

VIII. Telehealth/telemedicine:

- Ms. Cassin proposed a revision to Rule 18-5(J)(1) to allow providers to perform services in addition to those listed in CPT®, Appendix P by telemedicine with prior authorization.

- Ms. Pappas spoke against the proposal. She stated that CPT® has comprehensive criteria when determining which services should be listed in Appendix P.

- Ms. Culkin discussed the emerging field of tele-rehabilitation, for example speech therapy, which does not require hands-on treatment. Prior authorization would allow for additional services not listed in Appendix P for whatever reason to be provided by telemedicine on a case-by-case basis.

- Ms. Bickford stated that Coventry is a big proponent of telemedicine.

IX. Next Steps:

- The next meeting will be held on March 28, 2019. Ms. Culkin projected a slide with issues scheduled for discussion at that meeting.

The meeting was adjourned at approximately 6:00 p.m.

COLORADO
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Meeting Title: Stakeholder Meeting for Annual Review of Rules 16 and 18

Meeting Date and Time: March 28, 2019

Meeting Location: Colorado Department of Labor and Employment, 633 17th Street, 2nd Floor Conference Room, Denver, CO 80202

Meeting Facilitator: Christy Culkin

Attendees (in person): Raylene Smith, City and County of Denver and Colorado Self-Insured Association; Greg Gilbert, Concentra; Katie Metcalfe, Chris Gross, Holly Pappas, and Kelly Bowland, Pinnacol Assurance; Christian Updike, M.D., and Brett DeMooy, Injury Care Associates, Rachel Wendt, Colorado Chiropractic Association; Katelyn Palazzolo, American Physical Therapy Association; Debra Northup, CorVel Corporation; Daniela Gosselova, citizen; James Becker, Ethan Moses, M.D., Ed Horak, Tara York-Winkler, David Indovina, Blair Ilsley, Gina Johannesman, Colleena Blakeman-Groves, Nina Fresquez, and Mariya Cassin, Division of Workers' Compensation.

Attendees (by telephone or webinar): Lisa Hamko, Dana Held, Kristin Mulhollen, and Mary Schmid, Pinnacol Assurance; Rhonda Koehn, Colorado Pain and Rehabilitation; Jen Bean and Tom Coccia, Automated Healthcare Solutions; Marilyn Rissmiller, Colorado Medical Society; Marvel Hammer, MJH Consulting; Betty Osborn, CorVel; Luv Dobbins, Denver Back Pain Specialists; Lisa Anne Bickford, Aetna; Bob Andrus, Midtown Occupational Health Services; Matt Rose, H-Wave; Tracy Euler and Isabel Hernandez, Heathesystems; Jordan Fritz, Ascent Medical Consultants; Carla Gee, Optum; Chris Gove, Red Rocks Billing; Kim Norwood, Health Psychology Associates; Gary Swenson, Colorado Hospital Association; Kelvin Washington, DC; Monika Valentine; Roy Foster, Division of Workers' Compensation;

I. Introduction:

- Ms. Culkin welcomed everyone to the meeting and asked each in-person attendee to state his or her name.

II. Injured Worker Travel Expenses, Rule 18-6(E):

- Ms. Culkin stated that mileage reimbursement totaled about 7 million dollars last year, which is a significant portion of the system. She acknowledged the injured workers are entitled to reimbursement of reasonable and necessary mileage expenses. The Division currently sets its mileage rate based on the IRS rate, but last year the Division inadvertently

did not update the rate. Currently, the IRS rate is 58 cents per mile and the Division rate is 53 cents per mile.

- Ms. Culkin proposed adopting into rule the formula for reimbursing mileage expenses of state employees: 90% of the IRS rate for travel in 2-wheel drive vehicles and 95% of the IRS rate for travel in 4-wheel drive vehicles, if such travel was necessary and authorized. The Division previously used this formula. The number of miles will be based on the most direct route to pharmacies or medical appointments.

- Ms. Metcalfe stated that adopting two different rates would be difficult administratively, in terms of programming and inquiring what car the injured worker was using each time. Mr. Bowland agreed with a single rate, even if it is 2 cents higher. Ms. Gosselova added she was reimbursed for 20 thousand miles as part of her claim and the additional 2 cents per mile would not have made much difference.

- Ms. Gosselova also questioned the how "the most direct route" would language apply if the most direct route is impractical due to weather or road closures. Ms. Culkin proposed the "most direct route available on the date of service" language.

- Ms. Culkin proposed language that the injured worker would submit claims for mileage or interpreting within 12 months of incurring the expense, unless there are extenuating circumstances. The payer shall reimburse the injured worker within 30 days of receipt of the claim (already a requirement for reimbursing providers). Ms. Culkin noted that § 8-43-203(3)(c)(IV), C.R.S., requires payers to provide claimants with a brochure informing them (among other things) of their right to mileage reimbursement.

- Ms. Gosselova stated 12 months is too much time. Ms. Culkin stated she did not want to allow injured workers less than 120 days, the time that providers have to submit claims to payers. Ms. Metcalfe proposed 6 months. Mr. Gilbert proposed 30 days after a provider bill is due, to allow the payer to verify a service occurred that day. Ms. Hammer agreed 120 days was reasonable.

- In response to Ms. Metcalfe, Ms. Culkin clarified that delay in establishing compensability would be an extenuating circumstance.

III. Interpreter Services, Rule 18-6(Q):

- Ms. Culkin explained that California has adopted stringent certification requirements for interpreters. California has a different demographic and the intent is not to create barriers to care. However, the Division received reports of family members interpreting during behavioral health and other appointments. The Division believes these arrangements prevent quality care and should not occur, except in emergencies. Even then, the family member will not be paid. Ms. Culkin introduced proposed rules defining a qualified interpreter.

- Ms. Metcalfe asked about the term "generally accepted interpreter ethics principles." Ms. Culkin explained this term is based on the California statute. Ms. Metcalfe said she agrees with the concept, but is hesitant about such a generic term.

- Ms. Culkin asked if any stakeholders were familiar with certifications that are available for interpreters. Ms. Gosselova stated that trust between the injured worker and interpreter is more important than certifications.

- Ms. Metcalf stated that all Pinnacol contracts for interpreters require impartiality and lack of a prior relationship between the interpreter and the injured worker.

- Ms. Held stated that Pinnacol contracts require certification if it is available. She supports the rule and will email the names of available certifications and certifying agencies.

- Ms. Bickford stated that, whatever the rule the Division adopts, it should be easy to auto-adjudicate interpreter bills.

- Ms. Culkin also noted the proposed language states that invoices would be acceptable for interpreter bills as opposed to claim forms. Ms. Metcalfe and Ms. Bickford agreed, so long as the invoice has information that the person meets the interpreter qualifications.

- Mr. DeMooy spoke against the proposed language prohibiting providers from relying on family or clinic staff. This language would force the provider to cancel appointments if an interpreter does not show up, even though a staff or family member is available. This also may interfere with case management. Mr. DeMooy argued providers need the flexibility. Ms. Northrup added that a certified interpreter may not be available for rare languages.

- Ms. Valentine discussed patient safety, interpreter bias, and interpreters leading the patient because they are more familiar with the process. Ms. Koehn agreed, but felt the proposal to prohibit providers from relying on staff or family is too restrictive. Sometimes there is no choice but to use them or to cancel the appointment.

- Ms. Culkin clarified the intent is for the rule to apply only to medical visits themselves, not to scheduling discussions. She noted that having an unqualified party interpreting could cause more harm than good.

- Mr. DeMooy cautioned against creating barriers to care for non-English speaking injured workers or treating them differently than other patients.

- Mr. Bowland suggested changing the language from "prohibited" to "shall refrain."

- Ms. Norwood, an employee of a behavioral health clinic in Greeley, said the clinic obtains a release from non-English speaking patients to discuss scheduling with family members. But, it is a conflict of interest for family members to sit in during actual appointments. The clinic will cancel an appointment if a certified interpreter is not available. Ms. Norwood

said it is also important to have a qualified interpreter due to cultural nuances. Finally, having a consistent interpreter is important, because sensitive topics come up in counseling.

- Dr. Updike stated the need to have a qualified interpreter is different in behavioral health appointments as opposed to follow-up appointments for low acuity laceration rechecks or routine physical therapy where the patient is already familiar with the exercises.

- Ms. Fritz likes the proposed language because it protects providers. The providers are at risk if the information is not relayed correctly to the patient. She said the Division should not single out behavioral health, but the same standard should apply to all providers. Some physiatrists in her clinic treat chronic issues and a qualified interpreter is very important in that context. She said only very routine visits should be an exception.

- Ms. Gross stated that medical professionals should be able to use professional judgment, especially in rural areas where an interpreter may not be available.

- In response to Dr. Updike, Ms. Culkin noted that any policies about switching individual interpreters every few visits are set by insurance companies rather than the Division.

- Ms. Palazzolo inquired whether the proposed language would prohibit clinics from using their bilingual staff to interpret. Ms. Culkin clarified this was not the intent, but if the staff member is not a certified interpreter he or she would not be paid separately.

IV. Clinical Drug Screening/Testing, Rule 18-5(G)(4):

- Ms. Culkin introduced the topic of drug testing, which is required for opioid monitoring. There are two types of testing: presumptive and definitive. Presumptive testing identifies possible use or non-use of drugs or drug classes and results in up to 50% of false positives. Definitive testing confirms drug use or non-use after a presumptive test, is more accurate, and can be qualitative or quantitative. Providers routinely order presumptive and definitive testing on the same date of service. The question is whether both are needed or whether some limits are appropriate. Ms. Culkin proposed limiting presumptive testing to the day of the accident and definitive testing for opioid monitoring.

- Dr. Moses noted that several medical societies and agencies recommend starting with presumptive testing and moving on to definitive if there is an unexpected result, although a recent study concludes definitive testing every time may be appropriate.

- Ms. Northrup suggested relying on provider discretion as to what type of testing is needed. Ms. Pappas replied that some providers order definitive tests even when presumptive tests are negative across the board.

- Mr. DeMooy suggested a rule language where definitive tests would be limited to cases where presumptive results are unexpected. Ms. Culkin responded that presumptive tests result in 50% false positives. She questioned the value of a test that is only 50% accurate.

- Ms. Metcalfe suggested this issue may be more appropriate for the Treatment Guidelines rather than Rule 18. Ms. Koehn agreed. She added that presumptive test produces quick results and is useful to test for illicit drugs. She stated that most commercial payers only pay for one type of testing per date of service.

- Ms. Hammer opposed to any limitations or providers not being paid for presumptive tests. Ms. Fritz agreed, stating a provider dispensing pain medications at an initial visit cannot wait for results of definitive tests.

- Ms. Pappas asked what would prompt a provider to test a higher number of drug classes. Dr. Moses was not sure.

- Ms. Northrup stated that sometimes providers perform presumptive tests in their office and then send the sample to the lab, which performs both presumptive and definitive testing. She stated the second presumptive test is duplicative and the Division could address this in the rule. Ms. Pappas said she has seen similar cases. Dr. Moses proposed changing the language in Rule 18-5(G)(4)(c) from "providers may only bill one presumptive test per date of service" to "payer shall only pay for one presumptive test per date of service" to accomplish this objective.

- Ms. Culkin then discussed the fee schedule for drug testing. The current fee schedule is about 175% of Medicare. She proposed decreasing the costs and frequency.

- Ms. Metcalfe asked what justifies higher cost of 22-panel test as opposed to a 7-panel test. Ms. Ilsley stated the higher cost may be due to the higher number of reagents used.

- Ms. Koehn reiterated her position that the issue should be addressed in the context of the Treatment Guidelines. Ms. Culkin noted the Division only has nine Treatment Guidelines, which do not apply to every condition, which is why opioid management is covered in Rule 18.

- Ms. Valentine noted that many lab contracts contemplate automatic definitive testing. In addition, most labs offer custom panels, so a 22-panel test every time is not necessary.

- Ms. Hammer stated the average reimbursement for a presumptive test is only $22.00. She also said that CPT® defines drug classes.

- Ms. Culkin stated that none of the stakeholders wished to commit to limitations on testing or changing fees, so she moved on to testing frequency.

- Dr. Moses noted that more frequent testing than what is listed in the rules or guidelines is appropriate in cases of addiction. Mr. DeMooy and Ms. Hammer added that maximum frequencies interfere with physician discretion.

- Ms. Culkin stated she is not inclined to recommend changes to Rule 18-5(G)(4) this year.

V. CPT®/Fee Schedule:

- Mr. Becker stated some stakeholders expressed confusion between status codes and status indicators. Mr. Becker explained that status codes apply to professional fees and are found in Rule 18-5(B)(3). Status indicators apply to facility fees and are found in Rule 18-6(J)(5).

- Mr. Becker also noted that, last year, the Division adopted some correct coding policies, including use of RBRVS status code B or "bundled." The Division also adopted status codes E, G, I, N, R, or X, which are not valid for Medicare, but are valid for Colorado workers' compensation. The Division intended all Status B codes that have both an RVU and a conversion factor in the fee schedule to be separately payable. Eighty-seven codes have a B status code, of which 8 are listed on Exhibit 9 and 41 have both an RVU and a conversion factor. The Division believes all other codes should be bundled. One of those codes is CPT® 99070, previously used to report DME supplies. Now the providers should use a more specific HCPCS A code, for example A9300 to report exercise equipment.

- Mr. Becker noted that, in regards to status codes E, G, I, N, R, or X, the Division has seen a lot of disputes, especially related to acupuncture. These codes are clearly payable in Colorado workers' compensation system even if they are not payable by Medicare.

- Mr. Becker acknowledged that hot and cold packs, previously reported under CPT® 99070 and payable at about $8, do not fall under any A code. Ms. Culkin added that Treatment Guidelines specifically approve of hot and cold packs, so there is a potential inconsistency in Division Rules. Mr. Becker added some A codes have a zero value in the fee schedule, but the rules establish a process for reimbursing DME supplies. Mr. Becker proposed language to address any confusion.

- Ms. Metcalfe stated that Medicare RVUs already account for the value of bundled codes. She stated that allowing separate payment when RVUs already account for these values would be double payment. Ms. Osborn and Ms. Northrup agreed, opining that separate payments for bundled codes destroy the relativity of the relative value system.

- Ms. Culkin invited comments on hot and cold packs specifically. Ms. Culkin noted that the approval of this modality in the Treatment Guidelines does not necessarily require a separate payment. Ms. Northrup noted that hot and cold packs normally are not performed in isolation, but before or after active therapy.

- Ms. Culkin noted that Medicare actually assigns a value to hot and cold packs, which is how the Division previously derived the fee schedule value.

- Ms. Palazzolo said the provider would still provide this service if necessary to assist in active therapy, the cost of which is a lot less than $8.

- Mr. Andrus stated hot and cold packs are very important to success of physical therapies. Midtown performs 2 to 3 thousand of these modalities per year and it has very good patient

outcomes. He stated the Division should resolve the conflict between the B status code and the Treatment Guidelines. He pointed to other recent decreases in therapy fees.

- Mr. Andrus also noted payers are inappropriately denying separate payment for take home exercise supplies, which are not included in the in-office therapy. In response, Ms. Culkin inquired whether any take home exercise supplies were not covered by a HCPCS A code. Ms. Metcalf responded that all of these supplies can be billed under A9300.

- Mr. DeMooy said the provider still incurs a cost in providing hot and cold pack therapy, such as maintaining the hydrocollators and replacing old packs.

- Mr. Becker asked the stakeholders to look at new CPT® 2019 codes, whether any of them may cause a problem in 2020. For example, some stakeholders inquired about new CPT® 96146, which requires an automated result. The Division believes that a provider who does not generate an automated result to the patient would not be able to bill that code in 2020.

- Ms. Pappas stated that CPT® 2019 psychological testing codes require providers to report them only after testing is complete. She asked the Division to incorporate that language into its 2020 rule.

VI. Next Steps:

- The next meeting will be held on April 25, 2019. Ms. Culkin projected a slide with issues scheduled for discussion at that meeting.

The meeting was adjourned at approximately 6:00 p.m.

COLORADO
Department of Labor and Employment

Meeting Title: Stakeholder Meeting for Annual Review of Rules 16 and 18

Meeting Date and Time: May 23, 2019

Meeting Location: Colorado Department of Labor and Employment, 633 17th Street, 2nd Floor Conference Room, Denver, CO 80202

Meeting Facilitator: Christy Culkin

Attendees (in person): Daniel Bruns, PsyD, Health Psychology Associates; Chris Gross and Kelly Bowland, Pinnacol Assurance; Simon Schwartz, Colorado Ambulatory Surgery Center Association, Robert Hamilton, M.D., and Valerie Garcia, EmergiCare Medical Clinics, Michael Moore, Excel Physical & Occupational Therapy, P.C., Pamela Heckert, M.D.; Christian Updike, M.D., and Brett DeMooy, Injury Care Associates, James Wiley and Rachel Wendt, Colorado Chiropractic Association; Lisa Anne Bickford, Coventry; Katelyn Palazzolo, American Physical Therapy Association; Debra Northup, CorVel Corporation; Daniela Gosselova, citizen; James Becker, Ethan Moses, M.D., Tara York-Winkler, Ed Horak, Marisa Cordova, Janelle Cobb, Luella House, Mike Nelson, Blair Ilsley, Gina Johannesman, Colleena Blakeman-Groves, Nina Fresquez, and Mariya Cassin, Division of Workers' Compensation.

Attendees (by telephone or webinar): Rhonda Koehn, Colorado Pain and Rehabilitation; Holly Pappas, Lisa Hamko, and Mary Schmid, Pinnacol Assurance; Marvel Hammer, MJH Consulting; Betty Osborn, CorVel; Chris Skagen and Dan Connolly, Colorado Ambulatory Surgery Center Association; Matt Rose, H-Wave; Joel Brill, M.D., and Chris O'Donnell, FairHealth; Cindy Gallagher, Coventry; Jen Bean and Tom Coccia, Automated Healthcare Solutions; Marilyn Rissmiller, Colorado Medical Society; Hank Hahne, Colorado Springs School District 11 and Colorado Self-Insured Association; Greg Gilbert, Concentra; Isabel Hernandez, Heathesystems; Karol Larrabee, Optum; Kristie Griffin, Express Scripts; Stephen Pottenger, WorkWell; Debbi Robison and Danielle Vyas, Mitchell; Trista Robrahn, CaseNet MC; Kelvin Washington, DC; Patricia Weddel, Equian; Roy Foster, Division of Workers' Compensation.

I. Introduction:

- Ms. Culkin welcomed everyone to the meeting and asked each in-person attendee to state his or her name. She thanked the stakeholders for their participation throughout the entire process.

II. Trauma Activation Fees:

- Ms. Culkin introduced the proposed trauma activation fees language. She explained the Division unintentionally omitted these fees from the 2019 version of the rule. Ms. Culkin

added that trauma activation fees remain payable, but negotiations can be burdensome. She stated that trauma activation fees are payable to hospitals that serve the most traumatic injuries in the workers' compensation system, there are only a few in Colorado. Ms. Culkin stated that trauma activation fees listed in prior versions of the rule did not have a strong foundation. She is working with the Colorado Hospital Association and Denver Health to develop a price for activating trauma teams (not just alerting them). Ms. Culkin stated that, once she receives that feedback, the Division will add proposed values to the rule. In the meantime, she invited other stakeholders to comment on this issue.

III. Psychological Testing:

- Ms. Culkin discussed proposed language regarding psychological/neuropsychological testing. CPT® 2019 significantly revised the psychological and neuropsychological testing codes. The Division previously developed modified RVUs for these codes and now must map the old codes to the new ones to develop new modified RVUs. Ms. Culkin stated the Division is working with specialty organizations to do so.

- Ms. Hammer expressed a concern with the proposed language allowing providers to bill a code for a feedback session separately when there is a delay in scheduling that session. Ms. Culkin stated the providers should bill the original psychological session and the feedback session on the same form so it is easy to track the total hours spent on testing. But, if there is a delay, providers may bill for the feedback session separately if some documentation references the original session.

- Ms. Hammer noted that electronic payment systems might deny an add-one code billed without a base code. Ms. Pappas responded that Pinnacol can probably modify its software to pay stand-alone add-on codes, but that may result in the system paying such codes inappropriately. She said Pinnacol would have to monitor these codes.

- Dr. Bruns stated that sometimes results of neuropsychological testing are not ready until the next session. If the feedback sessions occurs relatively soon, providers typically wait to bill all of the testing on one form. However, in a rare situation where this is not possible, the feedback from the testing rolls into the first psychotherapy session.

- Ms. Culkin suggested alternative rule language allowing providers to incorporate feedback into the first therapy session if there is a delay in scheduling feedback.

- Mr. Bowland asked for a clarification of whether the feedback would result in an additional appointment. Dr. Bruns replied feedback usually does not take long and it is interspersed with therapeutic discussion with the patient.

- Dr. Moses asked for a clarification of whether, in that situation, the provider would bill only the therapy code or the therapy code with the add-on testing code. Ms. Culkin and Dr. Bruns replied the provider would bill only the therapy code, but there may be an extra unit of time.

IV. Consultation Fees:

- Ms. Fresquez introduced a proposal to decrease consultation fees and increase other E&M fees. Ms. Culkin added that Medicare does not recognize consultation codes, while the Division does. The Division has received many disputes involving consultation codes where additional documentation requirements for these codes have not been met. Ms. Culkin stated that the work that goes into consultations is similar to the work that goes into new patient visits. She added that recommended RBRVS values for new patient visits and consultations are comparable, when additional minutes in the descriptions of consultation codes are taken into account. Ms. Culkin proposed that the Division either not recognize consultation codes and delete documentation requirements, or value them the same as new patient E&M visits. Colorado is the only state that values consultations so much more than new patient visits.

- In response to Dr. Hamilton, Dr. Moses gave some examples of new patient referrals and consultations. The main difference is whether the evaluating provider accepts the patient and initiates treatment (if so, a new patient E&M visit and not a consultation code should be billed).

- Dr. Hamilton noted that, if he refers a patient to a specialist, he will continue to manage the case. He stated that consultation codes recognize that the specialist will not have the power to refer the patient to further specialists or assume control over care. Ms. Culkin proposed keeping consultation codes, but deleting additional documentation requirements and valuing them the same as new patient E&M visits.

- Ms. Hammer said the AMA defines a consultation broader than merely giving an opinion and includes a determination of whether to accept the patient and take over a portion of the care. Further, a patient may be referred to a provider that saw the patient within the past three years for another consultation. In that case, the patient is an established patient and reimbursement would be much lower than for a consultation. Finally, Ms. Hammer questioned the validity of the comparison to other states because these states may have adopted RBRVS values without any adjustments. She noted the RBRVS suggested values for consultations have not changed since 2010s when Medicare stopped paying for these codes. Mr. Gilbert agreed with the last point made by Ms. Hammer.

- Dr. Hamilton stated that diagnosis, including consultation with a specialist, is paramount to successful care. Ms. Northrup agreed, noting that specialty providers play a role in the workers' compensation system.

- Ms. Culkin stated the Division will give the issue further consideration.

V. Conversion Factors:

- Ms. Culkin presented proposed conversion factors (CFs) for discussion purposes. She stated that increasing alignment between CFs has been a long-term Division goal. The existence of vastly different CFs undermines the relativity of unit values developed by the

Harvard School of Public Health. Currently, E&M and PM&R CFs are quite low and all other CFs are quite high as compared to other states. Ms. Culkin also explained it is not possible to increase some CFs without reducing others or raising employer premiums and affecting the economy. The goal is to keep annual increases to overall medical costs under 2%. Ms. Culkin stated surgery fees have significantly increased. The new WCRI study concluded that, if surgery fees are high, more surgeries are performed. But, these higher fees do not necessarily translate to better outcomes for injured workers. The proposal is to slightly reduce radiology, pathology, surgery, and medicine CFs, as well as to moderately increase E&M and PM&R CFs.

- Ms. Northrup stated the Division should consider utilization when establishing E&M and PM&R CFs. She opined the workers' compensation system still needs specialty providers such as surgeons. Ms. Culkin explained that development of budget neutral CFs does involve an analysis of utilization and new unit values set by RBRVS. She also noted that budget neutral CFs for radiology, pathology, surgery and medicine are closer to $71, so keeping these CFs at $72 would amount to an increase. On the other hand, the proposed increase to E&M and PM&R CFs does not look as substantial due to the high utilization.

- Dr. Hamilton inquired whether the proposed decrease to medicine CF would apply to primary care, which is essential to treating injured workers. Ms. Culkin responded that primary care mostly falls into the E&M CF. Further, many services that are highly valued in the workers' compensation system and are subject to the medicine CF (chiropractic and psychology) have modified unit values in the rule, so a drop in medicine CF will not affect these services as much. Ms. Culkin stated the overall goal is to have overall fees at about 185% of Medicare.

- Ms. Osborn suggested the Division evaluate the impact of proposed reduction to surgery CF to various surgical specialties, like neurosurgery or orthopedic surgery.

- Mr. Gilbert agreed with the Division's overall approach to developing proposed CFs and stated that Medicare conducts a similar analysis. He also stated that surgeons do not bill surgery codes only but also E&M codes, so the proposed CFs will may not necessarily lead to as much of a decrease in their fees. Ms. Culkin agreed with Mr. Gilbert.

- Ms. Northrup asked if the Division has reached out to radiologists. Ms. Culkin stated no. She added that every proposed change will result in winners and losers, but the specialties to which the $72 CF currently applies are already winners, at 200% of Medicare vs. 120% for other specialties. She emphasized the need to promote physical medicine and E&Ms with authorized treating physicians in the workers' compensation system.

- Ms. Northrup stated that the increase in surgery fees could be due to the use of unlisted or unpriced codes.

- Ms. Culkin noted the Division will continue to accept stakeholder comments in regards to the proposed CFs, up until the public hearing.

- Dr. Hamilton noted the importance of physical therapy to diagnosis, case management, and pain management.

- Ms. Northrup raised the issue of setting different fees for physical therapists vs. physical therapy assistants. Ms. Culkin stated the Division discussed this topic earlier this year, but held off on making any decisions until Medicare does.

- Dr. Hamilton stated his practice does not use physical therapy assistants, physical therapists are hands-on with the patients.

- Mr. DeMooy noted physical therapy assistants might be necessary in rural areas that do not have enough physical therapists.

- Ms. Osborn agreed the impact to surgeons might not be that dramatic because surgeons also perform E&M and other non-surgical services. Ms. Hammer responded that E&Ms performed by the surgeons frequently are part of the global surgical package and are not separately payable. Ms. Culkin added that unit values for surgery codes are already high. The proposed CF will result in about 194% of Medicare, still higher than any other payer in Colorado.

VI. Exhibit 9:

- Mr. Becker discussed Exhibit 9, which the Division added to the rule last year. He invited stakeholders to comment on whether they were using this exhibit or preferred to have modified values listed in the body of the rule itself. Ms. Northrup and Mr. Bowland said they liked both Exhibit 9, which makes the electronic system easier to load, and having modified values listed in the body of the rule for referenced.

VII. Division Code Changes:

- Mr. Becker overviewed deleted Z-codes and modified RVUs. Some of the deletions are the result of the Division adopting status indicators last year. The deletion of modified RVUs for codes with the B status indicator, which are not separately payable, will eliminate a conflict in the rule.

- Ms. Culkin discussed codes with the C status indicator. Medicare recognizes these codes as inpatient-only. Due to differences in patient population, the Division recognizes these procedures on an outpatient basis with prior authorization and negotiated price. But, the negotiation process is administratively burdensome for outpatient facilities. The Division is working with the Colorado Ambulatory Surgery Centers Association to develop fees for surgeries that are appropriate for outpatient setting. Ms. Skagen echoed these comments and thanked the Division staff for its work.

- Ms. Hammer disagreed with the proposed deletion of the Z-code for claimant-requested independent medical examinations. Even though the claimant, not the payer, pays for these services, the Z-code is useful for data collection purposes.

- Ms. Hammer also disagreed with the proposed deletion of the specimen handling code. She acknowledged Medicare does not pay for this service, but she stated providers still incur expenses in handling specimens.

- Ms. Culkin and Ms. Cassin asked the stakeholders to comment if it appeared the Division unintentionally omitted any codes or modified values from the rule or with any drafting concerns.

VIII. Radiology:

- Ms. Cassin introduced proposed deletion of language that "professional component for MRIs, CTs, and nuclear medicine scans is reimbursable at 130% of the fee schedule" from Rule 18-5(F)(2)(b). The Division adopted this language in 2017, with intent of reducing the radiology CF to around 200% of Medicare, but exempting advanced imaging services to make the transition more gradual. The proposed deletion also will make it easier to calculate the fee when providers bill the total component, and reduce disputes.

- In response to Dr. Hamilton, Ms. Culkin stated the proposal would reduce radiology fees but also the administrative burden to both payers and providers.

- Ms. Bickford asked for a clarification that the professional component of MRIs, CTs, and nuclear medicine scans will be paid at 100% of the fee schedule. Ms. Cassin agreed.

IX: Rule 18:

- Ms. Cassin overviewed the proposed overall organization for Rule 18.

- Ms. Northrup stated the proposed overall organization is an improvement, but opined the Division should keep the language that provides context for the reader.

- Ms. Hammer suggested clarifications to the language pertaining to definitive drug classes and progress reports.

- Mr. DeMooy discussed proposed language regarding employer-requested progress reports in Rule 18-7(G)(2)(d). He asked what payers would accept as proof that an employer has requested a progress report. Mr. Bowland stated an email or other brief documentation of the phone call requesting a progress report should be sufficient. He also asked for a clarification that the progress report language would not apply to post-MMI visits.

- Ms. Koehn suggested adding a box to Form WC164 to indicate the employer requested it. Ms. Culkin invited the parties to submit proposed language to the rule and Form WC164.

- Ms. Gosselova opined the indigence criteria in Rule 18-10 were low, as compared to fees for DIMEs and CIMEs. Ms. Culkin explained the indigence criteria seem out of place in Rule 18, but they are there because the Division updates Rule 18 annually. This is not the

case with other Division rules. The indigence criteria are based on the federal poverty guidelines, which the Division does not control. The DIME fees themselves are in Rule 11, not Rule 18.

- Ms. Gosselova argued the Division should lower the fee for CIMEs, which are proposed at $93.50 per 15-minute increments. Ms. Culkin noted $93.50 is the proposed maximum fee and claimants may negotiate lower fees. Ms. Koehn opined lower fees might discourage providers from performing CIMEs.

- Ms. Gosselova opined proposed rule defining a qualified interpreter as, among other things, a certified medical interpreter for five specific languages discriminates against claimants who speak other languages. Ms. Culkin stated "the certified medical interpreter" program is only available for these five specific languages. The Division has no control over this certification.

- Dr. Moses suggested an alternative language defining qualified interpreter as, among other things, "certified medical interpreter, if such certification exists for the specific language."

X. Next Steps:

- Ms. Culkin again thanked the stakeholders for their input. She emphasized the Division encourages additional input right up until the hearing. Ms. Culkin stated the draft rule will be available in late July and the rulemaking hearing will be sometime in August.

The meeting was adjourned at approximately 6:00 p.m.