RULE 16 TABLE OF CHANGES

Rule	Proposed Rule	Current Rule
16-1	Modify the language regarding legislative intent to match the language in the statute: In an effort to comply with the legislative charge to assure the quick and efficient delivery of medical benefits at a reasonable cost, the Director …	In an effort to comply with its legislative charge to assure appropriate and timely medical care at a reasonable cost, the Director …
16-2	Add the definition of certified medical interpreter: Certified Medical Interpreter - certified by the Certification Commission for Healthcare Interpreters or the National Board of Certification for Medical Interpreters.	
16-2	Delete the definition of telehealth:	Telehealth – a broad term describing a mode of delivery of health care services through telecommunications systems, including information, electronic, and communication technologies, to facilitate the assessment, diagnosis, consultation, treatment, education, care management, and/or self-management of an injured worker's health care while the injured worker is located at an originating site and the provider is located at a distant site. The term includes synchronous interactions and store-and-forward transfers. The term does not include the delivery of health care services via telephone with audio only function, facsimile machine, or electronic mail systems.
16-3(A)(1)	Add the Colorado Optometry Board to the list of Colorado agencies that license "physician providers" and, accordingly, delete optometrists from the list of non-physician providers.	
16-3(A)(4)	Modify the language regarding referrals to non-physician providers as follows:	All non-physician providers must have a referral from an authorized treating physician. An authorized treating physician making the referral to any listed or unlisted non-

	All non-physician providers must have a referral from a physician provider managing the claim (or NP/PA working under that physician provider). A physician making the referral to any listed or unlisted non-physician provider shall, upon request of any party, answer any questions and clarify the scope of the referral, prescription, or the reasonableness or necessity of the care.	physician provider is required to clarify any questions concerning the scope of the referral, prescription, or the reasonableness or necessity of the care. Any listed or non-listed non-physician provider is required to clarify any questions concerning the scope of the referral, prescription, or the reasonableness or necessity of the care with the referring authorized treating physician.
16-3(A)(5)	Delete redundant/unnecessary language.	The authorized treating physician must be immediately available in person or by telephone to furnish assistance and/or direction to the PA or NP while services are being provided to an injured worker. The service is within the scope of the PA's or NP's practice and complies with all applicable provisions of the Colorado Medical Practice Act or the Colorado Nurse Practice Act, and all applicable rules promulgated by the Colorado Medical Board or the Colorado Board of Nursing.
16-4	Add: Initial recommendations for a treatment or modality should not exceed the time to produce functional effect parameters in the applicable Medical Treatment Guidelines.	
16-9(A)(3)	Update the version of the American Dental Association's Dental Claim Form to 2019.	2012 version
16-9(A)(5)	Add: Bills for services incident to medical services, such as language interpreting or injured worker mileage reimbursement, may be submitted by invoice or other agreed-upon form.	

16-9(E)	Add the following to the timely filing language: For claims submitted through electronic data interchange (EDI), providers may prove timely filing by showing a payer acknowledgement (claim accepted). Rejected claims or clearinghouse acknowledgment reports are not proof of timely filing. For paper claims, providers may prove timely filing with a signed certificate of mailing listing the original date mailed and the payer's address; a fax acknowledgment report; or certified mail receipt showing the date the payer received the claim. All timely filing issues will be considered final 10 months from date of service unless extenuating circumstances exist. Injured workers shall submit requests for mileage reimbursement within 120 days of the date of service or reimbursement may be denied unless good cause exists.	
16-10(D)(1)	Modify the language regarding initial WC 164 reports to say: See Rule 18 for required fields.	This form shall include completion of items 1-7 and 11. Note that certain information in item 2 (such as Insurer Claim #) may be omitted if unknown by the provider.
16-10(D)(2)	Modify the language regarding closing WC 164 reports to say: See Rule 18 for required fields.	The form requires the completion of items 1-5, 6.B, 6.C, 7, 9, and 11.
16-11(A)(8)	Add the following: Payers shall reimburse injured workers for mileage expenses as required by statute or provide written or electronic notice of the reasons for denying reimbursement within 30 days of receipt.	

Rule 18 Table of Changes

Rule	Proposed Rule		Current Rule	
18-1 and 18-2 Currently 18-1, 18-2, and 18-3.	No substantive changes.			
18-3(A) Currently 18-2(D), 18-5(B)(1) and 18-5(B)(4).	No substantive changes.			
18-3(B) Currently 18-4	No substantive changes.			
18-3(C) Currently 18-5(B)(2)	No substantive changes.			
18-4(A)(1) Conversion factors	The maximum fees are determined by multiplying the following CFs by the established facility or non-facility total relative value units (RVUs) found in the corresponding RBRVS sections:		The following CFs determine the maximum fees. The fees are determined by multiplying the CFs by the established facility or non-facility total relative value units (RVUs) found in the corresponding RBRVS sections:	
	RBRVS SECTION Anesthesia Surgery Radiology Pathology Medicine Physical Medicine and Rehabilitation (Includes Medical Nutrition Therapy and Acupuncture)	CF $46.50/RVU $70.00/RVU $70.00/RVU $70.00/RVU $70.00/RVU $47.00/RVU	RBRVS SECTION Anesthesia Surgery Radiology Pathology Medicine Physical Medicine and Rehabilitation (Includes Medical Nutrition Therapy and Acupuncture)	CF $50.00/RVU $72.00/RVU $72.00/RVU $72.00/RVU $72.00/RVU $43.75/RVU

	Evaluation & Management (E&M)	$56.00/RVU	Evaluation & Management (E&M)	$54.81/RVU
18-4(A)(2) Currently 18-5(A)	Added subsection (c): The payer may negotiate reimbursement of travel expenses not addressed in the fee schedule (including transit time) to providers traveling to a rural area to serve an injured worker. Rural area is defined in subsection (2)(b)(i) above. This reimbursement shall be in addition to the maximum allowance for services addressed in the fee schedule.			
18-4(A)(3)(d) Currently 18-5(B)(3)(d)	Changed the definitions of several status codes: A Separately Payable E, G, I, N, R, or X Valid for CO WC T Paid When Only Payable Service, Otherwise Bundled		A Active Code E, G, I, N, R, or X Valid for CO WC T Injections	
18-4(B)(1) Currently 18-5(C)(1)	Deleted: 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 and the specifics of the discussion as it relates to the individual patient. 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. For adjusted RVUs and rates, see Exhibit #9.			

18-4(B)(6) Currently 18-5(C)(6)	Added: Subsequent Hospital modified RVUs are: CPT® 99231 = 2.21 RVUs CPT® 99232 = 3.15 RVUs CPT® 99233 = 4.22 RVUs Consultation modified RVUs are: CPT® 99241, non-facility RVU is 2.57, facility RVU is 2.15 CPT® 99242, non-facility RVU is 3.77, facility RVU is 3.18 CPT® 99243, non-facility RVU is 4.71, facility RVU is 3.96 CPT® 99244, non-facility RVU is 6.39, facility RVU is 5.57 CPT® 99245, non-facility RVU is 8.15, facility RVU is 7.23 CPT® 99251 = 2.79 RVUs CPT® 99252 = 3.83 RVUs CPT® 99253 = 4.95 RVUs CPT® 99254 = 6.39 RVUs CPT® 99255 = 8.47 RVUs	
18-4(C) Currently 18-5(D)	No substantive changes, but added subsection (5): Qualifying circumstance codes are reimbursed using the anesthesia CF: (a) Anesthesia complicated by extreme age (under 1 or over 70 years) 1 RVU (b) Anesthesia complicated by utilization of total body hypothermia 5 RVUs (c) Anesthesia complicated by utilization of controlled hypotension 5 RVUs (d) Anesthesia complicated by emergency conditions (specify) 2 RVUs	
18-4(D)(3)(f) Currently 18-5(E)(3)(f)	Added: Providers shall report only one removal code for removal of implants through the same incision, same anatomical site, or a single implant system during the same episode of care.	

18-4(D)(5)(d) Currently 18-5(E)(5)(d)	Extensive debridement (debridement that takes place in more than one location or region) is separately payable if documented in the medical record.	Extensive debridement is separately payable if documented in the medical record.
18-4(D)(8) Currently 18-5(E)(8)	The provider performing PRP injections in an office setting shall bill DoWC Z0813, maximum total allowance of $758.88, for professional fees. The provider performing PRP injections in a facility setting shall bill CPT® 0232T, maximum total allowance of $274.50, for professional fees. The above allowances include and apply to all body parts, imaging guidance, harvesting, preparation, the injection itself, kits, and supplies.	The Medical Treatment Guidelines (Rule 17) govern PRP injections. Any PRP injections outside of the Medical Treatment Guidelines require prior authorization. The provider performing PRP injections in an office setting shall bill DoWC Z0813 for professional fees. The provider performing PRP injections in a facility setting shall bill CPT® 0232T, for professional fees. For adjusted RVUs and rates, see Exhibit #9. The above allowances include and apply to all body parts, imaging guidance, harvesting, preparation, the injection itself, kits, and supplies.
18-4(E)(2) Currently 18-5(F)(2)	Amended subsection (2)(a): The Division recognizes the value of accreditation for quality and safe radiological imaging. Only offices/facilities that have attained accreditation from American College of Radiology (ACR), Intersocietal Accreditation Commission (IAC), RadSite, or The Joint Commission (TJC) may bill the technical component for Advanced Diagnostic Imaging (ADI) procedures (magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine scan). Providers reporting technical or total component of these services certify accreditation status. The provider shall supply proof of accreditation upon payer request. Deleted subsection (2)(b)	Subsection (2)(a): The Division recognizes the value of accreditation for quality and safe radiological imaging. Only offices/facilities that have attained accreditation from American College of Radiology (ACR), Intersocietal Accreditation Commission (IAC), RadSite, or The Joint Commission (TJC) may bill the technical component for Advanced Diagnostic Imaging (ADI) procedures (magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine scan). Providers separately reporting Z9999 certify accreditation status. The payer may also request proof of accreditation. Subsection (2)(b)

		The professional component for MRIs, CTs, and nuclear medicine scans is reimbursable at 130% of the fee schedule.
18-4(E)(3) Currently 18-5(F)(3)	Amended subsection (3)(b) as follows: Thermography Billing Codes: DoWC Z0200 Upper body w/ Autonomic Stress Testing $980.00 DoWC Z0201 Lower body w/Autonomic Stress Testing $980.00 Deleted unnecessary language from subsection (3)(c).	Subsection (3)(b): Thermography Billing Codes: DoWC Z0200 Upper body w/ Autonomic Stress Testing DoWC Z0201 Lower body w/Autonomic Stress Testing Prior authorization (see Rule 16-6) is required for thermography services only if the requested study does not meet the indicators for thermography as outlined in the Division's Chronic Regional Pain Syndrome Medical Treatment Guideline (Rule 17, Exhibit #7).
18-4(F)(4)(c) Currently 18-5(G)(4)(c)	All drug class immunoassays or enzymatic methods are considered presumptive. Payers shall only pay for one presumptive test per date of service, regardless of the number of drug classes tested. Deleted the table of definitive drug classed from subsection (4)(d).	All drug class immunoassays or enzymatic methods are considered presumptive. Providers may only bill one presumptive code per date of service, regardless of the number of drug classes tested.
18-4(G) Currently 18-5(H)	Deleted current sections (2) and (14)	Section (2): Anesthesia qualifying circumstance values are reimbursed in accordance with section 18-5(D)(5). Section (14): Special Services, Procedures and Reports in the Medicine Section of CPT® (for adjusted RVUs and rates, see Exhibit #9): (a) Handling and conveyance of specimens in connection with a transfer from an office to a laboratory is a flat rate.

		Any other handling and conveyance in connection with implementation of an order involving devices (such as orthotics) is a flat rate. (b) Post-operative follow-up visit is included in the global package and is not separately payable. (c) Educational supplies are considered "at cost" to the provider and may be billed based upon an agreement between the payer and provider. (d) Any stored clinical or physiological data analysis is not recognized unless the provider shows the reasonableness and necessity of these services and obtains prior authorization from the payer. (e) The charges for services performed after regular business hours, during holidays, or during scheduled disruptions of regular office services are not payable unless the provider shows the reasonableness and necessity of these services and obtains prior authorization. (f) Unusual travel expenses require prior authorization by the payer. The payer and billing provider shall agree upon maximum fees.
18-4(G)(2) Currently 18-5(H)(3)	Added the following and deleted reference to Exhibit 9: The modified RVUs for biofeedback services are: CPT® 90901, non-facility RVU is 2.14, facility RVU is 1.14 CPT® 90911, non-facility RVU is 4.76, facility RVU is 2.48	For adjusted RVUs and rates, see Exhibit #9.
18-4(G)(4) Currently 18-5(H)(5)	(a) Prior authorization shall be obtained before billing for more than four body regions in one (1) visit. The provider's medical records shall reflect medical necessity and prior authorization if treatment exceeds these limitations.	(a) Prior authorization (see Rule 16-6) shall be obtained before billing for more than four body regions in one (1) visit. Manipulative therapy is limited to the maximum allowed in the Medical Treatment Guidelines. The provider's medical records shall reflect medical

	(b) Osteopathic Manipulative Treatment and Chiropractic Manipulative Treatment codes include manual therapy techniques, unless provider performs manual therapy in a separate region and meets modifier 59 requirements. (c) An office visit may be billed on the same day as manipulation codes when the documentation meets the E&M requirements and an appropriate modifier is used. (d) The modified RVUs for chiropractic spinal manipulative treatment are: CPT® 98940 Non-facility RVU is 1.0, facility RVU is 0.79 CPT® 98941 Non-facility RVU is 1.44, facility RVU is 1.22	necessity and prior authorization if treatment exceeds these limitations. (b) An office visit may be billed on the same day as manipulation codes when the documentation meets the E&M requirements and an appropriate modifier is used. (c) For adjusted RVUs and rates, see Exhibit #9.
18-4(G)(5) Currently 18-5(H)(6)	Psychiatric/Psychological Services: (a) A licensed psychologist (PsyD, PhD, EdD) is reimbursed a maximum of 100% of the Medical Fee Schedule. Other non-physician providers performing psychological/psychiatric services shall be paid at 85% of the fee allowed for physicians. (b) Psychological diagnostic evaluation code(s) are limited to one per provider, per admitted claim, unless it is authorized by the payer or is necessary to complete an impairment rating recommendation as determined by the ATP. (c) Central Nervous System (CNS) Assessments/Tests~~,~~ (neuro-cognitive, mental status, speech) requiring more than six (6) hours require prior authorization.	Psychiatric/Psychological Services (for adjusted RVUs and rates, see Exhibit #9): (a) A licensed psychologist (PsyD, PhD, EdD) is reimbursed a maximum of 100% of the Medical Fee Schedule. Other non-physician providers performing psychological/ psychiatric services shall be paid at 85% of the fee allowed for physicians. (b) Prior authorization is required if the limitations discussed in this section are exceeded in a single day. Psychiatric diagnostic evaluation code(s) are limited to one per provider, per admitted claim, unless prior authorization is received from the payer.

	When testing, evaluation, administration, and scoring services are provided across multiple dates of service, all codes should be billed together on the last date of service when the evaluation process is completed. A base code shall be billed only for the first unit of service of the evaluation process, and add-on codes shall be used to capture services provided during subsequent dates of service. Documentation shall include the total time and the approximate time spent on each of the following activities, when performed: • face to face time with the patient • reviewing and interpreting standardized test results and clinical data • integrating patient data • clinical decision-making and treatment planning • report preparation If there is a delay in scheduling the feedback session, the provider may incorporate feedback into the first psychotherapy session. The modified RVUs for psychological and neuropsychological services are: CPT® 96116 = non-facility RVU is 3.4, facility RVU is 2.98 CPT® 96127 = non-facility and facility RVUs are 0.18 CPT® 96130 = non-facility RVU is 3.63, facility RVU is 3.4 CPT® 96131 = non-facility RVU is 2.92, facility RVU is 2.73 CPT® 96132 = non-facility RVU is 4.11, facility RVU is 3.2 CPT® 96133 = non-facility RVU is 3.11, facility RVU is 2.44 CPT® 96146 = non-facility and facility RVUs are 0.10	(c)	Central Nervous System (CNS) Assessments/Tests (neuro-cognitive, mental status, speech) requiring more than six (6) hours require prior authorization. Brief psychological screens (including, but not limited to, the Distress Risk and Assessment Method (DRAM), Primary Care Evaluation of Mental Disorders (PRIME-MD), Zung Self-Rating Depression Scale, Beck Depression Inventory, and CES-D (Center for Epidemiologic Studies Depression Scale) are not equivalent to psychological testing codes listed in the CNS section of CPT®. Most initial evaluations for delayed recovery, exclusive of testing, can be completed in two (2) hours. (d) The limit for psychotherapy services is 60 minutes per visit. Prior authorization is required any time the 60 minutes per visit limitation is exceeded. The time for internal record review/documentation is included in this limit. 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 unless specifically addressed in the Medical Treatment Guidelines. (e) When billing an evaluation and management (E&M) code in addition to psychotherapy:

		CPT® 90791 = non-facility RVU is 9.91, facility RVU is 9.6 CPT® 90792 = non-facility RVU is 11.12, facility RVU is 10.8 CPT® 96150 = non-facility RVU is 0.80, facility RVU is 0.79 CPT® 96151 = non-facility RVU is 0.78, facility RVU is 0.77 CPT® 96152 = non-facility RVU is 0.74, facility RVU is 0.73 CPT® 96153 = non-facility RVU is 0.18, facility RVU is 0.17 CPT® 96154 = non-facility RVU is 0.74, facility RVU is 0.73 CPT® 96155 = non-facility and facility RVUs are 0.73 (d) The limit for psychotherapy services is 60 minutes per visit, unless provider obtains prior authorization. The time for internal record review/ documentation is included in this limit. Psychotherapy for work-related conditions continuing for more than three (3) months after the initiation of therapy, requires prior authorization unless the Medical Treatment Guidelines recommend a longer duration. (e) When billing an evaluation and management (E&M) code in addition to psychotherapy: (i) both services must be separately identifiable; (ii) the level of E&M is based on history, exam and medical decision-making; (iii) time may not be used as the basis for the E&M code selection; and (iv) add-on psychotherapy codes are to be used by psychiatrists to indicate both services were provided. Non-medical disciplines cannot bill most E&M codes. (f) Any stored clinical or physiological data analysis is not recognized unless the provider shows the	(i) both services must be separately identifiable; (ii) the level of E&M is based on history, exam and medical decision- making; (iii) time may not be used as the basis for the E&M code selection; and (iv) add-on psychotherapy codes are to be used by psychiatrists to indicate both services were provided. Non-medical disciplines cannot bill most E&M codes. (f) Upon request of a party to a workers' compensation claim and pursuant to HIPAA regulations, a psychiatrist, psychologist or other qualified health care professional may generate a separate report and bill for that service.

	reasonableness and necessity of these services and obtains prior authorization from the payer. (g) Upon request of a party to a workers' compensation claim and pursuant to HIPAA regulations, a psychiatrist, psychologist or other qualified health care professional may generate a separate report and bill for that service as a special report.	
18-4(G)(8)(c)	Added: The fee schedule value for CPT® 95941 is equal to the fee schedule value for CPT® 95940.	
18-4(H)(1) Currently portions of 18-5(I)(1), (3), (4), and (13)	General Policies: (a) Physical therapy or any care provided under a physical therapist's plan of care shall be billed with a GP modifier appended to all codes. Occupational therapy or any care provided under an occupational therapist's plan of care shall be billed with a GO modifier appended to all codes. (b) Each PM&R billed service must be clearly identifiable. The provider must clearly document the time spent performing each service and the beginning and end time for each session. (c) Functional objectives shall be included in the PM&R plan of care for all injured workers. Any request for additional treatment must be supported by evidence of positive objective functional gains or PM&R treatment plan changes. The ordering ATP must also agree with the PM&R continuation or changes to the treatment plan. (d) The injured worker shall be re-evaluated by the prescribing provider within 30 calendar days from the	

	initiation of the prescribed treatment and at least once every month thereafter. (e) Unlisted services require a report.	
18-4(H)(3) and (4) Currently 18-5(I)(5) and (6)	Deletion of unnecessary language and inserted RVUs as follows: DoWC Z0501, initial 15 minutes, non-facility RVU is 1.3, facility RVU is 0.77 DoWC Z0502, each additional 15 minutes, non-facility RVU is 0.77, facility RVU is 0.72 The modified RVU for an unlisted procedure, CPT® 97139, is 0.92, non-facility and facility.	Demonstrated participation in an interdisciplinary rehabilitation program allows the use of the frequencies and durations listed in the relevant Medical Treatment Guideline's recommendations. The provider's medical records shall reflect the medical necessity and the provider shall obtain prior authorization if the procedures are not recommended or the frequency and duration exceeds the recommendations of the Medical Treatment Guidelines.
18-4(H)(5) Currently 18-5(I)(7)	There is a total limit of two (2) modalities (whether timed or non-timed) per visit, per discipline, per day. NOTE: Instruction and application of a transcutaneous electric nerve stimulation (TENS) unit for the patient's independent use at home shall be billed only once per workers' compensation claim using CPT® 64550. For Maximum Fee Schedule value, see section 18-6(A). The modified RVUs for an unlisted modality, CPT® 97039, are 0.36 non-facility, 0.00 facility.	There is a total limit of two (2) modalities (whether timed or non-timed) per visit, per discipline, per day. NOTE: Instruction and application of a transcutaneous electric nerve stimulation (TENS) unit for the patient's independent use at home shall be billed only once per workers' compensation claim using CPT® 64550. Rental or purchase of a TENS unit requires prior authorization. For Maximum Fee Schedule value, see section 18-6(H). The maximum value for unlisted modalities is equal to the value of an ultrasound.
18-4(H)(6) Currently 18-5(I)(8)	Added new subsection (f): The RVU for evaluation services performed by ATs shall be equal to the RVU for evaluation services performed by PTs.	
18-4(H)(7) Currently 18-5(I)(9)	Added:	

	The facility and non-facility RVU for DoWC Z0503 and Z0504 is 0.93.	
18-4(H)(10) Currently 18-5(I)(12)	Gyms, pools, etc., and training or supervision by non-medical providers require prior authorization and a written negotiated fee for every three month period.	Gyms, pools, etc., and training or supervision by non-medical providers require prior authorization and a written negotiated fee.
18-4(H)(11) Currently 18-5(I)(14)	Deleted unnecessary language and added new subsection (e): Modified facility and non-facility RVUs are 3.4 for initial 2 hours and 1.7 for each additional hour.	If the frequency and duration is expected to exceed the Medical Treatment Guidelines' recommendation, prior authorization is required.
18-4(H)(13) Currently 18-6(P)	No substantive changes.	
18-4(I) Currently 18-5(J)	Deleted references to the term "telehealth." Added the following new language to subsections (1) and (4)(c): Additional services [to those listed in Appendix P, G0459, G0508, and G0509] may be provided via telemedicine with prior authorization. The medical records shall document the physical locations of the rendering provider and the injured worker.	
18-5(A) Currently 18-6(I)	Deleted the prior authorization requirement for all non-emergency, inpatient admissions. Amended subsection (2)(c), currently subsection (3)(c): MLTCHs are reimbursed $3,350 per day, not to exceed 75% of total billed charges. If total billed charges exceed $300,000, reimbursement shall be 75% of billed charges. All charges shall be submitted on a final bill, unless the parties agree on interim billing. The rate in effect on the last date of service covered by an interim or a final bill shall determine payment.	All non-emergency, inpatient admissions require prior authorization (see Rule 16-6). MLTCHs are reimbursed at $3,350 per day, not to exceed 75% of billed charges. If total billed charges exceed $300,000, reimbursement shall be at 75% of billed charges. All charges shall be submitted on a final bill, unless the parties agree on interim billing.

	The total length of stay includes the date of admission but not the date of discharge. Typically, bed hold days or temporary leaves are not subtracted from the total length of stay. Updated the "difference" in subsection (2)(e), currently subsection (3)(e) to $26,994.00.	The difference is currently $27,545.00.
18-5(B) Currently 18-6(J) and (K)	New section 1 (currently 18-6(K), no substantive changes). Amend the language in sections 3(c) and (d) regarding outpatient facility reimbursement as follows: To identify which APC grouper is aligned with an Exhibit #4 APC code number and dollar value, use Medicare's 2019-Addendum B. The following CPT® codes listed with a "C" status indicator in Medicare's Addendum B, shall align to the following APC codes for payment: CPT® 22558 = APC 5116 CPT® 22600, 22610, 22630, 22633, and 22857 = APC 5115 CPT® 22632 = APC 5092 CPT® 22634, 22800, and 22830= APC 5114 CPT® 22846 = APC 5192 CPT® 22849, 22850, 22852, and 22855 = APC 1571 CPT® 23472, 23474, 27130, 27132, 27134, 27137, 27138, 27447, and 27702 = APC 1575 Corresponding change to section (5).	To identify which APC grouper is aligned with an Exhibit #4 APC code number and dollar value, use Medicare's 2018 Addendum B. Spinal fusion CPT® codes listed with a "C" status indicator in Medicare's Addendum B, shall have an equivalent value no greater than APC 5115.
18-5(B)(6)(a) Currently	Total maximum facility value for an outpatient hospital episode of care:	Total maximum facility value for an outpatient hospital episode of care:

18-6(J)(6)(a)	(a) Facility fee reimbursement is limited to a maximum of four (4) procedure codes per episode. The highest valued APC code is reimbursed at 100% of the allowed Exhibit #4 value for the type of facility, plus 50% of the following three highest valued codes. (i) The use of modifier 51 is not a factor in determining which codes are subject to multiple procedure reductions. (ii) Bilateral procedures require each procedure to be billed on separate lines using RT and LT modifiers. (iii) Immune globulins, vaccines, and toxoids, CPT® 90281-90399 and 90476-90756 are exempt from the multiple procedure reduction and shall be paid in addition to the four procedure codes at 100% of the fee schedule. (iv) When a code is billed with multiple units, multiple procedure reductions apply to the second through fourth units as appropriate. Units may also be subject to other maximum frequency per day policies.	a. The highest-valued CPT® code aligned to APC code per Exhibit #4 plus 50% of any lesser-valued CPT® code aligned APC code values. Facility fee reimbursement is limited to a maximum of four (4) CPT® procedure codes per episode, with a maximum of only one (1) procedure reimbursed at 100% of the allowed Exhibit #4 value for the type of facility: i. Hospitals are reimbursed based upon Column 3. ii. ASCs are reimbursed based upon Column 4.
18-5(B)(6)(b) Currently 18-6(J)(6)(f)	No substantive changes	
18-5(B)(6)(e) Currently 18-6(J)(6)(d)	Revised section (6)(e), currently section (6)(d): Trauma activation means a trauma team has been activated, not just alerted. Trauma activation is billed with 068X revenue codes. The level of trauma activation shall be determined by CDPHE's assigned hospital trauma level designation. Trauma activation fees are in addition to ED and inpatient fees and are not paid for alerts. APC 5045, Trauma Response with Critical Care, is not recognized for separate payment.	APC 5045, Trauma Response with Critical Care, is not recognized for separate payment. Trauma Center fees are not paid for alerts. Trauma activation revenue codes are 681, 682, 683, or 684. These fees are in addition to ED and inpatient fees. Activation fees mean a trauma team has been activated, not just alerted. The level of trauma activation shall be determined by CDPHE's assigned hospital trauma level designation.

	Trauma activation fees are as follows: Revenue Code 681 $3,303.00 Revenue Code 682 $1,433.00 Revenue Code 683 $1,408.00 Revenue Code 684 $954.00	
18-5(B)(6)(h) Currently 18-6(J)(6)(h)	Charges for observation status lasting longer than six (6) hours may be subject to retroactive review.	Observation room Maximum Fee Schedule value is limited to six (6) hours without prior authorization.
18-5(C)(1) Currently 18-6(L)(1)	Added the Joint Commission as an accrediting body.	
18-5(C)(2) Currently 18-6(L)(2)	Deleted the prior authorization and certification language from subsection (a) and inserted the fee for HCPCS code S9088. Amended subsection (2)(c) as follows: Bill G0378, $45.90 per hour, round to the nearest hour, for observation room services.	Prior authorization is recommended for all facilities billing a separate Urgent Care fee. Facilities must provide documentation of the required Urgent Care facility certification if requested by the payer. Subsection (2)(c): The Observation Room allowance is limited to a maximum of three (3) hours without prior authorization (see Rule 16-6). Bill G0378 per hour. For adjusted RVUs and rates, see Exhibit #9.
18-6(A) Currently 18-6(H)	Reorganized the section. No substantive changes intended except specifying HCPCS code A9300 for take home exercise equipment.	
18-6(B) Currently 18-6(M)	Inserted fees for various services and deleted conflicting prior authorization language.	
18-6(C) Currently 18-6(N)	Amend the language regarding opioids:	Opioids classified as Schedule II or Schedule III controlled substances that are prescribed for treatment lasting longer than 7 days shall be provided through a pharmacy.

	Opioids/scheduled controlled substances that are prescribed for treatment lasting longer than 3 days shall be provided through a pharmacy. The prescriber shall comply with applicable provisions of §§ 12-32-107.5, 12-35-114, 12-36-117.6, 12-38-111.6, 12-40-109.5, 12-42.5-404, and other statutes and rules. Added: Billing providers shall include the units and days supply for all dispensed medications in field 19 example: '60UN/30DY.' Inserted the prices of topical compounds.	
18-6(D) Currently 18-6(O)	COMPLEMENTARY INTEGRATIVE MEDICINE Complementary integrative medicine describes 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. Non-physician providers of complementary integrative medicine that are not listed in Rule 16 must have completed training in one (1) or more forms of therapy and certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in Chinese herbology.	COMPLEMENTARY ALTERNATIVE INTEGRATIVE MEDICINE Alternative integrative medicine describes 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. Non-physician providers of alternative integrative medicine may be both licensed and non-licensed health practitioners with training in one (1) or more forms of therapy and certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in acupuncture and/or Chinese herbology. Alternative integrative medicine services not priced in the fee schedule or not recommended in the Medical Treatment Guidelines require prior authorization.
18-6(E) Currently 18-6(R)	Inserted rates for ground ambulance transportation into section 3.	
18-7(A)-(C) Currently 18-6(A)-(C)	Inserted the rates into the body of the rules.	

18-7(D)(3) and (4) Currently 18-6(D)(3) and (4)	(3)	Deposition: Payment for testimony at a depositon shall not exceed $187.00, billed in half-hour increments, for a treating or non-treating physician as defined by Rule 16 or a psychologist (PsyD, PhD, or EdD). Bill DoWC Z0734. Calculation of the provider's time shall be "portal to portal." Other providers shall be paid 85% of this fee. If requested, the provider is entitled to a full hour deposit in advance in order to schedule the deposition. If the provider is notified of the cancellation of the deposition at least ten (10) days prior to the scheduled deposition, the provider shall be paid the number of hours s/he has reasonably spent in preparation, less any deposit paid by the deposing party. Bill DoWC Z0731, $187.00, in half-hour increments. If the provider is notified less than ten (10) days in advance of a cancellation or rescheduling, or the deposition is shorter than the time scheduled, the provider shall be paid the number of hours s/he has reasonably spent in preparation and has scheduled for the deposition. Bill DoWC Z0733, $187.00, in half-hour increments.	(3)	Deposition: Payment for a treating or non-treating provider's testimony at a deposition shall not exceed the hourly rate for DoWC Z0730 for physicians or psychologists, billed in half-hour increments. Calculation of the provider's time shall be "portal to portal." Other providers shall be paid 85% of this fee. If requested, the provider is entitled to a full hour deposit in advance in order to schedule the deposition. If the provider is notified of the cancellation of the deposition at least seven (7) business days prior to the scheduled deposition, the provider shall be paid the number of hours s/he has reasonably spent in preparation and shall refund to the deposing party any portion of an advance payment in excess of time actually spent preparing and/or testifying. Bill DoWC Z0731. If the provider is notified of the cancellation of the deposition at least five (5) business days but less than seven (7) business days prior to the scheduled deposition, the provider shall be paid the number of hours s/he has reasonably spent in preparation and one-half the time scheduled for the deposition. Bill DoWC Z0732. If the provider is notified less than five (5) business days in advance of a cancellation, or the deposition is shorter than the time scheduled, the provider
	(4)	Testimony: Treating or non-treating physician as defined by Rule 16 or psychologist (PsyD, PhD, or EdD):		

	DoWC Z0738, $259.00, billed in half-hour increments. Other providers shall be paid 85% of this fee. Calculation of the provider's time shall be "portal to portal" (includes travel time and mileage in both directions). For testifying at a hearing, if requested, the provider is entitled to a four (4) hour deposit in advance in order to schedule the testimony. If the provider is of the cancellation of the testimony at least ten (10) days prior to the scheduled testimony, the provider shall be paid the number of hours s/he has reasonably spent in preparation, less any deposit paid by the requesting party. DoWC Z0735, $259.00, in half-hour increments. If the provider is notified less than ten (10) days in advance of a cancellation or rescheduling, or the testimony is shorter than the time scheduled, the provider shall be paid the number of hours s/he has reasonably spent in preparation and has scheduled for the testimony. DoWC Z0737, $259.00, in half-hour increments.		shall be paid the number of hours s/he has reasonably spent in preparation and has scheduled for the deposition. Bill DoWC Z0733. Treating or non-treating physician as defined by Rule 16-3(A)(1)(a) or psychologist (PsyD, PhD, or EdD): DoWC Z0734, billed in half-hour increments. Other providers shall be paid 85% of this fee. (5) Testimony: Calculation of the provider's time shall be "portal to portal" (includes travel time and mileage in both directions). For testifying at a hearing, if requested, the provider is entitled to a four (4) hour deposit in advance in order to schedule the testimony. If the provider is of the cancellation of the testimony at least seven (7) business days prior to the scheduled testimony, the provider shall be paid the number of hours s/he has reasonably spent in preparation and shall refund any portion of an advance payment in excess of time actually spent preparing and/or testifying. Bill DoWC Z0735. If the provider is notified of the cancellation of the testimony at least five (5) business days but less than seven (7) business days prior to the scheduled testimony, the provider shall be paid the number of hours s/he has reasonably spent in preparation and

		one-half the time scheduled for the testimony. Bill DoWC Z0736. If the provider is notified less than five (5) business days in advance of a cancellation or the testimony is shorter than the time scheduled, the provider shall be paid the number of hours s/he has reasonably spent in preparation and has scheduled for the testimony. Bill DoWC Z0737. Treating or non-treating physician as defined by Rule 16-3(A)(1)(a) or psychologist (PsyD, PhD, or EdD): DoWC Z0738, billed in half-hour increments. Other providers shall be paid 85% of this fee.
18-7(E) Currently 18-6(E)	The payer shall reimburse the injured worker for reasonable and necessary mileage expenses for travel to and from medical appointments. The injured worker shall submit a request to the payer showing the date(s) of travel and mileage, and explain any other reasonable and necessary travel expenses incurred or anticipated. The number of miles shall be in whole numbers and calculated using the most direct route available on the date of service. If a trip has a fraction of a mile, round up to the nearest whole number. Mileage Expense Billing Code: DoWC Z0723, 53 cents per mile Other Travel Expenses Billing Code: DoWC Z0724, actual paid	The payer shall pay an injured worker for reasonable and necessary expenses for travel to and from medical appointments and reasonable mileage to obtain prescribed medications. The rate for mileage shall be 53 cents per mile. The injured worker shall submit a request to the payer showing the date(s) of travel and mileage, and explain any other reasonable and necessary travel expenses incurred or anticipated. Mileage Expense Billing Code: DoWC Z0723 Other Travel Expenses Billing Code: DoWC Z0724
18-7(F) Currently 18-6(F)	Inserted the rates for impairment ratings into the body of the rule.	

18-7(G)(2) through (5) Currently 18-6(G)(2) through (4)	(2) Completion of the Physician's Report of Workers' Compensation Injury (a) Initial Report WC164 The authorized treating physician (ATP) (generally the designated physician) or emergency department/urgent care physician when applicable shall complete the first report of injury. Items 1-7 and 11 must be complete, however item 2 may be omitted if not known by the provider. If completed by a PA or NP, the ATP must countersign the form. DoWC Z0750 Initial Report $50.00 (b) Closing Report WC 164 The ATP managing the workers' compensation claim must complete the WC164 closing report when the injured worker is at maximum medical improvement (MMI) for all covered injuries or diseases, with or without a permanent impairment. Items 1-5, 6 B-C, and 7-11 must be complete. If completed by a PA or NP, the ATP must countersign the form. DoWC Z0752 Closing Report $50.00 If the injured worker has sustained a permanent impairment, the following additional information must be attached to the bill when MMI is determined: (i) All necessary permanent impairment rating reports, medical reports and narrative relied	(2) Completion of the Physician's Report of Workers' Compensation Injury (WC164) (a) Initial Report The authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient completes the initial WC164 and submits it to the payer and to the injured worker after the first visit with the injured worker. When applicable, the emergency department or urgent care authorized treating physician for this workers' compensation injury may also create a WC164 initial report. Unless requested or prior authorized by the payer in a specific workers' compensation claim, no other authorized physician should complete and bill for the initial WC164 form. This form shall include completion of items 1-7 and 11. Note that certain information in Item 2 (such as Insurer Claim #) may be omitted if not known by the provider. (b) Closing Report The WC164 closing report is required from the authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient when the injured worker is at maximum medical improvement for all injuries or diseases covered under this workers' compensation claim, with or without a permanent impairment. The form requires the completion of items 1-5, 6 B-C, and

	upon by the ATP, when the ATP managing the workers' compensation claim of the patient is Level II Accredited; or (ii) The name of the Level II Accredited Physician requested to perform the permanent impairment rating when a rating is necessary and the ATP managing the workers' compensation claim is not determining the permanent impairment rating. (c) Initial and Closing Report WC 164 completed on the same form for the same date of service: DoWC Z0753 $50.00 (d) Progress Report WC 164 Any request from the payer or the employer for the information provided on this form is deemed authorization for payment. The provider shall document who requested the WC164, complete items 1, 2, 4-7, and 11, and send it to all parties within three business days of the request. If completed by a PA or NP, the ATP must countersign the form. DoWC Z0751 Progress Report$50.00 (3) Form Completion The requesting party shall pay for its request for physician to complete additional forms requiring 15 minutes or less, including forms sent by a payer or an employer. This code also may be billed when completing	7- 11. If the injured worker has sustained a permanent impairment, the following additional information shall be attached to the bill at the time MMI is determined: (i) All necessary permanent impairment rating reports, medical reports and narrative relied upon by the authorized treating physician (ATP), when the ATP (generally the designated or selected physician) managing the total workers' compensation claim of the patient is Level II Accredited; or (ii) The name of the Level II Accredited Physician requested to perform the permanent impairment rating when a rating is necessary and the ATP (generally the designated or selected physician) managing the total workers' compensation claim of the patient is not determining the permanent impairment rating. (c) Payer Requested WC164 Report If the payer requests a provider complete the WC164 report, the payer shall pay the provider for the completion and submission of the completed WC164 report. (d) Provider Initiated WC164 Report If a provider wants to use the WC164 report as a progress report or for any purpose other than those designated in section 18-6(G)(2)(a), (b), or (c), and seeks reimbursement for completion

	the requirements outlined in § 8-43-404(10)(a) or Desk Aid 15 for a non-medical discharge. DoWC Z0754 Form Completion $50.00 (4) Special Reports The term special report includes any form, questionnaire, letter or report with variable content not otherwise addressed in Rules. Examples include: (a) treating or non-treating medical reviewers or evaluators producing written reports pertaining to injured workers not otherwise addressed, (b) meeting with and reviewing another provider's written record, and amending or signing that record. Billable Hours: 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. Advance Payment: If requested, the provider is entitled to a two (2) hour deposit in advance in order to schedule a patient exam associated with a special report. DoWC Z0755 Written Report, $93.50 billable in 15 minute increments DoWC Z0757 Lengthy Form, $93.50 billable in 15 minute increments DoWC Z0758 Meeting and Report with Non-treating Physician, $93.50 billable in 15 minute increments	of the form, the provider shall get prior approval from the payer. (e) Billing Codes and Maximum Allowance for completion and submission of the WC164 report: DoWC Z0750 Initial Report DoWC Z0751 Progress Report (Payer Requested or Provider Initiated) DoWC Z0752 Closing Report DoWC Z0753 Initial and Closing Reports are completed on the same form for the same date of service (3) Request for physicians to complete additional forms sent to them by a payer or employer shall be paid by the requesting party. A form requiring 15 minutes or less of a physician's time shall be billed using DoWC Z0754. Forms requiring more than 15 minutes shall be paid as a special report. (4) Special Reports The term "special reports" includes any form, questionnaire or letter with variable content not otherwise addressed in Rules. This includes, but is not limited to: (a) independent medical evaluations or reviews when the physician is requested to review files and examine the patient to provide an opinion for the requesting party, performed outside § 8-42-107.2 (the Division IME process) and (b) treating or nontreating medical reviewers or evaluators producing written reports pertaining to injured workers not otherwise

		In cases of cancellation for those special reports not requiring a scheduled patient exam, the provider shall be paid for the time s/he has reasonably spent in preparation up to the date of cancellation. DoWC Z0761 Report Preparation with Cancelled Patient Exam, $93.50 billable in 15 minute increments	addressed. Special reports also include payment for meeting, reviewing another's written record, and amending or signing that record. Billable Hours: 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.
	(5)	Independent Medical Examinations: RIME: Respondent-requested Independent Medical Examination DoWC Z0756 RIME Report with patient exam, $93.50 billable in 15 minute increments Section 8-43-404 requires RIMEs to be recorded in audio in their entirety and retained by the examining physician for 12 months and made available by request to any party to the case. DoWC Z0766 RIME Audio Recording, $35.00 per exam DoWC Z0767 RIME Audio Copying Fee, $24.00 per copy CIME: Claimant-requested Independent Medical Examination, $93.50 billable in 15 minute increments to the injured worker, DoWC Code Z0770 DIME: Division Independent Medical Examination - see Rule 11 All IME reports must be served concurrently to all parties no later than 20 calendar days after the examination. Cancellations:	Advance Payment: If requested, the provider is entitled to a two (2) hour deposit in advance in order to schedule a patient exam associated with a special report. Cancellation: Written Reports Only: In cases of cancellation for those special reports not requiring a scheduled patient exam, the provider shall be paid for the time s/he has reasonably spent in preparation up to the date of cancellation. Bill DoWC Z0761. IME/report with patient exam: In cases of special reports requiring a scheduled patient exam, if the provider is notified of a cancellation at least seven (7) business days prior to the scheduled patient exam, the provider shall be paid for the time s/he has reasonably spent in preparation and shall refund to the party requesting the special report any portion of an advance payment in excess of time actually spent preparing. Bill DoWC Z0762. In cases of special reports requiring a scheduled patient exam, if the provider is notified of a cancellation at least five (5) business days but less than seven (7) business days prior to the scheduled patient exam, the provider

	In cases of a cancelled or rescheduled RIME or CIME, the provider shall be paid the following fees: If the provider is notified of the cancellation of the RIME or CIME at least ten (10) business days prior to the scheduled examination, the provider shall be paid the number of hours s/he has reasonably spent in preparation, less any deposit paid by the requesting party. DoWC Z0762, $93.50 billable in 15 minute increments. If the provider is notified less than ten (10) business days in advance of a cancelled or rescheduled RIME or CIME, the provider shall be paid the number of hours s/he has reasonably spent in preparation and has scheduled for the examination. DoWC Z0763, $93.50 billable in 15 minute increments.	shall be paid for the time s/he has reasonably spent in preparation and one-half the time scheduled for the patient exam. Any portion of a deposit in excess of this amount shall be refunded. Bill DoWC Z0763. In cases of special reports requiring a scheduled patient exam, if the provider is notified of a cancellation less than five (5) business days prior to the scheduled patient exam, the provider shall be paid for the time s/he has reasonably spent in preparation and has scheduled for the patient exam. Bill DoWC Z0764. Billing Codes: Written Report Only DoWC Code: Z0755 Lengthy Form Completion DoWC Code: Z0757 Meeting and Report with Non-treating Physician DoWC Code: Z0758 RIME: Respondent requested Independent Medical Examination (RIME)/Report with patient exam DoWC Code: Z0756 Section 8-43-404 requires RIMEs to be recorded in audio in their entirety and retained by the examining physician for 12 months and made available by request to any party to the case. IME Audio Recording DoWC Code: Z0766 IME Audio Copying Fee DoWC Code: Z0767

		CIME: Claimant requested Independent Medical Examination (CIME)/Report with patient exam DoWC Code: Z0770 DIME: Division Independent Medical Examination (DIME)/Report with patient exam See Rule 11 All RIME, CIME and DIME reports must be served concurrently to all parties no later than 20 calendar days after the examination.
18-7(H) Currently 18-6(Q)	Payers shall reimburse for the services of a qualified interpreter in specified settings if the injured worker does not proficiently speak or understand the English language. A qualified interpreter must be provided via video or audio remote interpreting service or on-site appearance at complex medical treatment appointments, at behavioral health appointments and when otherwise requested by the provider or injured worker. Providers may, but are not required to use bi-lingual staff to provide third party interpretation when a qualified interpreter is not available. Qualified interpreter is defined as: ● a Certified Medical Interpreter, if this certification is available for the injured worker's language; or ● for all other languages, is fluent in English and the necessary target language, has knowledge of basic medical and/or legal terminology, and knowledge of health care interpreting ethics and standards of practice. Providers are prohibited from relying on minor children and should refrain from using adult family members, and friends as interpreters. The exceptions are unavailability of a qualified	Rates and terms shall be negotiated. Prior authorization (see Rule 16-6) is required except for emergency treatment. Bill DoWC Z0722.

	interpreter in the case of "other" languages and in an emergency involving an imminent threat to the safety or welfare of an individual or the public. Rates and terms shall be negotiated. Prior authorization is required except for emergency treatment. Non-qualified interpreters are not eligible for reimbursement. Bill DoWC Z0722.	
18-8 Currently 18-7	No substantive changes.	
18-9 Currently 18-8	Clarified that the opioid management report fees are payable to the prescribing ATP and inserted the fees into the body of the rule. Modified the language that acute opioid prescriptions generally should be limited to three (3) to seven (7) days and 50 morphine milliequivalents (MMEs) per day.	Acute opioid prescriptions generally should be limited to seven (7) days and 50 morphine milliequivalents (MMEs) per day.
18-10 Currently 18-9	Clarified that the indigence standards are for purposes of Rule 11-12 and updated these standards.	