AAHAM, HFMA, & CMCC
“ALL PAYOR DAY”
CO WORKERS’ COMPENSATION UPDATES
EFFECTIVE: JANUARY 1, 2015

DEBRA J NORTHRUP, RN,CPC,CPMA
DIVISION OF WORKERS' COMPENSATION
CHILDREN'S HOSPITAL COLORADO
ANSCHEUTZ MEDICAL CAMPUS
AURORA, COLORADO
DECEMBER 1, 2014
OBJECTIVES

- Review Handouts
- Review New Web site and Locate where:
  - Employer WC Insurance information
  - Proposed and Adopted Rules
  - Medical/facility fees and interpretative bulletin
  - Medical Bill Dispute Resolution forms and information
- DWC’s Medical Bill Dispute Resolution Program Update
- Identify Significant Changes to Rule 16
- Identify Significant Changes to Rule 18
Insurance Coverage

Employer Requirements

Employers are required to obtain and maintain workers’ compensation insurance for one or more employees (with few exceptions).

Verification of Coverage

Verify if you or another employer has insurance coverage in Colorado.

Self Insurance Permit Listing

Coverage Rejection

Use this real-time database to search for evidence of rejection of Workers’ Compensation coverage by sole proprietors, and/or partners performing construction work as well as corporate officers, members of an LLC who are also at least 10% owners of the business and participate in the daily operations and/or management of the business.

Contact Us

Division of Workers’ Compensation | 303-318-8700 |
Workers' Compensation Proposed and Adopted Rules

Notices of Rule Hearings

- Rule 17: Exhibit 3 - Thoracic Outlet Syndrome and Exhibit 4 Shoulder Injury Medical Treatment Guidelines

Proposed Rules

- Rule 17 Exhibit 3 Thoracic Outlet Syndrome Medical Treatment Guidelines
  - Summary Table of Changes - Thoracic Outlet Syndrome
- Rule 17 Exhibit 4 Shoulder Injury Medical Treatment Guidelines
  - Summary Table of Changes - Shoulder Injury

Adopted Rules Effective July 1, 2014 - June 30, 2015

- Rule 5: Claims Adjusting Requirements (Effective January 1, 2015)
- Rule 16: Utilization Standards (Effective January 1, 2015)
- Rule 18: Medical Fee Schedule (Effective January 1, 2015)
- Rule 2-5: Surcharge Rate (Effective July 1, 2014)
- Rule 5-10: Lump Sum Payment of an Award (Effective July 1, 2014)

Contact Us

Division of Workers' Compensation
633 17th Street, Suite 400
Denver, CO 80202
Fee Schedule (Rule 18)

What is the Fee Schedule?

Section 8-42-101(3) of the Colorado Revised Statutes requires the Director of the Division of Workers' Compensation to annually review the medical fee schedule, which is promulgated in Rule 18. This Rule sets the maximum fees for medical services provided to injured workers covered by the Workers' Compensation Act.

Rule 18

Interpretive Bulletins

Exhibits

<table>
<thead>
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<th>Exhibit</th>
<th>Format</th>
</tr>
</thead>
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<tr>
<td>Exhibit 1 - DRGs with Relative Weights, Geometric, and Arithmetic Means</td>
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<td>Exhibit 2 - Base Rates and Cost-to-Charge Ratios</td>
<td>Word</td>
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<td>Exhibit 3 - Critical Access Hospitals</td>
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<td>Exhibit 4 - Outpatient Surgery Facility Codes and Fees</td>
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<td>Exhibit 6 - Dental Fee Schedule</td>
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<td>Exhibit 7 - Evaluation and Management (E&amp;M) Guidelines for Colorado Workers' Compensation Claims</td>
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</tr>
</tbody>
</table>

Contact Us

Sheila Jackson, CPC, CBCS
Workers' Compensation Specialist
303-318-8667
The link to the APC offset file for implants and biologicals, last checked October 15, 2014, is:

2015 OPPS APC Offset File

Rule 18-6(K) Freestanding (Not Affiliated with a Hospital) Outpatient Diagnostic Testing or Treatment Facilities

The types of facilities and their fees include:

- **ASC** — 5th column of Exhibit #4 (plus cost of implants only, + observation fees + pre-operative testing) in and applied per hospital Rules under Rule 18-6(J).
- **Physician’s Offices** — 100% of appropriately modified RVP x the applicable conversion factor.
- **Freestanding Radiology Imaging and Cardiovascular Testing and procedure Centers (includes arteriograms and arthrography)** — 90% of RVP x applicable conversion factors — maximum of 4 CPT codes the highest allowed at 100% of maximum fees and 50% the subsequent 3 additional codes.
- **Urgent Care** — non hospital $75.00 facility fee if criteria is met in this Rule 18-6(K).
- The maximum fees for all clinical laboratory testing shall be reimbursed according to the fees as outlined under the Pathology section in 18-5(F).

Dyes, contrast and supplies are included and not separately payable for Freestanding Urgent Care, Radiology or Cardiovascular facilities.

All observation services must be prior approved by the payer if time is greater than 3 hours at an Urgent Care Facility or 6 hours if at an ASC -- G0378 at $45.00/hour

Rule 18-6(M)(8)(b)

Pharmacy fees for pharmaceuticals that have no NDC code are appropriately billed as a supply using the RVP© supply code 99070 and the documented invoice.

Rule 18-6(O)

Acupuncture service codes are the physical medicine codes 97810-97814.

Division Established Zxxxx Codes and Values

Click here for a link to Excel® spreadsheet of Division established codes and values (Z codes)

Click here for link the 2015 APC crosswalk of Rule 18, Exhibit 4

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Treatment Guidelines.

**Rule 16 - Utilization Standards**

When parties have followed the contesting payment process as outlined in Rule 16-11(A)-(D) and a payment dispute still exists, or a party is unable to contest a payment because the other party has not satisfied the 30-day notice requirements, the parties should follow dispute resolution. Either party may initiate a dispute by completing and submitting a Medical Billing Dispute Resolution Intake Form to the Division's Medical Policy Unit (MPU).

- **Medical Billing Dispute Resolution Intake Form (PDF) | (Word)**

The Intake Form provides guidance on the information the MPU will require in order to properly review your request. We ask that all applicable information be provided at the time of submission, including all relevant supporting documentation as outlined at the bottom of the form.

The Intake Form and all supporting documentation can be submitted to the MPU by fax at 303-318-8758, encrypted email to the Medical Policy Unit, or mail to:

Division of Workers' Compensation  
Medical Policy Unit  
633 17th Street, Suite 400  
Denver, CO 80202-3626

Once a completed request has been received, you will receive a Confirmation of Receipt and your case will be assigned to an MPU staff member. The dispute will be reviewed to determine compliance with Rules 16 and 18. Communication between parties will ensue as needed until a determination is reached. Disputes resulting from violation of Rules 16 and/or 18 may result in a Director's Order that cites the specific violation and failure to respond or cure said violations may result in penalties. Resolution of disputes not pertaining to Rule violations will be facilitated by the MPU to the extent possible. Typical review time is within 30 days and parties will be notified in writing once the case is closed.

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**Contact Us**

Colleena Blakeman-Groves  
303-318-8765 (Phone)  
303-318-8758 (Fax)  
colleena.blakeman@state.co.us
MEDICAL BILL DISPUTE RESOLUTION

WHAT WE’VE LEARNED FROM PROVIDERS?
WHAT CAN EVERYONE DO BETTER
DWC MEDICAL BILL DISPUTE STATS:
AS OF 9/30/2014

• # of disputes received: 1151
• Total dollars addressed in disputes: > one million $
• Total number of orders: 101
• Total # of orders for penalties: 16
DWC MEDICAL BILL DISPUTE STATS: AS OF 9/30/2014

- Types of disputes:
  - E&M levels
  - Implants
  - Incorrect payments
  - Prior Authorization
  - Timely filing
  - No payment or response received
WHAT CAN PROVIDERS DO BETTER?
PROVIDERS TIMELY SUBMIT BILLS AND REQUIRED DOCUMENTATION TO PAYERS......

- Rule 16-7(F) - Requires bills to be submitted within 120 days from the date of service unless unusual circumstances exist.
- Rule 16-7(E)(2) & (3) requires documentation to be submitted:
  - With the bill for professionals; and
  - As specified by payers for hospitals.
PROVIDERS NEED EFFECTIVE ACCOUNTS RECEIVABLE AND COLLECTION PROCEDURES

• To enable timely follow-up on billed services.

  1. F/U by telephone early (15 to 45 days at the latest)
     • Verify correct payer, spelling, DOS, addresses etc..
     • Determine bill status with payer
     • Look for payer rejected electronic bill filings early
  2. Perform written appeals
  3. DWC Medical Bill Dispute Resolution program
  4. Go to collections if necessary
PROVIDERS NEED TIMELY AND SUPPORTABLE WRITTEN APPEALS

• Written appeals done within 60 days from receipt of payment and/or EOR from the payer as required by Rule 16-11(D)(1):
  • Some providers only show telephone calls were done to dispute payment or denial
  • Make sure you include the necessary medical records with the bills!!!

• Clearly written:
  • Identify the reason(s) from the payers EOR/EOBs
    • If you can not determine, then send a letter that identifies:
      • Verify if codes were correct based upon the documentation according to CPT and/or RVP and/or Rule 18.
      • Include the math calculations
  • One letter per EOR/EOB
    • Identify the incorrect adjustment or denial and the payers reason for the adjustment or denial
The provider’s office completes and submits the (WC #181) Medical Billing Dispute Intake Form submits all necessary documentation:

- Evidence bills were submitted within 120 days from the date of service or have documentation of what the extenuating circumstances were to cause the billing not to be submitted within 120 days
- Copies of detailed telephone logs showing telephone calls to payers with inquires on billed services; and
- Copies of all written appeals showing the appeal was completed within 60 days from receipt of EOB/EOR and all associated documentation; and
- Bills and any associated EOB/EORs received from payer; and
- Copies of all pertinent service/procedure documentation related to the billed services or copies of any applicable invoices
MEDICAL BILLING DISPUTE RESOLUTION INTAKE FORM

Name of Contacting Party: ____________________________________________
Title: ____________________________
Mailing Address: ____________________________________________________
Email Address: ______________________________________________________
Phone: ( ) __________________ Fax: ( ) __________________

Provider/Payer Initiating Dispute: _____________________________________
NPI or Tax ID#: ______________________________________________________

Other Party Involved in Dispute:
Claimant: __________________________________________________________
Employer: __________________________________________________________
Date of Service: _____________________________________________________

Dollar Amount in Dispute:
- Payment you received: $ __________________
- Payment you feel you should have received: $ __________________
- Explain how you arrived at this amount: ________________________________

Have you followed the procedures in Rule 16-11(D)?
☐ Yes ☐ No

If not, why? _________________________________________________________

Issue(s) in Dispute (check all that apply):
☐ Rule ☐ UCR ☐ CPT ☐ Supply ☐ PPO Contract ☐ Other

Please provide a detailed explanation of the dispute:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

What actions have you taken to resolve this dispute? (include person(s) you spoke with and dates if available)
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Please attach all supporting documents that are applicable in your dispute:
☐ Original bill ☐ Office/procedure/operation notes
☐ EOB(s)/EOR(s) ☐ Call logs/emails
☐ Prior authorization ☐ Correspondence from other party
☐ Invoice(s) ☐ Copy of request for contract
☐ Appeal(s)
RULE 16

Effective for Date(s) of service on and after January 1, 2015
• Edit to Paragraph (E):
  • “The payer should note that the current in-effect International Classification of Diseases (ICD) codes, when submitted, shall not be used to establish the work relatedness of an injury or treatment.”
RULE 16-7(B)(3)
UPDATED DENTAL BILLING FORM FROM THE
2006 TO THE 2012 ADA CLAIM FORM
RULE 16-9(J)  
NEW PARAGRAPH ADDED

• “(J) All medical records should be signed by the rendering provider. Electronic signatures are accepted.”

• EMR:
  • Attestation
  • Approval process

• Paper
  • Legible
• (6) In the event of continued disagreement, and within 12 months of the date the original bill should have been processed in compliance with section 16-11, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts.
RULE 18 - CHANGES
MEDICAL FEE SCHEDULE

Effective for Date(s) of service on and after January 1, 2015
• Incorporated by Reference Document Updated to:
  • Relative Values for Physicians (RVP), 2014 edition, developed by Relative Value Studies, Inc., published by OptumInsight, Inc.
  • Medicare Severity Diagnosis Related Groups (MSDRG) Definition's Manual, Version 32 developed and published by 3M Health Information Systems using MS-DRG effective after October 1, 2014
## RULE 18-4
### CONVERSION FACTORS

<table>
<thead>
<tr>
<th>RVP Section</th>
<th>Conversion Factors 2014</th>
<th>Conversion Factors for 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia</td>
<td>$53.20</td>
<td>$53.73</td>
</tr>
<tr>
<td>Surgery</td>
<td>$98.96</td>
<td>$99.83</td>
</tr>
<tr>
<td>Radiology</td>
<td>$18.23</td>
<td>$18.41</td>
</tr>
<tr>
<td>Pathology</td>
<td>$13.58</td>
<td>$13.72</td>
</tr>
<tr>
<td>Medicine</td>
<td>$7.91</td>
<td>$8.33</td>
</tr>
<tr>
<td>PM&amp;R</td>
<td>$6.17</td>
<td>$6.23</td>
</tr>
<tr>
<td>E&amp;M</td>
<td>$10.06</td>
<td>$10.16</td>
</tr>
</tbody>
</table>
“Any billed CPT® code identified as a “separate procedure” in CPT shall have an appropriate modifier appended to the code for the payer to allow separate payment (i.e., modifier 59).”

Normally considered as a component of another service or procedure.
• Billing Example:

95833 - 59 “Muscle testing, manual (separate procedure) with report; extremity (including hand) or trunk

97001 – PT Initial Evaluation
RULE 18-5(B) NEW PARAGRAPH – “ADD-ON” CODES +

- No code listed in CPT® identified as an “add-on” code is payable unless an appropriate primary code is billed with the “add-on” code in the same episode of care.

- Normally, the “add-on” service can not be done without the primary procedure.
• Billing Example:

Complex repair code 13102 “each additional 5cm or less (List separately in addition to code for primary procedure)” has to be billed with either

13100 Complex repair, trunk; 1.1cm to 2.5cm; or

+13101 Complex repair, trunk; 2.6cm to 7.5cm
ANESTHESIA SECTION

RULE 18-5(D)(1)
SIGNIFICANT CHANGES TO: RULE 16-5 “RECOGNIZED HEALTH CARE PROVIDERS” (A)(1) “NON” PHYSICIANS”

• (b) "Non-physician providers" are those individuals who are registered or licensed by the State of Colorado Department of Regulatory Agencies (DORA), the Colorado Secretary of State, or certified by a national entity recognized by the State of Colorado as follows:

• Added:(3) “Anesthesiologist Assistant (AA) – licensed by the Colorado Department of Regulatory Agencies
• Incorporated the new “Anesthesia Assistants” (AA) as allowed by the Colorado Medical Practice Act.

• AA must be under the supervision of the Anesthesiologist.
• *If billing separately, CRNA and AA’s*, under the medical direction of an anesthesiologist shall be reimbursed 50% of the maximum anesthesia value. The other 50% is payable to the anesthesiologist providing the medical direction to the CRNA or AA.
• Anesthesia time begins with the anesthesiologist prepares the patient for the induction of anesthesia and ends when the anesthesiologist is no longer in personal attendance and the patient is placed in post operative supervision.

• “Anesthesia Time” is calculated at 1 unit for every 15 minutes of anesthesia. > 5 minutes into the next 15 minutes warrants the additional time unit.
(e) Physical status modifiers are reimbursed as follows, using the anesthesia conversion factor:

<table>
<thead>
<tr>
<th>Physical Status Modifier</th>
<th>Description</th>
<th>RVUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>P-1</td>
<td>Healthy patient</td>
<td>0 RVUs</td>
</tr>
<tr>
<td>P-2</td>
<td>Patient with mild systemic disease</td>
<td>0 RVUs</td>
</tr>
<tr>
<td>P-3</td>
<td>Patient with severe systemic disease</td>
<td>1 RVUs</td>
</tr>
<tr>
<td>P-4</td>
<td>Patient with severe systemic disease that is a constant threat to life</td>
<td>2 RVUs</td>
</tr>
<tr>
<td>P-5</td>
<td>A moribund patient who is not expected to survive without the operation</td>
<td>3 RVUs</td>
</tr>
<tr>
<td>P-6</td>
<td>A declared brain-dead patient</td>
<td>0 RVU</td>
</tr>
</tbody>
</table>
(f) Qualifying circumstance codes are reimbursed using the medicine conversion factor:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>RVUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>99100</td>
<td>Anesthesia complicated by extreme age; under 1 year old or &gt; 70 years old</td>
<td>1 RVU</td>
</tr>
<tr>
<td>99116</td>
<td>Anesthesia complicated by utilization of total body hypothermia</td>
<td>5 RVUs</td>
</tr>
<tr>
<td>99135</td>
<td>Anesthesia complicated by utilization of controlled hypotension</td>
<td>5 RVUs</td>
</tr>
<tr>
<td>99140</td>
<td>Anesthesia complicated by emergency conditions (specify)</td>
<td>2 RVUs</td>
</tr>
</tbody>
</table>
RULE 18-5(D)(1) ANESTHESIA CODING EXAMPLE WITH MAXIMUM FEE CALCULATION

- 99140 - “Anesthesia complicated by emergency conditions (specify)(List separately in addition to code for primary anesthesia procedure.)

2.0 units from Rule 18-5(D)(1)(f) (NOT FROM THE MEDICINE SECTION OF RVP)

x53.73 Anesthesia conversion factor

$107.46 from Rule 18-4

- 00210 = “Anesthesia for procedures on external, middle, and inner ear including biopsy; not otherwise specified

5 anesthesia base units from 014 RVP

+ any “P” modifier additional RVUs

+ 10 (150 minutes/15 = 10 time units)

15 total RVUs

X $53.73 Anesthesia Conversion Factor

$805.95 Total maximum fees for AA (MD/DO Anesthesiologist

X 90% if the service was done by a CRNA without medical direction

X 50% if CRNA provided service under the direction of the anesthesiologist and billing separately.
NON-TIMED BASED ANESTHESIA PROCEDURES

• Regional or general anesthesia provided by the surgeon add modifier 47 to the basic service Do not use on anesthesia procedures (00100-01999).
  • Bill CPT code with modifier 47 appended for regional nerve block injection code - paid as surgical code.
  • Not sure when a surgeon could perform both general anesthesia and perform the surgery at the same time.
NON-TIMED BASED ANESTHESIA PROCEDURES

• Anesthesia (not therapeutic procedures) provided by an anesthesiologist maximum fees are covered in the Anesthesia Section with time.

• Therapeutic procedures, such as, spine injections for pain would be paid according to the RVU ‘s listed in Rule 18-5(D)(2)(k)1-10
SURGERY SECTION

RULE 18-5(D)(2)
• Updated the American College of Surgeons’ *Physicians as Assistants at Surgery* to the 2013 Study (January 2013)

  • [https://www.facs.org/~/media/files/advocacy/pubs/pas%202013.ashx](https://www.facs.org/~/media/files/advocacy/pubs/pas%202013.ashx)
All surgical procedures include the following:

- Local infiltration, metacarpal/metatarsal/digital block or typical anesthesia;
- One related E&M encounter on the date immediately prior to or on the date of the procedure (including history and physical);
- Intraoperative services that are normally a usual and necessary part of a surgical procedure;
All surgical procedures include the following:

• Immediate postoperative care, including dictating operative notes, talking with the family and other physicians;

• Evaluating the patient in the post-anesthesia recovery room;

• Post-surgical pain management by the surgeon;
RULE 18-5(D)(2)
GLOBAL SURGICAL PACKAGE

All surgical procedures include the following:

• Typical postoperative follow-up care during the global period of the surgery that is related to recovery from the surgery as identified in RVP© as global:

• Supplies – Except for those identified as exclusions;
  • Examples include: Needle/syringes for injections; casting material for initial application of cast
RULE 18-5(D)(2)
GLOBAL SURGICAL PACKAGE

All surgical procedures include the following:

- Miscellaneous Services – Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts and splints; insertion, irrigation and removal of urinary catheters, routine peripheral IV lines, nasogastric and rectal tubes; changes and removal of tracheostomy tubes;
RULE 18-5(D)(2)  
GLOBAL SURGICAL PERIOD

• Typical postoperative follow-up care during the global period of the surgery that is related to recovery from the surgery as identified in RVP© as global:

  • 000 – are endoscopies or some minor surgical procedures, typically a 0 day postoperative period. Visits on the same day of procedures are included in the allowance for the procedure, unless:

    • a separately identifiable service is performed and billed with the appropriate modifier.
RULE 18-5(D)(2)
GLOBAL SURGICAL PERIOD

- Postoperative follow-up care during the global period of the surgery related to recovery from the surgery as identified in RVP© as global:
  - 010 - are other minor procedures, 10 day postoperative period.
  - 090 - are major surgeries, 90 day postoperative period.
  - XXX – does not apply
  - ZZZ – are covered under another procedure’s global days
RULE 18-5(D)(2)  
GLOBAL SURGICAL PERIOD

• Postoperative follow-up care during the global period of the surgery related to recovery from the surgery as identified in RVP© as global:
  • MMM – global service day’s concept does not apply. (See Medicare’s Global Maternity Care reporting rule.)
  • Global period, defined RVP©, begins the day after surgery and continues for the defined period.
RULE 18-5(D)(2)
APPLICABLE REQUIRED MODIFIERS

• 24 - Unrelated E&M service by the same physician during a postoperative period.
• 25 - Significant and separately identifiable E&M service on the same day of the procedure within the global period of minor surgical procedures (0 or 10 days).
• 57 - Decision for surgery.
RULE 18-5(D)(2)
APPLICABLE REQUIRED MODIFIERS

• 54 - Surgical Care only. Fee is 60% of the billed surgery code Maximum Fee Schedule value.
• 55 - Postoperative management only. Fee is 30% of the billed surgery code Maximum Fee Schedule value.
• 56 - Preoperative management only. Fee is 10% of the billed surgery code Maximum Fee Schedule value.
APPLICABLE REQUIRED MODIFIERS

• When an operation requires two primary surgeons performing two distinct portions of the operation, modifier -62 is used with the procedure in question
  • reimbursement is increased to 125% of the value, apportioned in relation to the responsibilities and work of each surgeon or 50% of the total increased maximum fee to each surgeon.

• Surgical team reimbursement requires prior authorization and the use of modifier - 66 on the surgical codes.
RULE 18-5(D)(2)  
APPLICABLE REQUIRED MODIFIERS

• Assistant Surgeon (MD/DO), indicated by modifier -80 or -82 has a maximum allowance of 20% of the surgeon’s fees.

• Minimum Assistant Surgeon, such as a physician’s assistant, a nurse practitioner, or a clinical nurse specialist, is indicated by modifier -81 and reimbursed at 10% of the surgeon’s fees.
RULE 18-5(D)(2)
SERVICES PERFORMED DURING THE GLOBAL PERIOD AND WARRANT SEPARATE BILLING...

a) Unrelated E&M service (different ICD dx code)
b) Unusual circumstances, complications, exacerbations, or recurrences
c) Unrelated diseases or injuries
d) Services necessary to stabilize the patient for the primary surgical procedure
The reported E&M service:

1. Can not be a part of the surgical procedure; and

2. Must have an appropriate modifier (-24 or -25) appended to the E&M level of the service code when the surgeon is performing services during the global period.

3. Must be pointing to (field 24E on CMS 1500 – to which field 21 ICD code) an appropriate identifying ICD diagnosis code to indicate that the service is unrelated to the surgical procedure.
RULE 18-5(D)(2)
SERVICES PERFORMED DURING THE GLOBAL PERIOD AND WARRANT SEPARATE BILLING..

The reported E&M service:

4. Medical record must clearly identify:
   • The “reasonableness and necessity” for the E&M service
   • The E&M service is separate and identifiable from the surgical procedure
Disability management of an injured worker for the same diagnosis requires the managing physician to clearly identify in the medical record the specific disability management detail that was performed during that visit.

- The definitions of what is considered disability counseling can be located under 18-5(I)(1) and in Exhibit #7 of this Rule.
DWC DISPUTE RESOLUTION PROGRAM DOES LOOK FOR INAPPROPRIATE BILLING...

- During the Global Period:
  a. Pre operative H&P or post operative visits during the global period of a surgical procedure
  b. Time must be in your documentation when you are to be paid based upon any time procedure or service.
  c. Clearly identify what you are “managing” – RTW, MMI, physical limitations, all of the health care components (referrals etc..).
Possible Example of Disability Management Part 1:

- 9/2/2014 - I telephoned Dr. Spinals today to inquire about Ms. Jones post 60 day (percutaneous discectomy) surgery progress and her possible return to work status. He stated she was progressing excellent and her prognosis was good. Dr. Spinals stated she did not have any signs of infection, her pain continues to decrease after each visit. Dr. Spinals stated she will probably be released from his care within the next week or so without any limitations. 20 minutes on the phone
Possible Example of Disability Management Part 1:

• Time must be documented in the record to be paid based upon time whether it is telephone calls or visits.

• Get in the habit of documenting time for all visits, but be careful!
  • If every patient is a 60 minute appointment and you work 8 hours a day, then you can only see 8 patients in a day; not 20 patients.
Example of Disability Management Part 2:

- 9/2/2014 – Ms. Jones came in today to discuss her return to work within the next couple of weeks. I explained to Ms. Jones that I had talked to Dr. Spinals about her process and relayed to her what he told me. Ms. Jones was somewhat surprised that Dr. Spinals thought she was probably going to be released within a couple of weeks. She did not feel her pain was decreasing in the least.
Example of Disability Management Part 2:

- 9/2/2014 - Ms Jones and I spent 40 minutes of a 60 minute visit talking about my conversation with Dr. Spinal. We discussed her functional progress with activities of daily living and her PT goals and progress. I pointed out to Ms. Jones that she is now able to lift > 20 pounds, which she was unable to do one week after surgery.

- Make sure the amount of time spent face to face with the injured worker is documented!
Example of Disability Management Part 3:

9/2/2014 – Continue with your own documentation of your patient’s:

a. History
   • HPI
   • ROS
   • History

b. Exam; and

c. Plan of care
RULE 18-5(D)(2)
MULTIPLE SURGICAL PROCEDURES

• Multiple Surgical Procedures during the same operative episode remains the same:
  • 100% of the maximum fees for the highest valued procedure
  • 50% of the maximum fees for all lowered valued procedures
RULE 18-5(D)(2)
MULTIPLE SURGICAL PROCEDURES

Surgeon’s Example:

- 23410 – Repair of musculotendinous cuff (e.g., rotator cuff) open, acute
- 23130 – Acromioplasty or acrominectomy, partial with or without coracoacromial ligament release.

1. 23410 = 14 rvus from RVP x $99.83 = $1,397.62
2. 23130-51 = 8.8 rvus from RVP x $99.83 = $878.50 x 50% = $439.25
RULE 18-5(D)(2)

RVU CHANGES BY RULE 18

The following relative values listed in the 2014 RVP Surgery Section for the following injections shall be replaced as follows:

1) 62273 - Epidural for: blood or clot patch injection = 1.9 units

2) Epidurals diagnostic or therapeutic injections substance(s) including anesthetic antispasmodic, opioid, steroid, other solutions (NOT Neurolytic substances) for subarachnoid
   a) 62310 - Cervical or thoracic level = 2.0
   b) 62311 - Lumbar or sacral (caudal) = 1.65

3) Epidurals (including indwelling catheter placement), for continuous infusion or intermittent bolus of diagnostic or therapeutic substance(s) anesthetic antispasmodic, opioid, steroid, other solutions (NOT Neurolytic substances) for subarachnoid
   a) 62318 - Cervical or thoracic level = 1.85
   b) 62319 - Lumbar or sacral (caudal) = 1.77

4) Somatic Nerve Injections:
   a) 64405 - Greater Occipital nerve = 1.5 units
   b) 64412 - Spinal Accessory nerve = 1.5 units
   c) 64416 - Injection, brachial plexus, continuous infusion by catheter (including catheter placement = 1.0 units
   d) 64421 - Regional Block (intercostal) multiple = 1.7 units
   e) 64446 - Sciatic nerve, continuous infusion = 1.3 units
   f) 64447 - Femoral Nerve = 1.5 units
   g) 64448 - Femoral Nerve, continuous infusion by catheter (including catheter placement) = 1.2 units
   h) 64449 - Lumbar plexus, posterior approach, continuous infusion = 2.0 units
   i) 64450 - Other peripheral nerve or branch = 1.25 units

5) Paravertebral facet joint injections:
   a) 64490 - Single Level Cervical/Thoracic Levels = 2.0
   b) 64491 - Second Levels at Cervical/Thoracic = 1.25 units
   c) 64492 - Third and any additional levels at Cervical/Thoracic = 1.10 units

6) Paravertebral facet joint injections:
   a) 64493 - Single Level Lumbar/Sacral Levels = 1.75
   b) 64494 - Second Levels at Lumbar/Sacral = 1.0 units
   c) 64495 - Third and any additional levels at Lumbar/Sacral = 1.0 units

7) Autonomic Nerve Injection
   a) 64517 - Anesthetic agent, superior hypogastric plexus = 1.3
   b) 64520 - Anesthetic agent, lumbar or thoracic (paravertebral sympathetic) = 2.0 units

8) Destruction of nerve by neurolytic agent:
   a) 64605 - Trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch, second and third division branches at foramen ovalis = 5.5 units
   b) 64620 - Intercostal nerve = 3.0
   c) 64630 - Prudental nerve = 3.0
   d) 64633 - Paravertebral facet Joints at Cervical and Thoracic single level = 4.4 units
   e) 64634 - Paravertebral facet Joints at Cervical and Thoracic each additional level = 2.0 units
   f) 64635 - Paravertebral facet Joints at Lumbar or sacral single level = 4.2 units
   g) 64636 - Paravertebral facet Joints at Lumbar or sacral each additional level = 1.8 units
   h) 64640 - Other peripheral nerve or branch = 1.6 units
   i) 64680 - Celiac Plexus = 2.9 units

9) Tympanic Membrane surgery
   a) 69610 - Tympanic membrane repair, with or without site preparation of perforation for closure, with or without patch = 11.7
RULE 18-5(D)(2)  
BILATERAL PROCEDURE BILLING

- Bill on one line with one unit in the “Days/Units” column.
- Maximum fees will be multiplied x 150% if the -50 modifier is appended to the code.
RULE 18-5(D)(2)
BILATERAL PROCEDURE PAYMENT

• Surgeon’s Example:
64484 – 50 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT) lumbar or sacral;
  • 2 rvus from RVP surgery x $99.83 = $199.66 x150% = $299.49
  • Apply modifier -51 after applying modifier -50 for bilateral
    2 rvus from RVP surgery x $99.83 = $199.66 x150% = $299.49 x 50% = $149.75

64483 – 50 lumbar or sacral, each additional level (List separately in addition to code for primary procedure
  • 1 rvu from RVP surgery x$99.83 = $99.83 x 150% = $149.75
  • For unilateral procedures use the anatomic modifiers (RT or LT)
RADIOLOGY & PATHOLOGY SECTIONS

RULE 18-5(E) & (F)
• No more “00” modifier!

• Urea Breath test C-14 (isotopic) acquisition for analysis and the analysis maximum fees are listed under Exhibit #8 of this Rule.
RULE 18-5(F)
PATHOLOGY SECTION

• Medicare’s Clinical Laboratory Fee Schedule for CO was adopted under a new Exhibit #8 to Rule 18.
• The Medicare dollar values was multiplied by 216%. (Including urine drug testing for “G” codes)
RULE 18-5(F)
PATHOLOGY SECTION

- No separate “TC” or “26” fee allowance is covered under Exhibit #8 laboratory tests.
- Only when a physician clinical pathologist is required to interpret and produce a separate report would an RVP dollar value be payable. (see code list of RVP codes and dollars)
- See Handout (All Pathology codes paid by RVP or BR or RNE or paid by another HCPC code # in Exhibit #8)
MEDICINE SECTION

BIOFEEDBACK, PSYCHIATRIC/PSYCHOLOGICAL, VACCINES/TOXOIDS
(IN OFFICE IV INFUSION IS IN SLIDES, JUST NOT IN PRESENTATION)
RULE 18-5(G)(3)
BIOFEEDBACK

- Updated the name of the required certification to “Biofeedback Certification International Alliance” (BCIA)
- Requiring the appropriate DORA licensure for any provider who is performing psychotherapy along with biofeedback.
RULE 18-5(G)(3)
BIOFEEDBACK

• Relative Value unit changes as listed for the RVP 2014 2\textsuperscript{nd} quarter errata values:
  • 90901 - .3 units/minute
  • 90911 - .3 units/minute
RULE 18-5(G)(6)
PSYCHIATRIC/PSYCHOLOGICAL SERVICES

- Expanded the code allowance as follows:
  - 90791 can be billed up to 2Xs (not CPT congruent)
  - 90792 can be billed up to 2Xs (not CPT congruent)
RULE 18-5(G)(6)

PSYCHIATRIC/PSYCHOLOGICAL SERVICES

Allowed up to six hours of “Central Nervous System Assessments/Tests (e.g., Neuro-Cognitive, Mental Status, Speech Testing)” without prior authorization: 96101-96125
Use Health and Behavior Assessments code(s) 96150-96155 when the injured worker does not have a DSM-IV diagnosis.

- The **Kessler 6 & Kessler 10** are mental health screening tools used with a general adult population.
- The **Duke Health Profile (Duke)** is a 17-item standardized self-report instrument containing six health measures (physical, mental, social, general, perceived health, and self-esteem), and four dysfunction measures (anxiety, depression, pain, and disability).
- **Patient Stress Questionnaire** is a tool used in primary care settings to screen for behavioral health symptoms. It was adapted from the PHQ-9, GAD-7, PC-PTSD, and AUDIT.
Vaccines and toxoids shall be billed using the appropriate “J” code or CPT code as listed in the Medicare Part B Average Sale Price or at cost to the billing provider if no dollar value is listed in ASP.
RULE 18-5(G) VACCINE AND TOXOIDS

Examples:

- 90471 – Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid) = 4 RVUs x $8.33 = $33.32

- Plus the vaccine itself using the Medicare ASP $ or cost (invoice) to the provider:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
<th>HCPCS Code Dosage</th>
<th>Payment Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>90715</td>
<td>Tdap =&gt; 7 yo, im</td>
<td>0.5 ML</td>
<td>$31.84</td>
</tr>
<tr>
<td>J1670</td>
<td>Tetanus immune globulin inj</td>
<td>250 UNITS</td>
<td>$274.42</td>
</tr>
</tbody>
</table>

Payment Allowance Limits for Medicare Part B Drugs
Effective January 1, 2014 through March 31, 2014
RULE 18-5(G)(13)
IV INFUSION PERFORMED IN A PHYSICIAN'S OFFICE

When IV infusions are performed in a physician’s office the maximum fees are determined by the;

- CPT codes and RVP RVUs listed in under the Medicine Section subsection: “Therapeutic, Prophylactic, and Diagnostic Injections and Infusions” and the “Chemotherapy” and other “Highly Complex Drug” or “Highly Complex Biologic Agent Administration”
RULE 18-5(G)(13)
IV INFUSION PERFORMED IN A PHYSICIAN'S OFFICE

• Medications are allowed at cost to the physicians office if the infusion is done the provider’s office.

Example:
1. 96365 Intravenous Infusion, for therapy prophylaxis or diagnosis (specify substance or drug); initial, up to 1 hour.
   10.6 rvus x $8.33 = $88.30; plus
2. Drug at cost to provider

• Supplies are included per CPT:
  • IV start, access to indwelling IV, subcutaneous catheter or port, flush at conclusion of infusion, standard tubing, syringes
RULE 18-5(G)(13)
IV INFUSION A PHYSICIAN'S OFFICE
PATIENT SELF ADMINISTERED AT HOME

When IV infusions are sent home with the patient from the physician’s office the maximum fees are determined by Rule 18-6(L)(1):

Example:

- S9501 - once every 12 hours - $110.00/Day x # of days
- S9123 - RN Visit at home initial evaluation -$111.00/hr. limit of 2 hrs.'
- Drugs Maximum Fees:
  - ASP Fees or if non exist under the ASP fee schedule
  - AWP
PHYSICAL MEDICINE & REHABILITATION SECTION

RULE 18-5(H)
Rule 18-5(H)(6) Dry Needling Moved to (5) “Procedures”

- Dry Needling was moved from the “modalities” category to a “procedures” category with the following values:
  - DoWC Z0501 initial 15 minutes of dry needling = 5.4 units
  - DoWC Z0502 each add’l 15 minutes of dry needling = 4.5 units

- As a procedure the limitation of one hour per procedure per discipline per day still applies.
RULE 18-5(H)(8)
SPECIAL TESTS — REDUCED # ALLOWED

• Computer-Enhanced Evaluations and Work Tolerance Screenings require prior authorization for payment for more than 4 hours per test or more than 3 tests per claim.
  • Reduced the # of tests from 6 to 3 tests to be in alignment with the DWC Medical Treatment Guidelines.
NEW TELEHEALTH FEES

RULE 18-5(J)
SIGNIFICANT CHANGES TO:
RULE 16-2 “STANDARD TERMINOLOGY”
FOR RULE 16 & RULE 18

• Added: (Y) Telemedicine – the use of medical information exchanged from one site to another via electronic communications to improve, maintain or assist patient’s health status.
• “Closely associated with tele-medicine is the term “TeleHealth”, which is often used to encompass a broader definition of remote health care that does not always involve clinical services. Videoconferencing, transmission of still images, e-health including patient portals, remote monitoring of vital signs and continuing medical education are all considered part of telemedicine and TeleHealth.”

• “Telemental Health is a broad term that refers to providing mental healthcare from a distance...”
RULE 18-5(J)(6) TELEHEALTH
HIPAA PRIVACY AND SECURITY STILL APPLIES

• (3) HIPAA privacy and electronic security standards are required for both the originating site and the rendering providers.

  (a) Protecting patient health information, and patient / client decision making and consent are vital.

  (b) Policies and procedures need to be in place to protect the electronic security of data, and the physical security of TeleHealth equipment so that patient health information is protected.
RULE 18-5(J)(6) TELEHEALTH
HIPAA PRIVACY AND SECURITY STILL APPLIES

• (3) HIPAA privacy and electronic security standards are required for both the originating site and the rendering providers.

  (c) Compliance with accreditation requirements, regulations, and relevant legislation is necessary.

  (d) Health professionals providing TeleHealth services shall be fully licensed, registered, and credentialed by the appropriate governing agency.
(4) All TeleHealth procedures are required to be at an originating site that is deemed appropriate with the appropriate HIPAA privacy and electronic security standards in place. Authorized originating sites are:

(a) The office of a physician or practitioner  
(b) A hospital (inpatient or outpatient)  
(c) A critical access hospital (CAH)  
(d) A rural health clinic (RHC)
Who can be originating sites?

(4) All TeleHealth procedures are required to be at an originating site that is deemed appropriate with the appropriate HIPAA privacy and electronic security standards in place. Authorized originating sites are:

- (e) A federally qualified health center (FQHC)
- (f) A hospital based or critical access hospital based renal dialysis center (including satellites)
- (g) A skilled nursing facility (SNF)
- (h) A community mental health center (CMHC)
RULE 18-5(J)(6)
TELEHEALTH - WHERE CAN IT BE DONE?

• Services provided via telecommunications technologies are not covered if the client has access to a comparable service within 30 miles of his/her place of residence.
RULE 18-5(J)(6)
TELEHEALTH - WHERE CAN IT BE DONE?

• (2) TeleHealth facilities can bill for the originating fee only if the patient’s originating site is located in a:

  (a) County outside of a Metropolitan Statistical Area (MSA), or

  (b) A Health Professional Shortage Area (HPSA), either located outside of an:

       • MSA or

       • In a rural census tract, as determined by the office of Rural Health Policy within the Health resources and Services Administration (HRSA).
RULE 18-5(J)(6)
TELEHEALTH – ORIGINATING SITE FEES

TeleHealth originating site facility fee:
Q3014 $35.00 /per 15 minutes
(5) The physician-patient / psychologist-patient relationship needs to be established.

(a) This relationship is established through assessment, diagnosis and treatment of the patient. Two way live audio / video services is acceptable to ‘establish' a patient relationship.

(b) Physicians / psychologists need to meet standard of care.

(c) The patient is required to provide the appropriate consent for treatment.
(6) Communication Protocol

(a) Video conferencing is an advanced communication technology that may be used for TeleHealth.

(b) It is the originating site’s required responsibility to establish provider and patient identity verification.
RULE 18-5(J)(6) TELEHEALTH PAYMENT TO TELEHEALTH PROVIDER

(7) Payment for TeleHealth services for initial inpatient hospital or Emergency Room Department:

(a) TeleHealth consultations; 30 minutes
   TeleHealth G0425 $187.95

(b) TeleHealth consultations; 50 minutes
   TeleHealth G0426 $256.69

(c) TeleHealth consultations; 70 minutes
   TeleHealth G0427 $375.88
(7) Payment for TeleHealth services – Follow-up Inpatient

(d) Follow up inpatient TeleHealth consultations;

G0406 limited (typically 15 min.) $54.81
G0407 intermediate (typically 25 mins) $97.45
G0408 complex (typically 35 min.) $140.09
(7) Payment for TeleHealth services – Follow-up

Inpatient:

Subsequent inpatient hospital care services are limited to one TeleHealth visit every 3 days.

Subsequent nursing facility care services are limited to one TeleHealth visit every 30 days.
(7) Payment for TeleHealth services for all other services that can safely and reasonably be done by TeleHealth:

(e) For all other physician / psychologist TeleHealth services, the physician / psychologist shall bill the appropriate RVP© CPT® code with the GT modifier. Reimbursement is the RVU value for the CPT® code times the appropriate CF + $5.00 when modifier GT is appended to the appropriate CPT® code(s).
(7) Payment for TeleHealth services for all other services that can safely and reasonably be done by TeleHealth:

GT – Attached to the distance (rendering) physician / psychologist billed CPT® or HCPCS indicates the service was performed via interactive audio and video telecommunication systems. Using the modifier certifies that the patient was present at an eligible originating site when the TeleHealth service was furnished.
CHANGES TO RULE 18-6

DIVISION ESTABLISHED CODES AND VALUES
RULE 18-6(C) COPYING FEES

Reasonable cost for paper copies shall not exceed:

- $18.53 for the first 10 or fewer pages,
- $0.85 per page for pages 11-40; and
- $0.57 per page thereafter.

- Actual postage or shipping costs and applicable sales tax, if any, may also be charged.
- Copying charges do not apply for the initial submission of records that are part of the required documentation for billing.
Reasonable cost for non-paper copies shall not exceed:

- Copies from microfilm shall be $1.50 per page.
- $14.00 per computer disc.
- $0.10 per electronic record page, if appropriate security is in place (includes email)
- Actual postage or shipping costs and applicable sales tax, if any, may also be charged.
- Copying charges do not apply for the initial submission of records that are part of the required documentation for billing.
RULE 18-6(C)COPYING FEES

Use the same billing code regardless of the type of copying being done

- Copying Fee Billing Code: DoWC Z0721
RULE 18-6(G)(2)(E)
COMPLETION OF THE WC164 FORM FEE

1. Z0750 = $47.00 - Initial Report Form
2. Z0751 = $47.00 – Progress Report Form
3. Z0752 = $47.00 – Closing Report Form
4. Z0753 = $47.00 – Initial and Closing Reports on the same WC 164 Report Forms.
5. Z0754 = $47.00 - Complete additional forms for payer or employer requiring 15 minutes or less.
(4) Modified sentence to read as follows:

“The opioids prescribed for long term treatment (opioids being prescribed for > 30 days for non-surgical cases and >30 days post procedure for surgical cases) shall be provided through a pharmacy”
PRE AND POST OPERATIVE SPINE AND SI JOINT INJECTION(S)

FUNCTIONAL ASSESSMENT FEES
RULE 18-5(G)(6)
FUNCTIONAL ASSESSMENT REPORT FOR PRE AND POST SPINE INJECTIONS

Pre-and post- spinal or SI joint injection assessments must be done by a trained:

1. Physician; or
2. Nurse; or
3. Physician’s Assistant; or
4. Occupational Therapist; or
5. Physical Therapist; or
6. Medical Assistant.
FUNCTIONAL ASSESSMENT REPORT FOR PRE AND POST SPINE INJECTIONS

Pre-and post- assessments shall include the following documented in a detailed report:

• A brief commentary on the procedures, including the anesthesia used in the injection and verification of the needle placement by fluoroscopy, CT or MRI.
Pre-and post-assessments **shall include** the following documented in a detailed report:

- Pre-and post-injection procedure **shall have at least 3 objective, diagnostically appropriate, functional measures identified, measured and documented initially and post procedure at the most appropriate time for medication effect (usually 30 minutes post procedure):**
  1. spinal range of motion;
  2. tolerance and time limits for sitting, walking and lifting;
  3. straight leg raises for herniated discs;
  4. a variety of provocative SI joint maneuvers such as Patrick’s sign, Gaeslen, distraction or gapping and compression tests.
Pre-and post assessments should include the following documented in a detailed report:

- The patient(s) should be instructed to keep a post injection pain diary that details the patient’s pain level for all pertinent body parts, including any affected limbs.
- The patient pain diary should be kept for at least 8 hours post injection and preferably up to seven (7) days.
- The patient should be encouraged to also report any changes in activity level post injection.
RULE 18-5(G)(6)  
FUNCTIONAL ASSESSMENT REPORT FOR  
PRE AND POST SPINE INJECTIONS

(6) Functional Assessments

(b) If all three elements are documented, the billing code and maximum fee is as follows:

DoWC Z0770: $91.44 per episode of care; pre- and post, functional assessment related to spinal or SI joint injections.
SUPPLIES, DME, ORTHOTICS, PROSTHETICS

RULE 18-6(H)
RULE 18-6(H) SUPPLIES, DME, ORTHOTICS AND PROSTHETICS

- “Supplies necessary to perform a service or procedure are considered inclusive and not separately reimbursable. Only supplies that are not an integral part of a service or procedure are considered to be over and above those usually included in the service or procedure.”

- Examples of non-payable items include:
  - Electrodes/supplies used for EMG/NCV, or EKGs or U/S
  - Needles/syringes/supplies/drugs used for injections or acupuncture needles
  - Drug(s)/Supplies used for iontophoresis
Essentially, supplies are defined as anything that is given to and taken home by the injured worker.

If the supply or device is necessary to perform the procedure or service, it is more than likely not separately reportable/payable.
RULE 18-6(H)  **MEDICAL PROFESSIONALS SUPPLIES, DME, ORTHOTICS AND PROSTHETICS**

- PT supplies for injured workers to take home do not require an invoice if the *total supply/billed cost* to the billing provider *is $50.00 or less*.  

- The maximum fees is 100% of the total billed charges of $50.00 or less.
• Take home supplies included but not limited to the following:

Therabands, theratubes, band/tube straps, theraputty, bow-tie tubing, fitness cables/trainers, overhead pulleys, exercise balls, cuff weights, dumbbells, ankle weight bands, wrist weight bands, hand squeeze balls, flexbars, digiflex hand exercisers, power webs, plyoballs, spring hand grippers, hand helper rubber band units, ankle stretchers, rocker boards, balance paws, and aqua weights.
**RULE 18-6(H) MEDICAL PROFESSIONALS** - SUPPLIES, DME, ORTHOTICS AND PROSTHETICS

*Medical professionals* shall bill for supplies, including Supply et al.,” orthotics, prostheses, DME or drugs, including injectable, using:

- *Medicare’s HCPCS Level II codes;*
RULE 18-6(H) **MEDICAL PROFESSIONALS** - SUPPLIES, DME, ORTHOTICS AND PROSTHETICS

**Medical professionals** shall maximum fees are as identified in either the:

**Medicare’s DMEPOS CO January 2014 fee schedule**
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html or

**Medicare Part B Drug Average Sale Price (ASP) fees**
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html

If no code or $ value exist in Medicare’s DMEPOS or ASP schedules
Invoice from biller is required and payers pay the invoice at **120% of the billers cost**
(6) Payment for professional services associated with the fabrication and/or modification of orthotics, custom splints, adaptive equipment, and/or adaptation and programming of communication systems and devices shall be paid in accordance with the Colorado Medicare HCPCS Level II values.
(5) Reimbursement of supplies to facilities shall be in compliance with sections 18-6 (I) – (N).
SIGNIFICANT CHANGES TO:
RULE 16-5 "RECOGNIZED HEALTH CARE PROVIDERS" (A)(1)(B) "NON" PHYSICIANS"

• Added: (7) "Durable Medical Equipment, Prosthetic, Orthotics, and Supplies (DMEPOS) Supplier – Licensed by the Colorado Secretary of State"
RULE 18-6(H) **DMEPOS SUPPLIERS FEES-SUPPLIES, DME, ORTHOTICS AND PROSTHETICS**

Suppliers bill and maximum fees are based upon Medicare's DMEPOS HCPCS Level II codes.

1. If no dollar value is listed in Medicare’s DMEPOS fee schedule then the maximum fees is: **100% of Colorado Medicaid’s July 2014 fee schedule**. The Colorado Medicaid Fee Schedule can be found at: [https://www.colorado.gov/hcpf/provider-rates-fee-schedule](https://www.colorado.gov/hcpf/provider-rates-fee-schedule).

2. If no Medicare or Medicaid fee schedule value exists maximum fee schedule fees is: The published Manufactures Suggested Retail Price (MSRP), the item will be reimbursed at **MSRP less 20%**.

3. If there is no established fee schedule value or MSRP, the maximum fee schedule is: **120% of the cost of the item** as indicated on the supplier’s invoice.
HB14-1369 – Signed by Governor – requires DMEPOS suppliers, if they intend to bill Medicare or Medicaid, to:

• Be licensed by the Colorado Secretary of State
• Be physically located within the state or within 50 miles of the state
• Have sufficient inventory and staff to do business
• Be accredited by organization recognized by the Centers for Medicare and Medicaid Services (CMS).
HB14-1211 – Signed by Governor – requires the Colorado Department of Health Care Policy and Financing (Medicaid) to:

• Define “Complex Rehabilitation Technology (CRT)”
• Recognize CRT as a specific need of persons with complex diagnoses or medical conditions that result in significant physical or functional needs; and
• Develop parameters of CRT benefits; and
• Establish DMEPOS supplier quality standards
HB14-1211 – Signed by Governor – requires the Colorado Department of Health Care Policy and Financing (Medicaid) to:

- Evaluation of complex patient needs by qualified professionals for purpose of identifying appropriate CRT.
- Continue to evaluate the reimbursement rates for CRT to ensure to support continued access to CRT benefits.
- Give public notice prior to a collaborative process that includes discussion of the type of equipment that should be included in CRT benefit.
“Complex rehabilitation technology (CRT) items, including products such as complex rehabilitation power wheelchairs, highly configurable manual wheelchairs, adaptive seating and positioning systems, and other specialized equipment, such as standing frames and gait trainers, enable individuals to maximize their function and minimize the extent and costs of their medical care.”
CRT products must be provided by suppliers who are:

- Accredited by a Center for Medicare and Medicaid Services (CMS) deemed accreditation organization as a supplier of CRT; and
- Licensed as a DMEPOS Supplier with the Colorado Secretary of State.
The maximum fee schedule allowance for CRT is 100% of Medicare’s January 2014 DMEPOS Colorado HCPCS Level II listed fee values.

The DMEPOS schedule can be found at: http://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html

If no Medicare fee schedule value exists for the billed CRT HCPCS code, the Maximum Fee Schedule value is the published Manufacturer’s Suggested Retail Price (MSRP), less 20%.
INPATIENT HOSPITAL

RULE 18-6(I)
FACILITY FEE SCHEDULE CHANGES
• Updated Exhibit #3 to Rule 18 certified by Medicare as being a “Critical Access Hospitals” (CAH) facility.
• Updated Exhibit #1 to Medicare’s adopted Final version of Table #5 (MSDRG Relative Weights), effective 10/1/2014 for Medicare.
• Updated Exhibit #2 using Medicare’s adopted final federal rates (Labor/Non-Labor and Capital), effective 10/1/2014. Assume all hospitals submitted:
  • Quality data and were Meaningful EHR Users
RULE 18-6(I)

UPDATES TO THE INPATIENT EXHIBITS

• Adopted the “fixed loss cost threshold” dollar of $25,799.00 as published in Medicare’s proposed rule for 10/1/2014.

• Carve-Outs remain the same:
  • Trauma Center Activation Fees
  • Organ acquisition fees remain
RULE 18-6(J) UPDATES TO OUTPATIENT HOSPITAL FACILITY FEES

- Updated Exhibit #4 to Rule 18 using Medicare’s Addendum B with implants subtracted from the Addendum B value (Medicare’s Addendum M) and Status Indicators (SI) updated as well.
- The adjusted Addendum B rate is then multiplied by 170% for hospital maximum fee dollars.
- 15% less of DWC hospital rates for ASC’s in Exhibit #4.
- Updated Exhibit #5 Medicare certified as a Primary Rural Health Facilities.
Clarified “implants” as:

• “All surgically implanted items remain in the body post-surgery and are payable at cost to the facility”

• “Implanted items” include, but not limited to:
  • mesh used to augment a hernia repair,
  • nuts, screws, plates etc., used to repair bones
  • Instrumentation hardware used during a back fusion
  • Grafts
Items that do not remain in the body are not considered “implants”. The following items do not meet the DWC’s definition of implants (not an all inclusive list of “non-implant” items):

- The balloon used to inflate the abdomen during a “laparoscopic” hernia repair
- Needles and suture material(s)
- Clotting materials/drugs
- Items common to any surgery episode
RULE 18-6(J) UPDATES TO OUTPATIENT HOSPITAL FACILITY FEES

- Outpatient ERD maximum fee values includes the following:
  - Exhibit #4 Column #3 dollar value update
  - The Column #3 multiplier was dropped from 275% to 260%
  - Trauma Activation fees remain the same
  - Outlier Calculation remains the same
    (hospitals’ CCR x charges = cost, if >$500 on the line level)
  - Observation maximum fee value remains ($45.00/hour)
(h) Outpatient Hospital Clinic and Urgent Care (Form Locator (FL) 4 are 07xx and revenue codes 51x-53x) Facility Fees

Clinic Visit fees are limited for all facilities in accordance with the following:

1) No separate facility fees are allowed for follow-up care visits. Subsequent care for an initial diagnosis does not qualify for a separate facility fee. To receive another facility fee, any subsequent diagnosis shall be a new acute care situation entirely different from the initial diagnosis.
(h) Outpatient Hospital Clinic and Urgent Care (Form Locator (FL) 4 are 07xx and revenue codes 51x-53x) Facility Fees

Clinic Visit fees are limited for all facilities in accordance with the following:

2) No facility fee is appropriate when the injured worker is sent to the employer’s designated provider for a non-urgent episode of care during regular business hours of 8 am to 5 pm, Monday through Friday.
RULE 18-6(J) UPDATES TO OUTPATIENT HOSPITAL FACILITY FEES

(h) Outpatient Hospital Clinic and Urgent Care (Form Locator (FL) 4 are 07xx and revenue codes 51x-53x) Facility Fees

Clinic Visit fees are limited for all facilities in accordance with the following:

3) Any specialty care clinic (wound/infections) that require expensive drugs/supplies that are typically not provided by a physician’s office may be allowed a separate clinic fee with prior approval from the payer as outlined in Exhibit #4.
SIGNIFICANT CHANGES TO:
RULE 16-2 “STANDARD TERMINOLOGY” FOR RULE 16 & RULE 18

• Added: (J) Free-Standing Facility – an entity that furnishes healthcare services and is not integrated with any other entity as a main provider, a department of a provider, remote location of a hospital, satellite facility, or provider –based entity.
  • Used in Rule 18-6(K).
  • No changes were made
  • to Rule 18-6(K)
HOME CARE SERVICES

• All skilled home care service providers shall be licensed by the Colorado Department of Public Health and Environment (CDPHE) as Type A providers.
HOME CARE SERVICES

• To prevent disputes the payer and the home health entity should agree in writing on the following:
  a. On the type of care; and
  b. The type and skill level of provider; and
  c. Frequency of care and duration of care at each visit; and
  d. Any financial arrangements.
Skilled Nursing fees are separately payable when the nurse travels to the injured workers home. Services provided by the skilled nurses include:

a. Initial evaluation; and/or,
b. Subsequent patient evaluation(s); and/or,
c. Education; and/or,
d. Coordination of care.

Skilled nursing fees are billed and payable as indicated under section 18-6(L)(2).
The per day or refill rates for home infusion therapy includes all of the following items:

a. All reasonable and necessary products,
b. Equipment,
c. IV administration sets,
d. Supplies,
e. Supply management, and
f. Delivery services necessary to perform the infusion therapy.
Per diem rates are only payable when licensed professionals (RNs) are providing “reasonable and necessary” skilled assessment and evaluation services in the patient’s home.
HOME CARE SERVICES – NURSING FEES

(2) Nursing Services

(a) Skilled Nursing (LPN & RN)

S9123 RN     $111.00/hr.
S9124 LPN     $89.00/hr.

There is a limit of two (2) hours without prior authorization for payment (see Rule 16-9).

(b) Certified Nurse Assistant (CNA):

S9122 CNA     $45.00/hr. (increased from $25.00/hr.)

The amount of time spent with the injured worker must be specified in the medical records and on the bill.
HOME CARE SERVICES – IV INFUSION MEDICATIONS

• Medication maximum fees are either:
  a. Medicare’s Average Sale Price (ASP), if none exist, then use
  b. Average Wholesale Price (AWP) for the Medication given.

• AWP (see section 18-6(M)) of the drug is determined through the use of industry publications such as the monthly Price Alert, First Databank, Inc.
DRUGS AND MEDICATIONS

RULE 18-6(M)
The Rule 18-6(M)(4) Compounded Topical Medication fee schedule for Category I through IV can be applied to commercially prepackaged medications.
(4) Compounded Drugs

All ingredient materials must be listed by quantity used per prescription. Category fees include materials, shipping and handling, and time. Regardless of how many ingredients or what type, compounded drugs cannot be reimbursed higher than the Category IV fee. The 30 day Maximum Fee Schedule value shall be fractioned down to the prescribed and dispensed amount given to the injured worker.

Example: Category II Z0791 Fee $150.00 per 30 day supply

  15 day supply maximum fees = $75.00
  7.5 day supply maximum fees = $37.50
RULE 18-6(M)- NEW PARAGRAPH
DRUGS AND MEDICATIONS

(8) Required Billing Forms

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

“Physicians shall list the “repackaged” and the “original” NDC numbers in field number 24 of the CMS-1500. List the “repackaged” NDC number and the “original NDC number with the prefix “ORIG” appended.

Verbiage is also included under Rule 16-7(B)
RULE 18-6 (R)
ACUPUNCTURE RATE CHANGES

(3) Billing Codes

(b) Non-Physician evaluation services

(2) LAc new patient visit: DOWC Z0800

Maximum value $99.68

(3) LAc established patient visit: DOWC Z0801

Maximum value $67.28
## AMBULANCE FEES

<table>
<thead>
<tr>
<th>Ground Ambulance</th>
<th>HCPCS Code Description</th>
<th>Urban Medicare Rate *250%</th>
<th>Rural (R = Zip Code) First 17 miles or &gt; if not a Super Rural Medicare Rate *250%</th>
<th>Super Rural (B = Zip code) Medicare Rate *250%</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0425</td>
<td>Ground mileage, per statue mile</td>
<td>$ 17.90</td>
<td>$ 18.08</td>
<td>$ 18.08</td>
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<tr>
<td>A0426</td>
<td>Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1-Non-Emergency)</td>
<td>$ 671.89</td>
<td>$ 678.48</td>
<td>$ 831.82</td>
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<td>A0427</td>
<td>Ambulance service, advanced life support, emergency transport, level 1 (ALS1-Emergency)</td>
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<td>$1,074.26</td>
<td>$1,317.04</td>
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<td>A0428</td>
<td>Ambulance service, basic life support, non-emergency transport (BLS)</td>
<td>$ 559.91</td>
<td>$565.40</td>
<td>$ 693.18</td>
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<td>A0429</td>
<td>Ambulance service, basic life support, emergency transport (BLS-Emergency)</td>
<td>$ 895.86</td>
<td>$904.64</td>
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<td>A0433</td>
<td>Advanced life support, level 2 (ALS2)</td>
<td>$1,539.75</td>
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<td>$1,906.25</td>
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<td>A0434</td>
<td>Specialty care transport (SCT)</td>
<td>$1,819.71</td>
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<td>$2,252.84</td>
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<td>A0432</td>
<td>Paramedic intercept (PI), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers.</td>
<td>$ 979.84</td>
<td>$ 989.45</td>
<td>$ 989.45</td>
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</tbody>
</table>
Contact Information

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Email Address: debra.northrup@state.co.us
DWC Website: https://www.colorado.gov/cdle/dwc