RULE 16 TABLE OF CHANGES

Rule	2018	2017
	Inserted a table of contents to assist the reader in navigating the rule.	
16-2(I)	Added the following clarification: In computing any period of time prescribed or allowed by Rules 16 or 18, the parties shall refer to Rule 1-2.	
16-2(S)	Added "as a psychiatric hospital" to the definition of a psychiatric hospital to clarify the type of licensure required.	
16-2(X)	Added "a broad term describing" to the definition of telehealth, to clarify telehealth is a broader term than telemedicine.	
16-2(Y)	Added the following definition of telemedicine: Telemedicine – two-way, real time interactive communication between the injured worker, and the provider at the distant site. This electronic communication involves, at minimum, audio and video telecommunications equipment. Telemedicine enables the remote diagnoses and evaluation of injured workers in addition to the ability to detect fluctuations in their medical condition(s) at a remote site in such a way as to confirm or alter treatment plan, including medications and/or specialized therapy.	
16-3	Deleted "AND PAYMENT FOR SERVICE" from the title of the rule.	
16-4(A), 16-5(B)(3), and 16-6(B)	Added: "… but the payer and provider may negotiate reimbursement in excess of this fee schedule when necessary to obtain reasonable and necessary care for an injured worker" to Rule 16-5(B)(3) and	16-5(B)(3) currently states: The Colorado fee schedule should govern reimbursement for out-of-state providers.

	corresponding references to Rules 16-4(A) and 16-6(B).	
16-5(A)(1)(b)(xiii)	Added a definition for an occupational therapy assistant: "Occupational Therapist Assistant (OTA) – licensed by the Office of Occupational Therapy, Colorado Department of Regulatory Agencies;"	
16-5(A)(6)(d)	Added: "… as required by §§ 8-42-105(2)(b) and (3), C.R.S." to clarify the statutory support for the rule requirement.	
16-6(E) and 16-7(C)	Deleted Rule 16-6(E) which stated: International Classification of Diseases (ICD) codes shall not be used to establish the work relatedness of an injury or treatment. Revised 16-7(C) to state as follows: International Classification of Diseases (ICD) Codes All provider bills shall list the current ICD-10- Clinical Modification (CM) diagnosis code(s) and preferably include the Chapter 20 External Causes of Morbidity code(s). If ICD-10-CM requires a seventh character, the provider must apply it in accordance with the ICD-10-CM Chapter Guidelines provided by the Centers for Medicare and Medicaid Services (CMS). The ICD-10-CM diagnosis code(s) shall not be used as a sole factor to establish work-relatedness of an injury or treatment.	Rule 16-7(C) currently states: International Classification of Diseases (ICD) Codes All provider bills, including outpatient hospital bills, shall list the appropriate diagnosis codes using the current ICD-10-Clinical Modification (CM) code(s). If a seventh character is required by ICD-10-CM, it must be applied in accordance with ICD-10-CM Chapter Guidelines provided by the Centers for Medicare and Medicaid Services (CMS).
16-7(H)	Updated the reference to the most current version of the Medicare Program Integrity Manual (from the July 2016 version to the June 2017 version).	

16-8(C)	Added section (C) to state (previously Rule 16-10(J): "All medical records should be signed by the rendering provider. Electronic signatures are accepted."	
16-9(D)	Added the following to clarify the requirements on the payer responding to a notification request: (1) The payer may limit its approval to the number of treatments or treatment duration specified in the relevant Medical Treatment Guideline(s), without a medical review. If subsequent medical records document functional progress, additional treatment may be approved. (2) If payer proposes to discontinue treatment before the maximum number of treatments/treatment duration has been reached due to lack of functional progress, payer shall support that decision with a medical review compliant with section 16-11(B).	
16-10(D)	Deleted the requirement that the payer shall: "… upon receipt of the "Employer's First Report of Injury" or a "Worker's Claim for Compensation," shall give written notice to the injured worker stating that the requirements for obtaining prior authorization for payment are available from the payer.	
16-11(A) and (E) and 16-12(B)(2)	Updated the rule to state that the medical review, IME, or an ATP report addressing relatedness of the requested treatment may precede the prior authorization request or billed service. Also clarified the procedural timelines involved in requesting a hearing or an IME in response to prior authorization requests.	Rule 16-11(A) currently states: If the payer contests a request for prior authorization for non-medical reasons as defined under section 16-12(B)(1), the payer shall notify the provider and parties, in writing, of the basis for

	16-11(A) new language: The medical review, IME report, or report from an ATP that addresses the relatedness of the requested treatment to the admitted claim may precede the prior authorization request. *16-11(E) new language:* Failure of the payer to timely comply in full with section 16-11(A), (B), or (C) shall be deemed authorization for payment of the requested treatment unless the payer has scheduled an independent medical examination (IME) and notified the requesting provider of the IME within the time prescribed for responding set forth in section 16-11(B). (1) The IME must occur within 30 days, or upon first available appointment, of the prior authorization request, not to exceed 60 days absent an order extending the deadline. (2) The IME physician must serve all parties concurrently with his or her report within 20 days of the IME. (3) The insurer shall respond to the prior authorization request within five business days of the receipt of the IME report. (4) If the injured worker does not attend or reschedules the IME, the payer may deny the prior authorization request pending completion of the IME. (5) The IME shall comply with Rules 8-8 to 8-13 as applicable. 16-12(B)(2) new language: The medical review, IME report, or report from an ATP that	the contest within seven (7) business days from receipt of the provider's completed request as defined in section 16-10(F). A certificate of mailing of the written contest must be sent to the provider and parties. If an ATP requests prior authorization and indicates in writing, including their reasoning and relevant documentation, that they believe the requested treatment is related to the admitted workers' compensation claim, the insurer cannot deny based solely on relatedness without a medical review as required by section 16-11(B). Rule 16-11(E) currently states: Failure of the payer to timely comply in full with the requirements of section 16-11(A) or (B), shall be deemed authorization for payment of the requested treatment unless: (1) A hearing is requested within the time prescribed for responding as set forth in section 16-11(A) or (B) and the requesting provider is notified accordingly. A request for hearing shall not relieve the payer from conducting a medical review of the requested treatment, as set forth in section 16-11(B); or (2) The payer has scheduled an independent medical examination (IME) within the time prescribed for responding as set forth in section 16-11(B). Rule 16-12(B)(2) currently states: If an ATP bills for medical services and indicates in writing, including their reasoning and relevant documentation that they believe the medical services are related to the admitted WC claim, the payer cannot deny based solely on

	addresses the relatedness of the requested treatment to the admitted claim may precede the received billed service.	relatedness without a medical review as required by section 16-12(C).
16-12(B)(4)	Amended the rule to read as follows: Prior to modifying a billed code, the payer must contact the billing provider and determine if the code is accurate. If the payer disagrees with the level of care billed, the payer may deny the claim or contact the provider to explain why the billed code does not meet the level of care criteria. (a) If the billing provider agrees with the payer, then the payer shall process the service with the agreed upon code and shall document on the explanation of benefits (EOB) the agreement with the provider. The EOB shall include the name of the person at the provider's office who made the agreement. (b) If the provider disagrees, then the payer shall proceed according to section 16-12(B) or 16-12(C), as appropriate.	The rule currently states: Prior to modifying a billed code, the payer must contact the billing provider and determine if the modified code is accurate.
16-12(B)(6)	Amended the rule to read as follows: When no established fee is given in the Medical Fee Schedule and the payer agrees the service or procedure is reasonable and necessary, the payer shall list on the written notice of contest (see section 16-12(A)(1)) one of the following payment options: (a) A reasonable value based upon the similar established code value recommended by the requesting provider, or (b) The provider's requested payment based on an established similar code value as required by section 16-10(E).	The rule currently states: When no established fee is given in the Medical Fee Schedule and the payer agrees the service or procedure is reasonable and necessary, the payer shall list on their written notice of contest (see section 16-12(A)(1)) one of the following payment options: (a) A reasonable value based upon the similar established code value recommended by the requesting provider; (b) The provider's requested payment based on an established similar code value as required by section 16-10(F); or

	If the payer disagrees with the provider's recommended code value, the payer's notice of contest shall include an explanation of why the requested fee is not reasonable, the code(s) used by the payer, and how the payer calculated/derived its maximum fee recommendation. If the payer is contesting the medical necessity of any non-valued procedure after a prior authorization was requested, the payer shall follow section 16-12(C).	(c) The billed charges. If the payer disagrees with the provider's recommended code value, the payer's notice of contest shall include an explanation of why the requested fee is not reasonable and what their recommendation is, based on the payment options. If the payer is contesting the medical necessity of any non-valued procedure after a prior authorization was requested, the payer shall follow section 16-12(C).
16-12(D)(6)	Amended the rule to read: In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts. The parties shall do so within 12 months of the date the original bill should have been processed in compliance with section 16-12, unless extenuating circumstances exist.	Rule currently reads: In the event of continued disagreement, and within 12 months of the date the original bill should have been processed in compliance with section 16-12, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts.
16-13	Deleted the word "Billing" from the "Medical Billing Dispute Resolution Intake Form" (Form WC 181)" to clarify the form may be used for non-billing disputes submitted under Rule 16-13. Added Rules 11 and 17 to the list of rules of which the alleged violation may be brought before the MPU through the dispute resolution process and result in the Director's Order. Added: In addition, the payer shall pay interest at the rate of eight percent per annum in accordance with § 8-43-410(2), C.R.S., upon all sums not paid timely and in accordance with the Division Rules.	

RULE 18 TABLE OF CHANGES

RULE	2018	2017
18-4	Updated conversion factors as follows: Anesthesia $50.00/RVU Surgery $71.17/RVU Radiology $71.17/RVU Pathology $68.40/RVU Medicine $68.34/RVU Physical Medicine/Rehabilitation $42.38/RVU Evaluation & Management (E&M) $53.53/RVU	Anesthesia $55.61/RVU Surgery $68.01/RVU Radiology $71.99/RVU Pathology $68.31/RVU Medicine $67.00/RVU Physical Medicine/Rehabilitation $41.14/RVU Evaluation & Management $50.20/RVU
	Added: "02 Telehealth Services" to the place of service codes table.	
18-5(A)(2)	Changed to: "The PA or NP has received Level I accreditation" as the circumstance in which a physician's assistant or a nurse practitioner may be allowed 100% of the fee schedule for services performed in a non-rural area.	The PA or NP may be allowed 100% of the Medical Fee Schedule if "the 'incident to' criteria found in 42 CFR §§ 410.26(a) and (b), 410.27, and 410.32(b)(3) have been met."
18-5(D)(6)(a)(ix)	Corrected a typographical error in the word "nasogastric."	"Nasograstric"
18-5(D)(6)(a)(x)	Added Modifier 22 as a recognized surgical modifier: 22 – Increased procedural service. The payer and provider shall negotiate the value based on the fee schedule and the amount of additional work.	
18-5(D)(11)	Amended the rule to read as follows: Platelet Rich Plasma (PRP) Injections	The rule currently states:

	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, maximum total allowance of $744.00, for his or her professional fees. The provider performing PRP injections in a facility setting shall bill CPT® 0232T, maximum total allowance of $269.50, for his or her professional fees. The above allowances include and apply to all body parts, imaging guidance, harvesting, preparation, the injection itself, and kits and supplies.	Platelet Rich Plasma (PRP) Injections The Medical Treatment Guidelines promulgated by the Director of the Division of Workers' Compensation (Rule 17) govern when PRP injections are appropriate. Any PRP injections outside of the Medical Treatment Guidelines require prior authorization. The provider shall bill DoWC Z0813, maximum total all-inclusive allowance of $735.00, for PRP injections to any body part. This includes imaging guidance, harvesting and preparation (if performed), the injection itself, as well as kits and supplies.
18-5(E)(2)(a)	Added: "The payer may also request proof of accreditation."	
18-5(E)(2)(g)	Added: Providers using film instead of digital X-rays shall append "FX" modifier. The fee is 80% of the maximum fee schedule.	
18-5(E)(3)(d)	Increased maximum fees for thermography billing codes as follows: DoWC Z0200 Upper body w/ Autonomic Stress Testing: $980.00 DoWC Z0201 Lower body w/ Autonomic Stress Testing: $980.00	DoWC Z0200 Upper body w/ Autonomic Stress Testing: $865.37 DoWC Z0201 Lower body w/ Autonomic Stress Testing: $865.37

18-5(F)(4)(c)	Amended the rule regarding presumptive drug testing to read as follows: "Presumptive drug class screening shall be billed using one of three codes – 80305, 80306, or 80307."	(i) Drug test(s), presumptive, any number of drug classes; any number of devices or procedures (e.g. immunoassay) capable of being read by a direct optical observation only (e.g. dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service (G0477). (ii) Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g, immunoassay) read by instrument-assisted direct optical observation (e.g. dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service (G0478). (iii) Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers (e.g, immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service (G0479). Presumptive drug class screening shall be billed using one of three codes - G0477, G0478 or G0479.
18-5(F)(4)(d)(i)	Added the following language to the rule governing drug screens while the injured worker is receiving chronic opioid management: "(see section 18-8(A) for examples)." Deleted and moved to Rule 18-8(A): Examples of documented justification include the following: · Concern regarding the functional status of the patient	

	· Abnormal results on previous testing · Change in management of dosage or pain · Chronic daily opioid dosage above 150 mg of morphine or equivalent Added the following language to the description of the four definitive tests G0480, G0481, G0482, G0482: "(2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift);" Added the following definitive drug test code: · G0659 - Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to gc/ms (any type, single or tandem) and lc/ms (any type, single or tandem), excluding immunoassays (e.g., Ia, eia, elisa, emit, fpia) and enzymatic methods (e.g., alcohol dehydrogenase), performed without method or drug-specific calibration, without matrix-matched quality control material, or without use of stable isotope or other universally recognized internal standard(s) for each drug, drug metabolite or drug class per specimen; qualitative or quantitative, all sources, includes specimen validity testing, per day, any number of drug classes.	
18-5(F)(4)(d)(ii)	Updated the table of definitive drug classes to align it with the AMA CPT® manual.	

18-5(G)(4)	Amended the rule to read: Appendix J of the 2017 CPT® identifies mixed, motor, and sensory nerve conduction studies and applicable billing requirements. EMG and NCV values generally include an evaluation and management (E&M) service. However, an E&M service may be separately payable if the requirements listed in Appendix A of the 2017 CPT® for billing modifier 25 have been met.	The rule currently states: Appendix J of the 2016 CPT® identifies mixed, motor and sensory nerve conduction studies and their appropriate billing.
18-5(G)(8)(b)	Increased maximum fee for the QSART (Quantitative Sudomotor Axon Reflex Test) DoWC Z0401 to $1,066.00	DoWC Z0401: $1,007.00
18-5(G)(9)(a)(ii)	Amended the first sentence of the rule to read (stylistic edit): A Colorado -licensed physician trained in neurophysiology shall monitor the patient's nervous system throughout the surgical procedure.	The rule currently states: A specifically neurophysiology trained Colorado -licensed physician shall monitor the patient's nervous system throughout the surgical procedure.
18-5(G)(9)(c)	Amended billing requirements for intraoperative neuro-monitoring to read as follows: Billing Restrictions CPT® 95940 and 95941 do not have separate professional and technical components. However, certain tests performed in conjunction with CPT® 95940 and 95941 throughout the surgical procedure do have separate professional and technical components, which may be separately payable if documented and otherwise allowed under Rule 18. The monitoring physician is the only billing party allowed to report CPT® 95940 or 95941.	The rule currently states: Billing Restrictions The technical component (equipment, technical certified staff) is only payable to the person who owns the equipment. The monitoring physician is the only billing party allowed to report the intraoperative neuro-monitoring codes (95940 or 95941).

18-5(G)(13)	Added: Moderate (conscious) sedation Providers billing for moderate sedation services shall comply with all applicable 2017 CPT® billing instructions. The maximum fee schedule value is determined using the Medicine Conversion Factor.	
18-5(G)(14)(g)	Deleted: Medical testimony is covered under Rule 18-6(D) and special reports are covered under Rule 18-6(G)(3)&(4).	
18-5(H)(8)(a)	Added "as outlined in the 2017 CPT®" to the first sentence of the rule. Amended the third paragraph of the rule to read as follows: A reexamination, reevaluation, or re-assessment is different from a progress note. Therapists should not bill these codes for a progress note. Therapists may bill CPT® codes 97164, 97168, or 97172 for a reevaluation only in the following cases:	The rule currently states: A reexamination, reevaluation, or reassessment (CPT® codes 97002, 97004, or 97006) are different from a progress note. Therapists should not bill these codes for a progress note. Therapists may bill CPT® codes 97002, 97004, or 97006 for a reevaluation only in the following cases:
18-5(H)(8)(b)	Updated the rule to read: PT and OT and Athletic Trainer Evaluation and Re-Evaluation RVU changes are as follows: 97161 – PT initial evaluation, low complexity, 1.66 RVUs 97162 – PT initial evaluation, moderate complexity, 2.48 RVUs 97163 – PT initial evaluation, high complexity, 3.71 RVUs 97164 – PT re-evaluation, 1.60 RVUs	The rule currently states: PT and OT and Athletic Trainer Evaluation and Re-Evaluation RVU changes are as follows: (i) CPT® code 97001 PT and 97003 OT Initial Evaluation = 2.48 RVUs, facility and non-facility; (ii) CPT® code 97005 Athletic Trainer Initial Evaluation is 85% of the PT/OT initial evaluation service value;

	97165 – OT initial evaluation, low complexity, 1.66 RVUs 97166 – OT initial evaluation, moderate complexity, 2.48 RVUs 97167 – OT initial evaluation, high complexity, 3.71 RVUs 97168 – OT re-evaluation, 1.60 RVUs 97169 – ATC initial evaluation, low complexity, 1.41 RVUs 97170 – ATC initial evaluation, moderate complexity, 2.10 RVUs 97171 – ATC initial evaluation, high complexity, 3.10 RVUs 97172 – ATC re-evaluation, 1.36 RVUs The above RVUs are for both facility and non-facility providers.	(iii) CPT® code 97002 PT and 97004 OT Re-Evaluation = 1.68 RVUs, facility and non-facility; (iv) CPT® code 97006 Athletic Trainer re-evaluation is 85% of the PT/OT reevaluation value.
18-5(I)(1)	Amended the first paragraph of the rule to read: Evaluation and management codes may be billed by medical providers as defined in Rule 16-5(A)(1)(a), nurse practitioners (NP), and physician assistants (PA). To justify the billed level of E&M service, medical record documentation shall utilize the 2017 CPT® E&M Services Guidelines and either the "E&M Documentation Guidelines" criteria adopted in Exhibit #7 of this Rule, or Medicare's 1997 Evaluation and Management Documentation Guidelines.	The rule currently states: Evaluation and management codes may be billed by medical providers as defined in Rule 16-5(A)(1)(a) as well as nurse practitioners (NP) and physician assistants (PA). Medical record documentation shall encompass the "E&M Documentation Guidelines" criteria as adopted in Exhibit #7 of this Rule or Medicare's 1997 Evaluation and Management Documentation Guidelines, to justify the billed level of E&M service.
18-5(I)(4)	Amended the rule to read: Treating Physician Telephone or On-line Services (CPT® 99441-99444): Telephone or on-line services may be billed if the medical records/documentation specifies all the following: (a) The amount of time and date; (b) The patient, family member, or healthcare provider talked to; and	The rule currently states: Treating Physician Telephone or On-line Services Telephone or on-line services may be billed if: (a) The service is performed more than one (1) day prior to a related E&M office visit, or (b) The service is performed more than seven (7) days following a related E&M office visit, and

	(c) The specifics of the discussion and/or decision made during the communication. The telephone or on-line services may be billed even if performed within the one day and seven day timelines listed in CPT®.	(c) The medical records/documentation specifies all the following: (i) The amount of time and date; (ii) The patient, family member, or healthcare provider talked to; and (iii) The specifics of the discussion and/or decision made during the communication.
18-5(I)(7)	Added: Prolonged Services: Providers shall document the medical necessity of prolonged services utilizing patient-specific information. Providers shall comply with all applicable CPT® requirements and the following additional requirements: (a) Physicians or other qualified health care professionals (MDs, DOs, DCs, DMPs, NPs, and PAs) with or without direct patient contact: (i) An E&M code shall accompany prolonged services codes CPT® 99354-99357. (ii) The provider must exceed the average times listed in the E&M section of CPT® by 30 minutes or more, in addition to the prolonged services codes. (iii) If using time spent (rather than three key components) to justify the level of primary E&M service, the provider must bill the highest level of service available in the applicable E&M subcategory before billing for prolonged services. (iv) The provider billing CPT® 99358 and 99359 for extensive record review shall document the names of providers and dates of service reviewed, as well as briefly summarize the records reviewed.	Deleted: When billing for prolonged services, either face-to-face or non-face-to-face, the provider shall provide a report that documents time distinguishable from the E&M visit.

	(b) Prolonged clinical staff services (RNs or LPNs) with physician or other qualified health care professional supervision: (i) The supervising physician or other qualified health care professional may not bill CPT® 99354-99359 for the time spent supervising clinical staff. (ii) Clinical staff services cannot be provided in an urgent care or emergency room setting.	
18-5(J)	Amended the rule to read: TELEHEALTH (1) "Telehealth" and "Telemedicine" are defined in Rules 16-2(X) and (Y). The healthcare services listed in Appendix P of CPT® and Division Z-codes (when appropriate) may be provided via telehealth or telemedicine. The provider shall append modifier 95 to the services listed in Appendix P to indicate synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system. All healthcare services provided through telehealth or telemedicine shall comply with the applicable requirements found in the Colorado Medical Practice Act and Colorado Mental Health Practice Act, as well as the rules and policies adopted by the Colorado Medical Board and the Colorado Board of Psychologist Examiners. (2) HIPAA privacy and electronic security standards are required for the originating site(s) and the rendering	The rule currently states: TELEHEALTH (1) "Telehealth" is defined in Rule 16-2(X). All healthcare services provided through telehealth shall comply with the applicable requirements found in the Colorado Medical Practice Act and Colorado Mental Health Practice Act, as well as the rules and policies adopted by the Colorado Medical Board and the Colorado State Board of Psychologist Examiners. (2) Telehealth facilities can bill for the originating fee as follows: Q3014 $35.00 /per 15 minutes A private residence at which an injured worker is located when he or she is receiving healthcare services through telehealth may not bill for the originating fee. (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

	provider(s). (3) 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 are among acceptable methods to 'establish' a patient relationship. (b) The patient is required to provide the appropriate consent for treatment. (4) Payment for telehealth and telemedicine services: (a) Telehealth services performed outside of an authorized originating site must be billed without an originating site fee. The distance (rendering) provider may be the only provider involved in the provision of telehealth services. The rendering provider shall bill CPT® place of service (POS) code 02, with modifier 95. This POS code does not apply to the originating site billing a facility fee. The originating site is responsible for establishing and verifying injured worker and provider identity. Authorized originating sites include: • The office of a physician or practitioner • A hospital (inpatient or outpatient) • A critical access hospital (CAH) • A rural health clinic (RHC) • A federally qualified health center (FQHC) • A hospital based or critical access hospital based renal dialysis center (including satellites)	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. (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. The originating site is responsible for establishing and verifying injured worker and provider identity. Authorized originating sites include: (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) (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) (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

	• A skilled nursing facility (SNF) • A community mental health center (CMHC) (b) Reimbursement is the RBRVS unit value for the CPT® code times the appropriate CF + $5.00 when modifier 95 is appended to the appropriate CPT® code(s). 95 – Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system. (c) Telehealth: (i) Approved telehealth facilities can bill for the originating fee as follows: Q3014 $35.00 /per 15 minutes A private residence at which an injured worker is located when he or she is receiving healthcare services through telehealth may not bill for the originating fee. (ii) Payment for telehealth services that have professional and technical components: The originating site provider shall bill the technical component (modifier TC). The distant site provider interpreting the results shall bill the professional component (modifier 26). (iii) The equipment or supplies at distant sites are not separately payable. (iv) Professional fees of the supporting providers at originating sites are not	are among acceptable methods 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) Payment for telehealth services from distant site practitioners (a) The medical providers shall bill codes G0425-G0427 for telehealth consultations, emergency department or initial inpatient. The maximum fee values are determined by multiplying the RBRVS RVUs and the E&M conversion factor listed in Rule 18-4. (b) The medical providers shall bill codes G0406-G0408 for follow up inpatient telehealth consultations. The maximum fee values are determined by multiplying the RBRVS RVUs and the E&M conversion factor listed in Rule 18-4. (c) For all telehealth services, the provider shall bill the appropriate RBRVS 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). GT – Attached to the distance (rendering) provider billed CPT® or HCPCS indicates the service was performed via telehealth. Using the modifier certifies that the patient was present at an eligible originating site when the telehealth service was furnished.

	separately payable. (d) Telemedicine: (i) The medical providers shall bill codes G0425-G0427 for telehealth consultations, emergency department or initial inpatient. The maximum fee values are determined by multiplying the RBRVS RVUs and the E&M conversion factor listed in Rule 18-4. (ii) The medical providers shall bill codes G0406-G0408 for follow up inpatient telehealth consultations. The maximum fee values are determined by multiplying the RBRVS RVUs and the E&M conversion factor listed in Rule 18-4.	
18-6(A)(1)(b)(v)	Increased maximum fee for certain face-to-face or telephonic meetings by treating physician, accompanied by a report or written record signed by the physician, DoWC Z0701 to $85.00 per 15 minutes.	DoWC Z0701, $75.00 per 15 minutes
18-6(A)(2)	Increased maximum fee for certain face-to-face or telephonic meetings by treating physician, not accompanied by a report or written record, DoWC Z0601 to $74.00 per 15 minutes.	DoWC Z0701, $65.00 per 15 minutes
18-6(A)(4)	Added: Peer-to-peer review by a treating physician with a medical reviewer, following the treating physician's complete prior authorization request as defined in Rule 16-10(E). Billing Code DoWC Z0602: $74.00 per 15 minutes billed to the requesting party.	

18-6(B)(1)	Amended the rule to read: A cancellation fee is payable only when a payer schedules an appointment the injured worker fails to keep, and the payer has not canceled three (3) business days prior to the appointment. The payer shall pay one-half of the usual fee for the scheduled services, or $180.00, whichever is less: Cancellation Fee Billing Code: DoWC Z0720 For payer-made appointments scheduled for four hours or longer, the payer shall pay one-half of the usual fee for the scheduled service. The provider shall bill the code corresponding to the service that has been cancelled and append modifier 51.	The rule currently states: A cancellation fee is payable only when a payer schedules an appointment the injured worker fails to keep, and the payer has not canceled three (3) business days prior to the appointment. The payer shall pay: One-half of the usual fee for the scheduled services, or $150.00, whichever is less. Cancellation Fee Billing Code: DoWC Z0720
18-6(D)(2), (3), and (4)	Increased maximum fees for the following deposition and testimony billing codes: DoWC Z0730: preparation time for a treating or non-treating physician as defined by Rule 16-5(A)(1)(a) or psychologist (PsyD, PhD, or EdD), $367.00 per hour, billed in half-hour increments. DoWC Z0734: deposition by a treating or non-treating physician as defined by Rule 16-5(A)(1)(a) or psychologist (PsyD, PhD, or EdD), $367.00 per hour, billed in half-hour increments. DoWCZ0738: testimony by a treating or non-treating physician as defined by Rule 16-5(A)(1)(a) or psychologist (PsyD, PhD, or EdD), $508.00 per hour, billed in half-hour increments.	DoWC Z0730: $325.00 per hour, billed in half-hour increments. DoWC Z0734: $325.00 per hour, billed in half-hour increments. DoWC Z0738: $450.00 per hour, billed in half-hour increments.

	Clarified that other providers shall be paid 85% of this fee.	
18-6(F)(4)(b)	Increased maximum fee for the permanent impairment rating determination by a Level II Accredited Authorized Treating Physician Providing Primary Care, DoWC Z0759 to $575.00 Increased maximum fee for the Referral, Level II Accredited Authorized Physician, DoWC Z0760 to $775.00 and clarified "the claimant is not a previously established patient to that physician."	DoWC Z0759, $355.00 DoWCZ0760, $575.00
18-6(G)(2)(e) and (3)(b)	Increased maximum fees for the completion and submission of the WC164 reports as follows: DoWC Z0750 $49.00 (Initial Report) DoWC Z0751 $49.00 (Progress Report, payer requested or provider initiated) DoWC Z0752 $49.00 (Closing Report) DoWC Z0753 $49.00 (Initial and Closing Reports are completed on the same form for the same date of service) DoWC Z0754 $49.00 per form completion (Additional forms sent to physician by payer or employer requiring more than 15 minutes to complete)	DoWC Z0750 $47.00 DoWC Z0751 $47.00 DoWC Z0752 $47.00 DoWC Z0753 $47.00 DoWC Z0754 $47.00 per form completion
18-6(G)(4)	Increased maximum fees for and/or added billing codes for special reports as follows: DoWC Z0755 (Written Report Only) DoWC Z0757 (Lengthy Form Completion) DoWC Z0758 (18-5(I)(8) meeting and report with non-treating physician) DoWC Z0756 (RIME: Respondent requested Independent Medical Examination (RIME)/Report with patient exam)	DoWC Z0755, DoWC Z0757, DoWC Z0758, DoWC Z0756, and DoWC Z0770 maximum fees: $325.00 per hour billed in 15-minute increments. IME Audio Recording DoWC Code: Z0766 $30.00 per exam IME Audio copying fee DoWC Code: Z0767 $20.00 per copy

	DoWC Z0770 (CIME: Claimant requested Independent Medical Examination (CIME)/Report with patient exam) Special Report Maximum Fees: $367.00 per hour billed in 15-minute increments. IME Audio Recording DoWC Code: Z0766 $34.00 per exam IME Audio copying fee DoWC Code: Z0767 $23.00 per copy Added: All RIME, CIME and DIME reports are due no later than 20 calendar days after the examination.	
18-6(H)(5)	Amended the rule to read: Durable Medical Equipment (DME) is equipment that can withstand repeated use and allows injured workers accessibility in the home, work, and community. DME can be categorized as: a. Inexpensive or Routinely Purchased: These items cost less than $50.00. The maximum fee for these items is identified in section (9) of this rule. b. Capped Rental/Purchased Equipment: i. Rented DME items must be purchased or discontinued after 15 months of continuous use, unless another treatment duration is listed in the Medical Treatment Guidelines or prior authorization is obtained from the payer. ii. The monthly rental rate cannot exceed 10% of the total fee scheduled price of the item to the provider or the supplier (after taking into account	The rule currently states: The payer shall not pay for rental fees once the purchase price of the rented item has been reached. When the item is purchased, all rental fees shall be deducted from the purchase price.

	any discounts/rebates the supplier or the provider may have received). The payer shall not pay for rental fees once the total fee scheduled price of the rented item has been reached. When the item is purchased, all rental fees shall be deducted from the total fee scheduled price. If necessary, the parties should use an invoice to establish the purchase price. iii. Items that cost $100.00 or less (according to invoice) shall be purchased and reimbursed pursuant to section (4) of this rule. iv. Purchased items may require maintenance/servicing agreements or fees. The fees are separately payable. Rented items typically include these fees in the monthly rental rates. c. All electrical stimulators are bundled kits that include the portable unit(s), 2 to 4 leads and pads, initial battery(s), electrical adapters, and carrying case. The kits that cost more than $100.00 shall be rented for the first month of use before a potential purchase. The monthly rental rate shall not exceed 10% of the total fee scheduled price. Provider shall request prior authorization and document the effectiveness of the kit for the injured worker prior to purchasing an item that costs more than $100.00. Effectiveness should include functional improvement and decreased pain. The billing provider shall append modifiers "NU" for new or "UE" for used purchased items or modifier "RR" for rented items. Billing codes for the items are as follows: i. TENS Machines/Kits, IF Machines/Kits, and Combination Kits: E0720 for a kit with 2 leads or E0730 for a kit with 4 leads;	

	ii. Electrical Muscle Stimulation Machines/Kits: E0744 for scoliosis; or E0745 for neuromuscular stimulator, electric shock unit; iii. Osteogenesis electrical stimulation: E0748 or E0749 for non-invasive spinal application, or E0760 for ultrasound low intensity; iv. All replacement supplies may be billed no more than once a month using A4595 for electrical stimulator supplies, 2 leads, or A4557 for replacement leads. Code A4557 should not be billed with the first month's rent. v. Conductive Garments: E0731; d. Continuous Passive Motion Devices (CPMs): E0935 – continuous passive motion exercise device for use on the knee only; or E0936 – continuous passive motion exercise device for use on body parts other than knee. These devices are bundled into the facility fees and not separately payable. e. Intermittent Pneumatic Devices (including, but not limited to, Game Ready and cold compression) are bundled into the facility fees and not separately payable. The use of these devices after discharge requires prior authorization. The billing codes are as follows: E0650-E0676 – Codes based on body part(s), segmental or not, gradient pressure and cycling of pressure and purpose of use; and A4600 – Sleeve for intermittent limb compression device, replacement only, per each limb.	

18-6(H)(6)	Added: Auto-shipping of monthly DMEPOS supplies is not allowed.	
18-6(I)(3)(e)(iv)	Increased the threshold (difference between hospital's cost and maximum fee allowance) when additional payments to hospitals are warranted for extraordinary cost admissions: If the difference is greater than $26,601.00, additional reimbursement is warranted.	The rule currently states: The difference is "greater than $23,570.00."
18-6(J)(4)	Added: However, the maximum allowable fees in Exhibit #4 may be exceeded in the rare case a more expensive implant is medically necessary. The facility must request prior authorization for additional payment with a separate report documenting medical reasonableness and necessity and submit an invoice showing cost of the implant(s) to the facility. Payers must report authorized exceptions to the Division's Medical Policy Unit on a monthly basis.	
18-6(J)(6)(g)	Deleted: "Modifier L1 should be appended to the billed laboratory services."	
18-6(M)(5)	Increased the maximum fee for travel time for home care service providers, DoWC Z0773, to $34.00 per hour.	DoWC Z0773: $30.00 per hour
18-6(N)(3)(e)	Added: The provider may bill for the discarded portion of drug from a single use vial or a single use package, appending the JW	

	modifier to the HCPC Level II code. The provider shall bill for the discarded drug amount and the amount administered to the injured worker on two separate lines. The provider must document the discarded drug in the medical record.	
18-6(N)(4)	Increased the maximum fees for prescription strength topical compounds as follows: Category I compound, Z0790 Fee $ 80.00 per 30 day supply Category II compound, Z0791 Fee $160.00 per 30 day supply Category III compound, Z0792 Fee $265.00 per 30 day supply Category IV compound, Z0793 Fee $370.00 per 30 day supply	Category I compound, Z0790 Fee $ 75.00 per 30 day supply Category II compound, Z0791 Fee $150.00 per 30 day supply Category III compound, Z0792 Fee $250.00 per 30 day supply Category IV compound, Z0793 Fee $350.00 per 30 day supply
18-6(N)(8)(d)	Added: The opioids classified as Schedule II or Schedule III controlled substances that are prescribed for treatment lasting longer than 30 days shall be provided through a pharmacy.	
18-6(N)(9)	Deleted: Physicians shall list the “repackaged” and the “original” NDC numbers in field 24 of the CMS-1500. List the “repackaged” NDC number first and the “original” NDC number second, with the prefix ‘ORIG’ appended.	
18-6(P)(3)(b)(ii) and (iii)	Increased the maximum fees for acupuncture services as follows: LAc new patient visit: DOWC Z0800, maximum value $105.10 LAc established patient visit: DOWC Z0801, maximum value $67.80	LAc new patient visit: DOWC Z0800, maximum value $99.80 LAc established patient visit: DOWC Z0801, maximum value $67.60

18-6(R)(4)(a)	Updated ambulance service codes and values to align them with the latest version of Healthcare Common Procedure Coding System (HCPCS).	
18-6(R)(5)	Added the following modifiers to append to ambulance codes: GM Multiple patients on one ambulance trip QL Patient pronounced dead after ambulance called QM Ambulance service under arrangement by a provider of service QN Ambulance service furnished directly by a provider of service.	
18-8(A)	Updated the rule language to add acute and subacute opioid management to chronic opioid management to read as follows: OPIOID MANAGEMENT (1) Codes and maximum fees are payable to the ATP for a written report with all the following opioid review services completed and documented: (a) Ordering and reviewing drug tests for subacute or chronic opioid management; (b) Ordering and reviewing Colorado Prescription Drug Monitoring Program (PDMP) results; (c) Reviewing the medical records; (d) Reviewing the injured workers' current functional status; (e) Evaluating the risk of misuse and abuse initially and periodically; and (f) Determining what actions, if any, need to be taken.	The rule currently states: CHRONIC OPIOID MANAGEMENT (1) When the authorized treating physician prescribes long-term opioid treatment, s/he shall use the Division of Workers' Compensation Chronic Pain Disorder Medical Treatment Guidelines and review the Colorado Medical Board Policy #40-26, "Policy for Prescribing and Dispensing Opioids." Urine drug tests for chronic opioid management shall employ testing methodologies that meet or exceed industry standards for sensitivity, specificity and accuracy. The test methodology must be capable of identifying and quantifying the parent compound and relevant metabolites of the opioid prescribed. In-office screening tests designed to screen for drugs of abuse are not appropriate for chronic opioid compliance monitoring. (a) Drug testing shall be done prior to the initial

	In determining the prescribed levels of medications, the ATP shall review and integrate the drug screening results required for subacute and chronic opioid management as appropriate; the PDMP and its results; an evaluation of compliance with treatment and risk for addiction or misuse; as well as the injured worker's past and current functional status. A written report also must document the treating physician's assessment of the patient's past and current functional status of work, leisure, and activities of daily living. The patient should initially and periodically be evaluated for risk of misuse or addiction. The ATP may consider whether the injured worker experienced an opiate-related drug overdose event that resulted in an opiate antagonist being prescribed or dispensed pursuant to §§ 12-36-117.7, 12-38-125.5, 12-42.5-120, or 13-21-108.7, C.R.S. If the patient is deemed to be at risk for an opiate overdose, an opioid antagonist may be prescribed (see section 18-6(N)(3)(c)). Opioid Management Billing Codes: Acute Phase DoWC Code: Z0771 $84.00 per 15 minutes – maximum of 30 minutes per report Subacute/Chronic Phase DoWC Code: Z0765 $84.00 per 15 minutes – maximum of 30 minutes per report	long-term drug prescription being implemented and randomly repeated at least annually. (b) When drug screen tests are ordered, the authorized treating physician shall utilize the Colorado Prescription Drug Monitoring Program (PDMP). (c) While the injured worker is receiving chronic opioid management, additional drug screens with documented justification may be conducted. Examples of documented justification include the following: (i) Concern regarding the functional status of the patient (ii) Abnormal results on previous testing (iii) Change in management of dosage or pain (iv) Chronic daily opioid dosage above 100 mg of morphine or equivalent (d) The opioids classified as Schedule II or Schedule III controlled substances that are prescribed for treatment longer than 30 days shall be provided through a pharmacy. (e) The authorized treating physician may consider whether the injured worker experienced an opiate-related drug overdose event that resulted in an opiate antagonist being prescribed or dispensed pursuant to §§ 12-36-117.7, 12-38-125.5, 12-42.5-120, or 13-21-108.7, C.R.S. (2015). For reimbursement for an

	(2) Definitions: (a) Acute opioid use refers to the prescription of opioid medications (single or multiple) for duration of 30 days or less for non-traumatic injuries, or 6 weeks or less for traumatic injuries or post-operatively. (b) Subacute opioid use refers to the prescription of opioid medications for longer than 30 days for non-surgical cases and longer than 6 weeks for traumatic injuries or post-operatively. (c) Chronic Opioid use refers to the prescription of opioid medications for longer than 90 days. (3) Acute opioid prescriptions generally should be limited to seven (7) days and 50 morphine milliequivalents (MME) per day. Providers considering repeat opioid refills at any time during treatment are encouraged to perform the actions in this section and bill accordingly. (4) When the ATP prescribes long-term opioid treatment, s/he shall comply with the Division's Chronic Pain Disorder Medical Treatment Guideline (Rule 17, Exhibit 9) and other relevant Treatment Guidelines, and review the Colorado Medical Board Policy #40-26, "Policy for Prescribing and Dispensing Opioids." (5) Urine drug tests are required for subacute and chronic opioid management and shall employ testing methodologies that meet or exceed industry standards for sensitivity, specificity and accuracy. The test methodology must be capable of identifying and	opiate antagonist, please see Rule 18-6(N)(3)(c). (f) The prescribing authorized treating physician shall review and integrate the screening results, PDMP, and the injured worker's past and current functional status on the prescribed levels of medications. A written report will document the treating physician's assessment of the patient's past and current functional status of work, leisure activities and activities of daily living competencies. (2) Codes and maximum fees for the authorized treating physician for a written report with all the following review services completed and documented: (a) Ordering and reviewing drug tests (b) Ordering and reviewing PDMP results (c) Reviewing the medical records (d) Reviewing the injured workers' current functional status (e) Determining what actions, if any, need to be taken (f) Appropriate chronic pain diagnostic code (ICD-10) Bill using code DoWC Z0765 $75.00 per 15 minutes – maximum of 30 minutes per report NOTE: This code is not to be used for acute or sub-acute pain management.

	quantifying the parent compound and relevant metabolites of the opioid prescribed. In-office screening tests designed to screen for drugs of abuse are not appropriate for subacute or chronic opioid compliance monitoring. Refer to section 18-5(F)(4) for clinical drug screening testing codes and values. (a) Drug testing shall be done prior to the initial long-term drug prescription being implemented and randomly repeated at least annually. (b) While the injured worker is receiving opioid management, additional drug screens with documented justification may be conducted. Examples of documented justification include: (i) Concern regarding the functional status of the patient; (ii) Abnormal results on previous testing; (iii) Change in management of dosage or pain; and (iv) Chronic daily opioid dosage above 50 MME.	
18-8(B)(2)	Increased the maximum fees for pre- and post-injection functional assessments as follows: DOWC Z0811 $62.00 DOWC Z0812 $33.00 DOWC Z0814 $33.00	DOWC Z0811 $60.00 DOWC Z0812 $31.44 DOWC Z0814 $31.44
18-8(C)(1)	Amended the rule to read:	The rule currently states:

	Medical providers who are Level I or II accredited, or who have completed the Division-sponsored Level I or II accreditation program and have successfully completed the QPOP training may bill separately for documenting functional progress made by the injured worker. The medical providers must utilize both a Division-approved psychological screen and a Division-approved functional tool. The psychological screen and the functional tool are approved by the Division and are validated for the specific purpose for which they have been created. […]	Medical providers who are Level I or II accredited, or who have completed the Division-sponsored Level I or II accreditation program and have successfully completed the QPOP training may bill separately for documenting functional progress made by the injured worker. The medical providers must utilize both a validated psychological screen and the validated functional data provided by the injured worker or another health care provider. […]