DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation

7 CCR 1101-3

WORKERS' COMPENSATION RULES OF PROCEDURE

Rule 16 UTILIZATION STANDARDS

16-1 STATEMENT OF PURPOSE

In an effort to comply with the legislative charge to assure the quick and efficient delivery of medical benefits at a reasonable cost, the Director (Director) of the Division of Workers' Compensation (Division) has promulgated these utilization standards, effective January 1, 2021. This Rule defines the standard terminology, administrative procedures, and dispute resolution procedures required to implement the Division's Medical Treatment Guidelines (Rule 17) and Medical Fee Schedule (Rule 18).

16-2 STANDARD TERMINOLOGY FOR RULES 16, 17, AND 18

A. Ambulatory Surgical Center (ASC) means licensed as such by the Colorado Department of Public Health and Environment (CDPHE).

B. Authorized Treating Provider (ATP) means any of the following:

1. The treating physician designated by the employer and selected by the injured worker;

2. A healthcare provider to whom an ATP refers the injured worker for treatment, consultation, or impairment rating;

3. A physician selected by the injured worker when the injured worker has the right to select a provider;

4. A physician authorized by the employer when the employer has the right or obligation to make such an authorization;

5. A healthcare provider determined by the Director or an administrative law judge to be an ATP;

6. A provider who is designated by the agreement of the injured worker and the payer.

C. Billed Service(s) means any billed service, procedure, equipment, or supply provided to an injured worker by a Provider.

D. Billing Party means a service provider or an injured worker who has incurred authorized medical expenses.

~~E. Certified Medical Interpreter means certified by the Certification Commission for Healthcare Interpreters or the National Board of Certification for Medical Interpreters.~~

E. Children's Hospital means federally qualified, and certified by CDPHE, and licensed as a general hospital by CDPHE.

~~G. Convalescent Center means licensed by the CDPHE.~~

F. Critical Access Hospital means federally qualified, and certified by CDPHE, and licensed as a general hospital by CDPHE. A list is available at www.ruralcenter.org/resource-library/cah-locations.

G. Day means a calendar day unless otherwise noted. In computing any period of time prescribed or allowed by Rules 16, 17, or 18, the parties shall refer to Rule 1-2.

H. Designated Provider List means a list of physicians as required under § 8-43-404(5)(a)(I) and Rule 8.

I. Freestanding Facility means 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 a provider-based entity.

J. Hospital means licensed as such by CDPHE.

K. Long-Term Acute Care Hospital ~~Facility~~ means federally certified and licensed as such by CDPHE.

L. Medical Fee Schedule means Division's Rule 18, its exhibits and the documents incorporated by reference in that Rule.

M. Medical Treatment Guidelines (MTGs) means Division's Rule 17, its exhibits, and the documents incorporated by reference in that Rule.

N. Non-Physician Provider means individual who is registered, certified or licensed by the Colorado Department of Regulatory Agencies (DORA), the Colorado Secretary of State, or a national entity recognized by the State of Colorado as follows:

1. Acupuncturist (Lac) licensed by the Office of Acupuncture Licensure, DORA;

2. Advanced Practice Nurse (APN) licensed by the Colorado Board of Nursing, Advanced Practice Nurse Registry;

3. Anesthesiologist Assistant (AA) licensed by the Colorado Medical Board, DORA;

4. Athletic Trainer (ATC) licensed by the Office of Athletic Trainer Licensure, DORA;

5. Audiologist (AU.D. CCC-A) licensed by the Office of Audiology and Hearing Aid Provider Licensure, DORA;

6. Certified Medical Interpreter certified by the Certification Commission for Healthcare Interpreters or the National Board of Certification for Medical Interpreters.

7. Certified Registered Nurse Anesthetist (CRNA) licensed by the Colorado Board of Nursing;

8. Clinical Social Worker (LCSW) licensed by the Board of Social Work Examiners, DORA;

9. Durable Medical Equipment, Prosthetic, Orthotics and Supplies (DMEPOS) Supplier licensed by the Colorado Secretary of State;

10. Marriage and Family Therapist (LMFT) licensed by the Board of Marriage and Family Therapist Examiners, DORA;

11. Massage Therapist licensed as a massage therapist by the Office of Massage Therapy Licensure, DORA;

12. Nurse Practitioner (NP) licensed as an APN and authorized by the Colorado Board of Nursing;

13. Occupational Therapist (OTR) licensed by the Office of Occupational Therapy, DORA;

14. Occupational Therapist Assistant (OTA) licensed by the Office of Occupational Therapy, DORA;

15. Pharmacist licensed by the Board of Pharmacy, DORA;

16. Physical Therapist (PT) licensed by the Physical Therapy Board, DORA;

17. Physical Therapist Assistant (PTA) licensed by the Physical Therapy Board, DORA;

18. Physician Assistant (PA) licensed by the Colorado Medical Board;

19. Practical Nurse (LPN) licensed by the Colorado Board of Nursing;

20. Professional Counselor (LPC) licensed by the Board of Professional Counselor Examiners, DORA;

21. Psychologist (PsyD, PhD, EdD) licensed by the Board of Psychologist Examiners, DORA;

22. Registered Nurse (RN) licensed by the Colorado Board of Nursing;

23. Respiratory Therapist (RTL) certified by the National Board of Respiratory Care and licensed by the Office of Respiratory Therapy Licensure, DORA;

24. Speech Language Pathologist (CCC-SLP) certified by the Office of Speech-Language Pathology Certification, DORA;

25. Surgical Assistant registered by the Office of Surgical Assistant and Surgical Technologists Registration, DORA.

O. Over-the-Counter Drugs means medications that are available for purchase by the general public without a prescription.

P. Payer means an insurer, self-insured employer, or designated agent(s) responsible for payment of medical expenses. (Use of agents, including but not limited to Preferred Provider Organization (PPO) networks, bill review companies, third party administrators (TPAs), and case management companies shall not relieve the insurer or self-insured employer from their legal responsibilities for compliance with these Rules).

Q. Physician Provider means individual who is licensed by the State of Colorado through one of the following boards:

1. Colorado Medical Board;

2. Colorado Dental Board;

3. Colorado Podiatry Board;

4. Colorado Optometry Board; or

5. Colorado Board of Chiropractic Examiners.

R. Prior Authorization means a guarantee of payment for the treatment requested ~~by a provider assurance that appropriate reimbursement for a specific treatment will be paid~~ in accordance with this Rule. ~~18, its exhibits and the documents incorporated by reference in that Rule.~~

S. Provider means a person or entity providing authorized health care service, whether involving treatment or not, to a worker in connection with a work-related injury or occupational disease.

T. Psychiatric Hospital means licensed as such by CDPHE.

U. Rehabilitation Hospital ~~Facility~~ means licensed as such by CDPHE.

V. Rural Health Clinic ~~Facility~~ means clinic located in areas designated by the United States Census Bureau as rural, or the state as medically underserved, that is federally qualified, and certified by CDPHE. A list is available at www.colorado.gov/pacific/cdphe/rural-health-clinic-consumer-resources.

W. Skilled Nursing Facility (SNF) means federally certified, and licensed as a nursing care facility by CDPHE.

X. State-run Psychiatric Hospital means mental health institute operated by the Colorado Department of Human Services, Office of Behavioral Health.

Y. Telemedicine means two-way, real time interactive communication between the injured worker and the provider at the distant site. This electronic communication involves, at a minimum, audio and video telecommunications equipment. Telemedicine enables the remote evaluation and diagnosis 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 the treatment plan, including medications and/or specialized therapy.

Z. Treatment means any service, procedure, or supply prescribed by an ATP as may reasonably be needed at the time of the injury or occupational disease and thereafter to cure and/or relieve the employee from the effects of the injury or occupational disease.

AA. Veterans Administration Hospital means all medical facilities overseen by the United States Department of Veterans' Affairs.

AB. Writing, for the purposes of Rules 16 and 18, means transmitted by letter, email, fax, or other electronic means of communication.

16-3 PROVIDER REQUIREMENTS

A. Any provider not listed above must obtain Prior Authorization when providing services related to a compensable injury.

B. Upon request, healthcare providers must provide copies of accreditation, licensure, registration, certification, or evidence of healthcare training for billed services.

C. To the extent not otherwise precluded by the laws of this state, contracts between providers, payers, and any agents acting on behalf of providers or payers shall comply with this Rule.

D. Referrals:

1. All ~~non-physician~~ providers must have a referral from a physician provider managing the claim (or NP/PA working under that physician provider). A physician making the referral to another ~~listed or unlisted non-physician~~ provider shall, upon request of any party, answer any questions and clarify the scope of the referral, prescription, or the reasonableness or necessity of the care.

2. A payer or employer shall not redirect or alter the scope of a referral to another provider for evaluation or treatment of a compensable injury. Any party who has concerns regarding a referral or its scope shall advise the other parties and providers involved.

E. Use of PAs and NPs ~~in Colorado Workers' Compensation Claims~~:

1. All Colorado workers' compensation (WC) claims (medical only and lost time claims) shall have a Physician responsible for all services rendered to an injured worker by any PA or NP.

2. The Physician must evaluate the injured worker at least once within the first three visits to the Designated Provider's office.

3. For services performed by a PA or NP, the Physician must counter-sign patient records related to the injured worker's inability to work resulting from the claimed work injury or disease and the injured worker's ability to return to regular or modified employment, as required by §§ 8-42-105(2)(b) and (3). The Physician must sign the WC-164 form, certifying that all requirements of this rule have been met.

16-4 OUT-OF-STATE PROVIDERS

A. Relocated Injured Worker

1. Upon receipt of the "Employer's First Report of Injury" or the "Worker's Claim for Compensation" form, the payer shall notify the injured worker that the procedures for change of provider can be obtained from the payer should ~~s/he~~ the injured worker relocate out of state.

2. A change of provider must be made through referral by the Physician managing the claim or in accordance with § 8-43-404(5)(a).

B. In the event an injured worker has not relocated out of state but is referred to an out-of-state provider for treatment not available within Colorado, the referring provider shall obtain Prior Authorization. The referring provider's written request for out of state treatment shall include:

1. Description of treatment requested, including medical justification, the estimated frequency and duration, and known associated medical expenses;

2. Explanation as to why the requested treatment cannot be obtained within Colorado;

3. Name, complete mailing address, and phone number of the out-of-state provider; and

4. Out-of-state provider's qualifications to provide the requested treatment.

16-5 REQUIRED USE OF THE MEDICAL TREATMENT GUIDELINES

When an injury or occupational disease falls within the purview of Rule 17, Medical Treatment Guidelines and the ~~date of~~ injury occurs on or after July 1, 1991, providers and payers shall use the MTG, in effect at the time of service, to prepare or review their treatment plan(s) for the injured worker. A payer may not dictate the type or duration of medical treatment or rely on its own internal guidelines or other standards for medical determination. Initial recommendations for a treatment or modality should not exceed the time to produce functional effect parameters in the applicable MTG. When treatment exceeds or is outside of the MTGs, Prior Authorization is required. Requesters and reviewers should consider how their decision will affect the overall treatment plan for the individual patient. In all instances of denial, appropriate processes to deny are required.

16-6 NOTIFICATION TO TREAT

A. The Notification to Treat process applies to treatment that is consistent with the MTGs and has an established value under the Medical Fee Schedule. Providers may, but are not required to, utilize Notification to ensure payment for medical treatment that falls within the purview of the MTGs. The lack of response from the payer within the time period set forth below shall deem the proposed treatment authorized for payment.

B. Notification to Treat may be submitted by phone during regular business hours by informing the payer of the verbal "Notification," or by submitting the "Authorized Treating Provider's Notification to Treat" form (WC 195). Notification to Treat must include:

1. Provider's certification that the proposed treatment is medically necessary and consistent with the MTGs.

2. Citation of the specific MTG applicable to the proposed treatment.

3. Provider's email address or fax number to which the payer can respond.

C. Payers shall respond to a Notification to Treat submission within seven days from the receipt of the submission with an approval or a denial of the proposed treatment.

1. The payer may limit its approval to the number of treatments or treatment duration specified in the relevant MTG without a medical review. If subsequent medical records document functional progress, additional treatment should 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 this rule.

D. Payers may deny proposed treatment for the following reasons only:

1. For claims that ~~which~~ have been reported to the Division, no admission of liability or final order finding the injury compensable has been issued;

2. Proposed treatment is not related to the admitted injury;

3. Provider submitting Notification is not an ATP or is proposing treatment to be performed by a provider who is not eligible to be an ATP.

4. Injured worker is not entitled to the proposed treatment pursuant to statute or settlement;

5. Medical records contain conflicting opinions among the ATPs regarding proposed treatment;

6. Proposed treatment falls outside of the MTGs.

E. If the payer denies Notification to Treat per sections 16-6 D 2, 5, or 6, the payer shall notify the provider, allow the submission of relevant supporting medical documentation as defined in section 16-7 C and review the submission as a Prior Authorization request, allowing ~~7~~ 10 additional ~~business~~ days for review.

F. Appeals for denied Notifications to Treat shall be made in accordance with the Prior Authorization Appeals Process outlined in this rule.

G. Any provider or payer who incorrectly applies the MTGs in the Notification to Treat process may be subject to penalties under the Workers' Compensation Act.

16-7 PRIOR AUTHORIZATION

~~Granting of Prior Authorization is a guarantee of payment in accordance with Rule 18, RBRVS, and CPT for the treatment services/procedures requested by a provider. pursuant to section 16-6(E).~~

A. Prior Authorization may be requested using the "Authorized Treatment Provider's Request for Prior Authorization" (Form WC 188) or in the alternative, shall be clearly labeled as a Prior Authorization request. Prior Authorization for payment shall only be requested ~~by a provider~~ when:

1. A prescribed treatment exceeds the recommended limitations set forth in the MTGs.

2. The MTGs require Prior Authorization for that specific service;

3. A prescribed treatment is not priced in the Medical Fee Schedule or is identified in Rule as requiring Prior Authorization for payment.

B. Prior Authorization for prescribed treatment may be granted immediately and without a medical review. However, the payer shall respond to all Prior Authorization requests in writing within 10 days from receipt of a ~~provider's~~ completed request as defined per this Rule. ~~The duty to respond to a provider's request applies regardless of who transmitted the request.~~

The payer, unless it has previously notified the provider, shall give notice to the provider of the procedures for obtaining Prior Authorization for payment upon receipt of the initial bill from that provider.

C. When submitting a Prior Authorization request, a provider shall concurrently explain the reasonableness and medical necessity of the treatment requested, and shall provide relevant supporting documentation~~. Supporting medical documentation is defined as~~ (documentation used in the provider's decision making process to substantiate need for the requested treatment). A complete Prior Authorization request includes the following:

1. An adequate definition or description of the nature, extent and necessity for the treatment;

2. Identification of the appropriate MTG if applicable; and

3. Final diagnosis.

~~The Division recommends payers confirm, in writing, to all parties when a request for Prior Authorization is approved.~~

~~D. If, after the service was provided, the payer agrees the service was reasonable and necessary, lack of Prior Authorization does not warrant denial of payment. However, the provider is still required to provide with the bill, the documentation required by section 16-6(E) for any unlisted service or procedure for payment.~~

16-7-1 PRIOR AUTHORIZATION DENIALS

A. If a provider requests Prior Authorization and indicates in writing, including reasoning and ~~relevant~~ supporting documentation, that ~~s/he believes~~ the requested treatment is related to the admitted WC claim, the ~~insurer~~ payer cannot deny solely for relatedness without a medical opinion as required by this Rule. The medical review, independent medical examination (IME) report, or report from an ATP that addresses relatedness of the requested treatment to the admitted claim may precede the Prior Authorization request~~, unless the requesting physician presents new evidence as to why this treatment is now related~~ if:

1. The opinion was issued within 365 days prior to the date of the Prior Authorization request; and

2. An admission of liability has not been filed admitting the relatedness of the requested treatment to the admitted claim or a final order has not been entered finding the specific medical condition related to the admitted injury.

If not, the medical review, IME report, or report from the ATP must be subsequent to the prior authorization request.

B. The payer may deny a request for Prior Authorization for medical or non-medical reasons. Examples of non-medical reasons are listed in section 16-10-2 A.

1. If the payer is denying a request for non-medical reasons, the payer shall, within 10 days of receipt of the complete request, furnish the requesting provider and the parties with a written denial that sets forth clear and persuasive reasons for the denial, including citation of appropriate statutes, rules, and/or supporting documents (e.g., a copy of claim denial or a detailed explanation why the requesting provider is not authorized to treat).

2. If the payer is denying a request for medical reasons, the payer shall, within 10 days of receipt of the complete request:

a. Have all of the submitted documentation reviewed by a Physician, who holds a license in the same or similar specialty as would typically manage the medical condition or treatment under review. The physician provider performing this review shall be Level I or II Accredited. In addition, clinical Pharmacists (Pharm.D.) may review Prior Authorization requests for medications, and Psychologists may review requests for mental health services, without having received Level I or II Accreditation.

After reviewing all of the submitted documentation and documentation referenced in the Prior Authorization request that is available to the payer, the reviewing Physician may call the requesting provider to expedite the communication and processing of the Prior Authorization request.

b. Furnish the requesting provider and the parties with a written denial that sets forth an explanation of the specific medical reasons for the denial, including the name and professional credentials of the provider ~~Physician/Pharmacist~~ performing the medical review and a copy of the reviewer's opinion; the specific cite from the MTGs, when applicable; and identification of the information deemed most likely to influence a reconsideration of the denial, when applicable.

~~Documentation of response to the provider and parties.~~

16-7-2 PRIOR AUTHORIZATION APPEALS

A. The requesting party shall have 10 days from the date of the written denial to ~~provide a written response to the payer~~ submit an appeal with additional information to support the request. A written response is not considered a "special report" as defined in Rule 18. ~~when prepared by the provider of the requested treatment~~.

B. The payer shall have 10 days from the date of the appeal to issue a final decision and provide documentation of that decision to the provider and parties.

C. In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or the Office of Administrative Courts.

D. An urgent need for Prior Authorization of health care services, as recommended in writing by an ATP, shall be deemed good cause for an expedited hearing.

E. Failure of the payer to timely comply in full with all Prior Authorization requirements outlined in this rule 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 16-7(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 the ~~his/her~~ report within 20 days of the IME.

3. The payer shall respond to the Prior Authorization request within 10 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 Rule 8 as applicable.

~~E. Unreasonable delay of denial of Prior Authorization, as determined by the Director or an administrative law judge, may subject the payer to penalties under the Workers' Compensation Act.~~

16-8 REQUIRED USE OF THE FEE SCHEDULE

A. All providers and payers shall use the Medical Fee Schedule to determine the maximum allowable payments for any medical treatments or services within the purview of the Workers' Compensation Act of Colorado and the Colorado Workers' Compensation Rules of Procedure, unless one of the following exceptions applies:

1. If billed charges are less than the fee schedule, the payment shall not exceed the billed charges.

2. The payer and an out-of-state provider may negotiate reimbursement in excess of the fee schedule when required to obtain reasonable and necessary care for an injured worker.

3. Pursuant to § 8-67-112(3), the Uninsured Employer Board may negotiate rates of reimbursement for medical providers.

B. The Medical Fee Schedule does not limit the billing charges.

C. Payment for treatment not identified or identified but without established value in the Medical Fee Schedule shall require Prior Authorization ~~from the payer pursuant to section 16-6~~, except for when the ~~billed non-established valued~~ treatment is an emergency.~~ or a payment mechanism under Rule 18 is identifiable but not explicit. Examples of these exceptions include ambulance bills or supplies covered under Rule 18 with an identified payment mechanism.~~ Similar established code values from the Medical Fee Schedule, ~~recommended by the requesting provider~~ determined in compliance with section 16-10-1 B, shall govern ~~the maximum fee schedule~~ payment.

16-8-1 REQUIRED BILLING FORMS AND CODES

A. Medical providers shall use only the billing forms listed below or exact electronic reproductions. ~~Any reproduction shall be an exact duplication of the form(s) in content and appearance.~~ If the payer agrees, providers may place identifying information in the margin of the form. Payment for any service not billed on the forms identified below may be denied. ~~However, the payer shall comply with the applicable providers set forth in section 16-11.~~

1. A CMS-1500 ~~(Centers for Medicare & Medicaid Services)~~ shall be used by all providers billing for professional services (unless otherwise specified below), DMEPOS, and ambulance services. ~~with the exception of dental services~~. Medical providers shall provide their name and credentials in ~~the appropriate~~ box 31 of the CMS-1500. Non-hospital based ASCs may bill on the CMS-1500, however an SG modifier must be appended to the technical component of services to indicate a facility charge and to qualify for reimbursement as a facility claim.

2. A UB-04 shall be used by all hospitals and facilities meeting definitions found in section 16-2, hospital-based ambulance/air services, ~~Children's Hospitals, CAHs, Veteran's Administration Medical Facilities, home health and facilities meeting definitions found in section 16-2,~~ and ~~any~~ other provider~~s~~, such as hospital-based ASCs, when billing for hospital/facility services.

   a. Some outpatient hospital therapy services ~~(Physical, Occupational or Speech)~~ may also be billed on a UB-04. For these services, the UB-04 must have Form Locator Type 13x, 074x, 075x or 085x, and one of the following revenue codes:

      042X - Physical Therapy

      043X - Occupational Therapy

      044X - Speech Therapy

b. CAHs designated by Medicare or Exhibit # 3 to Rule 18 may use a UB- 04 to bill professional services if the professional has reassigned his or her billing rights to the CAH using Medicare's Method II. The CAH shall list bill type 851-854, as well as one of the following revenue code(s) and Health Care Common Procedure Coding System (HCPCS) codes in the HCPCS Rates field number 44:

- 0960 - Professional Fee General
- 0961 - Psychiatric
- 0962 - Ophthalmology
- 0963 - Anesthesiologist (MD)
- 0964 - Anesthetist (CRNA)
- 0971 - Professional Fee For Laboratory
- 0972 - Professional Fee For Radiology Diagnostic
- 0973 – Professional Fee - Radiology - Therapeutic
- 0974 - Professional Fee - Radiology - Nuclear
- 0975 - Professional Fee - Operating Room
- 0981 - Emergency Room Physicians
- 0982 - Outpatient Services
- 0983 - Clinic
- 0985 - EKG Professional
- 0986 - EEG Professional
- 0987 - Hospital Visit Professional (MD/DO)
- 0988 - Consultation (Professional (MD/DO)

All professional services billed by a CAH are subject to the same coding and payment rules as professional services billed independently. The following modifiers shall be appended to HCPCS codes to identify the type of provider rendering the professional service:

GF Services rendered in a CAH by a NP, clinical nurse specialist, certified registered nurse, or PA

SB Services rendered in a CAH by a nurse midwife

AH Services rendered in a CAH by a clinical psychologist

AE Services rendered in a CAH by a nutrition professional/registered dietitian

AQ Physician services in a physician-scarcity area

(c) No provider except those listed above shall bill for the professional fees using a UB-04.

3. American Dental Association's Dental Claim Form, Version 2019 shall be used by all providers billing for dental treatment.

4. An NCPCP (National Council for Prescription Drug Programs) Workers' Compensation/Property and Casualty universal claim form, version 1.1 shall be used by dispensing pharmacies and pharmacy benefit managers.

An ANSI ASC X12 (American National Standards Institute Accredited Standards Committee) or NCPCP electronic billing transaction containing the same information as in 1, 2, or 3 of this subsection may be used with payer agreement.

5. An invoice or other agreed upon form may be used for services incident to medical treatment, such as language interpreting or mileage reimbursement.

B. International Classification of Diseases (ICD) Codes

All medical provider bills shall list the ICD-10 Clinical Modification (CM) diagnosis code(s) that are current, accurate, and specific to each patient encounter, in accordance with the ICD-10-CM Chapter Guidelines provided by CMS (Centers for Medicare & Medicaid Services). Bills should include the ~~Chapter 20~~ External Causes ~~of Morbidity~~ code(s).~~, however these~~ ICD-10 codes shall not be used as a sole factor to establish work-relatedness of an injury or treatment.

C. Medical providers must accurately report their services using applicable billing codes, modifiers, instructions, and parenthetical notes as incorporated by reference in Rule 18. ~~listed in the Medical Fee Schedule; the National Relative Value Files, as published by CMS in the April 2019 Resource Based Relative Value Scale (RBRVS); and the American Medical Association's Current Procedural Terminology (CPT®) as incorporated by Rule 18 2019 edition.~~ The provider may be subject to penalties for inaccurate billing when the provider knew or should have known that the treatment billed was inaccurate, as determined by the Director or an administrative law judge.

D. National provider identification (NPI) numbers are required for WC bills. Provider types ineligible to obtain NPI numbers are exempt from this requirement. When billing on a CMS-1500, Dental Claim Form, or UB-04, the NPI shall be that of the rendering provider and shall include the correct place of service code(s) at the line level.

16-8-2 TIMELY FILING

A. Providers shall submit their bills for treatment rendered within 120 days of the date of service or the bill may be denied unless extenuating circumstances exist.

1. For bills submitted through electronic data interchange (EDI), providers may prove timely filing by showing a payer acknowledgement (claim accepted). Rejected claims or clearinghouse acknowledgement reports are not proof of timely filing.

2. For paper bills, providers may prove timely filing with a signed certificate of mailing listing the original date mailed and the payer's address; a fax acknowledgement report; or a certified mail receipt showing the date the payer received the bill.

3. All timely filing issues will be considered final 10 months from the date of service unless extenuating circumstances exist.

B. Injured workers shall submit requests for mileage reimbursement within 120 days of the date of service or reimbursement may be denied unless good cause exists.

C. Extenuating circumstances/good cause may include, but are not limited to, delays in compensability being decided or the ~~provider~~ party has not been informed of this benefit or where to send the bill.

16-9 REQUIRED MEDICAL RECORD DOCUMENTATION

A. The treating provider shall maintain medical records for each injured worker when billing for the provided treatment. The rendering provider shall sign the medical records. Electronic signatures are accepted.

B. All medical records shall legibly document the treatment billed and ~~The documentation shall itemize each contact with the injured worker. The documentation also~~ shall include ~~detail~~ at least the following information ~~per contact or if contact occurs more than once per week, detail at least once per week~~:

1. Patient's name;

2. Date of ~~contact, office visit or~~ treatment;

3. Name and professional designation of person providing treatment;

4. Assessment or diagnosis of current condition with appropriate objective findings;

5. Treatment provided; ~~status or patient's functional response to current treatment;~~

6. Treatment plan, when applicable; ~~including specific therapy with time limits and measureable goals and details of referrals;~~ and

~~7. Pain diagrams, where applicable;~~

7. If being completed by an authorized treating physician, all pertinent changes to work and or activity restrictions which reflect lifting, standing, stooping, kneeling, hot or cold environment, repetitive motion or other appropriate physical considerations. ~~and~~

~~9. All prior authorization(s) for payment received from the payer (i.e., who approved prior authorization, services authorized, dollar amount, length of time, etc.).~~

C. All treatment provided to injured workers is expected to be documented in the medical record at the time it is rendered. Occasionally, certain entries related to treatment provided are not made timely. In this event, the documentation will need to be amended, corrected, or entered after rendering treatment. Amendments, corrections, and delayed entries must comply with Medicare's widely accepted recordkeeping principles as outlined in the Medicare Program Integrity Manual Chapter 3, section 3.3.2.5, implemented August 2017. (This section does not apply to injured workers' requests to amend records as permitted by the Health Insurance Portability and Accountability Act (HIPAA)).

D. The ATP must sign (or counter-sign) and submit to the payer, within 14 days of the initial and final visit ~~billings~~, a completed WC-164 form. ~~specifying:~~

1. The form shall be completed as an "initial" report when the injured worker has the ~~his/her~~ initial visit with the ~~ATP managing the workers' compensation claim (generally the~~ designated physician, or in the case of a transfer of care, the new designated physician.~~)~~ If applicable, the emergency department (ED) or urgent care physician initially treating the injury may also complete a WC-164 initial report. In such cases, the initial reports from the ED or urgent care physician, and the designated physician shall be reimbursed. Unless requested or prior authorized by the payer, no other physician should complete and bill for the WC-164 initial report. See Rule 18 for required fields.

2. The form shall be completed as a "closing" report when the ATP managing the total WC claim determines the injured worker has reached maximum medical improvement (MMI) for all covered injuries or diseases, with or without permanent impairment. See Rule 18 for required fields. ~~If the injured worker has sustained permanent impairment, item 10 must also be completed and the following information shall be attached to the bill at the time of MMI:~~

~~a. When the ATP managing the total WC claim of the is Level II Accredited, all necessary permanent impairment rating reports, including a narrative report and appropriate worksheets; or~~

~~b. When the ATP managing the total WC claim of the is not Level II Accredited, a referral to a Level II Accredited physician to perform the permanent impairment rating.~~

3. The ATP shall supply the injured worker with a copy of the WC-164 at the time of completion, at no charge.

E. Providers other than hospitals shall provide the payer with all supporting documentation and treatment records at the time of billing unless the parties have made other agreements. ~~This shall include copies of the examination, surgical and/or treatment records.~~ Hospitals shall provide documentation to the payer upon request. Payers shall specify what portion of a hospital record is being requested (for example, only the ED chart notes, in-patient physician orders and chart notes, x-rays, pathology reports, etc.). The payer may deny payment for billed treatment until the provider submits the required medical documentation.

16-10 PAYMENT REQUIREMENTS FOR MEDICAL BILLS

A. All bills ~~submitted by a provider~~ are due and payable in accordance with the Medical Fee Schedule within 30 days after receipt by the payer, unless the payer provides timely and proper reasons set forth by section 16-10-2 or 3.

B. For every medical treatment bill submitted by a provider, the payer shall reply with a written notice (explanation of benefits) within 30 days of receipt of the bill that includes the following:

1. Injured worker's name;

2. Payer's name and address;

3. Date(s) of service;

4. Each procedure code billed; and

5. Amount paid.

C. If any adjustment is made to the amount submitted on the bill, the payer's written notice shall also include:

1. Payer's claim number and/or Division's WC number;

2. Specific identifying information coordinating the notice with any payment instrument associated with the bill;

3. Notice that the billing party may submit a corrected bill or an appeal within 60 days;

4. Name of insurer with admitted, ordered, or contested liability for the WC claim, when known;

5. Name and address of any third party administrator (TPA) and/or bill reviewer associated with processing the bill;

6. Name and contact information of a person who has responsibility and authority to discuss and resolve disputes on the bill;

7. Name and address of the employer, when known;

8. For compensable treatment related to a work injury, the payer shall notify the billing party that the injured worker shall not be balance-billed;

9. If applicable, a statement that the payment is being held in abeyance because a hearing is pending on a relevant issue.

D. Any written notice that fails to include the required information is defective and does not satisfy the 30-day notice requirement.

E. If the payer discounts a bill and the provider requests clarification in writing, the payer shall furnish to the requester the specifics of the discount within 30 days, including a copy of any contract relied upon for the discount. If no response is forthcoming within 30 days, the payer must pay the maximum Medical Fee Schedule allowance or the billed charges, whichever is less.

F. Date of bill receipt by the payer may be established by the payer's date stamp or electronic acknowledgment date; otherwise, ~~presumed~~ receipt is presumed to occur ~~three business~~ five days after the date the bill was mailed to the payer's correct address.

~~G. Unreasonable delay in processing payment or denial of payment of medical treatment bills, as determined by the Director or an administrative law judge, may subject the payer to penalties under the Workers' Compensation Act.~~

~~H. If the payer fails to make timely payment of uncontested billed treatment, the billing party may report the incident to the Division's Carrier Practices Unit to be used during an audit.~~

G. Payers shall reimburse injured workers for mileage expenses as required by statute or provide written ~~or electronic~~ notice of the reason(s) for denying reimbursement within 30 days of receipt.

H. An injured worker shall never be required to directly pay for admitted or ordered medical benefits covered under the Workers' Compensation Act. In the event the injured worker has directly paid for medical treatment that is then admitted or ordered under the Workers' Compensation Act, the payer shall reimburse the injured worker for the amounts actually paid for authorized treatment within 30 days of receipt of the bill. If the actual costs exceed the maximum fee allowed by the Medical Fee Schedule, the payer may seek a refund from the medical provider for the difference between the amount charged to the injured worker and the maximum fee.

16-10-1 MODIFIED, UNLISTED, AND UNPRICED CODES

A. 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.

1. 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 written notice the agreement with the provider. The written notice shall include the name of the party at the billing office who made the agreement.

2. If the billing provider disagrees with the payer, then the payer shall proceed with a denial.

B. When no established fee is identified 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 one of the following payment options:

1. Payment based on a similar established code value as recommended by the billing provider.

2. A reasonable value based upon a similar established code value as determined by the payer.

If the payer disagrees with the billing provider's recommended code value, the denial shall include an explanation of why the requested fee is not reasonable, identification of the similar code as determined by the payer, and how the payer calculated its fee recommendation. ~~If the payer is denying the medical necessity of a non-valued procedure after prior authorization was requested, the payer shall follow section 16-11(C).~~

16-10-2 DENYING PAYMENT OF BILLED TREATMENT FOR NON-MEDICAL REASONS

A. Non-medical reasons are administrative issues that do not require medical documentation review. Examples of non-medical reasons for denying payment include the following: no WC claim has been filed with the payer; compensability has not been established; the provider is not authorized to treat; the insurance coverage is at issue; typographic~~, gender~~ or date errors on the bill; failure to submit medical documentation; or unrecognized or improper use of a CPT® code.

B. If an ATP bills for medical treatment and indicates in writing, including reasoning and relevant documentation that ~~he or she believes~~ the medical services are related to the admitted WC claim, the payer cannot deny payment solely for relatedness without a medical opinion as required by section 16-10-3. 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 date of service, unless the requesting physician presents new evidence as to why treatment is now related.

C. In all cases where a billed treatment is denied for non-medical reasons, the payer's ~~shall send the billing party written notice of the denial within 30 days of receipt of the bill. The~~ written notice shall include all notice requirements set forth in sections 16-10 B and C, and shall also include:

1. Reference to each ~~item of the bill~~ code being denied; and

2. Clear and persuasive reasons for denying payment ~~of any item specific to that bill~~, including citation of appropriate statutes, rules and/or documents supporting the payer's reason(s).

~~Any notice that fails to include the required information set forth in this section is defective. Such defective notice shall not satisfy the 30-day notice requirement set forth in this section.~~

D. If after the treatment was provided, the payer agrees the service was reasonable and necessary, lack of prior authorization does not warrant denial of payment. However, the provider may still be required to provide additional supporting documentation.

16-10-3 DENYING PAYMENT OF BILLED TREATMENT FOR MEDICAL REASONS

A. The payer shall have the bill and all supporting medical documentation reviewed by a Physician ~~Provider as defined in section 16-3(A)(1)(a),~~ who holds a license and is in the same or similar specialty as would typically manage the medical condition or treatment under review. The Physician ~~Provider~~ shall be Level I or II Accredited. In addition, a clinical Pharmacist (Pharm.D.) may review billed services for medications, and a Psychologist may review billed services for mental health, without having received Level I or II Accreditation. After reviewing the supporting medical documentation, the reviewing provider may call the billing provider to expedite communication and timely processing of the bill.

B. In all cases where a billed treatment is denied for medical reasons, the payer's ~~shall send the billing party written notice of the denial within 30 days of receipt of the bill. The~~ written notice shall include all notice requirements set forth in sections 16-10 B and C, and shall also include:

1. Reference to each code being denied;

2. Clear and persuasive medical reasons for denying payment, including the name and professional credentials of the provider performing the medical review and a copy of the reviewer's opinion;

3. Citation from the M~~edical~~ T~~reatment~~ G~~uideline~~s, when applicable; and

4. Identification of additional information deemed likely to influence reconsideration, when applicable.

16-10-4 APPEALING BILLED TREATMENT DENIALS

A. The billing party shall have 60 days from the date of the written notice to request reconsideration. The billing party's appeal must include:

1. A copy of the original or corrected bill;

2. A copy of the written notice ~~or EOB received~~;

3. Identification of the specific code being appealed; and

4. Clear and persuasive reason(s) for the appeal, including additional supporting documentation when applicable.

B. If the billing party appeals the denial in compliance with above requirements, the payer shall:

1. When denied for non-medical reasons, have the bill and all supporting documentation reviewed by a person who has knowledge of the bill. After reviewing the provider's appeal, the reviewer may call the appealing party to expedite the communication and timely processing of the appeal.

2. When denied for medical reasons, have the bill and all supporting documentation reviewed by a Physician ~~Provider~~ who holds a license and is in the same or similar specialty as would typically manage the medical condition or treatment under review. The Physician ~~Provider~~ shall be Level I or II Accredited. In addition, a clinical pharmacist (Pharm.D.) ~~as defined by section 16-3(A)(1)(b)(xvi)~~ may review appeals for payment of medications and a Psychologist may review appeals for payment of mental health services without having received Level I or II Accreditation. After reviewing the supporting medical documentation, the reviewing provider may call the appealing provider to expedite communication and timely processing of the appeal.

3. If after reviewing the appeal the payer agrees with the billing party, payment for treatment is due and payable in accordance with the Medical Fee Schedule within 30 days of receipt of the appeal. Date of receipt may be established by the payer's date stamp or electronic acknowledgment date; otherwise, receipt is presumed to occur ~~three business~~ five days after the date the response was mailed to the payer's correct address.

4. If after reviewing the appeal the payer upholds its denial, the payer shall send the billing party written notice within 30 days of receipt of the appeal. The written notice shall include all notice requirements set forth in sections 16-10 B and C, and shall also include:

   a. Reference to each code being denied;

   b. Clear and persuasive medical or non-medical reasons for upholding the denial, including the name and professional credentials of the reviewer and a copy of the reviewer's opinion when medically based;

   c. Citation of appropriate statutes, rules and/or documents supporting the payer's reason(s).

5. In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or the Office of Administrative Courts. The parties shall do so within 12 months of the date of the original bill should have been processed in compliance with section 16-10, unless extenuating circumstances exist.

16-11 RETROACTIVE REVIEW OF MEDICAL BILLS

A. All medical bills ~~paid by a payer~~ shall be considered final at 12 months after the date of the original written notice unless the provider is notified that:

1. A hearing is requested within the 12 month period; or

2. A request for utilization review has been filed pursuant to § 8-43-501.

B. If the payer conducts a retroactive review to recover overpayments from a provider based on non-medical reasons, the payer shall send the billing party written notice that includes all notice requirements set forth in sections 16-10 B and C, and shall also include:

1. Reference to each item of the bill for which the payer seeks to recover payment:

2. Clear and persuasive reason(s) for seeking recovery of overpayment(s), including citation of appropriate statutes, rules and/or documents supporting the payer's reason(s).

3. Evidence that these payments were in fact made to the provider.

C. If the payer conducts a retroactive review to recover overpayments from a provider, based on medical reasons, the payer shall have the bill and all supporting documentation reviewed by a Physician, who holds a license and is in the same or similar specialty as would typically manage the medical condition or treatment under review. The Physician shall be Level I or II Accredited. In addition, a clinical pharmacist (Pharm.D.) ~~as defined by section 16-3(A)(1)(b)(xvi)~~ may review billed medications, and a Psychologist may review billed services for mental health, without having received Level I or II Accreditation. The payer shall send the billing party written notice that includes all notice requirements set forth in sections 16-10 B and C, and 16-11 B.

D. In the event of disagreement, the parties may follow dispute resolution and adjudication procedures available through the Division or the Office of Administrative Courts.

16-11-1 ONSITE REVIEW OF HOSPITAL OR MEDICAL FACILITY CHARGES

A. If the payer conducts a review of billed and non-billed hospital or medical facility charges related to a specific workers' compensation claim, the payer shall comply with the following procedures:

1. Within 30 days of receipt of the bill, send written notification to the hospital or ~~other~~ medical facility of its intent to conduct a review. Notification ~~shall be in writing and~~ shall include ~~set forth~~ the following information:

a. Name of the injured worker;

b. Division's WC number and/or hospital or medical facility patient identification number;

c. An outline of the items to be reviewed; and

d. Name and contact information of a person designated by the payer to conduct the review, if applicable.

B. The reviewer shall comply with the following procedures:

1. Obtain a signed release of information form from the injured worker;

2. Negotiate with the hospital or medical facility on a starting date for the review;

3. Assign staff members who are familiar with medical terminology, general hospital or medical facility charging, and medical documentation procedures or have a level of knowledge equivalent at least to that of an LPN;

4. Establish a schedule for the review which shall include, at a minimum, the dates for the delivery of preliminary findings to the hospital or medical facility, a ~~ten business~~ 14 day response period for the hospital or medical facility and the delivery of an itemized list of any discrepancies and an exit conference upon completion of the review; and

5. Provide the payer and hospital or medical facility with a written summary of the review within ~~20 business~~ 30 days of the exit conference.

C. The hospital or medical facility shall comply with the following procedures:

1. Allow the review to begin within 30 days from the payer's notification;

2. Upon receipt of the injured worker's signed release of information form, allow the reviewer access to all items identified on the form;

3. Designate an individual to serve as the primary liaison between the hospital or medical facility and the reviewer, who will acquaint the reviewer with the documentation and charging practices of the hospital or medical facility;

4. Provide a written response to each preliminary review finding within ~~ten business~~ 14 days of receipt of those findings; and

5. Participate in the exit conference in an effort to resolve any discrepancies.

16-12 DISPUTE RESOLUTION PROCESS

When seeking dispute resolution from the Division's Medical Dispute Resolution Unit, the requesting party must complete the Division's "Medical Dispute Resolution Intake Form" (WC 181) found on the Division's web page. The items listed on the bottom of the form must be provided at the time of submission. If necessary items are missing or if more information is required, the Division will forward a request for additional information and initiation of the process may be delayed.

When the request is properly made and the supporting documentation submitted, the Division will issue a confirmation of receipt. If, after reviewing the materials, the Division believes the dispute criteria have not been met, the Division will issue an explanation of those reasons. If the Division determines there is cause for facilitating the disputed items, the other party will be sent a request for a written response due in ~~ten (~~14~~)~~ ~~business~~ days.

The Division will facilitate the dispute by reviewing the parties' compliance with Rules 11, 16, 17, and 18 within 30 days of receipt of the complete supporting documentation; or as soon thereafter as possible. In addition, the payer shall pay interest at the rate of eight percent per annum in accordance with § 8-43-410(2), upon all sums not paid timely and in accordance with the Division Rules. The interest shall be paid at the same time as any delinquent amount(s).

Upon review of all submitted documentation, disputes resulting from violation of Rules 11, 16, 17, and 18, as determined by the Director, may result in a Director's Order that cites the specific violation.

Evidence of compliance with the order shall be provided to the Director. If the party does not agree with the findings, it shall state with particularity and in writing its reasons for all disagreements by providing a response with all relevant legal authority, and/or other relevant proof ~~upon which it relies~~ in support of its position(s) ~~concerning disagreements with the order~~.

Failure to respond or cure violations may result in penalties in accordance with § 8-43-304. Daily fines up to $1,000/day for each such offence will be assessed until the party complies with the Director's Order.

Resolution of disputes not pertaining to Rule violations will be facilitated by the Division to the extent possible. In the event both parties cannot reach an agreement, the parties will be provided additional information on pursuing resolution and adjudication procedures available through the Office of Administrative Courts. Use of the dispute resolution process does not extend the 12-month application period for hearing.

DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation

7 CCR 1101-3

WORKERS' COMPENSATION RULES OF PROCEDURE

Rule 18 MEDICAL FEE SCHEDULE

18-1 INTRODUCTION

Pursuant to § 8-42-101(3)(a)(I) and § 8-47-107, the Director promulgates this Medical Fee Schedule to review and establish maximum fees for healthcare services falling within the purview of the Workers' Compensation Act of Colorado. This Rule applies to services rendered on or after January 1, 2021. All other bills shall be reimbursed in accordance with the fee schedule in effect ~~at~~ on the date of ~~time~~ service ~~was rendered~~. This Rule shall be read together with Rule 16, Utilization Standards, and Rule 17, the Medical Treatment Guidelines (MTGs).

The unofficial copies of Rule 18, other Colorado Workers' Compensation Rules of Procedure, and Interpretive Bulletins are available on the Division's website, https://www.colorado.gov/pacific/cdle/dwc. The rules also may be purchased from LexisNexis. An official copy of this Rules is available on the Secretary of State's webpage, http://www.sos.state.co.us/CCR/Welcome.do, 7 CCR 1101-3.

18-2 INCORPORATION BY REFERENCE

The Director adopts and incorporates by reference the following materials:

(A) National Physician Fee Schedule Relative Value file (RBRVS-Resource Based Relative Value Scale), as modified and published by Medicare in April 2020. Copies ~~of RBRVS~~ are available on Medicare's website, www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/PhysicianFeeSched/Index.html.

(B) The Current Procedural Terminology CPT® 2020, Professional Edition, published by the American Medical Association (AMA). All CPT® modifiers are adopted, unless otherwise specified in this Rule.~~; and~~

(C) Medicare Severity Diagnosis Related Groups (MS-DRGs) Definitions Manual, Version 37 using MS-DRGs from CMS1716 Table 5 CN ~~effective August 2019~~. Copies are available on Medicare's website, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS. The MS-DRGs Definitions Manual may be purchased from 3M Health Information Systems.

(D) Hospital Outpatient Prospective Payment System (OPPS) Addendum A, Addendum B, and Addendum J, release date January 2020. Copies are available on Medicare's website, https://www.cms.gov/index.php/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

(E) Health Care Common Procedure Coding System (HCPCS) Level II Professional 2020, published by the AMA.

(F) Medicare's Clinical Laboratory Fee Schedule File, CY 2020 Q2 Release. Copies are available on Medicare's website, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Clinical-Laboratory-Fee-Schedule-Files.

(G) The Current Dental Terminology, CDT® 2020, published by the American Dental Association.

(H) Medicare's 2018 Anesthesia Base Units by CPT® Code. Copies are available on Medicare's website, https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.

All guidelines and instructions in the referenced materials are adopted, unless otherwise specified in this Rule. The incorporation is limited to the specific editions named and does not include later revisions or additions.

The Division shall make available for public review and inspection the copies of all materials incorporated by reference in Rule 18. Please contact the Medical Services Manager, 633 17th Street, Suite 400, Denver, Colorado 80202-3626. These materials also are available at any state publications depository library. All users are responsible for the timely purchase and use of these materials.

18-3 GENERAL POLICIES

(A) Billing Codes and Fee Schedule:

(1) The Division establishes the Medical Fee Schedule based on RBRVS, as modified by Rule 18 and its Exhibits.

(2) The Division incorporates CPT®, HCPCS, CDT® and National Drug Code (NDC) codes and values, unless otherwise specified in Rule 18. The Providers may use CPT® Category III codes listed in the

RBRVS with Payer agreement. Payment for the Category III codes shall comply with Rule 16 policy for unpriced codes. ~~services that are not identified or identified but without established value in the Medical Fee Schedule~~.

(3) Division-created codes and values (DoWC ZXXXX) supersede CPT®, HCPCS, CDT® and NDC codes and values. The CPT® mid-point rule for attaining a unit of time applies to these codes, unless otherwise specified in this Rule.

(4) Codes listed with ~~RVUs~~ values of "BR" (by report), not listed, or listed with a zero value and not included by Medicare in another procedure(s), require prior authorization.

(B) Place of Service Codes:

The table below lists the place of service codes corresponding to ~~used with~~ the RBRVS facility RVUs. All other maximum fee calculations shall use the non-facility RVUs listed in the RBRVS.

maximum fee

Place of Service Code	Place of Service Code Description
19	Off Campus – Outpatient Hospital
21	Inpatient Hospital
22	On Campus - Outpatient Hospital
23	Emergency Room-Hospital
24	Ambulatory Surgery Center (ASC)
26	Military Treatment Facility
31	Skilled Nursing Facility
34	Hospice
41	Ambulance - Land
42	Ambulance - Air or Water
51	Inpatient Psychiatric Hospital
52	Psychiatric Facility-Partial Hospitalization
53	Community Mental Health Center
56	Psychiatric Residential Treatment Center
61	Comprehensive Inpatient Rehabilitation Facility

(C) Correct Reporting and Payment Policies:

(1) Providers shall report codes and number of units based on all applicable code descriptions and this Rule. In addition, Providers shall document all services/ procedures in the medical record.

(2) Providers shall report the most comprehensive code that represents the entire service.

(3) Providers shall report only the primary services and not the services that are integral to the primary services.

(4) Providers shall document the time spent performing all time-based services or procedures in accordance with applicable code descriptions.

(5) Providers shall apply modifiers to clarify services rendered and/or adjust the maximum allowances as indicated in this Rule. ~~Prior to~~ When correcting a modifier, Payers shall comply with Rule 16.

(6) The Division does not recognize Medicare's Medically Unlikely Edits.

18-4 PROFESSIONAL FEES AND SERVICES

(A) GENERAL INSTRUCTIONS

(1) Conversion Factors (CFs):

~~The~~ Maximum ~~fee~~ allowances are determined by multiplying the following CFs by the established facility or non-facility total relative value units (RVUs) found in the corresponding RBRVS sections:

RBRVS SECTION	CF
Anesthesia	$46.50
Surgery	$70.00
Radiology	$70.00
Pathology	$70.00
Medicine	$70.00
Physical Medicine and Rehabilitation (Includes Medical Nutrition Therapy and Acupuncture)	$47.00
Evaluation & Management (E&M)	$56.00

(2) Maximum Allowance:

(a) Maximum allowance for most Providers shall be 100% of the Medical Fee Schedule ~~RBRVS value~~ unless otherwise specified in this Rule.

(b) The maximum allowance for ~~professional services performed by~~ Physician Assistants (PAs) and Nurse Practitioners (NPs) shall be 85% of the Medical Fee Schedule. However, PAs and NPs are allowed 100% of the Medical Fee Schedule if the requirements of Rule 16 have been met and one of the following conditions applies:

(i) The service is provided in a rural area. Rural area means:

- a county outside a Metropolitan Statistical Area (MSA) or
- a Health Professional Shortage Area, located either outside of an MSA or in a rural census tract, as determined by the Office of Rural Health Policy, Health Resources and Services Administration, United States Department of Health and Human Services.

(ii) The PA or NP is Level I Accredited.

(c) The Payer may negotiate reimbursement of travel expenses not addressed in the fee schedule (including transit time) with Providers traveling to a rural area to serve an injured worker. Rural area is defined in subsection (2)(b)(i) above. This reimbursement shall be in addition to the maximum allowance for services addressed in the fee schedule.

(3) The Division adopts the following RBRVS attributes or modifies them as follows:

(a) HCPCS (Healthcare Common Procedure Coding System) –including any ~~non-listed~~ CPT® codes; Level I (CPT®) and Level II (HCPCS) Modifiers (listed and unlisted).

~~Modifier;~~

(b) Description – short description as listed in the file and long description as specified in CPT®.

(c) Status Code:

Code	Meaning
A	Separately Payable
B & P	Bundled Code
C	Payer-Priced
D, F & H	Deleted Code or Modifier
E, G, I, N, R, or X	Valid for CO WC
J	Anesthesia Code
M & Q	Measurement or Functional Information Codes - No Value
T	Paid When It Is the Only Payable Service Performed ~~, Otherwise Bundled~~

(d) Increment of Service/Billable (when specified).

~~Conversion Factors listed in section 18-4(A)(1) or an exhibit to this Rule to establish value;~~

(e) Anesthesia Base Unit(s), see section 18-4(C).

(f) Non-Facility (NF) Total RVUs.

(g) Facility (F) Total RVUs.

(h) Professional Component/Technical Component Indicators.

Indicator	Meaning
0	Physician Service Codes – professional component/ technical component (PC/TC) distinction does not apply.
1	Diagnostic Radiology Tests - may be billed with or without modifiers 26 or TC.
2	Professional Component Only Codes – standalone professional service code (no modifier is appropriate because the code description dictates the service is professional only).

3	Technical Component Only Codes - standalone technical service code (no modifier is appropriate because the code description dictates the service is technical only.
4	Global Test Only Codes - modifiers 26 and TC cannot be used because the values equal to the sum of the total RVUs (work, practice expense, and malpractice).
5	Incident To Codes - do not apply.
6	Laboratory Physician Interpretation Codes – separate payments may be made (these codes represent the professional component of a clinical laboratory service and cannot be billed with modifier TC).
7	Physical Therapy Service – not recognized.
8	Physician Interpretation Codes – separate payments may be made only if a physician interprets an abnormal smear for a hospital inpatient.
9	Concept of PC/TC distinction does not apply.

(i) Global Days: the number of follow-up days beginning on the day after the surgery and continuing for the defined period.

Indicator	**Meaning**
000	Endoscopies or some minor surgical procedures, typically a zero day post-operative period. E&M visits on the same day as procedures generally are included in the procedure, unless a separately identifiable service is reported with an appropriate modifier.
010	Other minor procedures, 10-day post-operative period. E&M visits on the same day as procedures and during the 10-day post-operative period generally are included in the procedure, unless a separately identifiable service is reported with an appropriate modifier.
090	Major surgeries, 90-day post-operative period. E&M visits on the same day as procedures and during the 90-day post-operative period generally are included in the procedure, unless a separately identifiable service is reported with an appropriate modifier.
MMM	Global service days concept does not apply (see Medicare's Global Maternity Care reporting rule).
XXX	Global concept does not apply.

YYY	Identifies primarily “BR” procedures where “global days” need to be determined by the Payer.
ZZZ	Code is related to another service and always included in the global period of the other service. Identifies “add-on” codes.

(j) Pre-Operative Percentage Modifier: percentage of the global surgical package payable when pre-operative care is rendered by a Provider other than the surgeon.

Indicator	**Meaning**
%	The physician shall append modifier 56 when performing only the pre-operative portion of any surgical procedure. This modifier can be combined with either modifier 54 or 55, but not both. This column lists the ~~pre-operative~~ allowed percentage of the total surgical ~~fee~~ relative value unit.

(k) Intra-Operative Percentage Modifier: percentage of the global surgical package payable when the surgeon renders only intra-operative care.

Indicator	**Meaning**
%	The surgeon shall append modifier 54 when performing only the intra-operative portion of a surgical procedure. This modifier can be combined with either modifier 55 or 56, but not both. This column lists the ~~intra-operative~~ allowed percentage of the total surgical ~~fee~~ relative value unit.

(l) Post-Operative Percentage Modifier: percentage of the global surgical package payable when post-operative care is rendered by a Provider other than the surgeon.

Indicator	**Meaning**
%	The surgeon shall append modifier 55 when performing only the post-operative portion of a surgical procedure. This modifier can be combined with either modifier 54 or 56, but not both. This column lists the ~~post-operative~~ allowed percentage of the total surgical ~~fee~~ relative value unit.

(m) Multiple Procedure Modifier: ~~Payers shall reimburse~~ the maximum allowance for the highest-valued procedure ~~at~~ is 100% of the fee schedule, even if the Provider appends modifier 51. ~~Payers shall reimburse~~ The maximum allowance for the lesser-valued procedures performed in the same operative setting ~~at~~ is 50% of the fee schedule.

Indicator	**Meaning**

0	No payment adjustment for multiple procedures applies. These codes are generally identified as “add-on” codes in CPT®.
1, 2, or 3	Standard payment reduction applies (100% for the highest-valued procedure and 50% for all lesser-valued procedures performed during the same operative setting).
4, 5, 6, or 7	Not subject to the multiple procedure adjustments.
9	Multiple procedure concept does not apply.

(n) Bilateral Procedure Modifier.

Indicator	Meaning
0	Not eligible for the bilateral payment adjustment. Either the procedure cannot be performed bilaterally due to the anatomical constraints or another code more adequately describes the procedure.
1	Eligible for bilateral payment adjustment and should be reported on one line with modifier 50 and “1” in the units box. Providers performing the same bilateral procedure during the same operative setting on multiple sites ~~times~~ shall report the second and subsequent procedures with modifiers 50 and 59. Report on one line with one unit for each bilateral procedure performed. The maximum allowance ~~fee~~ is increased to 150% ~~of the fee schedule value~~. If Provider performs multiple bilateral procedures during the same setting, Payer shall apply the bilateral payment adjustment rule first, and then apply other applicable payment adjustments (e.g., multiple surgery).
2	Not eligible for the bilateral payment adjustment. These procedure codes are already bilateral.
3	Not eligible for the bilateral payment adjustment. Report these codes on two lines with RT and LT modifiers. There is one payment per line. ~~Indicator 3 codes are primarily diagnostic radiology and other diagnostic medicine procedures.~~
9	Not eligible for the bilateral payment adjustment because the concept does not apply.

(o) Assistant Surgeon, Modifiers 80, 81, 82, or AS: the designation of “almost always” for a surgical code in the Physicians as Assistants at Surgery: 2020 Update (April 2020), published by the American College of Surgeons shall indicate that separate payment for an assistant

surgeon is allowed for that code. If that publication does not make a recommendation on a surgical code or lists it as "sometimes" or "almost never," then RBRVS indicators shall determine whether separate payment for assistant surgeons is allowed.

Indicator	Meaning
0	Documentation of medical necessity and prior authorization is required to allow an assistant at surgery.
1	No assistant at surgery is allowed.
2	Assistant at surgery is allowed.
9	Concept does not apply.

No separate assistant surgeon or minimum assistant fees shall be paid if a co-surgeon is paid for the same operative procedure during the same surgical episode. See section 18-4(D)(1) for additional payment policies.

(p) Co-Surgeon, Modifier 62.

Indicator	Meaning
1 or 2	Indicators may require two primary surgeons performing two distinct portions of a procedure. Modifier 62 is used with the procedure and maximum allowance ~~fee value~~ is increased to 125% of the fee schedule value. The payment is apportioned to each surgeon in relation to ~~his or her~~ the individual responsibilities and work, or it is apportioned equally between the co-surgeons.
0 or 9	Not eligible for co-surgery fee allowance adjustment. These procedures are either straightforward or only one surgeon is required or the concept does not apply.

(q) Team Surgeon, Modifier 66.

Indicator	Meaning
0	Team surgery adjustments are not allowed.
1	Prior authorization is required for team surgery adjustments.
2	Team surgery adjustments may occur as a "BR." Each team surgeon must bill modifier 66. Payer must adjust the values in consultation with the billing surgeon(s).
9	Concept does not apply.

(r) Endoscopy base codes are not recognized for payment adjustments except when other modifiers apply.

(s) All other fields are not recognized.

(B) EVALUATION AND MANAGEMENT (E&M)

(1) E&M codes may be billed by Physicians ~~Providers~~, NPs, and PAs, as defined in Rule 16. To justify the billed level of E&M service, medical records shall utilize ~~the 2019~~ CPT® E&M Services Guidelines and either the "E&M Documentation Guidelines" criteria adopted in Exhibit #~~7~~ 1 or Medicare's 1997 Evaluation and Management Documentation Guidelines.

(2) New or Established Patients:

An E&M visit shall be billed as a "new" patient service for each new injury or new Colorado workers' compensation claim even if the Provider has seen the injured worker within the last three ~~(3)~~ years.

Any subsequent E&M visits for the same injury billed by the same Provider or another Provider of the same specialty or subspecialty in the same group practice shall be ~~reported~~ billed as an "established patient" visit.

Transfer of care from one physician to another with the same tax ID and specialty or subspecialty shall be billed as an "established patient" regardless of location.

(3) Number of Office Visits:

All Providers are limited to one ~~(1)~~ office visit per injured worker, per day, per workers' compensation claim, unless prior authorization is obtained.

(4) Treating Physician Telephone or On-line Services:

~~Telephone or on-line services may be billed if the medical records~~ Minimum required documentation elements include ~~the following~~:

(a) ~~The amount of~~ Total time spent on medical discussion and date;

(b) The injured worker, family member, or healthcare Provider spoken with ~~talked to~~; and

(c) Specific discussion and/or decision(s) made during the discussion ~~the communication~~.

Telephone or on-line services may be billed even if performed within the one day and seven day timelines listed in CPT®.

(5) Face-to-Face or Telephonic Treating Physician or Qualified Non-physician Medical Team Conferences:

A medical team conference can only be billed if all CPT® criteria are met. A medical team conference shall consist of medical professionals caring for the injured worker. The billing statement shall be prepared pursuant to Rule 16.

(6) Consultation/Referrals/Transfers of Care/Independent Medical Examinations:

A consultation occurs when a treating Physician seeks an opinion from another Physician regarding ~~a patient~~ an injured worker's diagnosis and/or treatment.

A transfer of care occurs when one Physician turns over the responsibility for the comprehensive care of ~~a patient~~ an injured worker to another Physician.

An independent medical exam (IME) occurs when a Physician is requested to evaluate ~~a patient~~ an injured worker by any party or party's representative and is billed in accordance with section 18-7(G).

To bill for any inpatient or outpatient consultation codes, the Physician ~~Provider~~ must document the following:

(a) Identity of the Physician requesting the opinion;

(b) The need for a consultant's opinion;

(c) Statement that the report was submitted to the requesting Physician ~~Provider~~.

Subsequent Hospital modified RVUs are:

CPT® 99231	Facility RVU is 2.21
CPT® 99232	Facility RVU is 3.15
CPT® 99233	Facility RVU is 4.22

Consultation modified RVUs are:

CPT® 99241	Non-facility RVU is 2.57, facility RVU is 2.15
CPT® 99242	Non-facility RVU is 3.77, facility RVU is 3.18
CPT® 99243	Non-facility RVU is 4.71, facility RVU is 3.96
CPT® 99244	Non-facility RVU is 6.39, facility RVU is 5.57
CPT® 99245	Non-facility RVU is 8.15, facility RVU is 7.23
CPT® 99251	Facility RVU is 2.79
CPT® 99252	Facility RVU is 3.83
CPT® 99253	Facility RVU is 4.95
CPT® 99254	Facility RVU is 6.39
CPT® 99255	Facility RVU is 8.47

(7) 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 healthcare professionals (MDs, DOs, DCs, DMPs, NPs, and PAs) with or without direct patient contact:

~~An E&M code shall accompany prolonged services codes.~~

~~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.~~

(i) 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.
(ii) The Provider billing for extensive record review shall document the names of Providers and dates of service reviewed, as well as briefly summarize each record reviewed.

(b) Prolonged clinical staff services (RNs or LPNs) with physician or other qualified healthcare professional supervision:

(i) The supervising physician or other qualified healthcare professional may not bill for the time spent supervising clinical staff.

(ii) Clinical staff services cannot be provided in an urgent care or emergency department setting.

(C) ANESTHESIA

(1) All anesthesia base values are set forth in Medicare's ~~2019~~ Anesthesia Base ~~Values~~ Units by CPT® code, as incorporated by 18-2. Anesthesia services are only reimbursable if the anesthesia is administered by a Physician, a Certified Registered Nurse Anesthetist (CRNA), or an Anesthesiologist Assistant (AA) who remains in constant attendance during the procedure for the sole purpose of rendering anesthesia.

When a CRNA or AA administers anesthesia:

(a) CRNAs not under the medical direction of an anesthesiologist shall be reimbursed 90% of the maximum anesthesia value;

(b) If billed separately, CRNAs and AAs, 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;

(c) Medical direction for administering anesthesia means the Anesthesiologist performs ~~includes~~ the following:

(i) examines and evaluates the injured worker before administering anesthesia;
(ii) prescribes the anesthesia plan;
(iii) personally participates in the most demanding procedures in the anesthesia plan including, if applicable, induction and emergence;
(iv) ensures that any procedure in the anesthesia plan ~~that s/he does not perform~~ is performed by a qualified anesthetist;
(v) monitors anesthesia administration at frequent intervals;
(vi) remains physically present and available for immediate diagnosis and treatment of emergencies; and
(vii) provides indicated post-anesthesia care.

~~(2) The supervision of AAs shall be in accordance with the Medical Practice Act.~~

(2) HCPCS Level II modifiers are required when billing for anesthesia services. Modifier AD shall be used when an Anesthesiologist supervises more than four ~~(4)~~ concurrent (occurring at the same time) anesthesia service cases. Maximum allowance for supervising multiple cases is calculated using three ~~(3)~~ base anesthesia units for each case, regardless of the number of base anesthesia units assigned to each specific anesthesia episode of care.

(3) Physical status modifiers are reimbursed as follows, using the Anesthesia CF:

(a)	P-1	Healthy patient	0 RVUs
(b)	P-2	Patient with mild systemic disease	0 RVUs
(c)	P-3	Patient with severe systemic disease	1 RVU
(d)	P-4	Patient with severe systemic disease that is a constant threat to life	2 RVUs
(e)	P-5	A moribund patient who is not expected to survive without the operation	3 RVUs

(f) P-6 A declared brain-dead patient 0 RVUs

(4) Qualifying circumstance codes are reimbursed using the anesthesia CF:

(a) Anesthesia complicated by extreme age (under one or over 70 years) 1 RVU

(b) Anesthesia complicated by utilization of total body hypothermia 5 RVUs

(c) Anesthesia complicated by utilization of controlled hypotension 5 RVUs

(d) Anesthesia complicated by emergency conditions (specify) 2 RVUs

(5) Multiple procedures are billed in accordance with CPT®. When more than one surgical procedure is performed during a single episode, only the highest-valued base anesthesia procedure value is added to ~~billed with~~ the total anesthesia time for all procedures.

(6) Total minutes are reported for reimbursement. Each 15-minutes of anesthesia time equals one additional RVU. Five minutes or more is considered significant time and adds one RVU to the payment calculation.

(7) Calculation of Maximum Allowance ~~Fees~~ for Anesthesia:

(a) Add the anesthesia base units, one unit for each 15 minutes of anesthesia time, and any physical status modifier units to calculate total relative value anesthesia units;

(b) Multiply the total relative value anesthesia units by the Anesthesia CF to calculate the total maximum anesthesia allowance.

~~+1 Unit/15 minutes of anesthesia time~~
~~+Any physical status modifier units~~
~~Total Relative Value Anesthesia Units~~
~~Multiplied by the Anesthesia CF in section 18-4(A)(1)~~
~~Total Maximum Anesthesia Fees~~

(8) Non-time based anesthesia procedures shall be billed with modifier 47.

(D) SURGERY

(1) Assistant Surgeons Payment Policies and Modifiers:

(a) The use of assistant surgeons shall be limited according to the American College Of Surgeons' Physicians as Assistants at Surgery: 2020 Update (April 2020) ~~2018 Update (February 2018)~~, available from the American College of Surgeons, Chicago, IL, or from its web page. ~~The incorporation is limited to the edition named and does not include later revisions or additions.~~

Provider shall document the medical necessity for any assistant surgeon in the operative report.

(b) Payment for more than one ~~(1)~~ assistant surgeon or minimum assistant surgeon requires prior authorization.

(c) Maximum allowance for an assistant surgeon reported by a physician, as indicated by modifier 80, 81, or 82 is 20% of the surgeon's fees.

(d) Maximum allowance for a minimum assistant surgeon, reported by a non-physician, as indicated by modifier~~s~~ AS ~~81~~is 10% of the surgeon's fees (the 85% adjustment in section 18-4(A)(2)(b) does not apply).

(e) The services performed by registered surgical technologists are bundled fees and are not separately payable.

See section 18-4(A)(3) for additional payment policies applicable to assistant surgeons.

(2) Global Package:

(a) All surgical procedures include the following:

(i) local infiltration, metacarpal/metatarsal/digital block, or typical anesthesia;
(ii) one related E&M encounter on the date immediately prior to or on the date of the procedure ~~(including history and physical)~~;
(iii) intra-operative services that are normally a usual and necessary part of a surgical procedure;
(iv) immediate post-operative care, including dictating operative notes, and talking ~~with~~ to the patient's family and other Providers ~~physicians~~;
(v) evaluating the patient in the post-anesthesia recovery room;
(vi) post-surgical pain management by the surgeon;
(vii) typical post-operative follow-up care during the global period of the surgery that is related to recovery, see section 18-4(A)(3).
(viii) supplies integral to an operative procedure. See section 18-6(A) to determine reimbursement for unrelated supplies or Durable Medical Equipment, Orthotics or Prosthetics (DMEPOS). Casting supplies are separately payable only if related fracture or surgical care code is not billed. The HCPCS Level II "Q" code(s) are used for reporting any associated DMEPOS fees.
(ix) pre- or post-operative services integral to the operative procedure and performed within the global follow-up period are not separately payable. These services include, but are not limited to the following:

- dressing changes;
- local incisional care;
- removal of operative pack;
- removal of cutaneous sutures and staples, lines, wires, tubes, or drains;
- initial application of casts and splints;
- insertion, irrigation, and removal of urinary catheters;
- routine peripheral IV lines;
- nasogastric and rectal tubes;
- changes and removal of tracheostomy tubes;
- post-surgical pain management by the surgeon;
- all complications leading to additional procedures performed by the surgeon, but not requiring an operating room. Complications requiring an operating room are separately payable with modifier 78.

(b) Modifiers:

Code	Payment policy
22	The Payer and Provider shall negotiate the value based on the fee schedule and the amount of additional work.
~~54~~	~~Surgical care only. This modifier can be combined with either modifier 55 or 56, but not both. Maximum allowance fee is the applicable percentage in the "intra-~~

	~~op %" RBRVS column multiplied by the fee schedule value.~~
~~55~~	~~Post-operative management only. This modifier can be combined with either modifier 54 or 56, but not both. Maximum allowance fee is the applicable percentage in the "post-op %" RBRVS column multiplied by the fee schedule value.~~
~~56~~	~~Pre-operative management only. This modifier can be combined with either modifier 54 or 55, but not both. Maximum allowance fee is the applicable percentage in the "pre-op %" RBRVS column multiplied by the fee schedule value.~~
58	Maximum allowance ~~fee value~~ is 100% of the fee schedule for prospective procedures that occur on the same day or staged over a couple of days.
~~62~~	~~Co-surgeon use when different surgical skills are necessary to perform a surgical procedure.~~
78	Maximum allowance ~~fee~~ for this unplanned return to the operating room is the intra-operative value of the procedure(s) performed only and the original post-operative global days continue from the initial surgical procedure(s).

(c) Significant and separately identifiable services performed during the global period are separately payable. The services involve unusual circumstances, complications, exacerbations, or recurrences; and/or unrelated diseases or injuries.

Modifiers 24, 25, and 57 shall be used to override the global package edits/limits:

Modifier	Payment and Billing Policies	Applicability/Documentation
24	E&M services unrelated to the primary surgical procedure. The reasonableness and necessity for an E&M service that is separately identifiable from the surgical global period shall be documented in the medical record. If possible, an appropriate ~~identifying~~ diagnosis code shall identify the E&M service as unrelated to the surgical global period. Disability management of an injured worker for the same diagnosis requires the	Services necessary to stabilize the patient for the primary surgical procedure. Services not considered part of the surgical procedure, including an E&M visit by an authorized treating physician for disability management. The definition of disability counseling is located in Exhibit #~~7~~ 1.

	physician to identify the specific disability management detail performed during that visit.	
25	Initial or follow-up visit that occurred on the same day/encounter as a minor surgical procedure.	E&M documentation must support the patient's condition. The visit must be significant and separately identifiable from the minor surgical procedure and the usual pre- and post-operative care required.
57	The surgeon's E&M visit that resulted in the decision for major surgery performed on either the same day or the day after the visit.	The E&M documentation must identify the medical necessity of the procedure and the discussion with the patient.

(3) General Surgical Payment Policies:

(a) Exploration of a surgical site is not separately payable except in cases of a traumatic wound or an exploration performed in a separate anatomic location.

(b) A diagnostic arthroscopy that resulted in a surgical arthroscopy at the same surgical encounter is bundled into the surgical arthroscopy and is not separately payable.

(c) An arthroscopy performed as a "scout" procedure to assess the surgical field or extent of disease is bundled into the surgical procedure performed on the same body part during the same surgical encounter and is not separately payable.

(d) An arthroscopy converted to an open procedure is bundled into the open procedure and is not separately payable. In this circumstance, Providers shall not report either a surgical arthroscopy or a diagnostic arthroscopy code.

(e) Only the joints/compartments listed in subsections (4) through (6) below are recognized for separate payment purposes.

(f) Providers shall report only one removal code for removal of implants through the same incision, same anatomical site, or a single implant system during the same episode of care.

(4) Knee Arthroscopies:

(a) Medial, lateral, and patella are the knee compartments recognized for purposes of separate payment of debridement and synovectomies.

(b) Chondroplasty is separately payable with another knee arthroscopy only if performed in a different knee compartment or to remove a loose/foreign body during a meniscectomy.

(c) Limited synovectomy involving one knee compartment is not separately payable with another arthroscopic procedure on the same knee.

(d) Separate payment for a major synovectomy procedure ~~shall~~ requires a synovial diagnosis and two or more knee compartments without any other arthroscopic surgical procedures performed in the same compartment.

(5) Shoulder Arthroscopies:

(a) Glenohumeral, acromioclavicular, and subacromial bursal space are the shoulder regions recognized for purposes of separate payment.

(b) Limited debridement performed with a shoulder arthroscopy is bundled into the arthroscopy and is not separately payable unless subsection (c) applies.

(c) Limited debridement performed in the glenohumeral region is separately payable if it is the only procedure performed in that region in the surgical encounter.

(d) Extensive debridement (debridement that takes place in more than one location or region) is separately payable if documented in the medical record.

(6) Spine and Nervous System:

(a) Spinal manipulation is integral to spinal surgical procedures and is not separately payable.

(b) Surgeon performing a spinal procedure shall not report intra-operative neurophysiology monitoring/testing codes.

(c) If multiple procedures from the same CPT® code family are performed at contiguous vertebral levels, Provider shall append modifier 51 to all lesser-valued primary codes. See section~~s 18-5(B)(6)(a) and~~ 18-4(A)(3) for applicable payment policies.

(d) Fluoroscopy is separately payable with spinal procedures only if indicated by a specific CPT® instruction.

(e) Lumbar laminotomies and laminectomies performed with arthrodesis at the same interspace are separately payable if the surgeon identifies the additional work performed to decompress the thecal sac and/or spinal nerve(s). If these procedures are performed at the same level, Provider shall append modifier 51 to the lesser-valued procedure(s). If procedures are performed at different interspaces, Provider shall append modifier 59 to the lesser-valued procedure(s). See section~~s~~ 18-4(A)(3) ~~and 18-5(B)(6)(a)~~ for applicable payment policies.

(f) Only one anterior or posterior instrumentation performed through a single skin incision is payable.

(g) Anterior instrumentation performed to anchor an inter-body biomechanical device to the intervertebral disc space is not separately payable.

(h) Anterior instrumentation unrelated to anchoring the device is separately payable with modifier 59 appended.

(7) Venipuncture maximum fee allowance is ~~covered under~~ addressed in section 18-4(F)(2) ~~Exhibit #8~~.

(8) Platelet Rich Plasma (PRP) Injections:

The ~~above~~ maximum allowance includes and applies to all body parts, imaging guidance, harvesting, preparation, the injection itself, kits, and supplies.

~~Codes and professional fees:~~

~~DoWC Z0813 Office setting $758.88~~

CPT® 0232T ~~Facility setting $274.50~~ Non-facility RVU is 10.84, facility RVU is 3.92

(E) RADIOLOGY

~~(1) General Policies~~

~~(a) Payers and Providers shall use professional component (26) or technical component (TC) modifiers per CPT® guidelines. The technical component represents the cost of equipment, supplies and personnel necessary to perform the procedure.~~

~~(b) A stand-alone procedure code describes the selected diagnostic tests for which there are associated codes that describe (a) the professional component of a test only, (b) the technical component of a test only and (c) the global test only. Modifiers 26 and TC cannot be billed with these codes.~~

(1) Payments:

(a) The Division recognizes the value of accreditation for quality and safe radiological imaging. Only offices/facilities that have attained accreditation from American College of Radiology (ACR), Intersocietal Accreditation Commission (IAC), RadSite, or The Joint Commission (TJC) may bill the technical component for Advanced Diagnostic Imaging (ADI) procedures (magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine scan). Providers reporting technical or total component of these services certify accreditation status. The Provider shall supply proof of accreditation upon Payer request.

(b) The cost of dyes and contrast shall be reimbursed in accordance with section 18-6(A).

(c) Copying charges for X-rays and MRIs shall be $15.00/film regardless of the size of the film.

~~(d) The Payer may use available billing information such as Provider credential(s) and clinical record(s) to determine if appropriate CPT®/RBRVS modifier should have been used on the bill. To modify a billed code, refer to Rule 16.~~

(d) Providers using film instead of digital X-rays shall append the FX modifier. The allowance ~~fee~~ is 80% of the Maximum Fee Schedule.

If a physician interprets the same radiological image more than once, or if multiple physicians interpret the same radiological image, only one ~~(1)~~ interpretation shall be reimbursed.

If an X-ray consultation is requested, the consultant's report shall include the name of the requesting Provider, the reason for the request, and documentation that the report was sent to the requesting Provider.

The maximum allowance ~~fee~~ for an X-ray consultation shall be no greater than the maximum allowance ~~fee~~ for the professional component of the original X-ray.

The time a physician spends reviewing and/or interpreting an existing radiological image is considered a part of the physician's E&M service code.

(2) Thermography:

(a) The Provider supervising and interpreting the thermographic evaluation shall be ~~board~~ certified by the examining board of one ~~(1)~~ of the following national organizations and follow their recognized protocols, or have equivalent documented training:

(i) American Academy of Thermology;
(ii) American Chiropractic College of Infrared Imaging; or
(iii) American Academy of Infrared Imaging.

(b) Thermography Billing Codes:

DoWC Z0200	Upper Body w/ Autonomic Stress Testing	$980.00
DoWC Z0201	Lower Body w/Autonomic Stress Testing	$980.00

(c) ~~The bill shall include a report that supplies the thermographic evaluation and complies with this section.~~
Documentation must include:

(i) Method of stress thermography supporting it was accomplished in a guideline-consistent fashion (cold water stress test, warm water stress test, or whole body thermal stress);
(ii) Temperature readings via infrared thermography and their locations on the affected and contralateral extremity and/or copies of any pictures or graphics obtained; and
(iii) Interpretation of the results.

~~(3) Urea breath test C-14 (isotopic), acquisition for analysis, and the analysis maximum fee are listed under Exhibit #8.~~

(F) PATHOLOGY

~~(1) General Policies~~

~~(a) Providers and Payers shall use professional component (PC) or technical component (TC) modifiers per CPT® guidelines. The technical component represents the cost of equipment, supplies and personnel necessary to perform the procedure.~~

~~(b) A stand-alone procedure code describes the selected diagnostic tests for which there are associated codes that describe (a) the professional component of a test only, (b) the technical component of a test only, and (c) the global test only. Modifiers 26 and TC cannot be billed with these codes.~~

(1) Clinical Laboratory Improvement Amendments (CLIA):

Only laboratories with a CLIA certificate of waiver may perform ~~only those~~ tests cleared by the Food and Drug Administration (FDA) as waived tests. Laboratories with a CLIA certificate of waiver, or other Providers billing for services performed by these laboratories, shall bill using the QW modifier.

Laboratories with a CLIA certificate of compliance or accreditation may perform non-waived tests. Laboratories with a CLIA certificate of compliance or accreditation, or other Providers billing for services performed by these laboratories, do not append the QW modifier ~~to claim lines~~.

(2) Payments:

All clinical pathology laboratory tests, except as allowed by this Rule, are reimbursed at 170% of the ~~total component value~~ rate listed in the CMS Clinical Diagnostic Laboratory Fee Schedule, as incorporated by 18-2 ~~under Exhibit #8 or billed charges, whichever is less~~.

Technical or professional component maximum split is not separately payable, and therefore should be negotiated between billing parties when applicable. ~~However, the billing parties may agree how to split the total maximum fees listed in Exhibit #8~~.

When a physician clinical pathologist is required for consultation and interpretation, and a separate written report is created, the maximum allowance ~~fee~~ is determined by using RBRVS values and the Pathology CF. The Pathology CF also determines the maximum ~~Fee Schedule~~ allowance ~~value~~ when the Pathology CPT® code description includes "interpretation" and "report" or when billing CPT® codes for the following services:

(a) physician blood bank services;

(b) cytopathology and cell marker study interpretations;

(c) cytogenics or molecular cytogenics interpretation and report;

(d) surgical pathology gross and microscopic and special stain groups 1 and 2 and histochemical stain, blood or bone marrow interpretations; and

(e) skin tests for unlisted antigen each, coccidoidomycosis, histoplasmosis, TB intradermal.

When ordering automated laboratory tests, the ordering physician may seek verbal consultation with the pathologist in charge of the laboratory's policy, procedures and staff qualifications. The consultation with the ordering physician is not payable unless the physician requested additional medical interpretation, judgment, and a separate written report. Upon such a request, the pathologist may bill using the ~~proper~~ appropriate CPT® code ~~and RBRVS values~~, not DoWC Z0755.

The maximum allowance for CPT® 80050 is $39.95 (equal to the total allowance for CPT® codes 80053, 85004 and 85027).

The modified RVUs for SARS-CoV-2 testing codes are:

CPT® 86328	Non-facility and facility RVU is 1.25
CPT® 86769	Non-facility and facility RVU is 1.16
CPT® 87635	Non-facility and facility RVU is 1.41
U0001	Non-facility and facility RVU is .997
U0002	Non-facility and facility RVU is 1.41
U0003	Non-facility and facility RVU is 2.77
U0004	Non-facility and facility RVU is 2.77

(3) Clinical Drug Screening and Testing ~~Codes and Values~~:

Clinical drug screening and testing may be appropriate for ~~to evaluate whether prescribed medications are at or below therapeutic or toxic levels (~~therapeutic drug monitoring; to assess compliance ~~the patient is taking prescribed controlled substance medications~~; or to identify ~~the patient is taking any~~ illicit or non-prescribed drug use.

(a) Billing requirements for clinical drug testing:

(i) documentation of medical necessity ~~of the clinical drug test~~ by the ordering physician.
(ii) the ordering physician shall specify which drugs require definitive testing to meet the injured worker's medical needs.
(iii) a physician order for quantification of illicit or non-prescribed drugs or drug classes.
~~(iv) Medicare codes used in the 2020 Medicare Fee Schedule shall be billed for presumptive and definitive urine drug tests.~~
~~(v) all recognized codes and maximum fee values allowances are listed in Exhibit #8.~~

(b) Presumptive Tests:

All drug class immunoassays or enzymatic methods are considered presumptive. Payers shall only pay for one presumptive test per date of service, regardless of the number of drug classes tested.

(c) Definitive qualitative or quantitative tests identify specific drug(s) and any associated metabolites, providing sensitive and specific results expressed as a concentration in ng/mL or as the identity of a specific drug.

- These tests may be billed using G0480-G0483.
- Providers may only bill one definitive HCPCS Level II code per day.

A physician must order definitive quantitative tests. The reasons for ordering a definitive quantification drug test may include:

- Unexpected positive presumptive or qualitative test results inadequately explained by the injured worker.
- Unexpected negative presumptive or qualitative test results and suspected medication diversion.
- Differentiate drug compliance:
  - Buprenorphine vs. norbuprenorphine
  - Oxycodone vs. oxymorphone and noroxycodone
- Need for quantitative levels to compare with established benchmarks for clinical decision-making, such as tetrahydrocannabinol quantitation to document discontinuation of a drug.
- Chronic opioid management:
  - Drug testing shall be done prior to the implementation of the initial long-term drug prescription and randomly repeated at least annually.
  - While the injured worker receives chronic opioid management, additional drug screens with documented justification may be conducted (see section 18-9(A) for examples).

CPT® ~~may be consulted for a~~ lists definitive drug classes ~~listing~~ and examples of individual drugs within each class. Each class of drug can only be billed once per day.

(G) MEDICINE

~~(See section 18-6(B) for home care services.)~~

(1) Biofeedback:

Licensed medical and mental health professionals who provide biofeedback must practice within the scope of their training. Non-licensed biofeedback Providers must hold Clinical Certification from the Biofeedback Certification International Alliance (BCIA), practice within the scope of their training, and receive prior approval of their biofeedback treatment plan from the injured worker's authorized treating Physician, or Psychologist. Professionals integrating biofeedback with any form of psychotherapy must be ~~licensed as~~ a Psychologist, a Clinical Social Worker, a Marriage and Family Therapist, or a ~~licensed~~ Professional Counselor.

Biofeedback treatment must be provided in conjunction with other psychosocial or medical interventions.

All biofeedback Providers shall document biofeedback instruments used during each visit (including, but not limited to, surface electromyography (SEMG), heart rate variability (HRV), electroencephalogram (EEG), or temperature training), placement of instruments, and patient response if sufficient time has passed.

The modified RVUs for biofeedback ~~services~~ are:

CPT® 90901 Non-facility RVU is 2.14, facility RVU is 1.14
~~CPT® 90911, non-facility RVU is 4.76, facility RVU is 2.48~~

(2) Appendix J of ~~2019~~ CPT® identifies mixed, motor, and sensory nerve conduction studies and applicable billing requirements. Electromyography (EMG) and nerve conduction velocity 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 ~~2019~~ CPT® for billing modifier 25 have been met.

(3) Manipulation -- Chiropractic (DC), Medical (MD) and Osteopathic (DO):

(a) Prior authorization shall be obtained before billing for more than four body regions in one ~~(1)~~ visit. ~~The Provider's medical records shall reflect medical necessity and prior authorization if treatment exceeds these limitations.~~

(b) Osteopathic Manipulative Treatment and Chiropractic Manipulative Treatment codes include manual therapy techniques, unless the Physician ~~Provider~~ performs manual therapy in a separate region and meets modifier 59 requirements.

(c) An office visit may be billed on the same day as manipulation codes when the documentation meets the E&M requirements and an appropriate modifier is used.

(d) The modified RVUs for chiropractic spinal manipulative treatment are:

CPT® 98940 Non-facility RVU is 1.0, facility RVU is 0.79
CPT® 98941 Non-facility RVU is 1.44, facility RVU is 1.22

(4) Psychiatric/Psychological Services:

(a) The maximum allowance for services performed by a ~~licensed P~~sychologist ~~(PsyD, PhD, EdD)~~ is ~~reimbursed a maximum of~~ 100% of the Medical Fee Schedule. The maximum allowance for psychological/psychiatric services performed by other non-physician Providers ~~performing shall be paid at~~ is 85% of the Medical Fee Schedule ~~allowed for physicians~~.

(b) Psychological diagnostic evaluation code(s) are limited to one per Provider, per admitted claim, unless it is authorized by the Payer or is necessary to complete an impairment rating recommendation as determined by the ATP.

(c) Central Nervous System (CNS) Assessments/Tests: ~~(neuro-cognitive, mental status, speech) requiring more than six (6) hours require prior authorization.~~

When testing, evaluation, administration, and scoring services are provided across multiple dates of service, all codes should be billed on the last date of service when the evaluation process is completed. A base code shall be billed only for the first unit of service of the evaluation process, and add-on codes shall be used to capture services provided during subsequent dates of service. The limit for these services is 16 hours unless the Provider obtains prior authorization.

Documentation shall include the total time and the approximate time spent on each of the following activities, when performed:

- face-to-face time with the patient;
- reviewing and interpreting standardized test results and clinical data;
- integrating patient data;
- clinical decision-making and treatment planning;

- report preparation.

If there is a delay in scheduling the feedback session, the Provider may incorporate feedback into the first psychotherapy session.

The modified RVUs for psychological and neuropsychological services are:

CPT® 96116	Non-facility RVU is 3.4, facility RVU is 2.98
CPT® 96127	Non-facility and facility RVUs are 0.18
CPT® 96130	Non-facility RVU is 3.63, facility RVU is 3.4
CPT® 96131	Non-facility RVU is 2.92, facility RVU is 2.73
CPT® 96132	Non-facility RVU is 4.11, facility RVU is 3.2
CPT® 96133	Non-facility RVU is 3.11, facility RVU is 2.44
CPT® 96146	Non-facility and facility RVUs are 0.10
CPT® 90791	Non-facility RVU is 9.91, facility RVU is 9.6
CPT® 90792	Non-facility RVU is 11.12, facility RVU is 10.8

~~CPT® 96150 = non-facility RVU is 0.80, facility RVU is 0.79~~
~~CPT® 96151 = non-facility RVU is 0.78, facility RVU is 0.77~~
~~CPT® 96152 = non-facility RVU is 0.74, facility RVU is 0.73~~
~~CPT® 96153 = non-facility RVU is 0.18, facility RVU is 0.17~~
~~CPT® 96154 = non-facility RVU is 0.74, facility RVU is 0.73~~
~~CPT® 96155 = non-facility and facility RVUs are 0.73~~

(d) The limit for psychotherapy services is 60 minutes per visit, unless Provider obtains prior authorization. The time for internal record review/ documentation is included in this limit.

Psychotherapy for work-related conditions continuing for more than three ~~(3)~~ months after the initiation of therapy requires prior authorization unless the ~~Medical Treatment Guideline~~ MTGs recommend a longer duration.

(e) When billing an E&M code in addition to psychotherapy:

(i) both services must be separately identifiable;

(ii) the level of E&M is based on history, exam, and medical decision-making;

(iii) time may not be used as the basis for the E&M code selection; and

(iv) add-on psychotherapy codes are to be used by psychiatrists to indicate both services were provided.

Non-medical disciplines cannot bill most E&M codes.

(f) A Provider billing for any stored clinical or physiological data analysis ~~is not recognized unless the Provider shows the reasonableness and necessity of these services and~~ must obtain prior authorization ~~from the Payer~~.

(g) Upon request of a party to a workers' compensation claim and pursuant to HIPAA regulations, a psychiatrist, psychologist or other qualified healthcare professional may generate a separate report and bill for that service as a special report.

(5) ~~Qualified Non-Physician Provider~~ Telephone or On-Line Services:

Reimbursement ~~to qualified non-physician~~ for coordination of care between medical professionals is limited to professionals outside of the Provider's practice and shall be based upon the telephone and on-line services codes ~~for qualified non-physician Providers~~ found in the CPT® ~~RBRVS~~ E&M and

Medicine sections. ~~Reimbursement for coordination of care between medical professionals is limited to telephone calls made professionals outside of the non-physician Provider's facility(ies) and to the injured worker or his or her family~~.

For reimbursement of face-to-face or telephonic meetings by a treating Physician or Psychologist with employer, claim representative, or attorney, see section 18-7(A)(1).

(6) Quantitative Autonomic Testing Battery (ATB) and Autonomic Nervous System Testing:

(a) Quantitative Sudomotor Axon Reflex Test (QSART) is a diagnostic test used to diagnose Complex Regional Pain Syndrome. This test is performed on a minimum of two ~~(2)~~ extremities and encompasses the following components:

(i) Resting Sweat Test;

(ii) Stimulated Sweat Test;

(iii) Resting Skin Temperature Test; and

(iv) Interpretation of clinical laboratory scores. Physician must evaluate the patient specific clinical information generated from the test and quantify it into a numerical scale. The data from the test and a separate report interpreting the results of the test must be documented.

(b) DoWC Z0401 QSART, $1,066.00, is billed when all of the services outlined above are completed and documented. This code may only be billed once per workers' compensation claim, regardless of the number of limbs tested.

(7) Intra-Operative Monitoring (IOM):

IOM identifies compromise to the nervous system during certain surgical procedures. Evoked responses are constantly monitored for changes that could imply damage to the nervous system.

(a) Clinical Services: ~~for IOM: Technical and Professional~~

(i) Technical staff: A qualified ~~specifically trained~~ technician shall set up the monitoring equipment in the operating room. The technician shall ~~and is expected to~~ be in constant attendance in the operating room with the physical or electronic capacity for real-time communication with the supervising neurologist or other physician trained in neurophysiology. The technician shall be specifically trained in/registered with:

- the American Society of Neurophysiologic Monitoring; or
- the American Society of Electrodiagnostic Technologists

(ii) Professional/Supervisory/Interpretive:

A Colorado-licensed physician trained in neurophysiology shall monitor the patient's nervous system throughout the surgical procedure. The monitoring physician's time is billed based upon the actual time the physician devotes to the individual patient, even if the monitoring physician is monitoring more than one patient. The physician's time does not have to be continuous for each patient and may be cumulative. The Physician shall not monitor more than three ~~(3)~~ surgical patients at one time. The physician shall provide constant neuromonitoring at critical points during the surgical procedure as indicated by the surgeon or any unanticipated testing responses. There must be a neurophysiology-trained Colorado licensed physician backup available to continue monitoring the other two patients if one of the patients being monitored has complications and/or requires the

monitoring physician's undivided attention ~~for any reason~~. There is no additional payment for the back-up neuromonitoring physician, unless ~~he/she is~~ utilized ~~in a specific case~~.

~~(iii) Technical Electronic Capacity for Real-Time Communication Requirements~~

~~The electronic communication equipment shall use a 16-channel monitoring and minimum real-time auditory system, with the possible addition of video connectivity between monitoring staff, operating surgeon and anesthesia. The equipment must also provide for all of the monitoring modalities that may be applied with the IOM procedure code.~~

(b) Procedures and Time Reporting:

Physicians shall include an interpretive written report for all primary billed procedures.

(c) Billing Restrictions:

Intra-operative neurophysiology codes do not have separate professional and technical components. However, certain tests performed in conjunction with these services ~~throughout the surgical procedure~~ have separate professional and technical components, which may be separately payable if documented and otherwise allowed in this Rule.

The neuromonitoring physician is the only party allowed to report these codes.

The ~~fee schedule value~~ maximum allowance for CPT® 95941 is equal to the ~~fee schedule value~~ maximum allowance for CPT® 95940.

(8) Speech-language therapy/pathology or any care rendered under a speech-language therapy/pathology plan of care shall be billed with a GN modifier ~~appended to all codes~~.

(9) Vaccines, toxoids, immune globulins, serums, or recombinant products shall be billed using the appropriate J code or CPT® code listed in the Medicare Part B Drug Average Sale Price (ASP), unless the ASP value does not exist for the drug or the Provider's actual cost exceeds the ASP. In these circumstances, the Provider may request reimbursement based on the actual cost, after taking into account any discounts/rebates the Provider may have received.

The maximum allowance for CPT® 90371 is $800.

(10) ~~IV Infusions Performed in Physicians' Offices or Sent Home with the Injured Worker:~~ IV infusion therapy performed in a physician's office or sent home with the injured worker shall be billed under the "Therapeutic, Prophylactic, and Diagnostic Injections and Infusions" and the "Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration" in the Medicine Section of CPT®. The maximum allowance for infused therapeutic drugs ~~are payable~~ shall be at cost to the billing Provider~~'s office~~.

Maximum allowance ~~fees~~ for supplies and medications provided by a physician's office for self-administered home care infusion therapy are covered in section 18-6(B).

(11) Moderate (Conscious) Sedation:

Providers billing for moderate sedation services shall comply with all applicable ~~2019~~ CPT® billing instructions. The maximum allowance ~~Fee Schedule value~~ is determined using the Medicine CF.

(H) PHYSICAL MEDICINE AND REHABILITATION (PM&R)

(1) General Policies:

(a) Physical therapy or any care provided under a physical therapist's plan of care shall be billed with a GP modifier ~~appended to all codes~~. Occupational therapy or any care provided under an occupational therapist's plan of care shall be billed with a GO modifier ~~appended to all codes~~.

(b) Each PM&R billed service must be clearly identifiable. The Provider must clearly document the time spent performing each service and the beginning and end time for each session.

(c) Functional objectives shall be included in the PM&R plan of care for all injured workers. Any request for additional treatment must be supported by evidence of positive objective functional gains or PM&R treatment plan changes. The ordering ATP must also agree with the PM&R continuation or changes to the treatment plan.

(d) The injured worker shall be re-evaluated by the prescribing Provider within 30 calendar days from the initiation of the prescribed treatment and at least once every month thereafter.

(e) Unlisted services require a report.

(2) Medical nutrition therapy requires prior authorization.

(3) Interdisciplinary Rehabilitation Programs: ~~– require prior authorization to determine fees.~~

~~An interdisciplinary rehabilitation program is one that provides focused, coordinated, and goal-oriented services using a team of professionals from varying disciplines to deliver care. These programs can benefit persons who have limitations that interfere with their physical, psychological, social, and/or vocational functioning.~~ As defined in the ~~Medical Treatment Guideline~~ MTGs, interdisciplinary rehabilitation programs may include, but are not limited to: chronic pain, spinal cord, or brain injury programs.

All billing Providers shall detail the services, frequency of services, duration of the program, and proposed fees for the entire program ~~and all professionals~~. The billing Provider and Payer shall attempt to agree upon billing code(s) and fee(s) for each interdisciplinary rehabilitation program.

If there is a single billing Provider for the entire interdisciplinary rehabilitation program and a daily per diem rate is mutually agreed upon, use code Z0500.

~~If i~~ndividual professionals billing separately for their participation in an interdisciplinary rehabilitation program shall use ~~, the~~ applicable CPT® codes ~~shall be used to bill for their services~~.

(4) Procedures (therapeutic exercises, neuromuscular re-education, aquatic therapy, gait training, massage, acupuncture, ~~dry needling of trigger points,~~ manual therapy techniques, therapeutic activities, cognitive development, sensory integrative techniques, and any unlisted physical medicine procedures):

The maximum amount of time allowed is one ~~(1)~~ hour of procedures per day per discipline unless medical necessity is documented and prior authorization is obtained ~~from the Payer~~. The total amount of time spent performing the procedures shall determine the appropriate number of time based units for a particular visit. ~~total amount of billed unit time cannot exceed the total time spent performing the procedures.~~

~~For Dry Needling of Trigger Points, single or multiple needles, use DoWC Z0501 or Z0502:~~

~~DoWC Z0501, initial 15 minutes, non-facility RVU is 1.3, facility RVU is 0.77~~

~~DoWC Z0502, each additional 15 minutes, non-facility RVU is 0.77, facility RVU is 0.72~~

CPT® 97139 Non-facility and facility RVUs are 0.92

(5) Modalities:

There is a limit of two ~~(2)~~ modalities (whether timed or non-timed) per visit, per discipline, per day.

~~NOTE: Instruction and application of a transcutaneous electric nerve stimulation (TENS) unit for the patient's independent use at home shall be billed only once per workers' compensation claim using CPT® 64550. For Maximum Fee Schedule value, see section 18-6(A).~~

CPT® 97039 Non-facility and facility RVUs are 0.36

(6) Evaluation Services for Physical Therapists (PTs), Occupational Therapists (OTs) and Athletic Trainers (ATs):

(a) All evaluation services must be supported by the appropriate history, physical examination documentation, treatment goals, and treatment plan or re-evaluation of the treatment plan, as outlined in ~~the 2019~~ CPT®. The Provider shall clearly state the reason for the evaluation, the nature and results of the physical examination, and the reason for recommending the continuation or adjustment of the treatment protocol. ~~Without appropriate supporting documentation, the Payer may deny payment.~~ The re-evaluation codes shall not be billed for routine pre-treatment patient assessment.

If a new problem or abnormality is encountered that requires a new evaluation and treatment plan, the Provider may perform and bill for another initial evaluation. A new problem or abnormality may be caused by a surgical procedure being performed after the initial evaluation has been completed.

A re-examination, re-evaluation, or re-assessment is different from a progress note. ~~Therapists~~ Providers should not bill these codes for a progress note. ~~Therapists~~ Providers may bill a re-evaluation code only if:

(i) professional assessment indicates a significant improvement or decline or change in the injured worker's condition or a functional status that was not anticipated in the plan of care for that time interval;
(ii) new clinical findings become known; or
(iii) the injured worker fails to respond to the treatment outlined in the current plan of care.

(b) A PT or OT may utilize a Rehabilitation Communication Form (WC 196) in addition to a progress note no more than every two ~~(2)~~ weeks for the first six ~~(6)~~ weeks, and once every four ~~(4)~~ weeks thereafter.

The WC 196 form should not be used for an evaluation, re-evaluation, or re-assessment. The form must be completed and specify which validated functional tool was used for assessing the injured worker. The form shall be sent to the referring physician before or at the injured worker's follow-up appointment with the physician~~, to aid in communication~~.

DoWC Z0817 $15.30.

(c) Only evaluation services directly performed by a PT, OT, or AT are payable. All evaluation notes or reports must be written and signed by the PT, OT, or AT.

(d) A injured worker may be seen by more than one ~~(1)~~ healthcare professional on the same day. Each professional may charge an evaluation service with appropriate documentation per patient, per day.

~~(e) Reimbursement to PTs and OTs for coordination of care with professionals shall be based upon the telephone codes for qualified non-physician Providers found in the Medicine Section of CPT®. Coordination of care reimbursement is limited to telephone calls made to outside professionals and/or to the injured worker or his or her family.~~

(e) The RVU for evaluation services performed by ATs shall be equal to the RVU for evaluation services performed by PTs.

~~(f) Interdisciplinary team conferences shall be billed per subsection (3) above.~~

(7) Special Tests:

(a) The following are considered special tests:

(i) Job Site Evaluation
(ii) Functional Capacity Evaluation
(iii) Assistive Technology Assessment
(iv) Speech
(v) Computer Enhanced Evaluation (DoWC Z0503)
(vi) Work Tolerance Screening (DoWC Z0504)

DoWC Z0503	Non-facility and facility RVUs are .93
DoWC Z0504	Non-facility and facility RVUs are .93

(b) Billing Restrictions:

(i) The following services require prior authorization: Job site evaluations exceeding two ~~(2)~~ hours ~~require prior authorization~~; Computer-Enhanced Evaluations and Work Tolerance Screenings for more than four ~~(4)~~ hours per test or more than three ~~(3)~~ tests per claim ~~require prior authorization~~; and Functional Capacity Evaluations for more than four ~~(4)~~ hours per test or two ~~(2)~~ tests per claim ~~require prior authorization~~.

(ii) The Provider shall specify the time required to perform the test in 15-minute increments.

(iii) The ~~value for the~~ analysis and the written report is included in the code's value.

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

(v) Data from computerized equipment shall always include the supporting analysis developed by the PM&R professional before it is payable as a special test.

(c) All special tests must be fully supervised by a Physician, PT, OT, SLP, or Audiologist. Final reports must be written and signed by the Physician, PT, OT, SLP, or Audiologist.

~~(8) Physical medicine supplies are reimbursed in accordance with section 18-6(A).~~

(8) Use of a facility or equipment for unattended procedures, in an individual or group setting, may be billed once per day with DoWC Z0505 RVU 0.23.

(9) Non-Medical Facility Fees:

Gyms, pools, etc., and training or supervision by non-medical Providers require prior authorization and a written negotiated fee for every three month period.

(10) Work Hardening, ~~Work~~ Conditioning, ~~Work~~ and Simulation:

~~Work Conditioning is a non-interdisciplinary program that is focused on the individual needs of the patient to return to work. Usually one (1) discipline oversees the patient in meeting goals to return to work.~~

~~Work Hardening is an interdisciplinary program that uses a team of disciplines to meet the goal of employability and return to work. This type of program entails a progressive increase in the number of hours a day that an individual completes work tasks until they can tolerate a full workday. In order to do this, the program must address the medical, psychological, behavioral, physical, functional and vocational components of employability and return to work.~~

~~Work Simulation is a program where an individual completes specific work-related tasks for a particular job and return to work. Use of this program is appropriate when modified duty can only be partially accommodated in the work place, when modified duty in the work place is unavailable, or when the patient requires more structured supervision. The need for work simulation should be based upon the results of a functional capacity evaluation and/or job analysis.~~

~~(a) Treatment Plan:~~

~~Providers shall submit a treatment plan including expected frequency and duration of treatment. If requested by the Provider, the Payer will prior authorize payment for the treatment plan services or shall identify any concerns including those based on the reasonableness or necessity of care.~~

These programs and recommendations for coverage are defined in the MTGs. All procedures must be performed by or under the onsite supervision of a Physician, Psychologist, PT, OT, SLP, or Audiologist.

~~Modified facility and non-facility RVUs are 3.4 for initial 2 hours and 1.7 for each additional hour.~~

CPT® 97545	Non-facility and facility RVUs are 3.4
CPT® 97546	Non-facility and facility RVUs are 1.7

(11) Wound Care:

Wound care is separately payable only when devitalized tissue is debrided using a recognized method (chemical, water, vacuums). ~~CPT® 97602 is not recognized for payment.~~

(12) Acupuncture:

(a) ~~Acupuncture may be performed with or without the electrical current on the needles at the acupuncture site.~~

All non-physician acupuncture Providers must be Licensed Acupuncturists (LAc) ~~by the Colorado Department of Regulatory Agencies as provided in Rule 16~~. Both Physician and LAcs ~~non-physician Providers~~ must provide evidence of training, and licensure upon request of the Payer.

(b) New or established patient evaluation services are payable if the medical record specifies the appropriate history, physical examination, treatment plan, or evaluation of the treatment plan. ~~Payers are~~ Only ~~required to pay for~~ evaluation services directly performed by a physician or an LAc are payable. All evaluation notes or reports must be written and signed by the physician or the LAc.

LAc new patient visit:	DOWC Z0800, $101.80
LAc established patient visit:	DOWC Z0801, $68.95

(I) TELEMEDICINE

(1) In addition to the healthcare services listed in Appendix P of CPT®, and Division Z-codes (when appropriate), the following CPT® codes may be provided via telemedicine: G0396, G0397, G0406-G0408, G0425-G0427, G0436, G0437, G0447, G0459, G0508, G0509, 97110, 97112, 97116, 91729, 97130, 97150, 97530, 97535, 97542, 97750, 97755, 97760, 97761, and 98960-98962. Additional services may be provided via telemedicine with prior authorization. The provider shall append modifier 95 to the appropriate CPT® code(s) to indicate synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system.

All treatment provided through 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 and shall follow applicable laws, rules and regulations for informed consent.

(2) HIPAA privacy and electronic security standards are required for the originating site and the rendering Provider.

(3) The physician-patient/psychologist-patient relationship needs to be established.

This relationship is established through assessment, diagnosis, and treatment of the injured worker. Both in-person evaluation and, two-way live audio/video services are among acceptable methods to 'establish' a patient relationship.

(4) Reimbursement:

(a) The rendering Provider may be the only Provider involved in the provision of telemedicine services. The rendering Provider shall bill place of service (POS) code 02. Maximum allowance is the appropriate CPT® code's non-facility relative weight from RBRVS multiplied by the appropriate CF, unless only a facility weight is established.

(b) An originating site fee may only be billed when the injured worker is receiving services at an authorized originating site. The originating site is responsible for verifying the injured worker and rendering Provider's identities. Originating site must bill with the appropriate facility POS code. Authorized originating sites include:

- A Hospital (inpatient or outpatient)
- A Critical Access Hospital (CAH)
- A Rural Health Clinic (RHC)
- A federally qualified health center (FQHC)
- A hospital based renal dialysis center (including satellites)
- A Skilled Nursing Facility (SNF)
- A community mental health center (CMHC)

Maximum allowance for Q3014 is $35.00 per 15 minutes. (Equipment, supplies, and professional fees of supporting Providers at the originating site are not separately payable.)

(5) Documentation:

Documentation requirements are the same as for a face-to-face encounter and shall also include the location of both the rendering Provider and the injured worker at the time of service, and a statement on how the treatment was rendered through telemedicine (such as secured video).

18-5 FACILITY FEES

(A) INPATIENT ~~HOSPITAL~~ FACILITY FEES

(1) Billing:

(a) Inpatient ~~hospital~~ facility fees shall be billed on a UB-04 and require summary level billing by revenue code. The Provider must submit itemized bills along with the UB-04.

(b) ~~The~~ Hospitals reimbursed based on MS-DRGs shall indicate the MS-DRG code ~~number~~ FL 71 of the UB-04 billing form and maintain documentation on file showing how the MS-DRG was determined. The hospital shall determine the MS-DRG using the MS-DRGs Definitions Manual in effect per section 18-2 at the time of discharge. The attending physician shall not be required to certify this documentation unless a dispute arises between the hospital and the Payer regarding MS-DRG assignment. The Payer may deny payment for services until the appropriate MS-DRG code is supplied.

(2) Reimbursement:

(a) The following types of inpatient facilities, as defined in Rule 16, are ~~reimbursed at~~ allowed a reasonable ~~billed inpatient~~ charge as negotiated by the Provider and Payer:

(i) Children's Hospitals
(ii) Veterans Administration Hospitals
(iii) State-run Psychiatric Hospitals
(iv) Psychiatric Hospitals

The Provider has the burden of proving reasonableness of reimbursement sought. Veterans Administration Hospital payments must comply with applicable rules promulgated by the United States Department of Veterans Affairs.

~~(b) The following types of inpatient facilities are reimbursed at 80% of billed inpatient charges:~~

~~(i) Medicare certified Critical Access Hospitals (CAHs), (listed in Exhibit #3)~~

~~(ii) Colorado Department of Public Health and Environment (CDPHE) licensed rehabilitation hospitals facilities,~~

~~(iii) CDPHE licensed psychiatric Hospitals Facilities that are privately owned.~~

~~(iv) CDPHE licensed skilled nursing facilities (SNF).~~

(b) The following inpatient facilities, as defined in Rule 16, are allowed a daily rate:

(i) Skilled Nursing Facilities (SNFs) are allowed $650 per day.

(ii) Rehabilitation Hospitals are allowed $1,450 per day.

(iii) ~~Medicare~~ Long Term Acute Care Hospitals (LTACHs) are allowed ~~reimbursed~~ $3,350 per day~~, not to exceed 75% of total billed charges~~. ~~If total billed charges exceed $300,000, reimbursement maximum allowance shall be 75% of billed charges.~~

The daily rates is all-inclusive for services related to the injured worker's compensable conditions. Physician's professional services, ambulance services, and chemotherapy drugs or radioisotopes may be billed separately. In the rare case extraordinary medical care is required, an additional payment of up to $300 on a per day basis may be authorized by the Payer.

All charges shall be submitted on a final bill, unless the parties agree on interim billing. The rate in effect on the last date of service covered by an interim or final bill shall determine payment.

The total length of stay includes the date of admission but not the date of discharge. Typically, bed hold days or temporary leaves are not subtracted from the total length of stay.

(c) All other inpatient facilities ~~are reimbursed as follows~~:

The maximum allowance ~~fee for inpatient hospitals,~~ is determined by ~~applying the Center for Medicare and Medicaid Services (CMS) "Medicare Severity Diagnosis Related Groups" (MS-DRGs) classification system in effect at the time of discharge. Exhibit #1 shows the relative weights per MS-DRGs that are used in calculating the maximum allowance. Retrieve~~ the relative weights for the assigned MS-DRG from ~~the MS-DRG~~ Table 5 in effect per section 18-2 at the time of discharge ~~in Exhibit #1~~ and ~~locate~~ the hospital's base rate in Exhibit #2, calculated as follows:

~~The Maximum Fee allowance is determined by calculating:~~

(MS-DRG Relative Wt x Specific hospital base rate x 185%) + (trauma center activation allowance) + (organ acquisition, when appropriate)

(i) For trauma center activation allowance, (revenue codes 680-685) see subsection (B)(6)(f);

(ii) For organ acquisition allowance, (revenue codes 810-819) see subsection (A)(2)(h).

~~Exhibit #1~~ Table 5 establishes the maximum length of stay (LOS) using the "arithmetic mean LOS." However, there is no additional allowance for exceeding this LOS, other than through the cost outlier criteria ~~under subsection 2(e) is allowed~~.

An~~y inpatient~~ admission requiring the use of both an acute care hospital (admission/discharge) and its ~~Medicare-certified~~ Rehabilitation Hospital ~~facility~~ (admission/discharge) is considered as one ~~(1)~~ admission and MS-DRG. ~~This does not apply to Long-Term Care and licensed Rehabilitation facilities.~~

(d) Outliers for inpatient hospitals identified in Exhibit #2:

Outliers are admissions with extraordinary cost warranting additional reimbursement beyond the maximum allowance. ~~under subsection (d) above.~~ To calculate the additional reimbursement, if any:

(i) Determine the hospital's cost by multiplying total billed charges (excluding any trauma center activation or organ acquisition billed charges) ~~multiplied~~ by the hospital's cost-to-charge ratio located in Exhibit #2;

~~(ii) Each hospital's cost-to-charge ratio is given in Exhibit #2.~~

(ii) The difference = hospital's cost – maximum ~~Fee~~ allowance excluding any trauma center activation or organ acquisition allowance; ~~(see (d) above).~~

(iii) If the difference is greater than $~~26,994.00~~ 26,552.00, additional reimbursement is warranted. The additional allowance ~~reimbursement~~ is determined by multiplying the difference by .80. ~~the following equation:~~

~~Difference x .80 = additional allowance~~

(e) ~~Inpatient combined with emergency department (ED):, trauma center or organ acquisition reimbursement:~~ If an injured worker is admitted to a hospital through the emergency department (ED), the ED ~~fee reimbursement~~ is included in the inpatient allowance ~~reimbursement under this section~~.

~~(ii) Trauma center activation fees and organ acquisition allowances are paid in addition to inpatient fees.~~

(f) If an injured worker is admitted to one hospital and is subsequently transferred to another hospital, the payment to the transferring hospital will be based upon a per diem value of the MS-DRG maximum allowance ~~value~~. The per diem value is calculated based upon the transferring hospital's MS-DRG relative weight multiplied by the hospital's specific base rate ~~(Exhibit #2)~~ divided by the MS-DRG geometric mean LOS established in Table 5 ~~(Exhibit #1)~~. This per diem amount is multiplied by the actual LOS. If the patient is admitted and transferred on the same day, the actual LOS equals one ~~(1)~~. The receiving hospital shall receive the appropriate MS-DRG maximum allowance ~~value~~.

(g) The Payer shall compare each billed charge type:

(i) The MS-DRG adjusted billed charges to the MS-DRG allowance (including any outlier allowance);
(ii) The trauma center activation billed charge to the trauma center activation allowance; and
(iii) The organ acquisition billed charges to the organ acquisition allowance ~~maximum fees~~.

The MS-DRG adjusted billed charges are determined by subtracting the trauma center activation billed charge and the organ acquisition billed charges from the total billed charges. The final payment is the sum of the lesser of each of these comparisons.

(h) The organ acquisition allowance is calculated using the most recent filed computation of organ acquisition costs and charges for hospitals that are certified transplant centers (CMS Worksheet D-4 or subsequent form) plus 20%.

(B) OUTPATIENT FACILITY FEES

(1) Provider Restrictions:

(a) All non-emergency outpatient surgeries require prior authorization unless the ~~Medical Treatment Guideline~~ MTGs recommend a surgery for the particular condition. All outpatient surgical procedures performed in an ASC shall warrant performance at an ASC level.

(b) A facility fee is payable only if the facility is licensed as a hospital or an ASC by the Colorado Department of Public Health and Environment (CDPHE) or applicable out of state governing agency or statute.

(2) Types of Bills for Service:

(a) Outpatient facility fees shall be billed on a UB-04 and require summary level billing by revenue code. The Provider must submit itemized bills along with the UB-04.

(b) All professional charges (professional services including, but not limited to, PT, OT, SLP, anesthesia, ~~speech therapy~~ etc.) are subject to the RBRVS and Dental Fee Schedules as incorporated by this Rule. These fee schedules apply to professional services performed in ~~and applicable to~~ all facilities. ~~regardless of whether the facility fees are based upon Exhibit #4 or billed charges.~~

(c) Outpatient hospital facility bills include all outpatient surgery, ED, clinics, Urgent Care, and diagnostic testing in the Radiology, Pathology or Medicine Section of CPT®/RBRVS.

(3) Outpatient Facility Reimbursement:

(a) The following outpatient facilities, as defined in Rule 16, are ~~reimbursed at~~ allowed a reasonable ~~100% of billed~~ charge~~s~~, as negotiated by the Provider and Payer, except for any associated professional fees:

(i) Children's Hospitals
(ii) Veterans Administration Hospitals
(iii) State-run Psychiatric Hospitals

The Provider has the burden of proving reasonableness of reimbursement sought. Veterans Administration Hospital payments must comply with applicable rules promulgated by the United States Department of Veterans Affairs.

~~(b) The CAHs listed in Exhibit #3 are reimbursed at 80% of billed outpatient facility charges, except for any associated professional fees.~~

(b) The maximum allowance for Ambulatory Payment Classifications (APC) is calculated at the following percentages of the payment rates listed in Medicare's OPPS Addendum A, as incorporated by 18-2: ~~Codes and Values~~:

(i) Outpatient hospital ~~reimbursement~~ is ~~calculated as~~ 180% ~~based upon Medicare's 2019 Outpatient Prospective Payment System (OPPS) Addendum B.~~
(ii) CAH is 250%
(iii) ASC is 153%

~~as modified in Exhibit #4. Exhibit #4 lists Medicare's Outpatient Hospital APC Codes and the Division's established rates for hospitals and other types of Providers as follows:~~

~~(i) Column A lists the APC code number.~~
~~(ii) Column 2 lists APC code description.~~
~~(iii) Column 3 is used to determine maximum fees for all hospital facilities not listed under subsections (a) and (b).~~
~~(iv) Column 4 is used to determine maximum fees for all ASCs when outpatient surgery is performed in an ASC.~~

To identify which APC grouper is aligned with a~~n Exhibit #4 APC~~ CPT® code ~~number~~ and dollar value, use Medicare's ~~2019~~ Addendum B, as incorporated by 18-2. For comprehensive APCs (C-APCs), see 18-5(B)(6).

(c) The following CPT® codes listed with a "C" status indicator in Medicare's Addendum B, shall align to the following APC codes and associated status indicators for payment. These codes are not eligible for a complexity adjusted APC payments.

~~CPT® 22558 = APC 5116~~
CPT® 22558, 22600, 22610, 22630, ~~22633,~~ 22857, 23472, 23474, 27132, 27134, 27137, 27138, and 27702 = APC 5115
~~CPT® 22632 = APC 5092~~
CPT® ~~22634,~~ 22800, and 22830 = APC 5114
~~CPT® 22846 = APC 5192~~
CPT® 22849, 22850, 22852, and 22855 = APC ~~1571~~ 5362
~~CPT® 23472, 23474, 27130, 27132, 27134, 27137, 27138, 27447, and 27702 = APC 1575~~

(4) ~~The~~ APC ~~Exhibit #4~~ values include the services and revenue codes listed below; therefore, these are generally not separately payable. ~~However, the maximum allowanceble fee 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.~~ Drugs and devices having a status indicator of G and H receive a pass-through payment. In some instances, the procedure code may have an APC code assigned. These are separately payable based on APC values, if given, ~~in Exhibit #4~~ or at cost to the facility.

Services and items included in the APC value:

(a) nursing, technician, and related services;

(b) use of the facility where the surgical procedure(s) was performed;

(c) drugs and biologicals for which separate payment is not allowed;

(d) medical and surgical supplies, durable medical equipment and orthotics not listed as a "pass through";

(e) surgical dressings;

(f) equipment;

(g) splints, casts and related devices;

(h) radiology services ~~when~~ for which separate payment is not allowed;

~~under Exhibit #4;~~

(i) administrative, record keeping and housekeeping items and services;

(j) materials, including supplies and equipment for the administration and monitoring of anesthesia;

(k) supervision of the services of an anesthetist by the operating surgeon;

(l) post-operative pain blocks; and

(m) implanted items.

Packaged Services	
Rev Code	Description
0250	Pharmacy; General Classification
0251	Pharmacy; Generic Drugs
0252	Pharmacy; Non-Generic Drugs
0254	Pharmacy; Drugs Incident to Other Diagnostic Services
0255	Pharmacy; Drugs Incident to Radiology
0257	Pharmacy; Non-Prescription
0258	Pharmacy; IV Solutions
0259	Pharmacy; Other Pharmacy
0260	IV Therapy; General Classification

Packaged Services	
Rev Code	Description
0261	IV Therapy; Infusion Pump
0262	IV Therapy; IV Therapy/Pharmacy Services
0263	IV Therapy; IV Therapy/Drug/Supply Delivery
0264	IV Therapy; IV Therapy/Supplies
0269	IV Therapy; Other IV Therapy
0270	Medical/Surgical Supplies and Devices; General Classification
0271	Medical/Surgical Supplies and Devices; Non-sterile Supply
0272	Medical/Surgical Supplies and Devices; Sterile Supply
0275	Medical/Surgical Supplies and Devices; Pacemaker
0276	Medical/Surgical Supplies and Devices; Intraocular Lens
0278	Medical/Surgical Supplies and Devices
0279	Medical/Surgical Supplies and Devices
0280	Oncology; General Classification
0289	Oncology; Other Oncology
0343	Nuclear Medicine; Diagnostic Radiopharmaceuticals
0344	Nuclear Medicine; Therapeutic Radiopharmaceuticals
0370	Anesthesia; General Classification
0371	Anesthesia; Anesthesia Incident to Radiology
0372	Anesthesia; Anesthesia Incident to Other DX Services
0379	Anesthesia; Other Anesthesia
0390	Administration, Processing & Storage for Blood & Blood Components; General Classification
0392	Administration, Processing & Storage for Blood & Blood Components; Processing & Storage
0399	Administration, Processing & Storage for Blood & Blood Components; Other Blood Handling
0621	Medical Surgical Supplies - Extension of 027X; Supplies Incident to Radiology
0622	Medical Surgical Supplies - Extension of 027X; Supplies Incident to Other DX Services
0623	Medical Supplies - Extension of 027X, Surgical Dressings
0624	Medical Surgical Supplies - Extension of 027X; FDA Investigational Devices
0630	Pharmacy - Extension of 025X; Reserved
0631	Pharmacy - Extension of 025X; Single Source Drug
0632	Pharmacy - Extension of 025X; Multiple Source Drug
0633	Pharmacy - Extension of 025X; Restrictive Prescription
0700	Cast Room; General Classification
0710	Recovery Room; General Classification
0720	Labor Room/Delivery; General Classification
0721	Labor Room/Delivery; Labor
0732	EKG/ECG (Electrocardiogram); Telemetry
0821	Hemodialysis-Outpatient or Home; Hemodialysis Composite or Other Rate
0824	Hemodialysis-Outpatient or Home; Maintenance - 100%
0825	Hemodialysis-Outpatient or Home; Support Services
0829	Hemodialysis-Outpatient or Home; Other OP Hemodialysis
0942	Other Therapeutic Services (also see 095X, an extension of 094x); Education/Training
0943	Other Therapeutic Services (also see 095X, an extension of 094X), Cardiac Rehabilitation

Packaged Services	
Rev Code	Description
0948	Other Therapeutic Services (also see 095X, an extension of 094X), Pulmonary Rehabilitation

(5) Status Indicators from Medicare's Addendum B apply as follows:

Indicator	Meaning
A	Use another fee schedule instead of Addendum B ~~Exhibit #4~~, such as conversion factors listed in section 18-4, RBRVS RVUs, Ambulance Fee Schedule, or section 18-4(F)(2) ~~Exhibit #8~~.
B	Is not recognized ~~by Medicare~~ for Outpatient Hospital Services ~~Part B~~ bill type (12x and 13x) and therefore is not separately payable unless separate fees are applicable under another section of this Rule.
C	~~Recognized by Medicare as inpatient-only procedures. However,~~ The Division recognizes these procedures on an outpatient basis with prior authorization. See subsection 18-5(B)(3)(c) for reimbursement of certain procedures with "C" status indicator.
~~D~~	~~Discontinued code.~~
E	Not generally reimbursable ~~paid by Medicare~~ when submitted on any outpatient bill type. However, services could still be reasonable and necessary, thus requiring hospital or ASC level of care. The billing party shall submit documentation to substantiate the billed service codes and any similar established codes with fees in Addendum A, as incorporated by 18-2. ~~Exhibit #4.~~
F	Corneal tissue acquisition, ~~and~~ certain CRNA services, and Hepatitis B vaccines are allowed at a reasonable cost to the facility. The facility must provide a separate invoice identifying its cost.
G	"Pass-Through Drugs and Biologicals"; separate APC payment. ~~under Exhibit #4 as an APC value~~.
H	"Pass-Through Device"; separate APC payment based on cost to the facility.
J1 or J2	The services are paid through a comprehensive APC. ~~for Medicare~~. ~~However, the DoWC has not adopted the "comprehensive APC." Therefore, an agreement between the Payer and the Provider is necessary.~~
K	"Nonpass-Through Drug or Biological or Device" for therapeutic radiopharmaceuticals, brachytherapy sources, blood and blood products; separate APC payment. ~~as listed under Exhibit #4 APC value~~.

L	Influenza Vaccine/Pneumococcal Pneumonia Vaccine and therefore is generally considered to be unrelated to work injuries.
M	Not separately payable.
N	Items and services packaged into APC rates; not separately payable.
P	Partial hospitalization paid based on observation fees outlined in this section.
Q1-Q4	~~Any "~~Packaged services subject to separate payment under OPPS payment criteria. ~~Codes" with Q1, Q2, Q3, Q4 or STVX combinations are not recognized unless the parties make a prior agreement.~~
R	Blood and blood products; separate APC payment.
S	Significant procedure, not discounted when multiple.
T	Significant procedure, multiple procedure reduction applies. ~~the highest-valued code allowed at 100% of the Exhibit #4 value and up to three (3) additional codes allowed at 50% of the Exhibit #4 value, per episode of care.~~
U	Brachytherapy source; separate APC payment.
V	Clinic or an ED visit; separate APC payment.
Y	Non-implantable Durable Medical Equipment paid pursuant to Medicare's Durable Medical Equipment Regional Carrier fee schedule for Colorado.

(6) ~~Total maximum facility value~~ Reimbursement for an outpatient facility episode of care:

(a) A comprehensive APC treats all individually reported codes as representing components of the comprehensive service, resulting in a single prospective payment.

As defined by status indicator J1, all covered outpatient services on the claim are packaged with the primary J1 service for payment, except services with a status indicator of F, G, H, L and U; ambulance services; diagnostic and screening mammography; rehabilitation therapy services; new technology services; self-administered drugs; and all preventative services.

When multiple codes with J1 status indicators are included on the claim, services are packaged with the primary (highest APC value) J1 code. Certain J1 codes, when billed together, may be eligible for a complexity adjusted APC payment listed on Medicare's Addendum J, as incorporated by 18-2.

Status indicator J2 indicates specific combinations of services designated as adjunct services that are reimbursed as part of the comprehensive observation service. All levels of emergency department (ED) and clinic visits, if billed in combination with observation time, can trigger the comprehensive composite rate. The requirements for payment under status indicator J2 require a minimum of eight units for G0378 *hospital observation service, per hour*; no status T procedure on the claim; and either an E&M visit on the same day or day before the G0378 date of service; or G0379 *direct admit to observation*. All covered services on the claim should be

considered adjunct to a J2 procedure and packaged into a single payment, except those items excluded by rule. Other excluded services include covered screening procedures, preventative services, pass-through drugs and devices, PT, OT and SLP services, certain vaccines, cornea tissue acquisition and certain services payable when an implant-only claim is billed. If the claim contains a J1 primary service, the J1 C-APC will be the composite under which the services will be paid. There is no complexity adjustment for J2 occurring on the same claim as J1.

(b) The maximum allowance for multiple procedures with a T status indicator is limited to four procedure codes per episode. The highest valued APC code is allowed at 100% of the maximum allowance, plus 50% of the maximum allowance for the following three highest valued codes.

(i) The use of modifier 51 is not a factor in determining which codes are subject to multiple procedure reductions.

(ii) Bilateral procedures require each procedure to be billed on separate lines using RT and LT modifier(s).

~~Immune globulins, vaccines, and toxoids, CPT® 90281-90399 and 90476-90756 are exempt from the multiple procedure reduction and shall be paid in addition to the four procedure codes at 100% of the fee schedule.~~

(iii) When a code is billed with multiple units, multiple procedure reductions apply to the second through fourth units as appropriate. Units may also be subject to other maximum frequency per day policies.

(c) Other surgical payment policies are as follows:

(i) All surgical procedures performed in one operating room, regardless the number of surgeons, are considered one outpatient surgical episode of care for payment purposes.

(ii) If an arthroscopic procedure ~~fails and~~ is converted to an open procedure, only the open procedure is reportable. ~~Thus, arthroscopic procedures are bundled into open procedures.~~ If an arthroscopic procedure and an open procedure are performed on different joints, the two procedures may be separately reportable with anatomic modifiers or modifier 59.

(iii) When reported in conjunction with other knee arthroscopy codes, any combination of surgical knee arthroscopies for removal of loose body, foreign body, and/or debridement/shaving of articular cartilage shall be paid only if performed in a different knee compartment using G0289.

(iv) Discontinued surgeries require the use of modifier 73 (discontinued prior to the administration of anesthesia) or modifier 74 (discontinued after administration of anesthesia). Modifier 73 results in an allowance ~~reimbursement~~ of 50% of the APC value for the primary procedure only. Modifier 74 allows ~~reimbursement of~~ 100% of the primary procedure value only.

(v) Facilities receive the lesser of the actual charge or the fee schedule allowance. A line-by-line comparison of charges is not appropriate.

(d) ~~Hospitals billing~~ Type “A” or “B” ED Visits ~~shall meet one of the following hospital licensure and billing criteria~~:

(i) Hospitals billing type “A” ~~The~~ ED visits must be physically located within a hospital licensed by the CDPHE as a general hospital or meet the out-of-state facility’s state’s licensure

requirements, and be open 24 hours a day, seven days a week. These EDs ~~and~~ bill~~ed~~ using revenue code 450 and applicable CPT® codes; ~~or~~

(ii) A freestanding type "B" ED must have operations and staffing equivalent to a licensed ED, be physically located inside a hospital, and meet Emergency Medical Treatment and Active Labor Act (EMTALA) regulations. All type "B" outpatient ED visits must be billed using revenue code 456 with level of care HCPCS codes G0380-G0384, even though the facility may not be open 24 hours a day, seven days a week. ~~/7;~~

(e) ED level of care is identified based upon one ~~(1)~~ of five ~~(5)~~ levels of care for either a type "A" or type "B" ED visit. The level of care is defined by CPT® E&M code descriptions ~~definitions~~ and internal level of care guidelines developed by the hospital in compliance with Medicare regulations. The hospital's guidelines should establish an appropriate gradation of hospital resources (ED staff and other resources) as the level of service increases. Upon request, the Provider shall supply a copy of its level of care guidelines to the Payer. (Only the higher one ~~(1)~~ of any ED levels or critical care codes shall be paid).

(f) Trauma activation means a trauma team has been activated, not just alerted. Trauma activation is billed with 068X revenue codes. The level of trauma activation shall be determined by CDPHE's assigned hospital trauma level designation. Trauma activation fees are in addition to ED and inpatient fees and are not paid for alerts. APC 5045, Trauma Response with Critical Care, is not recognized for separate payment.

Trauma activation allowances ~~fees~~ are as follows:

Revenue Code 681	$~~3,303~~5,534.00
Revenue Code 682	$~~1,433~~2,298.00
Revenue Code 683	$1,~~408~~289.00
Revenue Code 684	$954.00

~~(f) If an injured worker is admitted to the hospital through that hospital's ED, the ED reimbursement is included in the inpatient reimbursement under section 18-5(A).~~

(g) Any diagnostic testing, clinical labs, or therapies with a status indicator of "A" may be reimbursed using section 18-4(F)(3) ~~Exhibit #8~~ or the appropriate CF to the unit values for the specific CPT® code as listed in the RBRVS. Hospital bill types 13x are allowed payment for any clinical laboratory services (even if the SI is "N" for the specific clinical laboratory CPT® code) when these laboratory services are unrelated to any other outpatient services performed that day. The maximum ~~fee~~ allowances are based upon section 18-4(F)(3) ~~Exhibit #8~~.

(h) Charges for observation status lasting longer than six ~~(6)~~ hours may be subject to retroactive review. Documentation should support the medical necessity for observation or convalescent care. Observation time begins when the patient is placed in a bed for the purpose of initiating observation care in accordance with the physician's order. Observation or daily outpatient convalescence time ends when the patient is actually discharged from the hospital or ASC or admitted into a licensed facility for an inpatient stay. Observation time does ~~would~~ not include the time patients remain in the observation area after treatment is finished for reasons such as waiting for transportation home. Hospital or convalescence licensure is required for billing observation or convalescence time beyond 23 hours.

Billing Code is G0378, $45.90 per hour, round to the nearest hour.

(i) Professional fees are reimbursed in accordance ~~ing to the fee schedule times the appropriate CF~~ with 18-4 regardless of the facility type. Additional reimbursement is payable for the following services not included in the APC values, as incorporated by 18-2 ~~found in Exhibit #4~~:

(i) ambulance services (revenue code 540), see section 18-6(E)
(ii) blood, blood plasma, platelets (revenue codes 380X)
(iii) physician or physician assistant services
(iv) nurse practitioner services
(v) licensed clinical psychologist
(vi) licensed social workers
(vii) rehabilitation services (PT, OT, respiratory or SLP, revenue codes 420, 430,440)

(j) Any prescription for a drug supply to be used for longer than 24 hours, filled at any clinic, shall ~~fall under the requirements of and~~ be reimbursed in accordance with ~~as a pharmacy fee, see~~ section 18-6(C).

(k) Clinic facility fees are not separately payable unless otherwise specified in this Rule.

~~Clinics (part of a hospital or a freestanding clinic) (Form Locator (FL) 4 are 07xx and revenue codes 51x-53x):~~

~~(i) Provider Restrictions - types of facilities that are recognized for separate clinic facility fees:~~

- ~~Rural Health Clinics as identified in Exhibit #5 and/or as certified by the CDPHE;~~
- ~~Critical Access Hospitals as identified in Exhibit #3 and/or as certified by the CDPHE;~~
- ~~Any specialty care clinic (wound/infections) that requires expensive drugs/supplies that are not typically provided in a physician's office.~~

~~(ii) Billing and Maximum Fees Clinic fees are paid based on APC values, as incorporated by 18-2, Exhibit #4 and as outlined in this Rule.~~

- ~~Rural health facilities and CAHs listed in Exhibit #5 may be reimbursed are allowed a single separate clinic fee at 80% of billed charges per date of service, regardless of whether the clinic has been designated by the employer, the urgency of the episode of care, or the time of day.~~
- ~~CAHs listed in Exhibit #5 may be reimbursed a single separate clinic fee at 80% of billed charges per date of service.~~
- ~~Any specialty care clinic (wound/infections) that requires drugs/supplies that are typically not provided in a physician's office may be allowed a separate clinic fee with prior approval from the Payer, as outlined in Exhibit #4.~~
- ~~No other clinic facility fees are payable except those listed in section 18-5.~~
- ~~Maximum fees for hospital urgent care facilities or services are covered under section (C). These are identified by either place of service code 20, as billed on a CMS-1500, or by revenue code(s) 516 or 526 on a UB-04.~~

(l) IV infusion therapy performed in an outpatient hospital facility is separately payable in accordance with this section.

(m) Off campus (place of service code 19) freestanding imaging centers are ~~shall be~~ reimbursed using the RBRVS TC value(s) instead of the APC value.

(7) Rural Health Clinics

Rural Health Clinics are allowed a single separate clinic facility fee at 80% of billed charges per date of service.

Allowed revenue codes for clinic fees are 521 for physical health services and 900 for behavioral health services.

(C) URGENT CARE FACILITIES

(1) Provider Restrictions:

Facility fees are only payable if the facility qualifies as an Urgent Care facility. All Urgent Care facilities shall be accredited or certified by the Urgent Care Association (UCA) or accredited by the Joint Commission to be recognized for a separate facility payment for the initial visit.

(2) Billing and Maximum Allowances ~~Fees~~:

(a) ~~Urgent Care~~ Facility Fees:

(i) No separate facility fees are allowed for follow-up care. To receive a separate facility fee, a subsequent diagnosis shall be based on a new acute care situation and not the initial diagnosis.

(ii) 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.

(iii) Hospitals may bill on a UB-04 using revenue code 516 or 526 and the facility HCPCS code S9088, $76.50, with ~~1~~ one unit. All maximum allowances ~~fees~~ for other services billed on the UB-04 shall be in accordance with CPT® relative weights from RBRVS, multiplied by the appropriate CF.

(iv) Hospital and non-hospital based urgent care facilities may bill for the facility fee, HCPCS code S9088, $76.50, on the CMS-1500 with professional services. All other services and procedures provided in an urgent care facility, including a freestanding facility, are allowed ~~reimbursed~~ according to the appropriate CPT® code relative weight from RBRVS multiplied by the appropriate CF.

(b) All professional ~~physician or non-physician~~ fees shall be billed on a CMS-1500 with a Place of Service Code 20 and reimbursed ~~The maximum fees shall be~~ in accordance with 18-4 ~~the appropriate CPT® code relative weight from RBRVS multiplied by the appropriate CF~~.

(c) All supplies are included in the facility fee ~~for urgent care facilities~~.

(d) Any prescription for a drug ~~supply~~ to be used for longer than 24 hours, filled at any clinic, shall ~~fall under the requirements of and~~ be reimbursed in accordance with ~~as a pharmacy fee, see~~ section 18-6(C).

18-6 ANCILLARY SERVICES

(A) DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS)

(1) Durable Medical Equipment (DME):

This is equipment that can withstand repeated use and allows injured workers accessibility in the home, work, and community. DME can be categorized as:

(a) Purchased Equipment/Capped Rental:

(i) Items that cost $100.00 or less may not be rented.

(ii) Rented items must be purchased or discontinued after ten months of continuous use or once the total fee schedule allowance ~~price~~ has been reached.

(iii) The monthly rental rate cannot exceed 10% of the DMEPOS fee schedule, or if not available, the cost of the item to the Provider or the supplier (after taking into account any discounts/rebates the supplier or the Provider may have received). 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.

(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.

(v) Modifier NU shall be appended for new, UE for used purchased items or modifier RR for rented items.

(b) Take Home Exercise Equipment:

Items with a total invoice cost of $50 or less may be billed using A9300 without an invoice at a maximum allowance ~~fee~~ of actual cost ~~billed charges~~; however, Payers reserve the right to request an invoice, at any time, to validate the Provider's cost. Home exercise supplies can include, but are not limited to the following items: 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.

(c) Electrical Stimulators:

Electrical stimulators are bundled kits that include the portable unit(s), two to four leads and pads, initial battery, electrical adapters, and carrying case. Kits that cost more than $100.00 shall be rented for the first month of use and require documentation of effectiveness prior to purchase (effectiveness means functional improvement and decreased pain).

(i) TENS (Transcutaneous Electric Nerve Stimulator) machines/kits, IF (Interferential) machines/kits, and any other type of electrical stimulator combination kits: E0720 for a kit with two leads or E0730 for a kit with four 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 are not required to be rented before purchase when used in accordance with MTG recommendations.

(iv) Replacement supplies are limited to once per month and are not eligible with a first month rental.
A4595 - electrical stimulator supplies, two leads.
A4557 - replacement leads.

(v) Conductive Garments: E0731.

(d) Continuous Passive Motion Devices (CPMs):

These devices are bundled into the facility fees and not separately payable, unless the ~~Medical Treatment Guideline~~ MTGs recommend their use after discharge for the particular condition.

E0935 – continuous passive motion exercise device for use on the knee only.

E0936 – continuous passive motion exercise device for use on body parts other than knee.

(e) Intermittent Pneumatic Devices:

These devices (including, but not limited to, Game Ready and cold compression) are bundled into facility fees and are not separately payable. The use of these devices after discharge requires prior authorization.

E0650-E0676 – Codes based on body part(s), segmental or not, gradient pressure and cycling of pressure and purpose of use.

A4600 – Sleeve for intermittent limb compression device, replacement only, per each limb.

(f) Hearing and Vision Supplies:

These items are purchased. The maximum allowance is 120% of the cost to the Provider as indicated by invoice.

(2) ~~Prosthesis and~~ Orthotics:

Maximum allowance ~~fees~~ for any orthotic created using casting materials shall be ~~billed~~ determined using Medicare's Q codes and values listed under Medicare's DMEPOS fee schedule ~~for Colorado~~. The therapist time necessary to create the orthotic shall be billed using CPT® 97760.

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.

(3) Supplies:

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. ~~Reimbursement of~~ Allowances for supplies to facilities shall comply with the appropriate section of this Rule.

(4) Reimbursement:

Unless other limitations exist in this Rule, the maximum allowance for DMEPOS suppliers and medical Providers shall be based on ~~reimbursed using~~ Medicare's HCPCS Level II codes, when one exists, as established in the April 2020 ~~January 2019~~ DMEPOS schedule for rural (R) or non-rural (NR) areas. The DMEPOS schedule can be found at https://www.cms.gov.

If no code or value exists, ~~reimbursement~~ the maximum allowance shall be based on the total allowable amount listed in the Health First Colorado Fee Schedule Effective January 1, 2020, ~~Medicaid's DME, Upper Payment Limit, January 2019 Interim Rate for rural or non-rural areas~~ available at https://www.colorado.gov/hcpf/Provider-rates-fee-schedule.

If no Medicaid fee schedule value exists, ~~reimbursement shall be~~ the maximum allowance is based on 120% of the cost of the item as indicated by invoice. Shipping and handling charges are not separately payable. Payers shall not recognize the KE modifier.

Auto-shipping of monthly DMEPOS is not allowed.

(5) Complex Rehabilitation Technology dispensed and billed by Non-Physician DMEPOS Suppliers:

(a) 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.

(b) Complex Rehabilitation Technology products must be provided by suppliers who are specifically 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.

(B) HOME CARE SERVICES

Prior authorization is required for all home care–services, unless otherwise specified. All skilled home care service Providers shall be licensed by the Colorado Department of Public Health and Environment (CDPHE) as Type A or B Providers. The Payer and the home health entity should agree in writing on the type of care, the type and skill level of Provider, frequency of care, ~~and~~ duration of care at each visit, and any financial arrangements to prevent disputes.

(1) Home Infusion Therapy:

The per day or refill rates for home infusion therapy shall include all reasonable and necessary products, equipment, IV administration sets, supplies, supply management, and 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 injured worker's home.

Skilled Nursing fees are separately payable when the nurse travels to the injured worker's home to perform initial and subsequent evaluation(s), education, and coordination of care.

(a) Parenteral Nutrition:

Code	**Quantity**	**Max Bill Frequency**	**Daily Rate**
S9364	<1 Liter	once per day	$160.00
S9365	1 liter	once per day	$174.00
S9366	1.1 - 2.0 liter	once per day	$200.00
S9367	2.1 - 3.0 liter	once per day	$227.00
S9368	> 3.0 liter	once per day	$254.00

The daily rate includes the standard total parenteral nutrition (TPN) formula. Lipids, specialty amino acid formulas, and drugs other than those in standard formula are separately payable under section 18-6(C).

(b) Antibiotic Therapy is allowed a daily ~~per day~~ rate by professional + drug cost at Medicare's Average Sale Price (ASP). If ASP is not available, use Average Wholesale Price (AWP) (see section 18-6(C)).

Code	**Time**	**Max Bill Frequency**	**Daily Rate**
S9494	hourly	once per day	$158.00
S9497	once every 3 hours	once per day	$152.00

S9500	every 24 hours	once per day	$97.00
S9501	once every 12 hours	once per day	$110.00
S9502	once every 8 hours	once per day	$122.00
S9503	once every 6 hours	once per day	$134.00
S9504	once every 4 hours	once per day	$146.00

(c) Chemotherapy is allowed a daily ~~per day~~ rate + drug cost at ASP. If ASP is not available, use AWP.

Code	Description	Max Bill Frequency	Daily Rate
S9329	Administrative Services	once per day	$0.00
S9330	Continuous (24 hrs. or more) chemotherapy	once per day	$91.00
S9331	Intermittent (less than 24 hrs.)	once per day	$103.00

(d) Enteral nutrition (enteral formula and nursing services are separately payable):

Code	Description	Max Bill Frequency	Daily Rate
S9341	Via Gravity	once per day	$44.09
S9342	Via Pump	once per day	$24.23
S9343	Via Bolus	once per day	$24.23

(d) Pain Management per day or refill + drug cost at ASP. If ASP is not available, use AWP.

Code	Description	Max Bill Frequency	Daily Rate
S9326	Continuous (24 hrs. or more)	once per day	$79.00
S9327	Intermittent (less than 24 hrs.)	once per day	$103.00
S9328	Implanted pump (no separate daily rate)	Per refill	$116.00/refill. No separate daily rate.

(e) Fluid Replacement is allowed a daily ~~per day~~ rate + drug cost at ASP. If ASP is not available, use AWP.

Code	Quantity	Max Bill Frequency	Daily Rate
S9373	< 1 liter per day	once per day	$61.00
S9374	1 liter per day	once per day	$85.00
S9375	>1 but <2 liters per day	once per day	$85.00
S9376	>2 liters but <3 liters	once per day	$85.00
S9377	>3 liters per day	once per day	$85.00

(g) Multiple Therapies:

Highest cost per day or refill only + drug cost at ASP. If ASP is not available, use AWP.

(2) Nursing Services are limited to two ~~(2)~~ hours without prior authorization, unless otherwise indicated in the ~~Medical Treatment Guideline~~ MTGs:

Code	Type of Nurse	Max Bill Frequency	Hourly Rate
S9123	RN	2 hrs	$~~111~~125.00
S9124	LPN	2 hrs	$~~89~~ 125.00
S9122	CNA	The amount of time spent with the injured worker must be specified in the medical records and on the bill.	$~~45~~ 50.00

(3) Physical medicine procedures are payable in accordance with section 18-4(H).

(4) Mileage:

The parties should agree upon travel allowances and the mileage rate should not exceed ~~53~~ 52cents per mile, portal to portal. DoWC Z0772.

(5) Travel Time:

Travel is typically included in the fees listed. Travel time greater than one ~~(1)~~ hour one-way ~~shall~~ is allowed additional ~~be~~ reimbursement~~. The fee shall be agreed upon at the time of prior authorization and shall~~ not to exceed $34.68 per hour. DoWC Z0773.

(6) Drugs/Supplies/DME/Orthotics/Prosthetics Used For At-Home Care:

As defined in section 18-6(A), any drugs/supplies/DME/Orthotics/Prosthetics considered integral to at-home professional's service are not separately payable.

The maximum allowance for non-integral drugs/supplies/DME/Orthotics/Prosthetics used during a professional's home care visits are listed in section 18-6(A). All IV infusion supplies are included in the per diem or refill rates listed in this Rule.

(C) DRUGS AND MEDICATIONS

(1) All medications must be reasonably needed to cure and relieve the injured worker from the effects of the injury. Prior authorization is required for medications "not recommended" in the ~~Medical Treatment Guideline~~ MTGs for a particular diagnosis ~~or if Rules 16 and 17-4(A) apply~~.

(2) Prescription Writing:

(a) This Rule applies to all pharmacies, whether located in or out of state.

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

(c) All prescriptions shall be filled with bio-equivalent generic drugs unless the physician indicates "Dispense As Written" (DAW) on the prescription. In addition to the Rule 16 requirements, Providers prescribing a brand name with a DAW indication shall provide a written medical justification explaining the reasonableness and necessity of the brand name over the generic equivalent.

(d) The Provider shall not exceed a 60-day supply per prescription.

(e) Opioids/scheduled controlled substances that are prescribed for treatment lasting longer than three ~~3~~ days shall be provided through a pharmacy. The prescriber shall comply with applicable provisions of Title 12 ~~§§ 12-32-107.5, 12-35-114, 12-36-117.6, 12-38-111.6, 12-40-109.5, 12-42.5-404,~~ and other statutes and rules.

(3) Billing:

(a) Drugs (brand name or generic) shall be reported on bills using the applicable identifier from the National Drug Code (NDC) Directory as published by the Food and Drug Administration (FDA).

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

(i) CMS-1500 – dispensing Provider shall bill by using the metric quantity (number of tablets, grams, or mls) in column 24.G and NDC number of the drug being dispensed or, if one does not exist, the RBRVS supply code. For repackaged drugs, dispensing Provider shall list the "repackaged" and the "original" NDC numbers in field 24 of the CMS-1500. The dispensing Provider shall list the "repackaged" NDC number of the actual dispensed medication first and the "original" NDC number second, with the prefix 'ORIG' appended. Billing Providers shall include the units and days supply for all dispensed medications in field 19, example: '60UN/30DY.'

(ii) With the agreement of the Payer, the National Council for Prescription Drug Programs (NCPDP) or ANSI ASC 837 (American National Standards Institute Accredited Standards Committee) electronic billing transaction containing the same information as above may be used for billing. NCPDP Workers' Compensation/Property and Casualty (P&C) Universal Claim Form, version 1.1, for prescription drugs billed on paper shall be used by dispensing pharmacies and pharmacy benefit managers.

(c) Dispensing Provider shall keep a signature on file indicating the injured worker or the injured worker's ~~his/her~~ authorized representative has received the prescription.

(4) Average Wholesale Price (AWP):

(a) AWP for brand name and generic pharmaceuticals may be determined through the use of such monthly publications as Red Book Online or Medispan. In case of a dispute on AWP values for a specific NDC, the parties should take the lower of their referenced published values.

(b) If published AWP data becomes unavailable, substitute Wholesale Acquisition Cost (WAC) + 20% for AWP everywhere in this Rule.

(5) Reimbursement for Prescription Drugs & Medications:

(a) For prescription medications, except topical compounds, reimbursement shall be AWP + $4.00. If drugs have been repackaged, use the original AWP and NDC that was assigned by the source of the repackaged drugs to determine reimbursement.

(b) The entity packaging two or more products together makes an implied claim that the products are safe and effective when used together and shall be billed as individual line items identified by their original AWP and NDC. This original AWP and NDC shall be used to determine reimbursement. Supplies are considered integral to the package are not separately reimbursable.

(c) Reimbursement for an opiate antagonist prescribed or dispensed under §12-30-110 ~~12-36-117.7, 12-38-125.5, 12-42.5-120, 13-21-108.7~~, to an injured worker at risk of experiencing an opiate-related drug overdose event, or to a family member, friend, an employee or volunteer of a harm reduction organization, or other person in a position to assist the injured worker shall be AWP plus $4.00.

(d) ~~Drugs administered in the course of the Provider's direct care (~~ Injectables~~)~~ shall be reimbursed at Medicare's Part B Drug Average Sale Price (ASP), unless the ASP value does not exist for the drug or the Provider's actual cost exceeds the ASP. In this circumstance, Provider may request reimbursement based on the actual cost, after taking into account any discounts/rebates the Provider may have received.

(e) 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 HCPCS 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.

(6) Prescription-Strength Topical Compounds:

In order to qualify as a compound under this section, the medication must require a prescription; the ingredients must be combined, mixed, or altered by a licensed pharmacist or a pharmacy technician being overseen by a licensed pharmacist, a licensed physician, or, in the case of an outsourcing facility, a person under the supervision of a licensed pharmacist; and it must create a medication tailored to the needs of an individual patient. All topical compounds shall be billed using the DoWC Z code corresponding with the applicable category as follows:

Category I Z0790, $81.60 per 30 day supply

Any anti-inflammatory medication or any local anesthetic single agent.

Category II Z0791, $163.20 per 30 day supply

Any anti-inflammatory agent or agents in combination with any local anesthetic agent or agents.

Category III Z0792, $270.30 per 30 day supply

Any single agent other than anti-inflammatory agent or local anesthetic, either alone, or in combination with anti-inflammatory or local anesthetic agents.

Category IV Z0793, $377.40 per 30 day supply

Two ~~(2)~~ or more agents that are not anti-inflammatory or local anesthetic agents, either alone or in combination with other anti-inflammatory or local anesthetic agents.

All ingredient materials must be listed by quantity used per prescription. If the ~~Medical Treatment Guideline~~ MTGs approve some but not all of the active ingredients for a particular diagnosis, the insurer shall count only the number of the approved ingredients to determine the applicable category. In addition, initial prescription containing the approved ingredients shall be reimbursed without a medical review. Continued use (refills) may require documentation of effectiveness including functional improvement.

Category allowances ~~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 allowances ~~fee~~. The 30 day maximum allowance ~~fees schedule~~ value shall be fractioned down to the prescribed and dispensed amount given to the injured worker. Automatic refilling is not allowed.

(7) Over-the-Counter Medications:

(a) Medications that are available for purchase by the general public without a prescription and listed as over-the-counter in publications such as RedBook Online or Medispan, are reimbursed at NDC/AWP and are not eligible for dispensing fees. If drugs have been repackaged, use the original AWP and NDC that was assigned by the source of the repackaged drugs to determine reimbursement.

(b) The maximum allowance ~~reimbursement~~ for any topical muscle relaxant, analgesic, anti-inflammatory and/or antineuritic medications containing only active ingredients available without a prescription shall be ~~reimbursed~~ at cost to the billing Provider up to $30.00 per 30 day supply for any application (excludes patches). The maximum allowance ~~reimbursement~~ for a patch is cost to the billing Provider up to $70.00 per 30 day supply.

DoWC Z0794 per 30 day supply for any application (excludes patches).

DoWC Z0795 per 30 day supply for patches.

See subsection (6) for prescription-strength topicals and patches.

(8) Dietary Supplements, Vitamins and Herbal Medicines:

Reimbursement for outpatient dietary supplements, vitamins, and herbal medicines is authorized only by prior agreement of the Payer or if specifically indicated in the ~~Medical Treatment Guideline~~ MTGs. Reimbursement shall be at cost to the injured worker (see subsection (9) below).

(9) Injured Worker Reimbursement:

In the event the injured worker has directly paid for authorized medications (prescription or over-the-counter), the Payer shall reimburse the injured worker for the amount actually paid ~~for authorized prescriptions or authorized over-the-counter drugs~~ within 30 days after submission of the injured worker's receipt. See Rule 16.

(D) COMPLEMENTARY INTEGRATIVE MEDICINE

Complementary integrative medicine describes a broad range of treatment modalities, some of which are generally accepted in the medical community and others that remain outside the accepted practice of conventional western medicine. Non-physician Providers of complementary integrative medicine that are not listed in Rule 16 must have completed training in one ~~(1)~~ or more forms of therapy and certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in Chinese herbology.

(E) AMBULANCE TRANSPORTATION

(1) Maximum Allowance:

The maximum allowance for medical transportation consists of a base rate and a payment for mileage. Both the transport of the injured worker ~~to the nearest facility~~ and all items and services associated with such transport are included in the base rate and mileage rate.

(2) General Claims Submission:

(a) All hospitals billing for ground or air ambulance services shall bill on the UB-04. All other Providers shall bill on the CMS-1500.

(b) Providers shall use HCPCS codes and origin/destination modifiers.

(c) Providers shall list their name, complete address, and NPI number.

(d) Providers shall list the zip code for the place of origin in Item 23 of the CMS-1500 or FL 39-41 of the UB-04 with an "AO" code. If billing for multiple trips and the zip code for each origin is the same, services can be submitted on the same claim. If the zip codes are different, a separate claim must be submitted for each trip.

(3) Ground Ambulance Services Billing Codes and Fees:

The selection of the base code is based upon the condition of the injured worker at the time of transport, not the vehicle used and includes services and supplies used during the transport.

HCPCS	Base Rate	URBAN BASE RATE/ URBAN MILEAGE	RURAL BASE RATE/ RURAL MILEAGE	RURAL BASE RATE/ LOWEST QUARTILE	RURAL GROUND MILES
A0425	~~$18.50~~ $18.67	~~$18.88~~ $19.05	~~$19.05~~ $19.22	n/a	~~$28.58~~ $28.85
A0426	~~$574.78~~ $579.95	~~$712.40~~ $726.25	~~$719.38~~ $733.37	~~$881.95~~ $899.12	n/a
A0427	~~$574.78~~ $579.95	~~$1,127.95~~ $1,149.90	~~$1,139.00~~ $1,161.17	~~$1,396.43~~ $1,423.60	n/a
A0428	~~$574.78~~ $579.95	~~$593.65~~ $605.22	~~$599.48~~ $611.15	~~$734.95~~ $749.27	n/a
A0429	~~$574.78~~ $579.95	~~$949.85~~ $968.35	~~$959.18~~ $977.82	~~$1,175.95~~ $1,198.82	n/a
A0432	~~$574.78~~ $579.95	~~$1,038.90~~ $1,059.12	~~$1,049.08~~ $1,069.50	n/a	n/a
A0433	~~$574.78~~ $579.95	~~$1,632.55~~ $1,664.35	~~$1,648.58~~ $1,680.65	~~$2,021.15~~ $2,060.47	n/a

A0434	~~$574.78~~ $579.95	~~$1,929.38~~ $1,966.95	~~$1,948.30~~ $1,986.22	~~$2,388.63~~ $2,435.10	n/a

The "urban" base rate(s) and mileage rate(s) shall apply to all relevant/applicable ambulance services unless the zip code range area is "Rural" or "Super Rural." Medicare MSA zip code grouping is listed on Medicare's webpage with an "R" indicator for "Rural" and "B" indicator for "Super Rural." See Medicare's Zip Code to Carrier Locality File, available at https://www.cms.gov.

~~(4) Non-Emergent Medical Transportation Billing Codes:~~

~~The Payer shall reimburse for non-emergent medical transportation of the injured worker to and from reasonable and necessary medical services. The payment shall be for the least expensive means appropriate for the injured worker's condition.~~

~~Billing Code~~	~~Billing Code Description~~	~~Unit~~
~~A0130~~	~~Wheelchair Van Base Rate~~	~~One Way Trip~~
~~S0209~~	~~Wheelchair Van Mileage~~	~~Per Mile~~
~~T2005~~	~~Stretcher Van Base Rate~~	~~One Way Trip~~
~~T2049~~	~~Stretcher Van Mileage~~	~~Per Mile~~
~~A0120~~	~~Mobility Van Base Rate~~	~~One Way Trip~~

(4) Modifiers:

HCPCS modifiers identify place of origin and destination of the trip. The modifier is to be placed next to the HCPCS code billed. ~~The following is a list of current modifiers~~. Each of the modifiers may be utilized to make up the first and/or second half of a two-letter modifier. The first letter ~~must~~ describe~~s~~ the origin of the transport, and the second letter ~~must~~ describe~~s~~ the destination. ~~(Example: if a patient is picked up at his/her home and transported to the hospital, the modifier to describe the origin and destination would be RH).~~

~~**Code**~~	~~**Description**~~
~~D~~	~~Diagnostic or therapeutic site other than "P" or "H"~~
~~E~~	~~Residential, domiciliary, custodial facility, nursing home other than a skilled nursing facility~~
~~G~~	~~Hospital-based dialysis facility (hospital or hospital-related) which includes:~~ ~~- Hospital administered/Hospital located~~ ~~- Non-Hospital administered/Hospital located~~
~~GM~~	~~Multiple patients on one ambulance trip~~
~~H~~	~~Hospital~~

(5)

~~I~~	~~Site of transfer (i.e., airport, ferry, or helicopter pad) between modes of ambulance transport~~
~~J~~	~~Non-hospital-based dialysis facility~~ ~~- Hospital administered/Hospital located~~ ~~- Non-Hospital administered/Hospital located~~
~~N~~	~~Skilled Nursing Facility~~
~~P~~	~~Physician's Office (includes non-hospital facility, clinic, etc.)~~
~~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.~~
~~R~~	~~Residence~~
~~S~~	~~Scene of Accident or Acute Event~~
~~X~~	~~Destination Code Only (Intermediate stop at physician's office en route to the hospital, includes non-hospital facility, clinic, etc.)~~

Mileage:

Charges for mileage must be based on loaded mileage only, i.e., from ~~the~~ pickup ~~of a patient~~ to ~~his/her arrival at the~~ destination. ~~The miles billed must be in whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number.~~

18-7 DIVISION-ESTABLISHED CODES AND VALUES

(A) FACE-TO-FACE OR TELEPHONIC MEETINGS

(1) Face-to-face or telephonic meeting by a treating Physician ~~(as defined by Rule 16~~ or a Psychologist ~~(PsyD, PhD, or EdD)~~ with an employer, claim representative, or any attorney, and with or without the injured worker. Claim representatives include physicians or other qualified medical personnel performing Payer-initiated medical treatment reviews, but this Rule does not apply to Provider-initiated requests for prior authorization. The Physician or Psychologist may bill for the time spent attending the meeting and preparing the report (no travel time or mileage is separately payable). The fee includes the cost of the report for all parties, including the injured worker.

Before a meeting is separately payable, the following requirements must be met:

(a) Each meeting (including the time to document) shall be a minimum of 8 minutes.

(b) A report or written record signed by the Physician of Psychologist is required and shall include the following:

(i) Who was present at the meeting and their role at the meeting;
(ii) Purpose of the meeting;
(iii) A brief statement of recommendations and actions at the conclusion of the meeting;
(iv) Documented time (both start and end times).

(c) DoWC Z0701, $43.35, is payable in 8-minute increments. The CPT® mid-point rule for attaining a unit of time does not apply to this code. The Physician or Psychologist may bill multiple units of this code per date of service.

(d) For reimbursement to qualified non-physician Providers for coordination of care with medical professionals, see section 18-4(H).

(2) Face-to-face or telephonic meeting by a non-treating physician with the employer, claim representatives, or any attorney in order to provide a medical opinion on a specific workers' compensation case, which is not accompanied by a specific report or written record.

DoWC Z0601, $75.48 per 15 minutes billed to the requesting party.

(3) Face-to-face or telephonic meeting by a non-treating physician with the employer, claim representatives, or any attorney to provide a medical opinion on a specific workers' compensation case, which is accompanied by a report or written record, shall be billed as a special report (see section 18-6(G)(4)).

(4) Peer-to-peer review by a treating physician with a medical reviewer, following the treating physician's complete prior authorization request pursuant to Rule 16.

DoWC Z0602, $75.48 per 15 minutes billed to the requesting party.

(B) CANCELLATION FEES FOR PAYER-MADE APPOINTMENTS

(1) 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~~ five days prior to the appointment.

The Payer shall pay one-half of the usual fee for the scheduled services, or $183.60, whichever is less:

DoWC Z0720. The Provider shall indicate the code corresponding to the service that has been cancelled in Box 19 of the CMS-1500 form or electronic billing equivalent.

For Payer-made appointments scheduled for four ~~(4)~~ hours or longer, the Payer shall pay one-half of the usual fee for the scheduled service.

DoWC Z0740. The Provider shall indicate the code corresponding to the service that has been cancelled in Box 19 of the CMS-1500 form or electronic billing equivalent.

(2) Missed Appointments:

When ~~claimants~~ an injured worker fails to keep a scheduled appointment, the Provider should contact the Payer within ~~two (2) business~~ five days. Upon reporting the missed appointment, the Provider may inquire if the Payer wishes to reschedule the appointment for the ~~claimant~~ injured worker. If the ~~claimant~~ injured worker fails to keep the Payer's rescheduled appointment, the Provider may bill for a cancellation fee according to this section.

(C) REQUESTS FOR MEDICAL RECORDS AND COPYING FEES

The Payer, Payer's representative, injured worker, and injured worker's representative shall pay a reasonable fee for the reproduction of the injured worker's medical record. Requester and Provider should attempt to agree on a ~~reasonable~~ fee. Absent an agreement to the contrary, the fee shall be $0.10 per page. Copying charges do not apply for the initial submission of records that are part of the required documentation for billing. If the requester and Provider agree, the copy may be provided on a disc. If the requester and Provider agree and appropriate security is in place, including, but not limited to, compatible encryption, the copies may be submitted electronically. All records shall be provided no later than 30 days from the date the request is received.

Copying Fee Billing Codes and Maximum Fees:

DoWC Z0721, $18.53 for first 10 or fewer paper page(s), including faxed documents

DoWC Z0725, $0.85 per paper page for the next 11-40 paper page(s), including faxed documents

DoWC Z0726, $0.57 per paper page for remaining paper page(s), including faxed documents

DoWC Z0727, $1.50 per microfilm page

DoWC Z0728, $14.00 per computer disc or as agreed

DoWC Z0729, $0.10 per electronic page or as agreed

DoWC Z0802 actual postage paid

(D) DEPOSITION AND TESTIMONY FEES

(1) When requesting deposition or testimony from ~~physicians or~~ any ~~other type of~~ Provider, guidance should be obtained from the Interprofessional Code, prepared by the Colorado Bar Association, the Denver Bar Association, the Colorado Medical Society, and the Denver Medical Society. If the parties cannot agree upon lesser fees for the deposition or testimony services, or cancellation time periods and/or fees, the deposition and testimony rules and fees listed below shall be used.

If a party shows good cause to an Administrative Law Judge (ALJ) for exceeding the Medical Fee Schedule allowance, that ALJ may allow a greater fee.

(2) Preparation Time:

By prior agreement, the Provider may charge for preparation time for a deposition or testimony, for reviewing and signing the deposition or for preparation time for testimony.

Treating or non-treating Physician ~~as defined by Rule 16~~ or Psychologist ~~(PsyD, PhD, or EdD)~~:

DoWC Z0730, $187.00, billed in half-hour increments. Other Providers are allowed ~~shall be paid~~ 85% of this fee.

(3) Deposition:

Payment for testimony at a deposition shall not exceed $187.00, billed in half-hour increments, for a treating or non-treating Physician ~~as defined by Rule 16~~ or a Psychologist ~~(PsyD, PhD, or EdD)~~. DoWC Z0734, calculating the Provider's time from "portal to portal." Other Providers are allowed ~~shall be~~ 85% of this fee.

If requested, the Provider is entitled to a full hour deposit in advance in order to schedule the deposition.

If the Provider is notified of the cancellation of the deposition at least ten ~~(10)~~ days prior to the scheduled deposition, the Provider shall be paid the number of hours that have been ~~s/he has~~ reasonably spent in preparation, less any deposit paid by the deposing party. DoWC Z0731, $187.00, in half-hour increments.

If the Provider is notified less than ten ~~(10)~~ days in advance of a cancellation or rescheduling, or the deposition is shorter than the time scheduled, the Provider shall be paid the number of hours that have been ~~s/he has~~ reasonably spent in preparation and have been scheduled for the deposition. DoWC Z0733, $187.00, in half-hour increments.

(4) Testimony:

Treating or non-treating Physician ~~as defined by Rule 16~~ or Psychologist ~~(PsyD, PhD, or EdD)~~:

DoWC Z0738, $259.00, billed in half-hour increments. Other Providers are allowed ~~shall be~~ 85% of this fee.

Calculation of the Provider's time shall be "portal to portal" (includes travel time and mileage in both directions).

For testifying at a hearing, if requested, the Provider is entitled to a four ~~(4)~~ hour deposit in advance in order to schedule the testimony.

If the Provider is notified of the cancellation of the testimony at least ten ~~(10)~~ days prior to the scheduled testimony, the Provider shall be paid the number of hours that have been ~~s/he has~~ reasonably spent in preparation, less any deposit paid by the requesting party. DoWC Z0735, $259.00, in half-hour increments.

If the Provider is notified less than ten ~~(10)~~ days in advance of a cancellation or rescheduling, or the testimony is shorter than the time scheduled, the Provider shall be paid the number of hours that have been ~~s/he has~~ reasonably spent in preparation and has scheduled for the testimony. DoWC Z0737, $259.00, in half-hour increments.

(E) INJURED WORKER TRAVEL EXPENSES

The Payer shall reimburse the injured worker for reasonable and necessary mileage expenses for travel to and from medical appointments. The injured worker shall submit a request to the Payer showing the date(s) of travel and mileage, and explain any other reasonable and necessary travel expenses incurred or anticipated. The number of miles shall be in whole numbers and calculated using the most direct route available on the date of service. ~~If a trip has a fraction of a mile, round up to the nearest whole number.~~

Mileage Expense:	DoWC Z0723, ~~53~~ 52 cents per mile
Other Travel Expenses:	DoWC Z0724, actual paid

(F) PERMANENT IMPAIRMENT RATING

(1) The Payer is only required to pay for one ~~(1)~~ combined whole-person permanent impairment rating per claim, except as otherwise provided in the Workers' Compensation Rules of Procedures. Exceptions that may require payment for an additional impairment rating include, but are not limited to, reopened cases, as ordered by the Director or an Administrative Law Judge, or a subsequent request to review apportionment. The ATP is required to submit in writing all permanent restrictions and future maintenance care related to the injury or occupational disease.

(2) Provider Restrictions:

The ~~authorized treating~~ physician ~~(see Rule 5) shall~~ determining the permanent impairment rating must be Level II accredited and comply with Rule 5 as applicable.

(3) Maximum Medical Improvement (MMI) Determined Without any Permanent Impairment:

If a physician determines the injured worker is at MMI and has no permanent impairment, the physician should be reimbursed for the examination at the appropriate level of E&M service. The ATP ~~authorized treating physician (generally the designated or selected physician)~~ managing the total workers' compensation claim should complete the Physician's Report of Workers' Compensation Injury (Closing Report), WC 164 (see section 18-7(G)(2)).

(4) MMI Determined with a Calculated Permanent Impairment Rating:

(a) Calculated Impairment: The total fee includes the office visit, a complete physical examination, complete history, review of all medical records except when the amount of medical records is extensive (see below), determining MMI, completing all required measurements, referencing all tables used to determine the rating, using all report forms from the AMA's Guide to the Evaluation of Permanent Impairment, Third Edition (Revised), (AMA Guides), and completing the Physician's Report of Workers' Compensation Injury (Closing Report) WC 164.

Extensive medical records take longer than one ~~(1)~~ hour to review and require a separate report ~~is created~~. The separate report must document each record reviewed, specific details of the records reviewed, and the dates represented by the records reviewed. The separate record review can be billed as a special report ~~for written reports only~~ and requires prior authorization. ~~and agreement from the Payer for the separate record review fees.~~

(b) ~~DoWC codes:~~ Impairments Requiring Multiple Providers:

All Physicians (including Level II Accredited Physicians) providing consulting services for the completion of a whole person impairment rating shall bill using the appropriate E&M consultation code, or psychological diagnostic evaluation code, and shall forward their portion of the rating to the Physician determining the combined whole person rating.

A return visit for a range of motion (ROM) validation shall be billed with the appropriate code in the Medicine Section of CPT®.

The date the Physician sees the injured worker shall be the date of service billed.

DoWC Z0759, $586.00, for the Level II Accredited Authorized Treating Physician providing primary care.

DoWC Z0760, $790.00, for the Referral, Level II Accredited Authorized Physician (the claimant is not a previously established patient to that physician for that workers' compensation injury).

~~(i) Multiple impairment evaluation requiring more than one Level II Accredited Physician:~~

(G) REPORT PREPARATION

(1) Routine Reports:

Providers shall submit routine reports free of charge as directed in Rule 16 and by statute. Requests for additional copies of routine reports and for reports not in Rule 16 or statute are reimbursable under the copying fee section of this Rule. Routine reports include:

(a) Diagnostic testing
(b) Procedure reports
(c) Progress notes
(d) Office notes
(e) Operative reports
(f) Supply invoices, if requested by the Payer

(2) Completion of the Physician's Report of Workers' Compensation Injury

(a) Initial Report WC 164:

The ~~authorized treating physician (~~ATP,~~) (generally the designated physician) or~~ and ED ~~emergency department~~/urgent care physician when applicable, shall complete the first report

of injury. Items 1-7 and 11 must be complete, however item 2 may be omitted if not known by the Provider. If completed by a PA or NP, the ATP must countersign the form.

DoWC Z0750 Initial Report $50.00

(b) Closing Report WC 164:

The ATP managing the workers' compensation claim must complete the WC 164 closing report when the injured worker is at maximum medical improvement (MMI) for all covered injuries or diseases, with or without a permanent impairment. Items 1-5, 6 B-C, and 7-11 must be complete. If completed by a PA or NP, the ATP must countersign the form.

DoWC Z0752 Closing Report $50.00

If the injured worker has sustained a permanent impairment, the following additional information must be attached to the bill when MMI is determined:

(i) All necessary permanent impairment rating reports, medical reports, and narrative relied upon by the ATP, when the ATP managing the workers' compensation claim is Level II Accredited; or
(ii) The name of the Level II Accredited Physician requested to perform the permanent impairment rating when a rating is necessary and the ATP managing the workers' compensation claim is not determining the permanent impairment rating.

(c) Initial and Closing Report WC 164 completed on the same form for the same date of service:
DoWC Z0753 $50.00

(d) Progress Report WC 164:

Any request from the Payer or the employer for the information provided on this form is deemed authorization for payment. The Provider shall document who requested the WC 164, complete items 1, 2, 4-7, and 11, and send it to all parties within five ~~three business~~ days of the request. If completed by a PA or NP, the ATP must countersign the form.

DoWC Z0751 Progress Report $50.00

(3) Form Completion:

The requesting party shall pay for its request for physician to complete additional forms requiring 15 minutes or less, including forms sent by a Payer or an employer. This code also may be billed when completing the requirements outlined in § 8-43-404(10)(a) or Desk Aid 15 for a non-medical discharge.

DoWC Z0754 Form Completion $50.00

(4) Special Reports:

The term special report includes any form, questionnaire, letter or report with variable content not otherwise addressed in Rules. Examples include:

(a) treating or non-treating medical reviewers or evaluators producing written reports pertaining to injured workers not otherwise addressed, or

(b) meeting with and reviewing another Provider's written record, and amending or signing that record.

~~Billable Hours: Because narrative reports may have variable content~~ The content and total payment shall be agreed upon by the Provider and the report's requester before the Provider begins the report.

Advance Payment: If requested, the Provider is entitled to a two ~~(2)~~ hour deposit in advance in order to schedule a patient exam associated with a special report.

DoWC Z0755 Written Report, $93.50 billable in 15 minute increments

DoWC Z0757 Lengthy Form, $93.50 billable in 15 minute increments

DoWC Z0758 Meeting and Report with Non-treating Physician, $93.50 billable in 15 minute increments

In cases of cancellation for special reports not requiring a scheduled patient exam, the Provider shall be paid for the time ~~s/he has~~ reasonably spent in preparation up to the date of cancellation.

DoWC Z0761 Report Preparation with Cancelled Patient Exam, $93.50 billable in 15 minute increments

(5) Independent Medical Examinations:

RIME: Respondent-requested Independent Medical Examination

DoWC Z0756 RIME Report with patient exam, $93.50 billable in 15 minute increments

Section 8-43-404 requires RIMEs to be recorded in audio in their entirety and retained by the examining physician for 12 months and made available by request to any party to the case.

DoWC Z0766 RIME Audio Recording, $35.00 per exam

DoWC Z0767 RIME Audio Copying Fee, $24.00 per copy

CIME: Claimant-requested Independent Medical Examination, $93.50 billable in 15 minute increments to the injured worker, DoWC Code Z0770

DIME: Division Independent Medical Examination - see Rule 11

All IME reports must be served concurrently to all parties no later than 20 ~~calendar~~ days after the examination.

Cancellations:

In cases of a cancelled or rescheduled RIME or CIME, the Provider shall be paid the following fees:

If the Provider is notified of the cancellation of the RIME or CIME at least ~~ten business~~ fourteen days prior to the scheduled examination, the Provider shall be paid the number of hours ~~s/he has~~ reasonably spent in preparation, less any deposit paid by the requesting party. DoWC Z0762, $93.50 billable in 15 minute increments.

If the Provider is notified less than ~~ten (10) business~~ fourteen days in advance of a cancelled or rescheduled RIME or CIME, the Provider shall be paid the number of hours ~~s/he has~~ reasonably spent in preparation and ~~has~~ scheduled for the examination. DoWC Z0763, $93.50 billable in 15 minute increments.

(H) USE OF AN INTERPRETER

(1) Rates and terms shall be negotiated. Prior authorization is required except for initial and emergency treatment. DoWC Z0722, billable in 15 minute increments with a minimum of one hour.

(2) Payers shall reimburse for the services of an interpreter when interpretation is reasonable and necessary to provide access to medical benefits.

An interpreter may be provided on-site or via video or audio remote interpreting service, based on availability and the preference of the treating Provider.

(3) Providers are prohibited from relying on minor children and should refrain from using adult family members and friends as interpreters, except in an emergency.

(4) As of January 1, 2022, to be paid for interpreting services at a medical treatment appointments:

(a) Interpreters for certifiable languages must be listed as certified on the Certification Commission for Healthcare Interpreters (CCHI) or National Board of Certification for Medical Interpreters (National Board) website directory. Certifiable languages are:

- Spanish
- Cantonese
- Mandarin
- Russian
- Korean
- Vietnamese
- Arabic

(b) For all other languages, or in the event a certified interpreter is unavailable, the interpreter shall be qualified. Qualified means the interpreter has documentation showing completion of at least 40 hours of healthcare interpreter training.

(c) When a qualified interpreter is used in lieu of a certified interpreter, Payers must document a good faith effort was made to obtain a certified interpreter and submit this documentation to the Division upon request.

18-8 DENTAL FEE SCHEDULE

The dental fee schedule is adopted using the American Dental Association's ~~Current Dental Terminology, 2019 (~~CDT® as incorporated by 18-2 ~~2019)~~. However, surgical treatment for dental trauma and subsequent related procedures shall be billed using medical codes from RBRVS. If billed using RBRVS, reimbursement shall be in accordance with the values listed in the Surgery/Anesthesia section and the corresponding CF. See Exhibit #~~6~~3 for the listing and maximum ~~Fee Schedule value~~ allowance for CDT® ~~2019~~ ~~dental~~ codes.

Regarding prosthetic appliances, the Provider may bill and be reimbursed for 50% of the allowed fee at the time the master casts are prepared for removable prosthodontics or the final impressions are taken for fixed prosthodontics. The remaining 50% may be billed on insertion of the final prosthesis.

18-9 QUALITY INITIATIVES

(A) OPIOID MANAGEMENT

(1) Codes and maximum allowances ~~fees~~ are payable to the prescribing 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 worker's 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.

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 injured worker's past and current functional status of work, leisure, and activities of daily living.

The injured worker 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 § 12-30-110 ~~§ 12-36-117.7, 12-38-125.5, 12-42.5-120, or 13-21-108.7~~. If the injured worker is deemed to be at risk for an opiate overdose, an opioid antagonist may be prescribed (see section 18-6(C)(5)(c)).

Opioid Management Billing Codes:

Acute Phase:	DoWC Z0771, $85.00, per 15 minutes, maximum of 30 minutes per report
Subacute/Chronic Phase:	DoWC Z0765, $85.00, per 15 minutes, maximum of 30 minutes per report

(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 three ~~(3)~~ to seven ~~(7)~~ days and 50 morphine milliequivalents (MMEs) 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 is prescribed, the ATP~~, s/he~~ shall comply with the Division's Chronic Pain Disorder ~~Medical Treatment Guideline~~ MTG (Rule 17, Exhibit #9), 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 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 18-4(F)(3) 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 injured worker;
(ii) Abnormal results on previous testing;
(iii) Change in management of dosage or pain; and
(iv) Chronic daily opioid dosage above 50 MMEs.

(B) FUNCTIONAL ASSESSMENTS

(1) Pre-and post-injection assessments by a trained physician, nurse, physician's assistant, occupational therapist, physical therapist, chiropractor, or a medical assistant may be billed with spinal or sacroiliac (SI) joint injection codes. The following three ~~(3)~~ elements are required:

(a) A brief commentary on the procedures, including the anesthesia used in the injection and verification of the needle placement by fluoroscopy, CT, or MRI.

(b) Pre-and post-injection procedure shall have at least three ~~(3)~~ objective, diagnostically appropriate, functional measures identified, measured and documented. These may include spinal range of motion; tolerance and time limits for sitting, walking and lifting; straight leg raises for herniated discs; a variety of provocative SI joint maneuvers such as Patrick's sign, Gaenslen, distraction or gapping and compression tests. Objective descriptions, preferably with measurements, shall be provided initially and post procedure at the appropriate time for medication effect, usually 30 minutes post procedure.

(c) There shall be a trained physician or trained non-physician healthcare professional detailed report with a pre- and post-procedure pain diagram, normally using a 0-10 point scale. The ~~patient(s)~~ injured worker should be instructed to keep a post-injection pain diary that details the ~~patient's~~ injured worker's pain level for all pertinent body parts, including any affected limbs. The ~~patient~~ pain diary should be kept for at least eight ~~(8)~~ hours post injection and preferably up to seven ~~(7)~~ days. The ~~patient~~ injured worker should be encouraged to also report any changes in activity level post injection.

(2) If all three ~~(3)~~ elements are documented, the billing codes and maximum allowances are as follows:

DOWC Z0811, $63.00, per episode for the initial functional assessment of pre-injection care, billed with the appropriate ~~E&M~~ code, related to spinal or SI joint injections.

DOWC Z0812, $34.60, for a subsequent visit of therapeutic post-injection care (preferably done by a non-injectionist and at least seven ~~(7)~~ days after the injection), billed along with the appropriate E&M code, related to follow-up care of spinal or SI joint injections. The injured worker should provide post injection pain data, including a pain diary.

DOWC Z0814, $34.60, for post-diagnostic injection care (repeat functional assessment within the time period for the effective agent given).

(C) QUALITY PERFORMANCE AND OUTCOMES PAYMENTS (QPOP)

(1) 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. The medical Provider also must document whether the injured worker's perception of function correlates with clinical findings. The documentation of functional progress should assist the Provider in preparing a successful plan of care, including specific goals and expected time frames for completion, or for modifying a prior plan of care. The documentation must include:

(a) Specific testing that occurred, interpretation of testing results, and the weight given to these results in forming a reasonable and necessary plan of care;
(b) Explanation of how the testing goes beyond the evaluation and management (E&M) services typically provided by the Provider;
(c) Meaningful discussion of actual or expected functional improvement between the Provider and the injured worker.

(2) Billing codes and maximum fees:

DOWC Z0815, $81.60, for the initial assessment during which the injured worker provides functional data and completes the validated psychological screen, which the Provider considers in preparing a plan of care. This code also may be used for the final assessment that includes review of the functional gains achieved during the course of treatment and documentation of MMI.

DOWC Z0816, $40.80, for subsequent visits during which the injured worker provides follow-up functional data that could alter the treatment plan. The Provider may use this code if the analysis of the data leads ~~causes him or her~~ to a modification of the treatment plan. The Provider should not bill this code more than once every two ~~(2)~~ to four ~~(4)~~ weeks.

(3) QPOP for post-MMI patients requires prior authorization based on clearly documented functional goals.

(D) APP-BASED INTERVENTIONS

Providers may write an order for app-based interventions for the purpose of patient education and training to aid in curing and/or relieving the injured worker from the effects of the work injury. A duration for use shall be designated on the order, and may be reordered as clinically indicated. If ordered, the app must be payable by invoice and billed directly to the Payer. Providers who write such orders are not permitted to receive any remuneration from the service Provider for the referral. The maximum allowable charge is $25 per month and may be billed for a maximum duration of three months, or $75 per order. App-based interventions that exceed this allowance require prior authorization. Examples of app-based interventions include apps that utilize artificial intelligence to educate the user about pain neuroscience, chronic pain management, weight loss, mental well-being, glucose management, and home exercise routines.

(E) PILOT PROGRAMS

Payers may submit a proposal to conduct a pilot program(s) to the Director for approval. Pilot programs authorized by this Rule shall be designed to improve quality of care, determine the efficacy of clinic or payment models, and to provide a basis for future development and expansion of such models.

The proposal for a pilot program shall meet the minimum standards set forth in § 8-43-602 and shall include:

(1) beginning and end date for the pilot program;

(2) population to be managed (e.g. size, specific diagnosis codes);

(3) Provider group(s) participating in the program;

(4) proposed codes and fees; and

(5) process for evaluating the program's success.

Participating Payers must submit data and other information as required by the Division to examine such issues as the financial implications for Providers and ~~patients~~ injured workers, enrollment patterns, utilization patterns, impact on health outcomes, system effects and the need for future health planning.

18-10 INDIGENCE STANDARDS

(A) A person shall be found to be indigent for purposes of Rule 11-12 only if:

(1) income is at or below eligibility guidelines with liquid assets of $1,500 or less; or

(2) income is up to 25% above the eligibility guidelines, liquid assets equal $1,500 or less, and the claimant's monthly expenses equal or exceed monthly income; or,

(3) "extraordinary circumstances" exist which merit a determination of indigence.

(B) Income Eligibility Guidelines:

Family Size	Monthly income guidelines	Monthly income guideline plus 25%
1	~~$1,301~~ $1,329	~~$1,626~~ $1,661
2	~~$1,761~~ $1,796	~~$2,202~~ $2,245
3	~~$2,222~~ $2,263	~~$2,777~~ $2,828
4	~~$2,682~~ $2,729	~~$3,353~~ $3,411
5	~~$3,143~~ $3,196	~~$3,928~~ $3,995
6	~~$3,603~~ $3,663	~~$4,504~~ $4,578
7	~~$4,064~~ $4,129	~~$5,079~~ $5,161
8	~~$4,524~~ $4,596	~~$5,655~~ $5,745

*For family units with more than eight members, add $~~460~~ 467 per month for "monthly income" or $~~5,525~~ 5,600, per year for "yearly income" for each additional family member.

(1) Income is gross income from all members of the household who contribute monetarily to the common support of the household.

(2) Liquid assets include cash on hand or in accounts, stocks, bonds, certificates of deposit, equity and personal property or investments which could readily be converted into cash without jeopardizing the applicant's ability to maintain home and employment. "Liquid assets" exclude any equity in any vehicle which the injured worker or ~~his/her~~ family members must use for essential transportation unless the ALJ makes an affirmative finding of fact that the worker is credit worthy, can borrow against the equity in this vehicle, and can afford to pay back a loan without compromising food, clothing, shelter, and transportation needs.

(3) Expenses for nonessential items such as cable television, club memberships, entertainment, dining out, alcohol, cigarettes, etc. shall not be included.

18-11 LIST OF EXHIBITS

~~Exhibit #1 – MS-DRG Relative Weights~~

Exhibit #~~7~~ 1 - Evaluation and Management (E&M)

Exhibit #2 - Hospital Base Rates and Cost to Charge Ratios (CCRs)

~~Exhibit #3 - Critical Access Hospitals~~

~~Exhibit #4 - Hospital and ASC APCs~~

~~Exhibit #5 – Rural Health Clinics~~

Exhibit #~~6~~3 - Dental Fee Schedule

~~Exhibit #8 - Clinical Lab~~

Exhibit #1
Evaluation and Management (E&M) Documentation Guidelines~~
for Colorado Workers' Compensation Claims

Effective for Dates of Service on and after 1/1/2021

This E&M Guidelines~~~~ for Colorado Workers' Compensation Claims is intended for the providers who manage injured workers' medical and non-medical care. Providers may also use the "1997 Documentation Guidelines for Evaluation and Management Services" as developed by Medicare. The Level of Service is determined by:

Key Components:

1. History (Hx),
2. Examination (Exam), and
3. Medical Decision Making (MDM)

or

Time (as per CPT® and Rule 18)

Documentation requirements for any billed office visit:

- Chief complaint and medical necessity.

- Patient specific and pertain directly to the current visit.
- Information copied directly from prior records without change is not considered current or counted.
- CPT® criteria for a consultation is required to bill a consultation code.

Table I – History (Hx) Component: All three elements in the table must be met and documented.

History Elements	Requirements for a Problem Focused (PF) Level	Requirements for an Extended Problem Focused (EPF) Level	Requirements for a Detailed (D) Level	Requirements for a Comprehensive (C) Level
A. History of Present Illness/Injury (HPI)	1-3 elements	1-3 elements	4+ elements (requires a detailed patient specific description of the patient's progress with the current TX plan, which **should include objective functional gains/losses, ADLs, RTW, etc.)**	4+ elements (requires a detailed patient specific description of the patient's progress with the current TX plan, which **should include objective functional gains/losses, ADLs, RTW, etc.)**
B. Review of Systems (ROS)	Present	Present	Present	Present
C. Past Medical, Family, Social, Occupational History (PMFSOH)	None	None	Pertinent 1 of 4 types of histories	Pertinent 3 or more types of histories

A. HPI Elements represents the injured worker relaying his/her condition to the physician and should include the following:

1. Location (where?)
2. Quality (sharp, dull?)
3. Severity (pain level 1-10 or pain diagram)
4. Duration (how long?)
5. Timing (how often, regularity of occurrence, only at night, etc.?)
6. Context (what ADLs or functions aggravates/relieves, accident described?)
7. Modifying factors (doing what, what makes it worse or better?)
8. Associated signs (nausea, numbness or tingling when?)

For the provider to achieve an *"extended" HPI* in an initial patient/injured worker visit it is necessary for the provider to discuss the causality of the patient's work related injury(s) to the patient's job duties.

For the provider to achieve an *"extended" HPI* in an established patient/injured worker visit it is necessary to document a detailed description of the patient's progress since the last visit with current treatment plan that includes patient pertinent objective functional gains, such as ADLs, physical therapy goals and return to work.

B. Review of Systems (ROS) should be qualitative versus quantitative, documenting what is pertinent to that patient for the date of service.

1. Constitutional symptoms (e.g., fever, weight loss)
2. Eyes
3. Ears, Nose, Mouth, Throat
4. Cardiovascular
5. Respiratory
6. Gastrointestinal
7. Genitourinary
8. Musculoskeletal
9. Integumentary (skin and/or breast)
10. Neurological
11. Psychiatric
12. Endocrine
13. Hematologic/Lymphatic
14. Allergic/Immunologic

C. PMFSOH consists of a review of four areas (NOTE: Employers should **not** have access to any patient or family genetic/hereditary diagnoses or testing information, etc.)

1. Past history – the patient's past experiences with illnesses, operations, injuries and treatments.
2. Family history – a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk and any family situations that can interfere with or support the injured worker's treatment plan and returning to work.
3. Occupational/Social History/Military – an age appropriate review of past and current work activities, occupational history, current work status, any work situations that support or interfere with return to work. For established visits specific updates of progress must be discussed.
4. Non-Occupational/Social History – Hobbies, current recreational physical activities and the patient's support relationships, etc. For established visits specific updates of progress must be discussed.

TABLE II: Examination Component: Each bullet is counted only when it is pertinent and related to the workers' compensation injury and the medical decision making process.

Physician's Examination Component	
Level of Examination Performed and Documented	**# of Bullets Required for each level**
Problem Focused (PF)	1-5 elements identified by a bullet as indicated in the guideline
Expanded Problem Focused (EPF)	6 elements identified by a bullet as indicated in this guideline
Detailed (D)	7-12 elements identified by a bullet as indicated in this guideline
Comprehensive (C)	≥13 elements identified by a bullet as indicated in this guideline

Examination Components:

Constitutional Measurement:

- Vital signs (may be measured and recorded by ancillary staff) – any of three (3) vital signs is counted as one bullet:
  1. sitting or standing blood pressure
  2. supine blood pressure
  3. pulse rate and regularity
  4. respiration
  5. temperature
  6. height

7. weight or BMI

- One bullet for commenting on the general appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)

Musculoskeletal:

- Inspection and/or palpation of digits and nails (e.g., clubbing, cyanosis, inflammatory conditions, petechia, ischemia, infections, nodes) equals one bullet
- Gait and station assessment equals one bullet

Each of the six body areas with three (3) assessments is counted as one bullet.

1. head and or neck
2. spine or ribs and pelvis or all three
3. right upper extremity (shoulder, elbow, wrist, entire hand)
4. left upper extremity (shoulder, elbow, wrist, entire hand)
5. right lower extremity (hip, knee, ankle, entire foot)
6. left lower extremity (hip, knee, ankle, entire foot)

Assessment of a given body area includes:

- Inspection, percussion and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions
- Assessment of range of motion with notation of any pain (e.g., straight leg raise), crepitation or contracture
- Assessment of stability with notation of any dislocation (luxation), subluxation or laxity
- Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (fasciculation, tardive dyskinesia)

Neck: One bullet for both examinations.

- Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) and
- Examination of thyroid (e.g., enlargement, tenderness, mass)

Neurological: One bullet for each neurological examination/assessment(s) per extremity.

- Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities)
- Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (e.g.,Babinski)
- Examination of sensation (e.g., by touch, pin, vibration, proprioception)
- One bullet for all of the 12 cranial nerves assessments with notations of any deficits

Cardiovascular:

1. One bullet for any extremity examination/assessment of peripheral vascular system by:

- Observation (e.g., swelling, varicosities)
- Palpation (e.g., pulses, temperature, edema, tenderness)

2. One bullet for palpation of heart (e.g., location, size, thrills)
3. One bullet for auscultation of heart with notation of abnormal sounds and murmurs
4. One bullet for examination of each one of the following:
   - carotid arteries (e.g., pulse amplitude, bruits)
   - abdominal aorta (e.g., size, bruits)
   - femoral arteries (e.g., pulse amplitude, bruits)

Skin: One bullet for pertinent body part(s) inspection and/or palpation of skin and subcutaneous tissue (e.g., scars, rashes, lesions, café au lait spots, ecchymosis, ulcers.)

Respiratory: One bullet for each examination/assessment.

- Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)
- Percussion of chest (e.g., dullness, flatness, hyperresonance)
- Palpation of chest (e.g., tactile fremitus)
- Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)

Gastrointestinal: One bullet for each examination /assessment.

- Examination of abdomen with notation of presence of masses or tenderness and liver and spleen
- Examination of presence or absence of hernia
- Examination (when indicated) of anus, perineum and rectum, including sphincter tone, present of hemorrhoids, rectal masses and/or obtain stool sample of occult blood test when indicated

Psychiatric:

1. One bullet for assessment of mood and affect (e.g., depression, anxiety, agitation) if not counted under the Neurological system
2. One bullet for a mental status examination which includes:
   - attention span and concentration; and
   - language (e.g., naming objects, repeating phrases, spontaneous speech) orientation to time, place and person; and
   - recent and remote memory; and
   - fund of knowledge (e.g., awareness of current events, past history, vocabulary.)

Eyes: One bullet for both eyes and all three examinations/assessments.

- Inspection of conjunctivae and lids; and
- Examination of pupils and irises (e.g., reaction of light and accommodation, size and symmetry); and

- Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)

Ears, Nose, Mouth and Throat: One bullet for all of the following examinations/assessments:

- External inspection of ears and nose (e.g., overall appearance, scars, lesions, masses)
- Otoscopic examination of external auditory canals and tympanic membranes
- Assessment of hearing with tuning fork and clinical speech reception thresholds (e.g., whispered voice, finger rub, tuning fork)

One bullet for all of the following examinations/assessments:

- Inspection of nasal mucosa, septum and turbinates
- Inspection of lips, teeth and gums
- Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx (e.g., asymmetry, lesions, hydration of mucosal surfaces)

Genitourinary Male: One bullet for each of the following examinations of the male genitalia:

- The scrotal contents (e.g., hydrocele, spermatocele, tenderness of cord, testicular mass)
- Epididymides (e.g., size, symmetry, masses)
- Testes (e.g., size symmetry, masses)
- Urethral meatus (e.g., size location, lesions, discharge)
- Examination of the penis (e.g., lesions, presence of absence of foreskin, foreskin retract ability, plaque, masses, scarring, deformities)
- Digital rectal examination of prostate gland (e.g., size, symmetry, nodularity, tenderness)
- Inspection of anus and perineum

Genitourinary Female: One bullet for each of the following female pelvic examinations (with or without specimen collection for smears and cultures):

- Examination of external genitalia (e.g., general appearance, hair distribution, lesions) and vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele rectocele)
- Examination of urethra (e.g., masses, tenderness, scarring)
- Examination of bladder (e.g., fullness, masses, tenderness)
- Cervix (e.g., general appearance, lesions, discharge)
- Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent or support)
- Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity)

Chest: One bullet for both examinations/assessments of both breasts:

- Inspection of breasts (e.g., symmetry, nipple discharge); and
- Palpation of breasts and axillae (e.g., masses or lumps, tenderness.)

Lymphatic palpation of lymph nodes: Two or more areas are counted as one bullet:

- Neck
- Axillae
- Groin
- Other

Verify all of the completed examination components listed in the report are documented, including the relevance/relatedness to the injury and or "reasonable and necessity" for that specified patient's condition. Any examination bullet that is not clearly related to the injury or a patient's specific condition will not be counted/considered in the total number of bullets for the level of service.

TABLE III: Medical Decision Making Component (MDM): TABLES 1,2 & 3

Overall MDM is determined by the highest 2 out of 3 categories below:

Type of Decision Making	**A. # of Points for the # of Diagnosis and Management Options**	**B. # of Points for Amount and Complexity of Data**	**C. Level of Risk**
Straightforward	0-1	0-1	Minimal
Low	2	2	Low
Moderate	3	3	Moderate
High	4+	4+	High

TABLE 1 - Number of Diagnosis and Management Options:

Category of Problem(s)	**Occurrence of Problem(s)**		**Value**
Self-limited or minor problem	(max = 2)	X	1
Established problem, stable or improved		X	1
Established problem, minor worsening		X	2
Established patient with worsening of condition and no additional workup planned	(max = 1)	X	**3**
Established patient with less than anticipated improvement, Worsening of condition and additional workup planned		X	4
New problem with no additional workup planned	(max = 1)	X	**3**
New problem with additional workup planned		X	4

TABLE 2 - Amount and/or Complexity of Data Reviewed:

Amount and/or Complexity of Data Reviewed	Points
Lab(s) ordered and/or reports reviewed	1
X-ray (s) ordered and/or reports reviewed	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than the patient	1
Medicine section (CPT® 90701-99199) ordered and /or physical therapy reports reviewed and commented on progress (state whether the patient is progressing and how they are functionally progressing or not and document any planned changes to the plan of care).	2
Review and summary of old records and/or discussion with other health provider	2
Independent visualization of images, tracing or specimen	2

TABLE 3 - Table of Risk (the highest one in any one category determines the overall risk for this portion):

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered or Addressed	Management Option(s) Section
Minimal	One self-limiting or minor problem, e.g., cold, insect bite, tinea corporis, minor non-sutured laceration.	Lab tests requiring venipuncture; Chest X-rays; EKG, EEG; Urinalysis; Ultrasound; KOH prep	Rest; Gargles; Elastic bandages; Superficial dressings
Low	Two or more self-limited or minor problems; One stable chronic illness, e.g., well controlled HTN, NIDDM, cataract, BPH; Acute, uncomplicated illness or injury, e.g., allergic rhinitis, simple sprain, cystitis, acute laceration repair	Physiologic tests not under stress, e.g., PFTs; Non-cardiovascular imaging studies with contrast, e.g., barium enema; Superficial needle biopsy; Lab tests requiring arterial puncture; Skin biopsies	Over-the-counter drugs; Minor surgery with no identified risk factors; PT/OT; IV fluids w/o additives; Simple or layered closure; Vaccine injection
Moderate	One or more chronic illness with mild exacerbation, progression or side effects of treatment; Two or more stable chronic illnesses; Undiagnosed new problem with uncertain prognosis, e.g., new extremity neurologic complaints; Acute illness with systemic symptoms, e.g., pyelonephritis colitis; Acute complicated injury, e.g., head injury, with brief loss of consciousness.	Physiologic tests under stress, e.g., cardiac stress test; Discography; Diagnostic injections; Deep needle or incisional biopsies; Cardiovascular imaging studies, with contrast, and no identified risk factors, e.g., arteriogram, cardiac catheterization; Obtain fluid from body cavity, e.g., thoracentesis, lumbar puncture.	Minor surgery, with identified risk factors; Elective major surgery (open, percutaneous, or endoscopic), with no identified risk factors; Prescription drug management; Therapeutic nuclear medicine; IV fluids with additives; Closed treatment of fracture or dislocation, without manipulation; Disability counseling and/or work restrictions, Inability to return the injured worker to work and requiring detailed functional improvement plan.

High	One or more chronic illness, with severe exacerbation, progression or side effects of treatment; Acute or chronic illness or injury, which poses a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolism, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness, with potential threat to self or others; An abrupt change in neurological status, e.g., seizure, TIA, weakness, sensory loss.	Cardiovascular imaging studies with contrast, with identified risk factors; Cardiac EP studies; Diagnostic endoscopies, with identified risk factors.	Elective major surgery (open, percutaneous, endoscopic), with identified risk factors; Emergency major surgery; Parenteral controlled substances; Drug therapy requiring intensive monitoring for toxicity, Decision not to resuscitate, or to de- escalate care because of poor prognosis; Potential for significant permanent work restrictions or total disability which would significantly restrict employment opportunities; Management of addiction behavior or other significant psychiatric condition; Treatment plan for patients with symptoms causing severe functional deficits without supporting physiological findings or verified related medical diagnosis.

New Patient/Office Consultations Level of Service Based on Key Components: CPT® consultation criteria must be met before a consultation can be billed for any level of service.

Level of Service (requires all three key components at the same level or higher)	**History**	**Examination**	**Medical Decision Making (MDM)**
99201 / 99241	Problem Focused (PF)	PF	Straight Forward (SF)
99202 / 99242	Extended PF	EPF	SF
99203 / 99243	Detailed (D)	D	Low
99204 / 99244	Comprehensive (C)	C	Moderate
99205 / 99245	Comprehensive (C)	C	High

Established Patient Office Visit Level of Service Based on Key Components

Level of Service (requires at least two of the three key components at the same level or higher and one of the two must be MDM)	**History**	**Examination**	**Medical Decision Making (MDM)**
99211	N/A	N/A	N/A
99212	Problem Focused (PF)	PF	SF
99213	Extended PF	EPF	Low
99214	Detailed (D)	D	Moderate
99215	Comprehensive (C)	C	High

Time Component:

- If greater than 50% of a physician's time at an E&M visit is spent either face-to-face with the patient counseling and/or coordination of care, with or without an interpreter, and there is detailed patient specific documentation of the counseling and/or coordination of care, then time can determine the level of service.
- If time is used to establish the level of visit and total amount of time falls in between two levels, then the provider's time shall be more than half way to reaching the higher level.

A. Counseling: Primary care physicians should have *shared decision making conferences* with their patients to *establish viable functional goals* prior to making referrals for diagnostic testing and/or to specialists. Shared decision making occurs when the physician shares with the patient all the treatment alternatives reflected in the Colorado Medical Treatment Guidelines as well as any possible side effects or limitations, and the patient shares with the primary physician his/her desired outcome from the treatment. Patients should be encouraged to express their goals, outcome expectations and desires from treatment as well as any personal habits or traits that may be impacted by procedures or their possible side effects.

1. The physician's time spent face-to-face with the patient and/or their family counseling him/her or them in one or more of the following:

- Injury/disease education that includes discussion of diagnostic tests results and a disease specific treatment plan.
- Return to work, temporary and/or permanent restrictions
- Review of other physician's notes (i.e., IME consultation)
- Self-management of symptoms while at home and/or work

- Correct posture/mechanics to perform work functions
- Exercises for muscle strengthening and stretching
- Appropriate tool and equipment use to prevent re-injury and/or worsening of the existing injury/condition
- Patient/injured worker expectations and specific goals
- Family and other interpersonal relationships and how they relate to psychological/social issues
- Discussion of pharmaceutical management (includes drug dosage, specific drug side effects and potential of addiction /problems)
- Assessment of vocational plans (i.e., restrictions as they relate to current and future employment job requirements)
- Discussion of the workers' compensation process (i.e. IMEs, MMI, role of case manager)

B. Coordination of Care: Coordination of care requires the physician to either call another health care provider (outside of their own clinic) regarding the patient's diagnosis and/or treatment or the physician telephones or visits the employer in-person to safely return the patient to work.

New Patient/Office Consultations Based on Time

Level of Service	Avg. time (minutes) as listed for the specific CPT® code
99201 / 99241	10
99202 / 99242	20
99203 / 99243	30
99204 / 99244	45
99205 / 99245	60

Established Patient Office Visit Based on Time

Level of Service	Avg. time (minutes) as listed for the specific CPT® code
99211	5
99212	10
99213	15
99214	25
99215	40

Exhibit # 2

Base Rates and Cost-to-Charge Ratios

Source: Medicare FY 2020 IPPS Impact File - Correction Notice (August 2019)

Effective 1/1/2021

Provider Number	Name	Total CCR	Individual Hospital Base Rate
060001	North Colorado Medical Center	0.248	$7,103.15
060003	Longmont United Hospital	0.280	$6,549.94
060004	Platte Valley Medical Center	0.390	$6,442.07
060006	Montrose Memorial Hospital	0.384	$6,421.20
060008	San Luis Valley Health	0.390	$6,421.20
060009	Lutheran Medical Center	0.216	$6,521.51
060010	Poudre Valley Hospital	0.261	$6,682.59
060011	Denver Health Medical Center	0.312	$8,378.88
060012	Centura Health-St Mary Corwin Medical Center	0.237	$7,026.34
060013	Mercy Regional Medical Center	0.268	$8,212.13
060014	Presbyterian St Lukes Medical Center	0.155	$7,045.02
060015	Centura Health-St Anthony Hospital	0.208	$6,574.38
060020	Parkview Medical Center, Inc	0.147	$7,078.44
060022	University Colo Health Memorial Hospital Central	0.209	$6,691.82
060023	St Marys Medical Center	0.273	$7,153.44
060024	University Of Colorado Hospital Authority	0.166	$8,061.20
060027	Foothills Hospital	0.213	$6,405.67
060028	Saint Joseph Hospital	0.189	$7,162.96
060030	Mckee Medical Center	0.360	$6,497.94

Provider Number	Name	Total CCR	Individual Hospital Base Rate
060031	Centura Health-Penrose-St Francis Health Services	0.198	$6,490.07
060032	Rose Medical Center	0.125	$6,818.26
060034	Swedish Medical Center	0.104	$6,685.29
060044	Colorado Plains Medical Center	0.242	$6,771.99
060049	Uchealth Yampa Valley Medical Center	0.620	$9,919.44
060054	Community Hospital	0.328	$6,419.70
060064	Centura Health-Porter Adventist Hospital	0.206	$6,427.23
060065	North Suburban Medical Center	0.103	$6,749.63
060071	Delta County Memorial Hospital	0.458	$6,417.04
060075	Valley View Hospital Association	0.410	$8,488.41
060076	Sterling Regional Medcenter	0.471	$8,053.11
060096	Vail Health Hospital	0.531	$12,429.28
060100	Medical Center Of Aurora, The	0.123	$6,645.70
060103	Centura Health-Avista Adventist Hospital	0.267	$6,677.57
060104	St Anthony North Health Campus	0.243	$7,357.97
060107	National Jewish Health	0.218	$6,686.05
060112	Sky Ridge Medical Center	0.105	$6,903.57
060113	Centura Health-Littleton Adventist Hospital	0.184	$6,349.28
060114	Parker Adventist Hospital	0.204	$6,368.04
060116	Good Samaritan Medical Center	0.205	$6,327.75
060117	Animas Surgical Hospital, Llc	0.359	$6,247.62
060118	St Anthony Summit Medical Center	0.283	$6,442.07
060119	Medical Center Of The Rockies	0.268	$6,331.19
060124	Orthocolorado Hospital At St Anthony Med Campus	0.179	$6,267.92
060125	Castle Rock Adventist Hospital	0.229	$6,370.38

Provider Number	Name	Total CCR	Individual Hospital Base Rate
060126	Banner Fort Collins Medical Center	0.539	$6,421.20
060127	Scl Health Community Hospital- Northglenn	0.997	$6,686.05
060128	Longs Peak Hospital	0.394	$6,737.16
060129	UCHealth Broomfield Hospital	0.949	$6,511.90
060130	UCHealth Grandview Hospital	0.655	$6,490.77
*	Critical Access Hospitals	0.531	$12,429.28
069999	Any New Hospital	0.229	$6,370.38

* A list of Critical Access Hospitals is available at www.ruralcenter.org/resource-library/cah-locations.

Exhibit #3

Dental Fee Schedule

Effective 1/1/2021

Proc	Description	Rate
D0120	PERIODIC ORAL EVALUATION - EST PATIENT	$68.69
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	$115.17
D0145	ORAL EVAL PT UND 3 YR AGE CNSL W/PRIM CAREGIVER	$107.08
D0150	COMP ORAL EVALUATION - NEW OR EST PATIENT	$121.23
D0160	DTL&EXT ORAL EVALUATION - PROBLEM FOCUSED REPORT	$242.45
D0170	RE-EVALUATION - LIMITED PROBLEM FOCUSED	$80.82
D0171	RE-EVALUATION POST-OPERATIVE OFFICE VISIT	$80.82
D0180	COMP PERIODONTAL EVALUATION - NEW OR EST PATIENT	$131.33
D0190	SCREENING OF A PATIENT	$68.69
D0191	ASSESSMENT OF A PATIENT	$48.49
D0210	INTRAORAL-COMPLETE SERIES OF RADIOGRAPHIC IMAGES	$183.68
D0220	INTRAORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE	$36.74
D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL IMAGE	$33.06
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	$56.94
D0250	EXTRAORAL 2D PRJECTN RAD IMG BY RAD SRCE/ DTECTR	$69.80
D0251	EXTRAORAL POSTERIOR DENTAL RAD IMAGE	$64.29
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	$37.31
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	$59.70
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	$72.75
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	$83.95
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	$126.85

Proc	Description	Rate
D0310	SIALOGRAPHY	$552.58
D0320	TEMPOROMANDIBULAR JOINT ARTHROGRAM INCL INJ	$976.23
D0321	OTHER TEMPOROMANDIBULAR JOINT IMAGES BY REPORT	BR
D0322	TOMOGRAPHIC SURVEY	$792.03
D0330	PANORAMIC RADIOGRAPHIC IMAGE	$171.30
D0340	2D CEPHLOMTRIC RAD IMG - ACQSTN MEASRE& ANALYSIS	$193.40
D0350	2D ORAL/FACIAL PHOTOGRAPHIC IMAGES	$92.10
D0351	3D PHOTOGRAPHIC IMAGE	$92.10
D0364	CNE BEAM CAPTR & INTREP LESS THAN WHL JAW	$307.60
D0365	CNE BEAM CAPTR INTERP W FLD VIEW 1 ARCH MNDBL	$392.33
D0366	CNE BEAM CAPTR INTERP W FLD VIEW 1 ARCH MAXL	$392.33
D0367	CNE BEAM CAPTR INTERP W FLD VIEW BTH JAWS	$442.07
D0368	CNE BEAM CAPTR INTERP FR TMJ 2 OR MORE	$454.96
D0369	MAXILLOFACIAL MRI CAPTURE AND INTERPRETATION	$257.87
D0370	MAXLFCL US IMAGE CAPTR AND INTRP	$147.36
D0371	SIALOENDOSCOPY CAPTURE AND INTERPRETATION	BR
D0380	CNE BEAM CAPTR LMTD FLD <1 WHL JAW	$316.81
D0381	CNE BEAM CAPTR W FLD VIEW 1 ARCH MNDBL	$429.17
D0382	CNE BEAM CAPTR W FLD VIEW 1 ARCH MAXL	$429.17
D0383	CNE BEAM CAPTR W FLD VIEW BTH JAWS	$429.17
D0384	CNE BEAM CAPTR FR TMJ 2 OR MORE	$460.49
D0385	MAXILLOFACIAL MRI IMAGE CAPTURE	$2,827.38
D0386	MAXILLOFACIAL ULTRASOUND IMAGE CAPTURE	$707.30
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE	BR
D0393	TREATMENT SIMULATION USING 3D IMAGE VOLUME	BR

Proc	Description	Rate
D0394	DIGITAL SUBTR OF 2 > IMAGES OF THE SAME MODALITY	BR
D0395	FUSION OF 2/> 3D IMAGE VOLUMES OF 1/> MODALITIES	BR
D0411	HBA1C IN-OFFICE POINT OF SERVICE TESTING	BR
D0412	BLOOD GLCSE LVL TST - IN-OFFICE USING GLCSE MTR	BR
D0414	LAB MICRBAL SPEC CULTRE/SENS/REPORT PREP TRNSMSN	$71.13
D0415	COLLECTION MICROORGANISMS CULTURE & SENSITIVITY	$51.57
D0416	VIRAL CULTURE	$76.47
D0417	CLCT & PREP SALIVA SAMPLE FOR LAB DX TESTING	$69.36
D0418	ANALYSIS OF SALIVA SAMPLE	$71.13
D0419	ASSESSMENT OF SALIVARY FLOW BY MEASUREMENT	BR
D0422	COLLECT/PREP GENETIC SAMPLE FOR LAB ANALYSIS	$51.57
D0423	GENETIC TEST SUSCEPT TO DSEASE SPECIMEN ANLYS	BR
D0425	CARIES SUSCEPTIBILITY TESTS	$44.46
D0431	ADJUNCTIVE PREDX TST NOT INCL CYTOLOGY/BX PROC	$71.13
D0460	PULP VITALITY TESTS	$71.13
D0470	DIAGNOSTIC CASTS	$156.50
D0472	ACCESSION OF TISSUE GROSS EXAMINATION PREP/REPRT	$97.81
D0473	ACCESS TISSUE GR&MIC EXAMINATION PREP/REPRT	$206.29
D0474	ACCESS TISS GR&MIC EX ASSESS SURG MARG PREP/RPT	$231.19
D0475	DECALCIFICATION PROCEDURE	$124.49
D0476	SPECIAL STAINS FOR MICROORGANISMS	$120.93
D0477	SPECIAL STAINS NOT FOR MICROORGANISMS	$165.39
D0478	IMMUNOHISTOCHEMICAL STAINS	$151.16
D0479	TISSUE INSITU HYBRIDIZATION INCL INTERPRETATION	$231.19
D0480	ACESS EXFOLIATIVE CYTOL SMEAR MIC EXAM PREP/REPT	$142.27

Proc	Description	Rate
D0481	ELECTRON MICROSCOPY	$533.51
D0482	DIRECT IMMUNOFLUORESCENCE	$177.84
D0483	INDIRECT IMMUNOFLUORESCENCE	$177.84
D0484	CONSULTATION ON SLIDES PREPARED ELSEWHERE	$266.76
D0485	CONSULT INCL PREP SLIDES BX MATL SPL REF SRC	$368.12
D0486	ACCESSION TRANSEPITHELIAL CYTOLOG SAMPL MIC EXAM	$170.72
D0502	OTHER ORAL PATHOLOGY PROCEDURES BY REPORT	BR
D0600	DX PX QUANT/MNITR/RECRD CHNGS ENAML/DENTN/CEMNTM	BR
D0601	CARIES RISK ASSESS DOCU FINDING OF LOW RISK	$106.70
D0602	CARIES RISK AX AND DOCU WITH A FNDNG OF MOD RISK	$106.70
D0603	CARIES RISK AX AND DOCU WITH FNDNG OF HIGH RISK	$106.70
D0999	UNSPECIFIED DIAGNOSTIC PROCEDURE BY REPORT	BR
D1110	PROPHYLAXIS - ADULT	$120.75
D1120	PROPHYLAXIS - CHILD	$83.33
D1206	TOPICAL APPLICATION OF FLUORIDE VARNISH	$60.11
D1208	TOPICAL APPLICATION OF FLUORIDE EXCL VARNISH	$40.08
D1310	NUTRITIONAL COUNSELING CONTROL OF DENTAL DISEASE	$63.49
D1320	TOBACCO CNSL CONTROL&PREVENTION ORAL DISEASE	$68.93
D1330	ORAL HYGIENE INSTRUCTIONS	$87.07
D1351	SEALANT - PER TOOTH	$70.75
D1352	PREV RSN REST MOD HIGH CARIES RISK PT-PERM TOOTH	$90.70
D1353	SEALANT REPAIR PER TOOTH	$90.70
D1354	INTERIM CARIES ARRESTING MEDICATION APPLICATION	$70.75
D1510	SPACE MAINTAINER - FIXED - UNILATERAL	$434.90
D1516	SPACE MAINTAINER - FIXED - BILATERIAL MAXILLARY	$608.86

Proc	Description	Rate
D1517	SPACE MAINTAINER - FIXED - BILATERIAL MANDIBULAR	$608.86
D1520	SPACE MAINTAINER - REMOVABLE - UNILATERAL	$478.39
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL MAXILRY	$739.33
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL MNDBULR	$739.33
D1551	RECMT/REBND BILAT SPACE MAINTAINER MAXILLARY	$93.94
D1552	RECMT/REBND BILAT SPACE MAINTAINER MANDIBULAR	$93.94
D1553	RECMT/REBND UNI SPACE MAINTAINER PER QUADRANT	$62.63
D1556	REMOVAL FIXED UNI SPACE MAINTAINER PER QUADRANT	$60.89
D1557	REMOVAL FIXED BILAT SPACE MAINTAINER MAXILLARY	$90.46
D1558	REMOVAL FIXED BILAT SPACE MAINTAINER MANDIBULAR	$90.46
D1575	DISTAL SHOE SPACE MAINTANR - FIXED - UNILATERIAL	$478.39
D1999	UNSPECIFIED PREVENTIVE PROCEDURE BY REPORT	BR
D2140	AMALGAM - ONE SURFACE PRIMARY OR PERMANENT	$214.92
D2150	AMALGAM - TWO SURFACES PRIMARY OR PERMANENT	$278.14
D2160	AMALGAM - THREE SURFACES PRIMARY OR PERMANENT	$336.29
D2161	AMALGAM-FOUR/MORE SURFACES PRIMARY/PERMANENT	$409.62
D2330	RESIN-BASED COMPOSITE - ONE SURFACE ANTERIOR	$200.21
D2331	RESIN-BASED COMPOSITE - TWO SURFACES ANTERIOR	$255.51
D2332	RESIN-BASED COMPOSITE - THREE SURFACES ANTERIOR	$312.71
D2335	RESIN-BASED COMPOSITE 4/> SURFACES INCISAL ANGLE	$369.91
D2390	RESIN-BASED COMPOSITE CROWN ANTERIOR	$409.96
D2391	RESIN-BASED COMPOSITE - ONE SURFACE POSTERIOR	$234.53
D2392	RESIN-BASED COMPOSITE - TWO SURFACES POSTERIOR	$306.99
D2393	RESIN-BASED COMPOSITE - THREE SURFACES POSTERIOR	$381.35
D2394	RESIN COMPOS - FOUR OR MORE SURFACES POSTERIOR	$467.16

Proc	Description	Rate
D2410	GOLD FOIL - ONE SURFACE	$369.18
D2420	GOLD FOIL - TWO SURFACES	$615.30
D2430	GOLD FOIL - THREE SURFACES	$1,066.51
D2510	INLAY - METALLIC - ONE SURFACE	$976.27
D2520	INLAY - METALLIC - TWO SURFACES	$1,107.53
D2530	INLAY - METALLIC - THREE OR MORE SURFACES	$1,276.53
D2542	ONLAY - METALLIC - TWO SURFACES	$1,251.92
D2543	ONLAY - METALLIC - THREE SURFACES	$1,309.35
D2544	ONLAY - METALLIC - FOUR OR MORE SURFACES	$1,361.86
D2610	INLAY - PORCELAIN/CERAMIC - ONE SURFACE	$1,148.55
D2620	INLAY - PORCELAIN/CERAMIC - TWO SURFACES	$1,212.54
D2630	INLAY - PORCELAIN/CERAMIC - THREE/MORE SURFACES	$1,291.30
D2642	ONLAY - PORCELAIN/CERAMIC - TWO SURFACES	$1,255.20
D2643	ONLAY - PORCELAIN/CERAMIC - THREE SURFACES	$1,353.65
D2644	ONLAY - PORCELAIN/CERAMIC - 4 OR MORE SURFACES	$1,435.69
D2650	INLAY - RESIN-BASED COMPOSITE - ONE SURFACE	$754.76
D2651	INLAY - RESIN-BASED COMPOSITE - TWO SURFACES	$899.15
D2652	INLAY RESIN BASED COMPOSITE 3 OR MORE SURFACES	$945.10
D2662	ONLAY - RESIN-BASED COMPOSITE - TWO SURFACES	$820.40
D2663	ONLAY - RESIN-BASED COMPOSITE - THREE SURFACES	$964.78
D2664	ONLAY RESIN BASED COMPOSIT FOUR OR MORE SURFACES	$1,033.70
D2710	CROWN - RESIN-BASED COMPOSITE (INDIRECT)	$601.95
D2712	CROWN 3/4 RESIN-BASED COMPOSITE (INDIRECT)	$601.95
D2720	CROWN - RESIN WITH HIGH NOBLE METAL	$1,483.67
D2721	CROWN - RESIN WITH PREDOMINANTLY BASE METAL	$1,390.41

Proc	Description	Rate
D2722	CROWN - RESIN WITH NOBLE METAL	$1,420.93
D2740	CROWN - PORCELAIN/CERAMIC	$1,522.67
D2750	CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	$1,502.32
D2751	CROWN - PORCELAIN FUSED PREDOMINANTLY BASE METAL	$1,398.89
D2752	CROWN - PORCELAIN FUSED TO NOBLE METAL	$1,432.80
D2753	CROWN-PORCELAIN FUSED TITANIUM AND ALLOYS	$1,398.89
D2780	CROWN - 3/4 CAST HIGH NOBLE METAL	$1,441.28
D2781	CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	$1,356.50
D2782	CROWN - 3/4 CAST NOBLE METAL	$1,400.58
D2783	CROWN - 3/4 PORCELAIN/CERAMIC	$1,481.97
D2790	CROWN - FULL CAST HIGH NOBLE METAL	$1,449.76
D2791	CROWN - FULL CAST PREDOMINANTLY BASE METAL	$1,373.45
D2792	CROWN - FULL CAST NOBLE METAL	$1,398.89
D2794	CROWN - TITANIUM	$1,483.67
D2799	PROVISIONAL CROWN	$601.95
D2910	RECMNT/REBND INLAY/ONLAY/VNR/PART CVRGE RESTRATN	$130.23
D2915	RECMNT/REBND INDRCT OR PREFAB POST AND CORE	$130.23
D2920	RE-CEMENT OR RE-BOND CROWN	$132.03
D2921	REATTACHMENT OF TOOTH FRAG INCISAL EDGE/CUSP	$189.91
D2929	PREFABR PORC CROWN - PRIMARY TOOTH	$522.71
D2930	PREFABR STAINLESS STEEL CROWN - PRIMARY TOOTH	$359.93
D2931	PREFABR STAINLESS STEEL CROWN - PERMANENT TOOTH	$406.96
D2932	PREFABRICATED RESIN CROWN	$434.09
D2933	PREFABR STAINLESS STEEL CROWN W/RESIN WINDOW	$497.39
D2934	PREFAB ESTHETIC COAT STNLESS STEEL CROWN PRIM	$497.39

Proc	Description	Rate
D2940	PROTECTIVE RESTORATION	$137.46
D2941	INTERIM THERAPEUTIC RESTORATION PRIM DENTITION	$137.46
D2949	RESTOR FOUNDATION FOR INDIR RESTOR	$137.46
D2950	CORE BUILDUP INCLUDING ANY PINS WHEN REQUIRED	$343.65
D2951	PIN RETENTION - PER TOOTH ADDITION RESTORATION	$77.77
D2952	POST AND CORE ADDITION TO CROWN INDIRECTLY FAB	$542.61
D2953	EACH ADDITIONAL INDIRECTLY FAB POST SAME TOOTH	$271.30
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	$434.09
D2955	POST REMOVAL	$334.61
D2957	EACH ADDITIONAL PREFABRICATED POST - SAME TOOTH	$217.04
D2960	LABIAL VENEER (RESIN LAMINATE) - CHAIRSIDE	$1,049.04
D2961	LABIAL VENEER (RESIN LAMINATE) - LABORATORY	$1,190.12
D2962	LABIAL VENEER (PORCELAIN LAMINATE) - LABORATORY	$1,293.21
D2971	ADD PROC NEW CRWN UND XSTING PART DENTUR FRMEWRK	$208.00
D2975	COPING	$633.04
D2980	CROWN REPAIR MATERIAL FAILURE	$253.22
D2981	INLAY REPAIR BY REPORT	$253.22
D2982	ONLAY REPAIR BY REPORT	$253.22
D2983	VENEER REPAIR BY REPORT	$253.22
D2990	RESIN INFILT OF INCIPIENT LESIONS	$90.43
D2999	UNSPECIFIED RESTORATIVE PROCEDURE BY REPORT	BR
D3110	PULP CAP - DIRECT (EXCLUDING FINAL RESTORATION)	$125.52
D3120	PULP CAP - INDIRECT(EXCLUDING FINAL RESTORATION)	$100.42
D3220	TX PULP-REMV PULP CORONAL DENTINOCEMENTL JUNC	$257.33
D3221	PULPAL DEBRIDEMENT PRIMARY AND PERMANENT TEETH	$282.43

Proc	Description	Rate
D3222	PART PULPOTOMY FOR APEXOGENEIS PERM TOOTH	$261.51
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	$250.90
D3240	PULPAL THERAPY - POSTERIOR PRIMARY TOOTH	$308.80
D3310	ENDODONTIC THERAPY ANTERIOR TOOTH	$984.29
D3320	ENDODONTIC THERAPY PREMOLAR TOOTH	$1,206.24
D3330	ENODODONTIC THERAPY MOLAR	$1,495.73
D3331	TREATMENT RC OBSTRUCTION; NON-SURGICAL ACCESS	$386.00
D3332	INCOMPLETE ENDO TX; INOP UNRESTORABLE/FX TOOTH	$733.39
D3333	INTERNAL ROOT REPAIR OF PERFORATION DEFECTS	$337.75
D3346	RETREATMENT PREVIOUS RC THERAPY - ANTERIOR	$1,312.39
D3347	RETREATMENT PREVIOUS RC THERAPY - PREMOLAR	$1,543.98
D3348	RETREATMENT PREVIOUS ROOT CANAL THERAPY - MOLAR	$1,910.68
D3351	APEXIFICATION/RECALCIFICAT INIT VST	$563.13
D3352	APEXIFICAT/RECALCIFICAT INT MED REPL	$252.44
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	$776.73
D3355	PULPAL REGENERATION - INITIAL VISIT	$563.13
D3356	PULPAL REGEN - INTERIM MED RPLCMNT	$252.44
D3357	PULPAL REGENERATION - COMPLETION OF TREATMENT	BR
D3410	APICOECTOMY - ANTERIOR	$1,116.55
D3421	APICOECTOMY - PREMOLAR (FIRST ROOT)	$1,242.77
D3425	APICOECTOMY - MOLAR (FIRST ROOT)	$1,407.83
D3426	APICOECTOMY (EACH ADDITIONAL ROOT)	$475.75
D3427	PERIRADICULAR SURGERY WITHOUT APICOECTOMY	$1,009.75
D3428	BG IN CONJ PERIRADICULAR SURG/TOOTH SINGLE SITE	$1,471.91
D3429	BG IN CONJ PERIRADICUL SURG EACH CONTIG TH SSS	$1,403.94

Proc	Description	Rate
D3430	RETROGRADE FILLING - PER ROOT	$349.53
D3431	BIO MAT SFT OSS REGE CONJ PERIR SUR	$1,728.23
D3432	GTR RESORB BRRER PER SITE IN CONJ PERIRAD SURG	$1,485.50
D3450	ROOT AMPUTATION - PER ROOT	$728.19
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	$2,718.56
D3470	INTENTIONAL REIMPLANTATION W/NECESSARY SPLINTING	$1,388.41
D3910	SURGICAL PROCEDURE ISOLATION TOOTH W/RUBBER DAM	$194.18
D3920	HEMISECTION NOT INCLUDING ROOT CANAL THERAPY	$553.42
D3950	CANAL PREPARATION&FITTING PREFORMED DOWEL/POST	$252.44
D3999	UNSPECIFIED ENDODONTIC PROCEDURE BY REPORT	BR
D4210	GINGIVECT/PLSTY 4/>CNTIG/TOOTH BOUND SPACES-QUAD	$1,124.90
D4211	GINGIVECT/PLSTY 1-3 CNTIG/TOOTH BOUND SPACE-QUAD	$499.96
D4212	GINGIVECT/PLSTY FOR ACCESS RESTORATION PER TOOTH	$399.96
D4230	ANAT CROWN EXP 4/> CONTIGUOUS TEETH PER QUAD	$1,574.86
D4231	ANATOMICAL CROWN EXPOSURE 1-3 TEETH PER QUADRANT	$749.93
D4240	GINGL FLP PROC 4/> CONTIG/TOOTH BOUND SPACE-QUAD	$1,424.87
D4241	GINGL FLP PROC 1-3 CONTIG/TOOTH BOUND SPACE-QUAD	$824.93
D4245	APICALLY POSITIONED FLAP	$1,049.91
D4249	CLINICAL CROWN LENGTHENING - HARD TISSUE	$1,562.36
D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	$2,374.79
D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	$1,274.89
D4263	BONE REPLACEMENT GRAFT - FIRST SITE IN QUADRANT	$849.93
D4264	BONE REPLACEMENT GRAFT - EA ADD SITE QUADRANT	$724.94
D4265	BIOLOGIC MATERIALS AID SOFT&OSSEOUS TISSUE REGEN	BR
D4266	GUID TISSUE REGEN - RESORBABLE BARRIER PER SITE	$874.92

Proc	Description	Rate
D4267	GUID TISSUE REGEN - NONRESORB BARRIER PER SITE	$1,124.90
D4268	SURGICAL REVISION PROCEDURE PER TOOTH	BR
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	$1,687.35
D4273	AUTOGNS CONECTIVE TISSUE GRFT 1ST TOOTH/IMPLANT	$2,062.32
D4274	MESIAL OR DISTAL WEDGE PROCEDURE	$1,169.90
D4275	NONAUTGNS CONECTV TISSUE GRFT 1ST TOOTH/IMPLANT	$1,549.86
D4276	COMB CNCTIVE TISSUE&DBL PEDICLE GRAFT PER TOOTH	$2,312.30
D4277	FREE SOFT TISSUE GRAFT, 1ST TOOTH/ IMPLANT	$1,749.85
D4278	FREE SOFT TISSUE GRAFT, E/ADNL TOOTH, IMPLNT	$574.95
D4283	AUTO CNNCTV TISSUE GRFT PROC E/A TOOTH, IMPLANT	$1,757.35
D4285	NON-AUTO CNNCTV TSSUE GRFT PROC E/A TOOTH/IMPLNT	$1,322.38
D4320	PROVISIONAL SPLINTING - INTRACORONAL	$556.27
D4321	PROVISIONAL SPLINTING - EXTRACORONAL	$505.70
D4341	PRDONTAL SCALING&ROOT PLANING 4/MORE TEETH-QUAD	$320.28
D4342	PRDONTAL SCALING&ROOT PLANING 1-3 TEETH-QUAD	$185.42
D4346	SCALNG GNGIVAL INFLAMM FULL MOUTH AFTR ORAL EVAL	$185.42
D4355	FULL MOUTH DEBRID ENABLE COMP EVALUATION&DX	$219.14
D4381	LOC DEL ANTIMICROBL AGTS CREVICULR TISS TOOTH BR	BR
D4910	PERIODONTAL MAINTENANCE	$197.22
D4920	UNSCHEDULED DRESSING CHANGE	$143.28
D4921	GINGIVAL IRRIGATION PER QUADRANT	BR
D4999	UNSPECIFIED PERIODONTAL PROCEDURE BY REPORT	BR
D5110	COMPLETE DENTURE - MAXILLARY	$2,346.71
D5120	COMPLETE DENTURE - MANDIBULAR	$2,346.71
D5130	IMMEDIATE DENTURE - MAXILLARY	$2,558.69

Proc	Description	Rate
D5140	IMMEDIATE DENTURE - MANDIBULAR	$2,558.69
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	$1,980.57
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	$2,301.75
D5213	MAX PART DENTUR-CAST METL FRMEWRK W/RSN BASE	$2,592.94
D5214	MAND PART DENTUR- CAST METL FRMEWRK W/RSN BASE	$2,592.94
D5221	IMMED MAXILLARY PARTIAL DENTURE RESIN BASE	$2,160.43
D5222	IMMED MANDIBULAR PARTIAL DENTURE RESIN BASE	$2,509.44
D5223	IMMED MAXIL PART DENTURE CAST METL FRAME W/RESIN	$2,826.33
D5224	IMMED MAND PART DENTURE CAST METL FRAME W/RESIN	$2,826.33
D5225	MAXILLARY PARTIAL DENTRUE FLEXIBLE BASE	$1,980.57
D5226	MANDIBULAR PARTIAL DENTURE FLEXIBLE BASE	$2,301.75
D5282	RMVBL UNIL PRTL DNTR CST MTL INCL CLSP TTH MXLRY	$1,511.66
D5283	RMVBL UNIL PRTL DNTR CST MTL INCL CLSP TTH MNDBL	$1,511.66
D5284	RMVABLE UNI PRTL DNTURE 1 PC FLEX BASE PER QDRNT	$1,154.09
D5286	RMVABLE UNI PRTL DNTURE 1 PC RESIN PER QDRNT	$1,154.09
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	$128.47
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	$128.47
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	$128.47
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	$128.47
D5511	REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR	$256.94
D5512	REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY	$256.94
D5520	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	$214.12
D5611	REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR	$278.35
D5612	REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY	$278.35
D5621	REPAIR CAST FRAMEWORK, MANDIBULAR	$299.76

Proc	Description	Rate
D5622	REPAIR CAST FRAMEWORK, MAXILLARY	$299.76
D5630	REPAIR OR REPLACE BROKEN CLASP PER TOOTH	$364.00
D5640	REPLACE BROKEN TEETH - PER TOOTH	$235.53
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	$321.17
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE PER TOOTH	$385.41
D5670	REPLACE ALL TEETH&ACRYLIC CAST METAL FRMEWRK MAX	$942.11
D5671	REPLACE ALL TEETH&ACRYLIC CAST METL FRMEWRK MAND	$942.11
D5710	REBASE COMPLETE MAXILLARY DENTURE	$952.82
D5711	REBASE COMPLETE MANDIBULAR DENTURE	$909.99
D5720	REBASE MAXILLARY PARTIAL DENTURE	$899.29
D5721	REBASE MANDIBULAR PARTIAL DENTURE	$899.29
D5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)	$537.43
D5731	RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)	$537.43
D5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)	$492.47
D5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)	$492.47
D5750	RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)	$717.29
D5751	RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)	$717.29
D5760	RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)	$706.58
D5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)	$706.58
D5810	INTERIM COMPLETE DENTURE (MAXILLARY)	$1,134.81
D5811	INTERIM COMPLETE DENTURE (MANDIBULAR)	$1,220.46
D5820	INTERIM PARTIAL DENTURE (MAXILLARY)	$877.88
D5821	INTERIM PARTIAL DENTURE (MANDIBULAR)	$931.40
D5850	TISSUE CONDITIONING MAXILLARY	$224.82
D5851	TISSUE CONDITIONING MANDIBULAR	$224.82

Proc	Description	Rate
D5862	PRECISION ATTACHMENT BY REPORT	BR
D5863	OVERDENTURE COMPLETE MAXILLARY	$2,483.75
D5864	OVERDENTURE PARTIAL MAXILLARY	$3,275.97
D5865	OVERDENTURE COMPLETE MIBULAR	$2,483.75
D5866	OVERDENTURE PARTIAL MIBULAR	$3,404.44
D5867	REPLACEMENT REPL PART SEMI-PRCISN/PRCISN ATTCH	BR
D5875	MODIFICATION REMV PROSTH AFTER IMPLANT SURGERY	BR
D5876	ADD MTL SUBSTRUCTR TO ACRYLIC FULL DNTR PER ARCH	BR
D5899	UNS REMOVABLE PROSTHODONTIC PROCEDURE REPORT	BR
D5911	FACIAL MOULAGE (SECTIONAL)	$595.24
D5912	FACIAL MOULAGE (COMPLETE)	$595.24
D5913	NASAL PROSTHESIS	$12,534.35
D5914	AURICULAR PROSTHESIS	$12,534.35
D5915	ORBITAL PROSTHESIS	$16,962.27
D5916	OCULAR PROSTHESIS	$4,524.27
D5919	FACIAL PROSTHESIS	BR
D5922	NASAL SEPTAL PROSTHESIS	BR
D5923	OCULAR PROSTHESIS INTERIM	BR
D5924	CRANIAL PROSTHESIS	BR
D5925	FACIAL AUGMENTATION IMPLANT PROSTHESIS	BR
D5926	NASAL PROSTHESIS REPLACEMENT	BR
D5927	AURICULAR PROSTHESIS REPLACEMENT	BR
D5928	ORBITAL PROSTHESIS REPLACEMENT	BR
D5929	FACIAL PROSTHESIS REPLACEMENT	BR
D5931	OBTURATOR PROSTHESIS SURGICAL	$6,748.94

Proc	Description	Rate
D5932	OBTURATOR PROSTHESIS DEFINITIVE	$12,622.14
D5933	OBTURATOR PROSTHESIS MODIFICATION	BR
D5934	MANDIBULAR RESECTION PROSTHESIS W/GUIDE FLANGE	$11,504.45
D5935	MANDIBULAR RESECTION PROSTHESIS W/O GUIDE FLANGE	$10,009.92
D5936	OBTURATOR PROSTHESIS INTERIM	$11,243.23
D5937	TRISMUS APPLIANCE (NOT FOR TMD TREATMENT)	$1,413.17
D5951	FEEDING AID	$1,837.12
D5952	SPEECH AID PROSTHESIS PEDIATRIC	$5,965.27
D5953	SPEECH AID PROSTHESIS ADULT	$11,328.88
D5954	PALATAL AUGMENTATION PROSTHESIS	$10,498.11
D5955	PALATAL LIFT PROSTHESIS DEFINITIVE	$9,710.16
D5958	PALATAL LIFT PROSTHESIS INTERIM	BR
D5959	PALATAL LIFT PROSTHESIS MODIFICATION	BR
D5960	SPEECH AID PROSTHESIS MODIFICATION	BR
D5982	SURGICAL STENT	$952.82
D5983	RADIATION CARRIER	$2,141.16
D5984	RADIATION SHIELD	$2,141.16
D5985	RADIATION CONE LOCATOR	$2,141.16
D5986	FLUORIDE GEL CARRIER	$214.12
D5987	COMMISSURE SPLINT	$3,211.74
D5988	SURGICAL SPLINT	$642.35
D5991	VESICULOBULLOUS DISEASE MEDICAMENT CARRIER	$246.23
D5992	ADJUST MAXILLOFACIAL PROSTH APPLIANCE BY REPORT	BR
D5993	MAINT / CLEAN MAXILLOFACIAL PROSTH BY REPORT	BR
D5994	PERIDONL MEDIC CARRIER PERIPH SEAL LAB PRCESSD	BR

Proc	Description	Rate
D5999	UNSPECIFIED MAXILLOFACIAL PROSTHESIS BY REPORT	BR
D6010	SURG PLACEMENT IMPLANT BODY: ENDOSTEAL IMPLANT	$3,920.46
D6011	SECOND STAGE IMPLANT SURGERY	BR
D6012	SURG PLCMT INTERIM IMPL TRNSITIONL PROS: ENDOS	$3,704.21
D6013	SURGICAL PLACEMENT OF MINI IMPLANT	$3,920.46
D6040	SURGICAL PLACEMENT: EPOSTEAL IMPLANT	$13,489.31
D6050	SURGICAL PLACEMENT: TRANSOSTEAL IMPLANT	$10,063.45
D6051	INTERIM ABUTMENT	BR
D6052	SEMI-PRECISION ATTACHMENT ABUTMENT	$1,661.54
D6055	CONNECTING BAR IMPLANT OR ABUTMENT SUPPORTED	$1,177.64
D6056	PREFABRICATED ABUTMENT INCLUDES PLACEMENT	$813.64
D6057	CUSTOM FABRICATED ABUTMENT INCLUDES PLACEMENT	$1,006.35
D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	$2,256.78
D6059	ABUT SUPP PORCELAIN TO METL CROWN HI NOBLE METL	$2,226.81
D6060	ABUT SUPP PORCELAIN TO MTL CROWN PREDOM BASE MTL	$2,104.76
D6061	ABUT SUPP PORCELAIN TO METAL CROWN NOBLE METAL	$2,147.58
D6062	ABUTMENT SUPP CAST METAL CROWN HIGH NOBLE METAL	$2,139.02
D6063	ABUTMENT SUPP CAST METAL CROWN PREDOM BASE METAL	$1,862.81
D6064	ABUTMENT SUPP CAST METAL CROWN NOBLE METAL	$1,948.46
D6065	IMPL SUPP PORCELAIN/CERAMIC CROWN	$2,220.38
D6066	IMPL SUPP PORCLN FUSED METL CRWN TITNM/HIGH NOBL	$2,162.57
D6067	IMPL SUPP METAL CROWN TITIANM/HIGH NOBLE METL	$2,098.34
D6068	ABUT SUPP RETAINER PORCELAIN/CERAMIC FPD	$2,237.51
D6069	ABUT RETAINR PORCELN TO METL FPD HI NOBL METL	$2,226.81
D6070	ABUT RETN PORCELN TO METL FPD PREDOM BASE METL	$2,104.76

Proc	Description	Rate
D6071	ABUT SUPP RETN PORCELN FUSD METAL FPD NOBLE METL	$2,147.58
D6072	ABUT SUPP RETN CAST METL FPD HIGH NOBLE METL	$2,173.28
D6073	ABUT RTNR CAST METL FPD PREDOM BASE METL	$1,984.86
D6074	ABUTMENT RTNR CAST METAL FPD NOBLE METAL	$2,109.04
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	$2,220.38
D6076	IMPL SUPP RTNR PORCLN FUSED METL FPD TITNM/HIGH	$2,162.57
D6077	IMPL SUPP RTNR CST METL FPD TITNM/HIGH NOBLE	$2,098.34
D6080	IMPL MAINT PROC REMV CLEAN PROSTH & ABUT REINSRT	$184.14
D6081	SCALNG/DBRDMNT IMPLNT WO FLAP ENTRY/CLOS	$94.21
D6082	IMPL SUPP CROWN PORCLN FUSED BASE ALLOY	$2,162.57
D6083	IMPL SUPP CROWN PORCLN FUSED TO NOBLE ALLOYS	$2,162.57
D6084	IMPL SUPP CROWN PORCLN FUSED TO TITANIUM ALLOYS	$2,162.57
D6085	PROVISIONAL IMPLANT CROWN	$646.63
D6086	IMPLANT SUPPORTED CROWN PREDOM BASE ALLOYS	$2,098.34
D6087	IMPLANT SUPPORTED CROWN NOBLE ALLOYS	$2,098.34
D6088	IMPLNT SUPRTD CROWN TITANIUM AND ALLOYS	$2,098.34
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS BY REPORT	BR
D6091	REPL ATTACHMNT IMPL/ABUT SUPP PROS PER ATTACHMNT	$888.58
D6092	RECEMENT / REBOND IMPLANT/ABUTMENT SUPP CROWN	$173.43
D6093	RECMNT/REBOND IMPL/ABUTMNT SUPP FIX PART DENTURE	$271.93
D6094	ABUTMENT SUPPORTED CROWN TITANIUM	$1,766.46
D6095	REPAIR IMPLANT ABUTMENT BY REPORT	BR
D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	BR
D6097	ABUT SUPP CROWN PORCLN FUSED TO TITANIUM ALLOYS	$2,162.57
D6098	IMPL SUPP RETAINER PORCELAIN FUSED TO BASE ALLOY	$2,104.76

Proc	Description	Rate
D6099	IMPL SUPP RETAINR FPD PORCLN FUSED NOBLE ALLOYS	$2,147.58
D6100	IMPLANT REMOVAL BY REPORT	BR
D6101	DBRDMNT OF SNGL PERI-IMPLANT DEFECT/S	$635.92
D6102	DBRDMNT AND OSSEOUS CNTUR OF PERI-IMPLANT DEFECT	$873.59
D6103	BONE GRFT RPR PERIIMPLNT DFCT W/O FLAP ENTR/CLSE	$727.99
D6104	BONE GRAFT AT TIME OF IMPLANT PLACEMENT	$727.99
D6110	IMPL/ABUTMENT SUPPORTED RD - MAXILLARY	$2,926.97
D6111	IMPL/ABUTMENT SUPPORTED RD - MANDIBULAR	$2,926.97
D6112	IMPL/ABUTMENT SUPPORTED RPD - MAXILLARY	$2,926.97
D6113	IMPLANT / ABUTMENT SUPPORTED RPD - MANDIBULAR	$2,926.97
D6114	IMPLANT / ABUTMENT SUPPORTED FD - MAXILLARY FULL	$5,125.94
D6115	IMPLANT/ABUTMENT SUPPORTED FD - MANDIBULAR FULL	$5,125.94
D6116	IMPL/ABUTMENT SUPPORTED FD - MAXILLARY - PARTIAL	$3,931.17
D6117	IMPL/ABUT SUPPORTED FD - MANDIBULAR - PARTIAL	$3,931.17
D6118	IMP/ABUT SPRTD INTRM FIXED DENTR EDENTLS MANDBLR	$2,665.74
D6119	IMP/ABUT SPRTD INTRM FIXED DENTR EDENTLS MAXLARY	$2,665.74
D6120	IMPL SUPP RETAINR PORCLN FUSED TITNM AND ALLOYS	$2,104.76
D6121	IMPL SUPP RETAINER METAL FPD BASE ALLOYS	$1,984.86
D6122	IMPL SUPP RETAINER METAL FPD NOBLE ALLOYS	$2,109.04
D6123	IMPL SUPP RETAINR METAL FPD TITNM AND ALLOYS	$1,984.86
D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX BY REPORT	$396.11
D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD-TITANM	$1,819.99
D6195	ABUT SUPP RETAINR PORCLN FUSED TITANIUM ALLOYS	$2,143.30
D6199	UNSPECIFIED IMPLANT PROCEDURE BY REPORT	BR
D6205	PONTIC - INDIRECT RESIN BASED COMPOSITE	$934.81

Proc	Description	Rate
D6210	PONTIC - CAST HIGH NOBLE METAL	$1,429.19
D6211	PONTIC - CAST PREDOMINANTLY BASE METAL	$1,339.30
D6212	PONTIC - CAST NOBLE METAL	$1,393.23
D6214	PONTIC - TITANIUM	$1,438.18
D6240	PONTIC - PORCELAIN FUSED TO HIGH NOBLE METAL	$1,411.21
D6241	PONTIC - PORCELN FUSED PREDOMINANTLY BASE METAL	$1,303.35
D6242	PONTIC - PORCELAIN FUSED TO NOBLE METAL	$1,375.26
D6243	PONTIC PORCELAIN FUSED TO TITANIUM AND ALLOYS	$1,303.35
D6245	PONTIC - PORCELAIN/CERAMIC	$1,456.15
D6250	PONTIC - RESIN WITH HIGH NOBLE METAL	$1,393.23
D6251	PONTIC - RESIN WITH PREDOMINANTLY BASE METAL	$1,285.37
D6252	PONTIC - RESIN WITH NOBLE METAL	$1,326.72
D6253	PROVISIONAL PONTIC	$600.44
D6545	RETAINER - CAST METAL RESIN BONDED FIX PROSTH	$523.34
D6548	RETAINER - PORCELN/CERAMIC RSN BONDED FIX PROSTH	$575.67
D6549	RESIN RETAINER FOR RESIN BONDED FIXED PROSTHESIS	$377.44
D6600	RETAINER INLAY - PORCELAIN/CERAMIC TWO SURFACES	$1,038.74
D6601	RETAINER INLAY - PORC/CERAMIC 3 OR MORE SURFACES	$1,089.49
D6602	RETAINER INLAY CAST HIGH NOBLE METAL 2 SURFACES	$1,110.11
D6603	RETAINR INLAY - CAST HI NOBLE METAL 3/MORE SURFS	$1,221.12
D6604	RETAINER INLAY - CAST PREDOM BASE METAL 2 SURFS	$1,087.91
D6605	RTAINR INLAY - CAST PREDOM BASE MTL 3/MORE SURFS	$1,152.93
D6606	RETAINER INLAY - CAST NOBLE METAL TWO SURFACES	$1,070.46
D6607	RETNR INLAY CAST NOBLE METAL 3 OR MORE SURFACES	$1,187.82
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC TWO SURFACES	$1,129.14

Proc	Description	Rate
D6609	RETAINER ONLAY PORCELAIN/CERAMIC 3/MORE SURFACES	$1,178.30
D6610	RETAINER ONLAY - HIGH NOBLE METAL TWO SURFACES	$1,197.33
D6611	RETAINER ONLAY HIGH NOBLE METAL 3/MORE SURFACES	$1,309.93
D6612	RETAINER ONLAY CAST PREDOM BASE METAL 2 SURFACES	$1,190.99
D6613	RETNR ONLAY CAST PREDOM BASE METAL 3/MORE SURFS	$1,244.91
D6614	RETAINER ONLAY - CAST NOBLE METAL TWO SURFACES	$1,165.61
D6615	RETNR ONLAY CAST NOBLE METAL 3 OR MORE SURFACES	$1,211.60
D6624	RETAINER INLAY - TITANIUM	$1,110.11
D6634	RETAINER ONLAY - TITANIUM	$1,165.61
D6710	RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE	$1,189.40
D6720	RETAINER CROWN - RESIN WITH HIGH NOBLE METAL	$1,387.64
D6721	RETAINER CROWN - RESIN WITH PREDOM BASE METAL	$1,316.27
D6722	RETAINER CROWN - RESIN WITH NOBLE METAL	$1,340.06
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	$1,459.00
D6750	RETNR CROWN PORCELAIN FUSED TO HIGH NOBLE METAL	$1,420.94
D6751	RETNR CROWN PORCELAIN FUSED PREDOM BASE METAL	$1,325.79
D6752	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	$1,357.50
D6753	RETAINR CROWN PORCLN FUSED TO TITANIUM AND ALLOY	$1,325.79
D6780	RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL	$1,340.06
D6781	RETAINER CROWN 3/4 CAST PREDOMINANTLY BASE METAL	$1,340.06
D6782	RETAINER CROWN - 3/4 CAST NOBLE METAL	$1,244.91
D6783	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	$1,379.71
D6784	RETAINER CROWN-3/4 TITANIUM AND ALLOYS	$1,340.06
D6790	RETAINER CROWN - FULL CAST HIGH NOBLE METAL	$1,371.78
D6791	RETAINER CROWN FULL CAST PREDOM BASE METAL	$1,300.41

Proc	Description	Rate
D6792	RETAINER CROWN - FULL CAST NOBLE METAL	$1,347.99
D6793	PROVISIONAL RETAINER CROWN	$562.98
D6794	RETAINER CROWN - TITANIUM	$1,347.99
D6920	CONNECTOR BAR	$334.92
D6930	RECEMENT / REBOND FIXED PARTIAL DENTURE	$195.37
D6940	STRESS BREAKER	$442.84
D6950	PRECISION ATTACHMENT	$855.91
D6980	FIXED PARTIAL DENTURE REPAIR MATERIAL FAILURE	BR
D6985	PEDIATRIC PARTIAL DENTURE FIXED	$744.27
D6999	UNSPECIFIED FIXED PROSTHODONTIC PROCEDURE REPORT	BR
D7111	EXTRACTION CORONAL REMNANTS - PRIMARY TOOTH	$171.23
D7140	EXTRACTION ERUPTED TOOTH OR EXPOSED ROOT	$227.62
D7210	EXTRACTION ERUPTED TOOTH REMV BONE ELEV FLAP	$332.57
D7220	REMOVAL OF IMPACTED TOOTH - SOFT TISSUE	$417.01
D7230	REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY	$554.86
D7240	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY	$651.36
D7241	REMV IMP TOOTH - CMPL BONY W/UNUSUAL SURG COMPS	$818.51
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS	$351.53
D7251	CORONECTOMY INTENTIONAL PARTIAL TOOTH REMOVAL	$689.27
D7260	OROANTRAL FISTULA CLOSURE	$2,699.76
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	$1,124.90
D7270	TOOTH REIMPL &/OR STBL ACC EVULSED/DISPLCD TOOTH	$843.68
D7272	TOOTH TRANSPLANTATION	$1,124.90
D7280	EXPOSURE OF AN UNERUPTED TOOTH	$787.43
D7282	MOBILIZ ERUPTED/MALPOSITIONED TOOTH AID ERUPTION	$393.72

Proc	Description	Rate
D7283	PLCMT DEVICE FACILITATE ERUPTION IMPACTED TOOTH	$337.47
D7285	BIOPSY OF ORAL TISSUE HARD	$1,574.86
D7286	BIOPSY OF ORAL TISSUE SOFT	$674.94
D7287	EXFOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	$269.98
D7288	BRUSH BIOPSY - TRANSEPITHELIAL SAMPLE COLLECTION	$269.98
D7290	SURGICAL REPOSITIONING OF TEETH	$674.94
D7291	TRANSSEPTAL FIBEROT/SUPRA CRESTAL FIBEROT BR	BR
D7292	PLACEMENT TEMP ANCHORAGE SCREW RET PLATE FLAP	$1,079.90
D7293	PLACEMENT TEMP ANCHORAGE DEVICE RQR SURG FLAP	$674.94
D7294	PLACEMENT TEMP ANCHORAGE DEVICE W/O SURG FLAP	$562.45
D7295	HARVEST BONE FOR USE AUTOGENOUS GRAFTING PROC	BR
D7296	CORTICOTOMY 1 - 3 TEETH OR TOOTH SPACES PER QUAD	BR
D7297	CORTCTMY 4 OR MORE TEETH OR TOOTH SPCES PER QUAD	BR
D7310	ALVEOLOPLASTY W/EXTRACTION 4/> TEETH/SPACE QUAD	$516.77
D7311	ALVEOLOPLSTY CONJNC XTRACT 1-3 TEETH/SPACES QUAD	$452.17
D7320	ALVEOLOPLASTY NOT W/EXTRACTIONS 4/> TEETH/SPACE	$839.74
D7321	ALVEOLOPLSTY NOT CNJNC XTRCT 1-3 TEETH/SPCE QUAD	$710.55
D7340	VESTIBULOPLASTY RIDGE EXT SEC EPITHELIALIZATION	$3,552.77
D7350	VESTIBULOPLASTY RIDGE EXT W/SOFT TISS GRAFTS	$10,335.32
D7410	EXCISION OF BENIGN LESION UP TO 1.25 CM	$1,550.30
D7411	EXCISION OF BENIGN LESION GREATER THAN 1.25 CM	$2,454.64
D7412	EXCISION OF BENIGN LESION COMPLICATED	$2,713.02
D7413	EXCISION OF MALIGNANT LESION UP TO 1.25 CM	$1,808.68
D7414	EXCISION OF MALIGNANT LESION > 1.25 CM	$2,713.02
D7415	EXCISION OF MALIGNANT LESION COMPLICATED	$3,036.00

Proc	Description	Rate
D7440	EXC MALIG TUMOR-LESION DIAMETER UP TO 1.25 CM	$2,454.64
D7441	EXC MALIG TUMOR-LESION DIAM GREATER THAN 1.25 CM	$3,617.36
D7450	REMOVL BENIGN ODONTOGENC CYST/TUMR-UP T0 1.25 CM	$1,550.30
D7451	REMOVAL BENIGN ODONTOGENIC CYST/TUMOR- > 1.25 CM	$2,118.74
D7460	REMOVAL BEN NONODONTOGENIC CYST/TUMR- UP 1.25 CM	$1,550.30
D7461	REMOVAL BEN NONODONTOGENIC CYST/TUMOR > 1.25 CM	$2,118.74
D7465	DESTRUCTION LESION PHYSICAL/CHEM METHOD BY REPRT	$839.74
D7471	REMOVAL OF LATERAL EXOSTOSIS	$1,919.79
D7472	REMOVAL OF TORUS PALATINUS	$2,281.52
D7473	REMOVAL OF TORUS MANDIBULARIS	$2,152.33
D7485	REDUCTION OF OSSEOUS TUBEROSITY	$1,919.79
D7490	RADICAL RESECTION OF MAXILLA OR MANDIBLE	$15,502.98
D7510	INCISION & DRAINAGE ABSCESS-INTRAORAL SOFT TISS	$555.52
D7511	I & D ABSCESS INTRAORAL SOFT TISSUE COMPLICATED	$839.74
D7520	INCISION & DRAINAGE ABSCESS-EXTRAORAL SOFT TISS	$2,645.84
D7521	I & D ABSCESS EXTRAORAL SOFT TISSUE COMPLICATED	$2,906.81
D7530	REMOVAL FB FROM MUCOSA SKIN/SUBCUT ALVEOL TISSUE	$953.43
D7540	REMV REACT-PRODUC FOREIGN BODIES-MUSCULOSKEL SYS	$1,056.79
D7550	PART OSTEC/SEQUESTRECTOMY REMOVAL NON-VITAL BONE	$658.88
D7560	MAXILLARY SINUSOTOMY REMOVAL TOOTH FRAGMENT/FB	$5,232.26
D7610	MAXILLA-OPEN REDUCTION	$8,462.04
D7620	MAXILLA-CLOSED REDUCTION	$6,345.89
D7630	MANDIBLE-OPEN REDUCTION	$11,001.95
D7640	MANDIBLE-CLOSED REDUCTION	$6,981.51
D7650	MALAR AND/OR ZYGOMATIC ARCH - OPEN REDUCTION	$5,289.10

Proc	Description	Rate
D7660	MALAR AND/OR ZYGOMATIC ARCH - CLOSED REDUCTION	$3,118.68
D7670	ALVEOLUS-CLOSED REDUCTION W/STABILIZATION TEETH	$2,433.97
D7671	ALVEOLUS-OPEN REDUCTION W/STABILIZATION TEETH	$4,586.30
D7680	FACE BONES-COMP RDUC W/FIX&MX SURG APPRCHES CPT	$15,867.30
D7710	MAXILLA - OPEN REDUCTION	$9,945.16
D7720	MAXILLA - CLOSED REDUCTION	$6,981.51
D7730	MANDIBLE - OPEN REDUCTION	$14,386.77
D7740	MANDIBLE - CLOSED REDUCTION	$7,118.45
D7750	MALAR AND/OR ZYGOMATIC ARCH - OPEN REDUCTION	$9,053.74
D7760	MALAR AND/OR ZYGOMATIC ARCH - CLOSED REDUCTION	$3,632.86
D7770	ALVEOLUS - OPEN REDUCTION STABILIZATION OF TEETH	$4,922.20
D7771	ALVEOLUS CLOSED REDUCTION STABILIZATION OF TEETH	$3,798.23
D7780	FACIAL BONES-COMP RDUC FIX & MULT APPROACHES	$21,156.40
D7810	OPEN REDUCTION OF DISLOCATION	$9,306.96
D7820	CLOSED REDUCTION OF DISLOCATION	$1,524.46
D7830	MANIPULATION UNDER ANESTHESIA	$873.33
D7840	CONDYLECTOMY	$12,686.61
D7850	SURGICAL DISCECTOMY WITH/WITHOUT IMPLANT	$10,955.44
D7852	DISC REPAIR	$12,544.49
D7854	SYNOVECTOMY	$12,944.99
D7856	MYOTOMY	$9,185.52
D7858	JOINT RECONSTRUCTION	$26,181.95
D7860	ARTHROTOMY	$11,159.56
D7865	ARTHROPLASTY	$17,983.46
D7870	ARTHROCENTESIS	$594.28

Proc	Description	Rate
D7871	NON-ARTHROSCOPIC LYSIS AND LAVAGE	$1,188.56
D7872	ARTHROSCOPY - DIAGNOSIS WITH OR WITHOUT BIOPSY	$6,343.30
D7873	ARTHROSCOPY: LAVAGE & LYSIS ADHESIONS	$7,637.80
D7874	ARTHROSCOPY: DISC REPSTN & STABILIZATION	$10,955.44
D7875	ARTHROSCOPY: SYNOVECTOMY	$12,001.89
D7876	ARTHROSCOPY: DISCECTOMY	$12,939.82
D7877	ARTHROSCOPY: DEBRIDEMENT	$11,420.53
D7880	OCCLUSAL ORTHOTIC DEVICE BY REPORT	$1,426.27
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	$155.03
D7899	UNSPECIFIED TMD THERAPY BY REPORT	BR
D7910	SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM	$847.50
D7911	COMPLICATED SUTURE - UP TO 5 CM	$2,116.16
D7912	COMPLICATED SUTURE - GREATER THAN 5 CM	$3,808.57
D7920	SKIN GRAFT	$6,239.95
D7921	COLL APPL AUTOLOGOUS BLD CNCNTRT PRODUCT	$576.19
D7922	PLACEMENT INTRASOCKET BIO DRESSING PER SITE	BR
D7940	OSTEOPLASTY - FOR ORTHOGNATHIC DEFORMITIES	BR
D7941	OSTEOTOMY - MANDIBULAR RAMI	$15,890.55
D7943	OSTEOT-MANDIB RAMI W/BONE GRFT;INCL OBTAIN GRAFT	$14,598.64
D7944	OSTEOTOMY - SEGMENTED OR SUBAPICAL	$13,009.58
D7945	OSTEOTOMY - BODY OF MANDIBLE	$17,311.66
D7946	LEFORT I (MAXILLA - TOTAL)	$21,445.79
D7947	LEFORT I (MAXILLA - SEGMENTED)	$18,035.13
D7948	LEFORT II/LEFORT III - W/O BONE GRAFT	$23,409.50
D7949	LEFORT II OR LEFORT III - WITH BONE GRAFT	$30,489.19

Proc	Description	Rate
D7950	OSSEOUS OSTEOPERIOSTEAL/CARTILAGE GRAFT MAND/MAX	BR
D7951	SINUS AUG WITH BONE OR BONE SUBSTITUTES-LAT APP	BR
D7952	SINUS AUGMENTATION VIA A VERTICAL APPROACH	BR
D7953	BONE REPLCMT GRAFT RIDGE PRESERVATION PER SITE	$878.50
D7955	REPAIR MAXLOFACIAL SOFT &/ HARD TISSUE DEFECT	BR
D7960	FRENULECTOMY SEP PROC NOT INCIDENTL ANOTHER PROC	$710.55
D7963	FRENULOPLASTY	$1,162.72
D7970	EXCISION OF HYPERPLASTIC TISSUE - PER ARCH	$1,033.53
D7971	EXCISION OF PERICORONAL GINGIVA	$387.57
D7972	SURGICAL REDUCTION OF FIBROUS TUBEROSITY	$1,446.94
D7979	NON-SURGICAL SIALOLITHOTOMY	BR
D7980	SURGICAL SIALOLITHOTOMY	$1,627.81
D7981	EXCISION OF SALIVARY GLAND BY REPORT	BR
D7982	SIALODOCHOPLASTY	$3,849.91
D7983	CLOSURE OF SALIVARY FISTULA	$3,694.88
D7990	EMERGENCY TRACHEOTOMY	$3,178.11
D7991	CORONOIDECTOMY	$7,751.49
D7995	SYNTHETIC GRAFT-MANDIBLE/FACIAL BONES BY REPORT	BR
D7996	IMPLANT-MANDIBLE AUGMENTATION PURPOSES BY REPORT	BR
D7997	APPLIANCE REMOVAL INCLUDES REMOVAL OF ARCHBAR	$594.28
D7998	INTRAORAL PLCMT FIX DEVICE NOT CONJUNCTION W/FX	$2,583.83
D7999	UNSPECIFIED ORAL SURGERY PROCEDURE BY REPORT	BR
D8010	LIMITED ORTHODONTIC TREATMENT PRIMARY DENTITION	BR
D8020	LTD ORTHODONTIC TREATMENT TRANSITIONAL DENTITION	BR
D8030	LTD ORTHODONTIC TREATMENT ADOLESCENT DENTITION	BR

Proc	Description	Rate
D8040	LIMITED ORTHODONTIC TREATMENT ADULT DENTITION	BR
D8050	INTERCEPTIVE ORTHODONTIC TX PRIMARY DENTITION	BR
D8060	INTRCPTV ORTHODONTIC TX TRANSITIONAL DENTITION	BR
D8070	COMP ORTHODONTIC TX TRANSITIONAL DENTITION	BR
D8080	COMPREHENSIVE ORTHODONTIC TX ADOLES DENTITION	BR
D8090	COMPREHENSIVE ORTHODONTIC TX ADULT DENTITION	BR
D8210	REMOVABLE APPLIANCE THERAPY	BR
D8220	FIXED APPLIANCE THERAPY	BR
D8660	PREORTHODONTIC TREATMENT VISIT	BR
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT	BR
D8680	ORTHODONTIC RETENTION	BR
D8681	REMOVABLE ORTHODONTIC RETAINER ADJUSTMENT	BR
D8690	ORTHODONTIC TREATMENT	BR
D8695	REMOVAL OF FIXED ORTHO APPLIANCES TX NOT COMPLT	BR
D8696	REPAIR ORTHODONTIC APPLIANCE MAXILLARY	BR
D8697	REPAIR ORTHODONTIC APPLIANCE MANDIBULAR	BR
D8698	RE-CEMENT OR RE-B0ND FIXED RETAINER MAXILLARY	BR
D8699	RE-CEMENT OR RE-BOND FIXED RETAINER MANDIBULAR	BR
D8701	REPAIR FIXED RETAINER, WITH REATTACH, MAXILLARY	BR
D8702	REPAIR FIXED RETAINER, WITH REATTACH, MANDIBULAR	BR
D8703	REPLACE LOST OR BROKEN RETAINER MAXILLARY	BR
D8704	REPLACE LOST OR BROKEN RETAINER MANDIBULAR	BR
D8999	UNSPECIFIED ORTHODONTIC PROCEDURE BY REPORT	BR
D9110	PALLIATIVE EMERGENCY TX DENTAL PAIN MINOR PROC	$179.08
D9120	FIXED PARTIAL DENTURE SECTIONING	$202.33

Proc	Description	Rate
D9130	TMJ JOINT DYSFUNCTION - NON-INVASIVE PHYSL THERP	BR
D9210	LOCAL ANES-NOT CONJUNCTION W/OP/SURGICAL PROC	$56.99
D9211	REGIONAL BLOCK ANESTHESIA	$62.89
D9212	TRIGEMINAL DIVISION BLOCK ANESTHESIA	$98.26
D9215	LOCAL ANESTHESIA CONJUCTION OPERATIVE/SURG PROC	$47.17
D9219	EVALUATION FOR MOD OR DEEP SEDATION / GA	$112.02
D9222	DEEP SEDATION / GENERAL ANESTHESIA FIRST 15 MIN	$334.10
D9223	DEEP SEDATION/ GEN ANESTH EACH 15 MIN INCREMENT	$255.49
D9230	INHALATION OF NITROUS OXIDE/ANXIOLYSIS ANALGESIA	$94.33
D9239	IV MOD (CONSCIOUS) SEDTION/ANALGSIA FIRST 15 MIN	$275.14
D9243	IV MOD (CONSCIOUS) SEDATION EACH 15 MIN INCRMENT	$216.18
D9248	NON-INTRAVENOUS CONSCIOUS SEDATION	$137.57
D9310	CONSULT DX SERV DENT/PHY NOT REQUESTING DENT/PHY	$260.94
D9311	CONSULT WITH A MEDICAL HEALTHCARE PROFESSIONAL	$260.94
D9410	HOUSE/EXTENDED CARE FACILITY CALL	$298.45
D9420	HOSPITAL OR AMBULATORY SURGICAL CENTER CALL	$482.74
D9430	OFFICE VISIT OBSERVATION NO OTHER SRVC PERFORMED	BR
D9440	OFFICE VISIT - AFTER REGULARLY SCHEDULED HOURS	$163.09
D9450	CASE PRESENTATION DTL&EXT TREATMENT PLANNING	$81.54
D9610	THERAPEUTIC PARENTERAL DRUG SINGL ADMINISTRATION	BR
D9612	TX PARENTERAL DRUGS 2/> ADMINISTRATIONS DIFF MED	BR
D9613	INFLTRN SUSTND RELSE THRPTIC DRG SNGLE MTPL SITE	BR
D9630	DRUGS AND/OR MEDICAMENTS BY REPORT, HOME USE	BR
D9910	APPLICATION OF DESENSITIZING MEDICAMENT	$94.60
D9911	APPLIC DESENZT RSN CERV &OR ROOT SURF-TOOTH	$132.44

Proc	Description	Rate
D9920	BEHAVIOR MANAGEMENT BY REPORT	BR
D9930	TX COMPLICATIONS - UNUSUAL CIRCUMSTANCES REPORT	BR
D9932	CLEAN/INSPECT REMOVBL COMPLETE MAXILLARY DENTURE	$232.45
D9933	CLEAN INSPECT REMVBL COMPLETE MANDIBULAR DENTURE	$232.45
D9934	CLEAN/ INSPECT REMVBL PARTIAL MAXILLARY DENTURE	$232.45
D9935	CLEAN INSPECT REMVBL PARTIAL MANDIBULAR DENTURE	$232.45
D9941	FABRICATION OF ATHLETIC MOUTHGUARD	$270.29
D9942	REPAIR AND/OR RELINE OF OCCLUSAL GUARD	$324.35
D9943	OCCLUSAL GUARD ADJUSTMENT	$162.17
D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL ARCH	$783.84
D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL ARCH	$783.84
D9946	OCCLUSAL GUARD HARD APPLIANCE PARTIAL ARCH	$783.84
D9950	OCCLUSION ANALYSIS - MOUNTED CASE	$513.55
D9951	OCCLUSAL ADJUSTMENT - LIMITED	$229.74
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	$1,081.15
D9961	DUPLICATE/COPY PATIENT'S RECORDS	BR
D9970	ENAMEL MICROABRASION	$121.63
D9971	ODONTOPLASTY 1-2 TEETH; INCL REMOVAL ENAMEL PROJ	$156.77
D9972	EXTERNAL BLEACHING - PER ARCH	$540.58
D9973	EXTERNAL BLEACHING - PER TOOTH	$89.20
D9974	INTERNAL BLEACHING - PER TOOTH	$473.00
D9975	EXTERNAL BLEACHING - PER ARCH (HOME)	$540.58
D9985	SALES TAX	BR
D9986	MISSED APPOINTMENT	BR
D9987	CANCELLED APPOINTMENT	BR

Proc	Description	Rate
D9990	CERT TRNSLATION OR SIGN LANGUAGE SRVCS PER VISIT	BR
D9991	DENTAL CASE MGMT ADDRESS APPNTMNT COMPL BARRIERS	$94.60
D9992	DENTAL CASE MANAGEMENT - CARE COORDINATION	$94.60
D9993	DENTAL CASE MGMT - MOTIVATIONAL INTERVIEWING	$94.60
D9994	DENTAL CASE MGMT - PATIENT EDU IMPRV ORAL HEALTH	$129.74
D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME ENCOUNTER	$432.46
D9996	TELDENTRY ASYNCHRNS INFO FWD DENTIST SBSQNT REVW	$324.35
D9997	DENTAL CASE MANAGEMENT SPECIAL HEALTH CARE NEEDS	BR
D9999	UNSPECIFIED ADJUNCTIVE PROC BY REPORT	BR