

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	2
16-2	STANDARD TERMINOLOGY FOR RULES 16, 17, AND 18	2
16-3	RECOGNIZED HEALTH CARE PROVIDERS	4
16-4	REQUIRED USE OF THE MEDICAL TREATMENT GUIDELINES	7
16-5	NOTIFICATION	7
16-6	PRIOR AUTHORIZATION	8
16-7	DENIAL OF A REQUEST FOR PRIOR AUTHORIZATION	9
16-8	REQUIRED USE OF THE FEE SCHEDULE	11
16-9	REQUIRED BILLING FORMS, CODES, AND PROCEDURES	11
16-10	REQUIRED MEDICAL RECORD DOCUMENTATION	14
16-11	PAYMENT OF MEDICAL BENEFITS	15
16-12	DISPUTE RESOLUTION PROCESS	23

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, 2020. This Rule defines the standard terminology, administrative procedures, and dispute resolution procedures required to implement the Division's Medical Treatment Guidelines and Medical Fee Schedule.

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

- (A) Ambulatory Surgical Center (ASC) – licensed as an ambulatory surgery center by the Colorado Department of Public Health and Environment.
- (B) Authorized Treating Provider (ATP) – may be any of the following:
 - (1) The treating physician designated by the employer and selected by the injured worker;
 - (2) A health care provider to whom an authorized treating physician 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 health care 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) – any billed service, procedure, equipment, or supply provided to an injured worker by a provider.
- (D) Billing Party – a service provider or an injured worker who has incurred authorized medical costs.
- (E) Certified Medical Interpreter - certified by the Certification Commission for Healthcare Interpreters or the National Board of Certification for Medical Interpreters.
- (F) Children's Hospital – federally qualified, and certified by the Colorado Department of Public Health and Environment.
- (G) Convalescent Center – licensed by the Colorado Department of Public Health and Environment.
- (H) Critical Access Hospital (CAH) – federally qualified, and certified by the Colorado Department of Public Health and Environment.
- (I) Day – defined as a calendar day unless otherwise noted. In computing any period of time prescribed or allowed by Rules 16 or 18, the parties shall refer to Rule 1-2.

- (J) Free-Standing Facility – an entity that furnishes healthcare services and is not integrated with any other entity as a main provider, a department of a provider, remote location of a hospital, satellite facility, or provider-based entity.
- (K) Hospital – licensed by the Colorado Department of Public Health and Environment.
- (L) Long-Term Care Facility –federally qualified, and certified by the Colorado Department of Public Health and Environment.
- (M) Medical Fee Schedule – Division's Rule 18, its exhibits, and the documents incorporated by reference in that Rule.
- (N) Medical Treatment Guidelines – the medical treatment guidelines as incorporated into Rule 17.
- (O) Over-the-Counter Drugs – medications that are available for purchase by the general public without a prescription.
- (P) Payer – 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 Organizations (PPO) networks, bill review companies, Third Party Administrators (TPAs), and case management companies, shall not relieve the self-insured employer or insurer from their legal responsibilities for compliance with these Rules.
- (Q) Prior Authorization – assurance that appropriate reimbursement for a specific treatment will be paid in accordance with Rule 18, its exhibits, and the documents incorporated by reference in that Rule.
- (R) Provider – a person or entity providing authorized health care service, whether involving treatment or not, to a worker in connection with work-related injury or occupational disease.
- (S) Psychiatric Hospital – licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.
- (T) Rehabilitation Hospital Facility – licensed as a rehabilitation hospital by the Colorado Department of Public Health and Environment.
- (U) Rural Health Clinic Facility – federally qualified, and certified by the Colorado Department of Public Health and Environment.
- (V) Skilled Nursing Facility (SNF) – licensed as a skilled nursing facility by the Colorado Department of Public Health and Environment.
- (W) Telemedicine – two-way, real time interactive communication between the injured worker, and the provider at the distant site. This electronic communication involves, at minimum, audio and video telecommunications equipment. Telemedicine enables the remote diagnoses and evaluation of injured workers in addition to the ability to detect fluctuations in their medical condition(s) at a remote site in such a way as to confirm or alter the treatment plan, including medications and/or specialized therapy.
- (X) Veterans' Administration Medical Facilities – all medical facilities overseen by the United States Department of Veterans' Affairs.

16-3 RECOGNIZED HEALTH CARE PROVIDERS

(A) Physician and Non-Physician Providers

- (1) For the purpose of this Rule, recognized health care providers are divided into the major categories of "physician" and "non-physician." Recognized providers are defined as follows:

- (a) "Physician providers" are those individuals who are licensed by the State of Colorado through one of the following boards:

- (i) Colorado Medical Board;
- (ii) Colorado Dental Board;
- (iii) Colorado Podiatry Board;
- (iv) Colorado Optometry Board, or
- (v) Colorado Board of Chiropractic Examiners;

Only physicians licensed by the Colorado Medical Board may be included as individual physicians on the employer's or insurer's designated provider list required under § 8-43-404(5)(a)(I).

- (b) "Non-physician providers" are those individuals who are 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:

- (i) Acupuncturist (LAc) – licensed by the Office of Acupuncture Licensure, Colorado Department of Regulatory Agencies;
- (ii) Advanced Practice Nurse (APN) – licensed by the Colorado Board of Nursing; Advanced Practice Nurse Registry;
- (iii) Anesthesiologist Assistant (AA) – licensed by the Colorado Medical Board, Colorado Department of Regulatory Agencies;
- (iv) Athletic Trainers (ATC) – licensed by the Colorado Department of Regulatory Agencies;
- (v) Audiologist (AU.D. CCC-A) – licensed by the Office of Audiology and Hearing Aid Provider Licensure, Colorado Department of Regulatory Agencies;
- (vi) Certified Registered Nurse Anesthetist (CRNA) – licensed by the Colorado Board of Nursing;
- (vii) Clinical Social Worker (LCSW) – licensed by the Board of Social Work Examiners, Colorado Department of Regulatory Agencies;
- (viii) Durable Medical Equipment, Prosthetic, Orthotics and Supplies (DMEPOS) Supplier – licensed by the Colorado Secretary of State;
- (ix) Marriage and Family Therapist (LMFT) – licensed by the Board of Marriage and Family Therapist Examiners, Colorado Department of Regulatory Agencies;

- (x) Massage Therapist (MT) – licensed as a massage therapist by the Office of Massage Therapy Licensure, Colorado Department of Regulatory Agencies.
 - (xi) Nurse Practitioner (NP) – licensed as an APN and authorized by the Colorado Board of Nursing;
 - (xii) Occupational Therapist (OTR) – licensed by the Office of Occupational Therapy, Colorado Department of Regulatory Agencies;
 - (xiii) Occupational Therapist Assistant (OTA) – licensed by the Office of Occupational Therapy, Colorado Department of Regulatory Agencies;
 - (xiv) Orthopedic Technologist (OTC) – certified by the National Board for Certification of Orthopedic Technologists;
 - (xv) Pharmacist – licensed by the Board of Pharmacy, Colorado Department of Regulatory Agencies;
 - (xvi) Physical Therapist (PT) – licensed by the Physical Therapy Board, Colorado Department of Regulatory Agencies;
 - (xvii) Physical Therapist Assistant (PTA) –certified by the Physical Therapy Board, Colorado Department of Regulatory Agencies;
 - (xviii) Physician Assistant (PA) – licensed by the Colorado Medical Board;
 - (xix) Practical Nurse (LPN) – licensed by the Colorado Board of Nursing;
 - (xx) Professional Counselor (LPC) – licensed by the Board of Professional Counselor Examiners, Colorado Department of Regulatory Agencies;
 - (xxi) Psychologist (PsyD, PhD, EdD) – licensed by the Board of Psychologist Examiners, Colorado Department of Regulatory Agencies;
 - (xxii) Registered Nurse (RN) – licensed by the Colorado Board of Nursing;
 - (xxiii) Respiratory Therapist (RTL) – certified by the National Board of Respiratory Care and licensed by the Office of Respiratory Therapy Licensure, Colorado Department of Regulatory Agencies;
 - (xxiv) Speech Language Pathologist (CCC-SLP) – certified by the Office of Speech-Language Pathology Certification, Colorado Department of Regulatory Agencies; and
- (2) Upon request, health care providers must provide copies of license, registration, certification, or evidence of health care training for billed services.

- (3) Any provider not listed in section 16-3(A)(1)(a) or (b) must comply with section 16-6, Prior Authorization when providing all services.
- (4) Referrals:
 - (a) A payer or employer shall not redirect or alter the scope of a referral to another provider for treatment or evaluation of a compensable injury. Any party who has concerns regarding a referral or its scope shall advise the other parties and providers involved.
 - (b) All non-physician providers must have a referral from a physician provider managing the claim (or NP/PA working under that physician provider). A physician making the referral to any listed or unlisted non-physician provider shall, upon request of any party, answer any questions and clarify the scope of the referral, prescription, or the reasonableness or necessity of the care.
- (5) Use of PAs and NPs in Colorado Workers' Compensation Claims:
 - (a) All Colorado workers' compensation claims (medical only or lost time claims) shall have an "authorized treating physician" responsible for all services rendered to an injured worker by any PA or NP.
 - (b) For services performed by an NP or a PA, the authorized treating 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 authorized treating physician also must counter-sign Form WC 164. The signature of the physician provider shall serve as a certification that all requirements of this rule have been met.
 - (c) The authorized treating physician must evaluate the injured worker within the first three visits to the physician's office.
- (A) Out-of-State Provider
 - (1) Relocated Injured Worker
 - (a) 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, should s/he relocate out-of-state, can be obtained from the payer.
 - (b) A change of provider must be made:
 - (i) Through referral by the injured worker's authorized treating physician; or
 - (ii) In accordance with § 8-43-404(5)(a).
 - (2) Referred Injured Worker

In the event an injured worker has not relocated out-of-state but is referred to an out-of-state provider for treatment or services not available within Colorado, the

referring provider shall obtain prior authorization from the payer as set forth in section 16-6. The referring provider's written request for out-of-state treatment shall include the following information:

- (a) Medical justification prepared by the referring provider;
- (b) Written explanation as to why the requested treatment/services cannot be obtained within Colorado;
- (c) Name, complete mailing address and telephone number of the out-of-state provider;
- (d) Description of the treatment/services requested, including the estimated length of time and frequency of the treatment/service, and all associated medical expenses; and
- (e) Out-of-state provider's qualifications to provide the requested treatment or services.

16-4 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 medical treatment guidelines, 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 Medical Treatment Guidelines. When treatment exceeds or is outside of the Medical Treatment Guidelines, 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.

16-5 NOTIFICATION

- (A) The Notification process is for treatment consistent with the Medical Treatment Guidelines that has an established value under the Medical Fee Schedule. Providers may, but are not required to, utilize the Notification process to ensure payment for medical treatment that falls within the purview of the Medical Treatment Guidelines. Therefore, lack of response from the payer within the time requirement set forth in section 16-5(D) shall deem the proposed treatment/service authorized for payment.
- (B) Notification may be made by phone, during regular business hours.
 - (1) Providers can accept verbal confirmation; or
 - (2) Providers may request written confirmation of an approval, which the payer should provide upon request.
- (C) Notification may be submitted using the "Authorized Treating Provider's Notification to Treat" (Form WC 195). The completed form shall include:
 - (1) Provider's certification that the proposed treatment/service is medically necessary and consistent with the Medical Treatment Guidelines.
 - (2) Documentation of the specific Medical Treatment Guideline(s) applicable to the proposed treatment/service.

- (3) Provider's email address or fax number to which the payer can respond.
- (D) Payers shall respond to a Notification submission within five (5) business days from receipt of the request 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 Medical Treatment Guideline(s), 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 section 16-7(B).
- (E) Payers may deny the proposed treatment only for the following reasons:
 - (1) For claims 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 for treatment to be performed by a provider who is not eligible to be an ATP;
 - (4) Injured worker is not entitled to proposed treatment pursuant to statute or settlement;
 - (5) Medical records contain conflicting opinions among the ATPs regarding proposed treatment;
 - (6) Proposed treatment falls outside the Medical Treatment Guidelines.
- (F) If the payer denies Notification under sections 16-5(E)(2), (5) or (6) above, the payer shall notify the provider, allow the submission of relevant supporting medical documentation as defined in section 16-6(E), and review the submission as a prior authorization request, allowing an additional seven (7) business days for review.
- (G) Appeals for denied Notification by a provider shall be made in accordance with the prior authorization appeals process outlined in 16-7(C).
- (H) Any provider or payer who incorrectly applies the Medical Treatment Guidelines in the Notification process may be subject to penalties under the Workers' Compensation Act.

16-6 PRIOR AUTHORIZATION

- (A) Granting of prior authorization is a guarantee of payment in accordance with Rule 18, RBRVS, and CPT® for the services/procedures requested by the provider pursuant to section 16-6(E). Prior authorization may be requested using the "Authorized Treating Provider's Request for Prior Authorization" (Form WC 188) or, in the alternative, shall be clearly labeled as a prior authorization request.
- (B) Prior authorization for payment shall only be requested by the provider when:

- (1) A prescribed service exceeds the recommended limitations set forth in the Medical Treatment Guidelines;
 - (2) The Medical Treatment Guidelines otherwise require prior authorization for that specific service;
 - (3) A prescribed service is identified within the Medical Fee Schedule as requiring prior authorization for payment; or
 - (4) A prescribed service is not identified in the Medical Fee Schedule as referenced in section 16-8(C).
- (C) Prior authorization for a prescribed service or procedure may be granted immediately and without a medical review. However, the payer shall respond to all prior authorization requests in writing within seven (7) business days from receipt of the provider's completed request, as defined in section 16-6(E). The duty to respond to a provider's request applies regardless of who transmitted the request.
- (D) The payer, unless it has previously notified said provider, shall give notice to the provider of these procedures for obtaining prior authorization for payment upon receipt of the initial bill from that provider.
- (E) To complete a prior authorization request, the provider shall concurrently explain the reasonableness and the medical necessity of the services requested, and shall provide relevant supporting medical documentation. Supporting medical documentation is defined as documents used in the provider's decision-making process to substantiate the need for the requested service or procedure. The following documentation is required:
- (1) An adequate definition or description of the nature, extent, and necessity for the procedure;
 - (2) Identification of the appropriate Medical Treatment Guideline, if applicable; and
 - (3) Final diagnosis.
- (F) The Division recommends payers confirm in writing, to providers and all parties, when a request for prior authorization is approved.
- (G) 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 DENIAL OF A REQUEST FOR PRIOR AUTHORIZATION

- (A) If an ATP requests prior authorization and indicates in writing, including reasoning and relevant documentation, that he or she believes the requested treatment is related to the admitted workers' compensation claim, the insurer cannot deny solely for relatedness without a medical opinion as required by section 16-7(B). The medical review, IME report, or report from an ATP that addresses the relatedness of the requested treatment to the admitted claim may precede the prior authorization request, unless the requesting physician presents new evidence as to why this treatment is now related.
- (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 16-11(B)(1). If the payer is denying

a request for prior authorization for medical reasons, the payer shall, within seven (7) business days of the completed request:

- (1) Have all the submitted documentation under section 16-6(E) 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, procedures, or treatment under review. The physician providers performing this review shall be Level I or Level II accredited. In addition, a clinical pharmacist (Pharm.D.) as defined by section 16-3(A)(1)(b)(xvi) may review prior authorization requests for medications without having received Level I or Level II accreditation.
- (2) After reviewing all the submitted documentation and other documentation referenced in the prior authorization request and available to the payer, the reviewing provider may call the requesting provider to expedite communication and processing of prior authorization requests. However, the written denial or approval still needs to be completed within the seven (7) business days specified under this section.
- (3) Furnish the provider and the parties with a written denial that sets forth the following information:
 - (a) An explanation of the specific medical reasons for the denial, including the name and professional credentials of the person performing the medical review and a copy of the medical reviewer's opinion.
 - (b) The specific cite from the Medical Treatment Guidelines, when applicable;
 - (c) Identification of the information deemed most likely to influence the reconsideration of the denial when applicable; and
 - (d) Documentation of response to the provider and parties.

(C) Prior Authorization Appeals

- (1) The requesting party or provider shall have seven (7) business days from the date of the written denial to provide a written response to the payer. The response is not considered a "special report" when prepared by the provider of the requested service.
- (2) The payer shall have seven (7) business days from the date of the response to issue a final decision and provide documentation of that decision to the provider and parties.
- (3) In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or 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 section 16-7(A), (B), or (C) shall be deemed authorization for payment of the requested treatment unless the payer has scheduled an independent medical examination (IME) and notified the requesting provider of the IME within the time prescribed for responding set forth in section 16-7(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 his or her report within 20 days of the IME.
 - (3) The insurer shall respond to the prior authorization request within five business days of the receipt of the IME report.
 - (4) If the injured worker does not attend or reschedules the IME, the payer may deny the prior authorization request pending completion of the IME.
 - (5) The IME shall comply with Rule 8 as applicable.
- (F) Unreasonable delay or 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 fee schedule does not limit the billing charges.
- (C) Payment for billed services 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 when the billed non-established valued service or procedure is an emergency or a payment mechanism under Rule 18 is identifiable, but not explicit. Examples of these exception(s) include ambulance bills or supply bills that are covered under Rule 18 with an identified payment mechanism. Similar established code values from the Medical Fee Schedule, recommended by the requesting physician, shall govern the maximum fee schedule payment.

16-9 REQUIRED BILLING FORMS, CODES, AND PROCEDURES

- (A) Medical providers shall use only the billing forms listed below or their 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 services not billed on the forms identified in this

Rule may be denied. However, the payer shall comply with the applicable provisions set forth in section 16-11.

- (1) CMS (Centers for Medicare & Medicaid Services) -1500 shall be used by all providers billing for professional services, durable medical equipment (DME) and ambulance services, with the exception of those providers billing for dental services or procedures. Health care providers shall provide their name and credentials in the appropriate box 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) UB-04 - shall be used by all hospitals, hospital-based ambulance/air services, Children's Hospitals, CAHs, Veterans' Administration Medical Facilities, home health and facilities meeting the definitions found in section 16-2, when billing for hospital services or any facility fees billed by any other provider, such as hospital-based ASCs.
 - (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 013x, 074x, 075x, or 085x, and one of the following revenue code(s):
 - Revenue Code 042X Physical Therapy
 - Revenue Code 043X Occupational Therapy
 - Revenue Code 044X Speech/Language 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 services or procedures.

- (4) With the agreement of the payer, the ANSI ASC X12 (American National Standards Institute Accredited Standards Committee) or NCPDP (National Council For Prescription Drug Programs) electronic billing transaction containing the same information as in (1), (2) or (3) in this subsection may be used.

Dispensing pharmacies and pharmacy benefit managers shall use NCPDP Workers' Compensation/Property and Casualty (P&C) universal claim form, version 1.1, for prescription drugs billed on paper. Physicians may use the CMS-1500 billing form as described in section 16-9(A)(1).

- (5) Bills for services incident to medical services, such as language interpreting or injured worker mileage reimbursement, may be submitted by invoice or other agreed-upon form.

(B) International Classification of Diseases (ICD) Codes

All provider bills shall list the ICD-10 Clinical Modification (CM) diagnosis code(s) that are current, accurate, specific to each patient encounter, and preferably include the Chapter 20 External Causes of Morbidity code(s). If ICD-10-CM requires a seventh character, the provider must apply it in accordance with the ICD-10-CM Chapter Guidelines provided by the Centers for Medicare and Medicaid Services (CMS). The ICD-10-CM diagnosis codes shall not be used as a sole factor to establish work-relatedness of an injury or treatment.

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

- (D) National provider identification (NPI) numbers are required for workers' compensation bills; providers who cannot obtain NPI numbers are exempt from this requirement. When billing on a CMS-1500, the NPI shall be that of the rendering provider and shall include the correct place of service codes at the line level.

- (E) Timely Filing

Providers shall submit their bills for services rendered within 120 days of the date of service or the bill may be denied unless extenuating circumstances exist. For claims submitted through electronic data interchange (EDI), providers may prove timely filing by showing a payer acknowledgement (claim accepted). Rejected claims or clearinghouse acknowledgment reports are not proof of timely filing. For paper claims, providers may prove timely filing with a signed certificate of mailing listing the original date mailed and the payer's address; a fax acknowledgment report; or certified mail receipt showing the date the payer received the claim. All timely filing issues will be considered final 10 months from date of service unless extenuating circumstances exist.

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

Extenuating circumstances may include, but are not limited to, delays in compensability being decided or the provider has not been informed where to send the bill.

16-10 REQUIRED MEDICAL RECORD DOCUMENTATION

- (A) The treating provider shall maintain medical records for each injured worker when billing for the provided services. The rendering provider shall sign the medical records. Electronic signatures are accepted.
- (B) All medical records shall legibly document the services billed. The documentation shall itemize each contact with the injured worker. The documentation also shall 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 the billed service;
 - (4) Assessment or diagnosis of current condition with appropriate objective findings;
 - (5) Treatment status or patient's functional response to current treatment;
 - (6) Treatment plan including specific therapy with time limits and measurable goals and detail of referrals;
 - (7) Pain diagrams, where applicable;
 - (8) 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 services provided to patients are expected to be documented in the medical record at the time they are rendered. Occasionally, certain entries related to services provided are not made timely. In this event, the documentation will need to be amended, corrected, or entered after rendering the service. Amendments, corrections, and delayed entries must comply with Medicare's widely accepted recordkeeping principles as outlined in the April 2018 Medicare Program Integrity Manual Chapter 3, section 3.3.2.5. (This section does

not apply to patients' requests to amend records as permitted by the Health Insurance Portability and Accountability Act (HIPAA)).

- (D) Authorized treating physicians must sign (or counter-sign) and submit to the payer, with their initial and final visit billings, a completed "Physician's Report of Workers' Compensation Injury" (Form WC 164) specifying:
 - (1) The report type as "initial" when the injured worker has his or her initial visit with the authorized treating physician managing the total workers' compensation claim (generally the designated or selected physician). If applicable, the emergency department (ED) or urgent care authorized treating physician for this workers' compensation injury also may create a Form WC 164 initial report. Unless requested or preauthorized by the payer to a specific workers' compensation claim, no other authorized physician should complete and bill for the initial Form WC 164. See Rule 18 for required fields.
 - (2) The report type as "closing" when the authorized treating physician (generally the designated or selected physician) managing the total workers' compensation 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 a permanent impairment, item 10 also must be completed and the following information shall be attached to the bill at the time of MMI:
 - (a) All necessary permanent impairment rating reports, including a narrative report and appropriate worksheets, when the authorized treating physician managing the total workers' compensation claim of the patient is Level II Accredited; or
 - (b) Referral to a Level II Accredited physician requested to perform the permanent impairment rating when a rating is necessary and the authorized treating physician managing the total workers' compensation claim of the patient is not determining the permanent impairment rating.
 - (3) At no charge, the physician shall supply the injured worker with one legible copy of the completed Form WC 164 at the time the form is completed.
 - (4) The provider shall submit to the payer the completed Form WC 164 no later than 14 days from the date of service.
- (E) Providers other than hospitals shall provide the payer with all supporting documentation 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.).
- (F) In accordance with section 16-11(B), the payer may deny payment for billed services until the provider submits the relevant required documentation.

16-11 PAYMENT OF MEDICAL BENEFITS

- (A) Payer Requirements for Processing Medical Service Bills
 - (1) For every medical service bill submitted by a provider, the payer shall reply with a written notice or explanation of benefits (EOB). If the payer reimburses the exact

billed amount, identification of the patient's name, the payer, the paid bill, the amount paid and the dates of service are required. If any adjustments are made, the payer's written notice shall include:

- (a) Name of the injured worker;
 - (b) Specific identifying information coordinating the notice with any payment instrument associated with the bill;
 - (c) Date(s) of service(s), if date(s) was (were) submitted on the bill;
 - (d) Payer's claim number and/or Division's workers' compensation claim number, if one has been created;
 - (e) Reference to the bill and each item of the bill;
 - (f) Notice that the billing party may submit corrected bill or appeal within 60 days;
 - (g) For compensable services related to a work-related injury or occupational disease the payer shall notify the billing provider that the injured worker shall not be balance-billed;
 - (h) Name of insurer with admitted, ordered or contested liability for the workers' compensation claim, when known;
 - (i) Name, address, e-mail (if any), phone number and fax of a person who has responsibility and authority to discuss and resolve disputes on the bill;
 - (j) Name and address of the employer, when known; and
 - (k) Name and address of the third party administrator (TPA) and name and address of the bill reviewer if separate company when known; and
 - (l) If applicable, a statement that the payment is being held in abeyance because a hearing is pending on a relevant issue.
- (2) The payer shall send the billing party written notice that complies with sections 16-11(A)(1) and (B) or (C) within 30 days of receipt of the bill. Any notice that fails to include the required information is defective and does not satisfy the 30-day notice requirement set forth in this section.
- (3) Unless the payer provides timely and proper reasons set forth by sections 16-11(B)-(D), 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.
- (4) 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 on 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.
- (5) Date of receipt of the bill may be established by the payer's date stamp or electronic acknowledgement date; otherwise, presumed receipt is presumed to

occur three (3) business days after the date the bill was mailed to the payer's correct address.

- (6) Unreasonable delay in processing payment or denial of payment of medical service bills, as determined by the Director or an administrative law judge, may subject the payer to penalties under the Workers' Compensation Act.
- (7) If the payer fails to make timely payment of uncontested billed services, the billing party may report the incident to the Division's Carrier Practices Unit to be used during an audit.
- (8) Payers shall reimburse injured workers for mileage expenses as required by statute or provide written or electronic notice of the reasons for denying reimbursement within 30 days of receipt.

(B) Process for Denying Payment of Billed Services Based on Non-Medical Reasons

- (1) Non-medical reasons are administrative issues. Examples of non-medical reasons for denying payment include the following: no 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 in the bill; failure to submit medical documentation; unrecognized CPT® code.
- (2) If an ATP bills for medical services 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 16-11(C). 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 received billed service, unless the requesting physician presents new evidence as to why this treatment is now related.
- (3) In all cases where a billed service is denied for non-medical reasons, the payer 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 section 16-11(A)(1) and shall also include:
 - (a) Date(s) of service(s) being denied, if submitted on the bill;
 - (b) If applicable, acknowledgement of specific paid items submitted on the same bill as denied services;
 - (c) Reference to the bill and each item of the bill being denied; and
 - (d) Clear and persuasive reasons for denying the payment of any item specific to that bill, including the citing of appropriate statutes, rules, and/or documents supporting the payer's reasons.

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.

- (4) Prior to modifying a billed code, the payer must contact the billing provider and determine if the code is accurate. If the payer disagrees with the level of care

billed, the payer may deny the claim or contact the provider to explain why the billed code does not meet the level of care criteria.

- (a) If the billing provider agrees with the payer, then the payer shall process the service with the agreed upon code and shall document on the EOB the agreement with the provider. The EOB shall include the name of the person at the provider's office who made the agreement.
 - (b) If the provider disagrees, then the payer shall proceed according to section 16-11(B) or (C), as appropriate.
- (5) 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.
- (6) When no established fee is given in the Medical Fee Schedule and the payer agrees the service or procedure is reasonable and necessary, the payer shall list on the EOB one of the following payment options:
 - (a) A reasonable value based upon the similar established code value recommended by the requesting provider, or
 - (b) The provider's requested payment based on an established similar code value.

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

(C) Process for Denying Payment of Billed Services Based on Medical Reasons

When denying payment of billed services based on medical reasons, the payer shall:

- (1) 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, procedures, or treatment under review. The physician providers performing this review shall be Level I or Level II accredited. In addition, a clinical pharmacist (Pharm.D.) as defined by section 16-3(A)(1)(b)(xvi) may review billed services for medications without having received Level I or Level II accreditation. After reviewing the supporting medical documentation, the reviewing provider may call the billing provider to expedite communication and timely processing of the medical bill.
- (2) In all cases where a billed service is denied for medical reasons, the payer shall send the provider and the parties written notice of denial within 30 days of receipt of the bill. The written notice shall include all notice requirements set forth in section 16-11(A)(1) and shall also include:
 - (a) Date(s) of service(s) being denied, if submitted on the bill;
 - (b) If applicable, acknowledgement of specific paid items submitted on the same bill as denied services;

- (c) Reference to the bill and each item of the bill being denied;
 - (d) Clear and persuasive medical reasons for the decision, including the name and professional credentials of the person performing the medical review and a copy of the medical reviewer's opinion;
 - (e) The specific cite from the Medical Treatment Guidelines, when applicable; and
 - (f) Identification of the information deemed most likely to influence the reconsideration of the denial, when applicable.
 - (3) Any notice that fails to include the required information set forth in this section is defective. Such defective notice shall not satisfy the payer's 30-day notice requirement set forth in this section.
 - (4) If the payer is denying the medical necessity of any non-valued procedure provided without prior authorization, the payer shall follow the procedures given in sections 16-11(C)(1) and (2).
- (D) Process for Appealing Billed Service Denials
- (1) The billing party shall have 60 days from the date of the EOB to respond to the payer's written notice under section 16-11(A)–(C). The billing party's timely response must include:
 - (a) A copy of the original or corrected bill;
 - (b) A copy of the written notice or EOB received;
 - (c) A statement of the specific item(s) denied;
 - (d) Clear and persuasive supporting documentation or reasons for appeal; and
 - (e) Any available additional information requested in the payer's written notice.
 - (2) If the billing party responds timely and in compliance with section 16-11(D)(1), the payer shall:
 - (a) When denying for medical reasons, have the bill and all supporting medical documentation and reasoning 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, procedures, or treatment under review. The physician providers performing this review shall be Level I or Level II accredited. In addition, a clinical pharmacist (Pharm.D.) as defined by section 16-3(A)(1)(b)(xvi) may review billed services for medications without having received Level I or Level II accreditation. After reviewing the documentation and response, the reviewing provider may call the billing provider to expedite communication and timely processing of the medical bill.
 - (b) When denying for non-medical reasons, have the bill and all supporting documentation and reasoning reviewed by a person who has knowledge

of the bill. After reviewing the provider's documentation and response, the reviewer may call the provider to expedite communication and timely processing of the medical bill.

- (3) If before or after conducting a review pursuant to section 16-11(D)(2), the payer agrees with the billing party's response, the billed service is due and payable in accordance with the Medical Fee Schedule within 30 days after receipt of the billing party's response. Date of receipt may be established by the payer's date stamp or electronic acknowledgement date; otherwise, receipt is presumed to occur three (3) business days after the date the response was mailed to the payer's correct address.
- (4) After conducting a review pursuant to section 16-11(D)(2), if there is still a dispute regarding the billed services, the payer shall send the billing party written notice of denial within 30 days of receipt of the response. The written notice shall include all notice requirements set forth in section 16-11(A)(1) and shall also include:
 - (a) Date(s) of service(s) being denied, if submitted by the provider;
 - (b) If applicable, acknowledgement of specific paid items submitted on the same bill as denied services;
 - (c) Reference to the bill and each item of the bill being denied;
 - (d) An explanation of the clear and persuasive medical or non-medical reasons for the decision, including the name and professional credentials of the person performing the medical or non-medical review and a copy of the medical reviewer's opinion when the denial is for a medical reason; and
 - (e) The explanation shall include the citing of statutes, rules and/or documents supporting the payer's reasons for denying payment.
- (5) Any notice that fails to include the required information set forth in this section is defective. Such defective notice shall not satisfy the payer's 30-day notice requirement set forth in this section.
- (6) In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts. The parties shall do so within 12 months of the date the original bill should have been processed in compliance with section 16-11, unless extenuating circumstances exist.

(E) Retroactive review of Medical Bills

- (1) All medical bills paid by a payer shall be considered final at 12 months after the date of the original EOB unless the provider is notified that:
 - (a) A hearing is requested within the 12 month period, or
 - (b) A request for utilization review has been filed pursuant to § 8-43-501.
- (2) 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 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, procedures, or treatment under review. The physician providers performing this review shall be Level I or Level II accredited. In addition, a clinical pharmacist (Pharm.D.) as defined by section 16-3(A)(1)(b)(xvi) may review billed services for medications without having received Level I or Level II accreditation. The payer shall send the billing party written notice that shall include all notice requirements set forth in section 16-11(A)(1) and also shall include:

- (a) Reference to each item of the bill where payer seeks to recover overpayments;
 - (b) Clear and persuasive medical reason(s) for seeking recovery of overpayment(s). The explanation shall include the citing of appropriate statutes, rules, and/or other documents supporting the payer's reason for seeking to recover overpayment; and
 - (c) Evidence that these payments were in fact made to the provider.
- (3) 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 shall include all notice requirements set forth in section 16-11(A)(1) and shall also include:
 - (a) Reference to each item of the bill where payer seeks to recover overpayments;
 - (b) Clear and persuasive reason(s) for seeking recovery of overpayment(s). The explanation shall include the citing of appropriate statutes, rules, and/or other documents supporting the payer's reason for seeking to recover overpayment; and
 - (c) Evidence that these payments were in fact made to the provider.
- (4) In the event of continued disagreement, the parties may follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts.
- (F) 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 services that are then admitted or ordered under the Workers' Compensation Act, the payer shall reimburse the injured worker for the amounts actually paid for authorized services within 30 days after 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. Each request for a refund shall indicate the service provided and the date of service(s) involved.
- (G) 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 section 16-11.
- (H) Onsite Review of Hospital or Other Medical Charges
 - (1) The payer may conduct a review of billed and non-billed hospital or medical facility charges related to a specific workers' compensation claim.

- (2) The payer shall comply with the following procedures:

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

- (a) Name of the injured worker;
- (b) Claim and/or hospital or other medical facility I.D. number associated with the injured worker's bill;
- (c) An outline of the items to be reviewed; and
- (d) If applicable, the name, address and telephone number of any person who has been designated by the payer to conduct the review (reviewer).

- (3) The hospital or other medical facility shall comply with the following procedures:

- (a) Allow the review to begin within 30 days of the payer's notification;
- (b) Upon receipt of the patient's signed release of information form, allow the reviewer access to all items identified on the injured worker's signed release of information form;
- (c) Designate an individual(s) to serve as the primary liaison(s) between the hospital or other medical facility who will acquaint the reviewer with the documentation and charging practices of the hospital or other medical facility;
- (d) Provide a written response to each of the preliminary review findings within ten (10) business days of receipt of those findings; and
- (e) Participate in the exit conference in an effort to resolve discrepancies.

- (4) The reviewer shall comply with the following procedures:

- (a) Obtain from the injured worker a signed information release form;
- (b) Negotiate the starting date for the review;
- (c) Assign staff members who are familiar with medical terminology, general hospital or other medical facility charging and medical records documentation procedures or have a level of knowledge equivalent at least to that of an LPN;
- (d) Establish the schedule for the review which shall include, at a minimum, the dates for the delivery of preliminary findings to the hospital or other medical facility, a ten (10) business day response period for the hospital or other medical facility, and the delivery of an itemized list of discrepancies at an exit conference upon the completion of the review; and
- (e) Provide the payer and hospital or other medical facility with a written summary of the review within 20 business days of the exit conference.

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" (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 (10) 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.