PINNACOL ASSURANCE

Permanent Impairment Ratings

Impairment ratings (IR) assess the severity of a disability and the degree to which an injured worker's injuries will affect future job performance following an on-the-job injury or disease.

IR codes

Z0759 - performed by the Level II-accredited authorized treating physician who is providing primary care for the injury

Z0760 - performed by a Level II-accredited physician who has not previously treated the injured worker for the injury

Guidelines for report preparation and billing:

- Based on the Colorado Division of Workers' Compensation (DOWC) Rule 18, the payer is only required to pay for one combined whole-person permanent IR per claim. Exceptions may include reopened cases or a subsequent request to review the apportionment.
- The physician performing the IR must be Level II accredited and comply with DOWC Rule 5 as applicable.
- The billed date of service is the date the physician examines the injured worker.
- A return visit for a range of motion validation shall be billed with the appropriate CPT code from the Medicine section.

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 authorized treating physician managing the claim should complete the WC164 closing report.

MMI determined with a calculated permanent IR

The total fee includes the office visit, a complete history and physical examination, the medical records review, the MMI determination, the required measurements, and the WC164 closing report completion. It also includes using the report forms and indicating the tables used to determine the rating from the AMA's Guide to the Evaluation of Permanent Impairment, Third Edition (revised).

Medical records that take longer than one hour to review require a separate report. The report must document each record reviewed, the record date and the specific details of the record. Extensive record reviews require prior authorization and are billed as a special report using code Z0755.

These items are not separately billed, as they are included in the IR:

- Office visit
- Medical record review
- Any measurements used to determine the IR
- WC164 closing report

Bills may be denied for incorrect billing when:

- The closing WC164 report is billed before the IR is performed,
- The office visit is billed separately from the IR,
- The IR measurements are billed separately, or
- The services are unbundled in the IR.

Canceled or rescheduled appointments

If an injured worker fails to attend an impairment rating appointment or if the physician is notified by the party of a canceled or rescheduled appointment five days or less from the appointment date, the physician can bill for one-half of the fee for the scheduled service. The physician should bill Z0764 and indicate the code corresponding to the scheduled service in Box 19 of the CMS-1500 form or electronic billing equivalent.

References

Colorado Division of Workers' Compensation, Rules 5 & 18

https://cdle.colorado.gov/workers-compensation-rules-of-procedure

If you have any questions or need additional information, please contact Pinnacol's provider medical billing auditors at 303.361.4940 or billingsuccess@pinnacol.com.