



The Chiropractic Guide to the 2025 Colorado Workers Comp Guide is brought to you by The Colorado Chiropractic Association (CCA) as a member benefit.

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This guide was prepared by the Colorado Chiropractic Association (CCA) expressly for use by doctors of chiropractic from Rule 16 and 18 (effective 1-1-2021) of the Division of Workers' Compensation. An official copy of the rules may be obtained by contacting LexisNexis Matthew Bender & Co. Inc.,

1275 Broadway | Albany, NY 12204, or by phone or website at (800) 223-1940 or customer.support@lexisnexis.com.

You may view a detailed unofficial copy of all the rules and procedures in various formats on the

Division of Workers Compensation website at <https://cdle.colorado.gov/dwc>

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Introduction

The workers' compensation insurance laws in Colorado were enacted to provide for the health care of workers injured on the job. Workers' compensation differs from many other types of insurance in that:

1. The employer, not the beneficiary of coverage (the injured worker), pays the premium.
2. The employer, not the injured worker, has the first right to select the treating doctor or health care facility.
3. Coverage and reimbursement are provided strictly in accordance with the laws and the rules established by the Division of Workers' Compensation (7 CCR1101-3).
4. Coverage is provided only for injuries sustained at the place of employment, or as a direct result of the injured worker's employment, and then only in an amount sufficient to return the injured worker to pre-accident status. Pre-existing conditions are NOT covered.

Workers' compensation insurance in Colorado is subject to state statutes and to rules promulgated by the Division of Workers' Compensation. The Division is charged by statute with adopting a fee schedule and treatment guidelines, utilizing input from the healthcare professions, the payer community, and representatives of injured workers. The following Rules and Fee Schedule are effective as of January 1, 2023.

NOTE: auto accidents are not work comp if the employee is on their way to or from work. However, if an employee is at work or on an errand for work, it would then be covered under work comp.

I. General Information

- a. Accreditation-** As a doctor of chiropractic, you must be LEVEL I ACCREDITED to treat workers' compensation patients beyond 12 visits. To obtain LEVEL I. ACCREDITATION, call the Division of Workers' Compensation at (303) 318-8763. **Doctors of Chiropractic are NOT authorized to perform workers' compensation impairment ratings.**

Rule 16-10

II. Authorized Treating Provider (ATP) – may be any of the following:

- a. The treating physician designated by the employer and selected by the injured worker;
- b. A health care provider to whom an authorized treating physician refers the injured worker for treatment, consultation, or impairment rating;
- c. A physician selected by the injured worker when the injured worker has the right to select a provider;

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- d. A physician authorized by the employer when the employer has the right or obligation to make such an authorization;
- e. A health care provider determined by the Director or an administrative law judge to be an ATP;
- f. A provider who is designated by the agreement of the injured worker and the payer.

Becoming the AUTHORIZED TREATING PROVIDER (ATP):

1. You are the employer's designated chiropractic provider. In this case, all chiropractic injuries from this employer will be sent to you. "Designated Provider" status means that *the employer must have selected you AND advised their workers comp carrier AND received their approval* for your designation. When an employee of this company sustains an injury which is treatable with chiropractic care, they will be assigned to you. The employer refers the patient to you following a work-related injury OR the employer allows the employee to select their own doctor.
2. You receive a patient via a referral from a doctor who has treated the patient.
3. *You should always verify your eligibility to treat a workers' compensation patient with the employer before you begin to treat the patient.*
4. *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), C.R.S.*

16-4. Required Use of the 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. These may be obtained at the Workers Comp web site <https://cdle.colorado.gov/dwc>

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Find the full list of codes and fees here: <https://cdle.colorado.gov/medical-fee-schedule>

Please review the 2025 Rule 18 Update Training Video here: <https://vimeo.com/1023347328>

I. Rules and Procedures for Billing Workers Comp Cases

1. Please read and follow the billing rules applicable to each procedure. These rules govern which procedures will be covered, what may be billed for on each visit, and how care will be paid for. *CPT codes AND SPECIAL CODES developed by Work Comp are used for Work Comp.* 16-9 (B) (C)
2. 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. Finally, providers must use codes, modifiers, and billing instructions listed in Rule 18, Medical Fee Schedule. The Medical Fee Schedule sets the maximum allowable payment but the fee schedule does not limit the billing charges.
3. In this guide, fees for common procedures used in a chiropractic clinic have been calculated for your use by the CCA. These should only be used as a guide. Please contact Workers' Comp. at (303) 318-8761 with any questions. If you plan to utilize a procedure not shown in this guide, you should contact the workers' compensation carrier to obtain pre-authorization. Fees for these procedures must be calculated, and in some cases, agreed upon separately. Please call Workers' Comp. at (303) 318-8761 for the procedures not listed in this guide.

II. Rule 16 and Rule 18 Changes

1. **IMPORTANT NOTE:** In 2026, you must submit bills electronically if submitting 25+ workers' compensation claims per month.

Radiology (72010-76140)

MODIFIERS: Professional component (read only) -26 | Total component should be billed with the (00) modifier to facilitate processing. The five-digit CPT code without a modifier indicates the provider performed both the professional and technical components of the radiological procedure. (If the provider only supplies the professional component, then the five-digit CPT code must carry the modifier -26.). If the provider supplies only the technical component, the modifier must be -TC. The technical component equals the "taken & read" minus the "read only" below.

Codes and Fees

CPT Code	Description	Read Only (-26)	Taken & Read
72082	Entire Spine, 2-3 Views	\$29.96	\$110.52
72020	Various Views, Singular View	\$15.31	\$33.29
72040	Cervical, AP/Lat, 2 or 3 Views	\$21.31	\$57.92
72050	Minimum of 4 Views	\$25.30	\$81.89
72052	Cervical, Complete Incl. Flex/Ext	\$28.63	\$96.54
72070	Thoracic, AP/Lat, 2 Views	\$19.31	\$46.61
72074	Thoracic, 4 Views	\$23.80	\$66.64
72080	Thoracolumbar; AP/Lat, 2 Views	\$19.97	\$49.27
72100	Lumbosacral; ; AP/Lat, 2 or 3 Views	\$21.31	\$58.59
72110	Lumbosacral, Comp. Oblique, Min of 4 Views	\$24.63	\$79.23
72114	Lumbosacral, Incl. Bending, Complete	\$28.63	\$93.88
72120	Lumbosacral, Min of 4 Views, Bending Only	\$21.31	\$59.92
72170	Pelvis, AP, 1 or 2 Views	\$16.65	\$39.28
73020	Shoulder, 1 View	\$14.65	\$28.63
73030	Shoulder, Min. 2 Views, Complete	\$17.98	\$51.93
73060	Humerus, 2 Views	\$15.31	\$48.60
73070	Elbow, AP/Lat, 2 Views	\$15.98	\$42.61
73090	Forearm, AP/Lat, 2 Views	\$15.31	\$43.28
73100	Wrist, AP/Lat, 2 Views	\$15.98	\$51.93
73110	Wrist, Min. 3 Views, Complete	\$16.65	\$65.91
73120	Hand, 2 Views	\$15.98	\$47.27
73130	Hand, Min. 3 views	\$16.65	\$57.92
73501	Hip, Unilateral, 1 View	\$18.36	\$48.96
73502	Hip, Unilateral, 2 – 3 Views	\$21.31	\$73.90
73522	Hip, Bilateral, 2 Views of Each Hip, Incl. AP Pelvis	\$27.96	\$79.90
73560	Knee, 1 or 2 Views	\$15.98	\$52.60
73590	Leg, 2 Views, Tibia & Fibula	\$15.31	\$47.94
73600	Ankle, 2 Views	\$15.31	\$49.27
73620	Foot, 2 Views	\$14.65	\$42.61
76140	X-Ray Reading, Consultation & Written Report	N/A	N/A

Chiropractic Manipulation(98940-98943)

I. Billing Rules

- a. Chiropractic manipulations service values include follow-up E&M service. An E&M service can only be billed separately when the provider's records document significant and identifiable services to perform manipulation. (For example, a new patient examination or examination due to an exacerbation would qualify as a significant and identifiable service. A pre- and/or post-adjustment brief exam would not.) The -25 modifier on the E & M Service is required when manipulation is billed at the same visit for the same patient.
- b. Prior authorization (Rule 16-6)
 - i. 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. Rule 18-4-G
 - i. Manipulation – Chiropractic (DC), Medical (MD) and Osteopathic (DO):
 1. 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.
 2. Osteopathic Manipulative Treatment and Chiropractic Manipulative Treatment codes include manual therapy techniques, unless provider performs manual therapy in a separate region and meets modifier 59 requirements.
 3. 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.
 4. The modified RVUs for chiropractic spinal manipulative treatment are:
 - a. CPT® 98940 Non-facility RVU is 1.03, facility RVU is 0.81
 - b. CPT® 98941 Non-facility RVU is 1.48, facility RVU is 1.26

Codes and Fees

<i>CHIROPRACTIC MANIPULATIVE TREATMENT</i>		
Code	Service	Fee
98940	Spinal: 1 – 2 Areas	\$68.58
98941	Spinal: 3 – 4 Areas	\$98.54
98942	Spinal: 5 Areas	\$101.20
98943	Extra-spinal (1 or More Area)	\$51.27

Physical Medicine and Rehabilitation (97001-97799)

I. Restrictions

- a. For recommendations on the use of the physical medicine and rehabilitation procedures, modalities, and testing, see Rule 17, Medical Treatment Guidelines Exhibits.
- b. Prior authorization for payment shall be obtained from the payer for any physical medicine treatment exceeding the recommendations of the Medical Treatment Guidelines as set forth in Rule 17.
- c. The injured worker shall be re-evaluated by the prescribing physician within thirty (30) calendar days from the initiation of the prescribed treatment and at least once every month while that treatment continues. Prior authorization for payment (see Rule 18-5(H)(1)) shall be required for treatment of a condition not covered under the medical treatment guidelines and exceeding sixty (60) calendar days from the initiation of treatment.
- d. Unless the provider's medical records reflect medical necessity and the provider obtains prior authorization for payment, the maximum amount of time allowed is **one hour of procedures per day**. (Rule 18-4(H))

II. Modalities

Codes 97010 – 97028, unattended

Codes 97032 – 97039, attended

Billing restrictions: Limit of two modalities may be billed in one visit per discipline.

- a. Rule 18-5(H)(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.)
- b. The provider's medical records shall reflect the medical necessity and the provider shall obtain prior authorization if the procedures are not recommended

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or the frequency and duration exceeds the recommendations of the Medical Treatment Guidelines.

- c. 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 billed unit time cannot exceed the total time spent performing the procedures.

III. 18-6 Ancillary Services

- a. Electrical Stimulators- Electrical stimulators are bundled kits that include the portable unit(s), 2 to 4 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.)
- b. 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 2 leads or E0730 for a kit with 4 leads;
- c. Replacement supplies are limited to once per month and are not eligible with a first month rental.
 A4595 - electrical stimulator supplies, 2 leads.
 A4557 - replacement leads.

IV. Dry Needling of Trigger Points

- a. Bill only one of the dry needling modality codes. See relevant treatment guidelines for limitations on frequencies.

Codes and Fees

Code	Description	Fee (No MOD)
20560	Needle Insertion without Injection 1 or 2 Muscles	\$51.27
20561	Needle Insertion without Injection 3 or More Muscles	\$73.90

Codes and Fees

<i>THERAPY MODALITIES-SUPERVISED</i>		
Code	Description	Fee (No MOD)
97010	Hot or Cold Packs, One or More Areas	\$9.49
97012	Traction, Mechanical	\$20.97
97014	Elec. Stim (Unattended)	\$18.47
97016	Vasopneumatic Devices	\$17.48
97018	Paraffin Bath	\$8.49
97022	Whirlpools	\$25.46

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97024	Diathermy/Microwave	\$10.98
97026	Infrared	\$9.99
97028	Ultraviolet	\$12.48

<i>THERAPY MODALITIES-CONSTANT ATTENDANCE</i>		
Code	Description	Fee (No MOD)
97032	Electrical Stim (Attended) – 15 min. Manual	\$21.47
97033	Iontophoresis – 15 min.	\$28.96
97034	Contrast Baths – 15 min.	\$20.97
97035	Ultrasound – 15 min.	\$20.97

Therapeutic Procedures (97110-97760)

The maximum amount of time allowed is one hour of procedures per day per discipline, unless the provider's medical records reflect medical necessity, and the provider obtains prior authorization from the payer to exceed the one-hour limitation.

Codes and Fees

Code	Description	Fee (No MOD)
97110	Therapeutic Exercises – 1 or More Areas-15 min.	\$43.94
97112	Neuromuscular Re-Education – 15 min.	\$53.43
97113	Aquatic Therapy w/ Therapeutic Exercises	\$54.92
97116	Gait Training – 15 min. (Incl. Stair Climbing)	\$43.94
97124	Massage – 15 min.	\$45.44
97139	Unlisted Therapeutic Procedure – PRIOR APPROVAL	\$43.94
97140	Manual Therapy Techniques - 1 or More Regions 15 min.	\$40.44
97150	Therapeutic procedures – Groups (2 or More People)	\$26.96
97530	Therapeutic Activities, Direct Contact – 15 min.	\$54.92
97535	Self-Care, Home Management Training – 15 min.	\$48.93
97537	Work Reintegration, Training – 15 min.	\$47.43
97545	Work Hardening – Initial 2 hrs.	\$169.26
97546	Work Hardening – 1 Additional hr.	\$84.88
97760	Orthotics Management and Training, Each 15 mins.	\$71.40

Evaluation and Management Section (E & M) (Codes 99201 – 99499)

- I. Evaluation and management codes may be billed by physician providers as defined in Rule 16, nurse practitioners (NP), and physician assistants (PA). To justify the billed level of E&M service, medical record documentation shall utilize the 2019 CPT® E&M Services Guidelines and either the "E&M Documentation Guidelines" criteria adopted in Exhibit #7, or Medicare's 1997 Evaluation and Management Documentation Guidelines.
- II. Disability counseling should be an integral part of managing workers' compensation injuries. The counseling shall be completely documented in the medical records, including, but not limited to, the amount of time spent with the injured worker and the specifics of the discussion as it relates to the individual patient. Disability counseling shall include, but not be limited to, return to work, temporary and permanent work restrictions, self-management of symptoms while working, correct posture/mechanics to perform work functions, job task exercises for muscle strengthening and stretching, and appropriate tool and equipment use to prevent re-injury and/or worsening of the existing injury.
- III. 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 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.
- IV. All providers are limited to one (1) office visit per patient, per day, per workers' compensation claim, unless prior authorization is obtained.

A modifier –25 on the E & M service is required when adjustment/manipulation is performed at the same visit for the same patient.

Codes and Fees

Code	Description	Fee
99202	New Patient -15-29 min. (Typically)	\$126.40
99203	New Patient – 30-44 min. (Typically)	\$195.14
99204	New Patient – 45-59 min. (Typically)	\$292.42
99205	New Patient – 60-74 min. (Typically)	\$385.62
99211	Established Patient - Minimal (Typically)	\$40.78
99212	Established Patient – 10-19 min. (Typically)	\$99.03
99213	Established Patient – 20-29 min. (Typically)	\$159.02
99214	Established Patient – 30-39 min. (Typically)	\$224.26
99215	Established Patient – 40-54 min. (Typically)	\$315.72

Treating Physician Telephone or On-line Services (see RULE 18-6 (A))

(available at <https://www.colorado.gov/cdle/dwc>)

Telehealth (see RULE 16-2 (V))

(available at <https://www.colorado.gov/cdle/dwc>)

Division of Work Comp Established codes and values 18-6

Cancellation Fees for Payer Made Appointments

- I. A cancellation fee is payable only when a payer schedules an appointment the injured worker fails to keep, and the payer has not canceled three (3) business days prior to the appointment. The payer shall pay:
 - a. One-half of the usual fee for the scheduled services, or \$187.50, whichever is less. Cancellation Fee Billing Code: Z0720
 - b. 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. 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.
- II. Missed Appointments:
 - a. When claimants fail to keep scheduled appointments, the provider should contact the payer within two (2) business days. Upon reporting the missed appointment, the provider may inquire if the payer wishes to reschedule the appointment for the claimant. If the claimant fails to keep the payer’s rescheduled appointment, the provider may bill for a cancellation fee according to this section.

Copying Fees

- I. 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. 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. 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.

Codes and Fees

Code	Description	Fee
Z0721	First 10 or Fewer Paper Page(s)	\$18.53
Z0725	Next 11-40 Paper Page(s)	\$.85/page
Z0726	Remaining Paper Page(s)	\$.57/page
Z0727	Microfilm Page	\$1.50/page
Z0728	Computer Disc or As Agreed	\$14.00/disc
Z0729	Electronic Page or As Agreed	\$6.50/copy
Z0802	Actual Postage Paid	-

Copying charges do not apply for the initial submission of records that are part of the required documentation for billing. Copying Fee Billing Code: Z0721

Deposition and Testimony Fees

- I. 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 Maximum Fee Schedule, that ALJ may allow a greater fee.
- II. 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.
 - a. Preparation Time: Treating or non-treating physician as defined by Rule 16 or psychologist (PsyD, PhD, or EdD): Z0730, \$190.74, billed in hour increments. Other providers shall be paid 85% of this fee.

III. Deposition:

- a. Payment for testimony at a deposition shall not exceed \$190.74, billed in hour increments, for a treating or non-treating physician as defined by Rule 16 or a psychologist (PsyD, PhD, or EdD). Z0734, calculating the provider's time from "portal to portal." Other providers shall be paid 85% of this fee.
- b. If requested, the provider is entitled to a full hour deposit in advance to schedule the deposition.
- c. 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 s/he has reasonably spent in preparation, less any deposit paid by the deposing party. Z0731, \$190.74, in hour increments.
- d. 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 s/he has reasonably spent in preparation and has scheduled for the deposition. Z0733, \$190.74, in hour increments.
- e. Deposition: Treating or Non-treating provider: Z0734 \$190.74 per hr. billed in hour increments.

IV. Testimony:

- a. Treating or non-treating physician as defined by Rule 16 or psychologist (PsyD, PhD, or EdD): Z0738, \$264.18, billed in half-hour increments. Other providers shall be paid 85% of this fee.
- b. Calculation of the provider's time shall be "portal to portal" (includes travel time and mileage in both directions).
- c. 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.
- d. 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 s/he has reasonably spent in preparation, less any deposit paid by the requesting party. Z0735, \$264.18, in half-hour increments.
- e. 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 s/he has reasonably spent in preparation and has scheduled for the testimony. Z0737, \$264.18, in half-hour increments.
- f. Testimony: Treating or Non-treating provider: Z0738 Maximum Rate of \$264.18 per 30-minutes

Permanent Impairment Ratings

Chiropractors are not eligible for Level II Accreditation (See CRS 8-42-101(3.5)(a)(I)(A)) and may not perform impairment ratings for workers compensation purposes.

Reporting

I. Routine Reports

- a. 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:

- i. Diagnostic testing
 - ii. Procedure reports
 - iii. Progress notes
 - iv. Office notes
 - v. Operative reports
 - vi. Supply invoices, if requested by the payer
- b. Providers other than hospitals shall provide the payer with all supporting documentation at the time of billing unless the parties have made other agreements (Rule 16-10(E)). Requests for additional copies of routine reports and for reports not in Rule 16-10(D) or in statute are reimbursable under the copying fee section of Rule 18.

II. Completion of the Physician's Report of Workers' Compensation Injury (WC164)

- a. The authorized treating physician (ATP) (generally the designated physician) or 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.
- b. 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. (See Rule 18-7 (G))

Codes and Fees

Code	Description	Fee
Z0750	Initial	\$50.00
Z0751	Progress (Payer Requested or Provider Initiated)	\$50.00
Z0752	Closing Report	\$50.00
Z0753	Initial and Closing Reports are completed on the same form for the same date of service	\$50.00

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Request for physicians to complete additional forms sent to them by a payer or employer shall be paid by the requesting party. A form requiring 15 minutes or less of a physician's time shall be billed pursuant to (a) and (b) below. Forms requiring more than 15 minutes shall be paid as a special report.

- a. Billing Code Z0754 b. The maximum fee is \$50.00 per form completion.

III. Special Reports

- a. The term special report includes any form, questionnaire, letter, or report with variable content not otherwise addressed in Rules. Examples include:
 - i. treating or non-treating medical reviewers or evaluators producing written reports pertaining to injured workers not otherwise addressed,
 - ii. meeting with and reviewing another provider's written record and amending or signing that record.
- b. 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.
- c. 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.

Codes and Fees

Code	Description	Fee
Z0755	Written Report	\$95.37
Z0757	Lengthy Form	\$95.37
Z0758	Meeting and Report with Non-Treating Physician In cases of cancellation for those 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.	\$95.37
Z0761	Report Preparation With Cancelled Patient Exam	\$95.37

- d. Independent Medical Examinations:
 - i. RIME: Respondent-requested Independent Medical Examination Z0756
RIME Report with patient exam, \$95.37 billable in 15-minute increments
 - 1. 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.
 - 2. Z0766 RIME Audio Recording, \$35.70 per exam
 - 3. Z0767 RIME Audio Copying Fee, \$24.48 per copy

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- ii. CIME: Claimant-requested Independent Medical Examination, \$95.37 billable in 15 minute increments to the injured worker, Code Z0770
- iii. DIME: Division Independent Medical Examination - see Rule 11
- iv. All IME reports must be served concurrently to all parties no later than 20 calendar days after the examination.
- v. Cancellations: In cases of a cancelled or rescheduled RIME or CIME, the provider shall be paid the following fees:
 - 1. If the provider is notified of the cancellation of the RIME or CIME at least ten (10) business 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. Z0762, \$95.37 billable in 15-minute increments.
 - 2. If the provider is notified less than ten (10) business 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. Z0763, \$95.37 billable in 15-minute increments.

IV. Use of an Interpreter

- a. Payers shall reimburse for the services of a qualified interpreter in specified settings if the injured worker does not proficiently speak or understand the English language.
- b. A qualified interpreter must be provided via video or audio remote interpreting service or onsite appearance at complex medical treatment appointments, at behavioral health appointments and when otherwise requested by the provider or injured worker. Providers may, but are not required to use bi-lingual staff to provide third party interpretation when a qualified interpreter is not available.
 - i. Qualified interpreter is defined as:
 - 1. a Certified Medical Interpreter, if this certification is available for the injured worker's language; or for all other languages, is fluent in English and the necessary target language, has knowledge of basic medical and/or legal terminology, and knowledge of health care interpreting ethics and standards of practice.
- c. Providers are prohibited from relying on minor children and should refrain from using adult family members, and friends as interpreters. The exceptions are unavailability of a qualified interpreter in the case of "other" languages and in an emergency involving an imminent threat to the safety or welfare of an individual or the public.
- d. Rates and terms shall be negotiated. Prior authorization is required except for emergency treatment.
- e. Non-qualified interpreters are not eligible for reimbursement.

Supplies, Durable Medical Equipment (DME), Orthotics, and Prosthesis

(Rule 18-6)

I. Durable Medical Equipment (DME)

1. This is equipment that can withstand repeated use and allows injured workers accessibility in the home, work, and community. DME can be categorized as:
2. Purchased Equipment/Capped Rental:
 - Items that cost \$100.00 or less may not be rented.
 - Rented items must be purchased or discontinued after 10 months of continuous use or once the total fee scheduled price has been reached.
 - 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

II. Take Home Exercise Equipment

1. Items with a total cost of \$50 or less may be billed using A9300 without an invoice at a maximum fee of actual 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: TheraBand, 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, flex bars, Digiflex hand exercisers, power webs, plyoballs, spring hand grippers, hand helper rubber band units, ankle stretchers, rocker boards, balance paws, and aqua weights.

III. Electrical Stimulators

1. Electrical stimulators are bundled kits that include the portable unit(s), 2 to 4 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.)
 - 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 2 leads or E0730 for a kit with 4 leads;
 - Electrical Muscle Stimulation machines/kits: E0744 for scoliosis; or

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E0745 for neuromuscular stimulator, electric shock unit;

- Replacement supplies are limited to once per month and are not eligible with a first month rental.
 - A4595 - electrical stimulator supplies, 2 leads.
 - A4557 - replacement leads.
- Conductive Garments: E0731.

IV. Prosthesis and Orthotics

1. Maximum fees for any orthotic created using casting materials shall be billed 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.
2. 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. Unless other limitations exist in this Rule, DMEPOS suppliers and medical providers shall be reimbursed using Medicare's HCPCS Level II codes, when one exists, as established in the January 2019 DMEPOS schedule for rural (R) or nonrural (NR) areas. The DMEPOS schedule can be found at <https://www.cms.gov>

If no code or value exists, reimbursement shall be based on Colorado Medicaid's DME, Upper Payment Limit, January 2019 Interim Rate for rural or non-rural areas. See <https://www.colorado.gov/hcpf/provider-rates-fee-schedule>. If no Medicaid fee schedule value exists, reimbursement shall be 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.

V. Dietary Supplements, Vitamins, and Herbal Medicines

1. 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 Guidelines. The reimbursement shall be at cost to the injured worker.

VI. Complementary Integrative Medicine

1. 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.

Acupuncture (Rule 18-4.H.13)

https://cdle.colorado.gov/sites/cdle/files/Rule_18_Medical_Fee_Schedule_2020.pdf

- I. Acupuncture may be performed with or without the electrical current on the needles at the acupuncture site. All non-physician acupuncture providers must be a Licensed Acupuncturist (LAc) by the Colorado Department of Regulatory Agencies as provided in Rule 16. Both physician and non-physician providers must provide evidence of training, and licensure upon request of the payer.
- II. 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. All evaluation notes or reports must be written and signed by the physician or the LAc.

LAc new patient visit: Z0800, \$103.84

LAc established patient visit: DOWC Z0801, \$70.33

ICD-10: Colorado Workers' Compensation

- I.** Rule 16-9 (B) 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.
- II.** 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.
- III.** 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.
- IV.** Timely Filing
 - 1. 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.
- V.** 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.
- VI.** Rule 16-10 REQUIRED MEDICAL RECORD DOCUMENTATION states:
 - 1. 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.

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2. 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:
 - Patient's name;
 - Date of contact, office visit or treatment;
 - Name and professional designation of person providing the billed service;
 - Assessment or diagnosis of current condition with appropriate objective findings;
 - Treatment status or patient's functional response to current treatment;
 - Treatment plan including specific therapy with time limits and measurable goals and detail of referrals;
 - Pain diagrams, where applicable;
 - 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
 - All prior authorization(s) for payment received from the payer (i.e., who approved prior authorization, services authorized, dollar amount, length of time, etc.).
3. 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)).

Workers' Compensation Resources

633 17th Street, Suite 400

Denver, CO 80202-3660

<https://cdle.colorado.gov/dwc>

Phone (303) 318-8700 Fax (303) 318-8710 Toll-Free (888) 390-7936

En Español (800) 685-0891

Email: cdle_wccustomer_service@state.co.us

Level I Accreditation: (303) 318-8754

Claims Management: (303) 318-8600

Insurance Compliance: (303) 318-8617

Independent Medical Exams: (303) 318-8655

Utilization Review: (303) 318-8769

Medical Policy Unit & Fee Schedule: (303) 318-8761

Medical Cost Containment: (303) 318-8755

Form 164: <https://codwc.app.box.com/v/WC164-physician>

Medical Treatment Guidelines: <https://cdle.colorado.gov/medical-providers/medical-treatment-guidelines>

Statutes & Rules: <https://cdle.colorado.gov/statute-rules-guidance>

Link to ALL forms: <https://cdle.colorado.gov/dwc/dwc-resources>

Link to FULL schedule: <https://cdle.colorado.gov/medical-fee-schedule>

