January 1, 2020

Dear Customer:

The State of New York has revised the *Official New York State Workers' Compensation Medical Fee Schedule* effective January 1, 2020. The enclosed pages will update the 2018 edition (effective April 1, 2019) with the updates effective January 1, 2020.

The new *Official New York State Workers' Compensation Acupuncture and Physical & Occupational Therapy Fee Schedules* booklet is not included in this update. This booklet is available separately by calling Optum360 at 1.800.464.3649, option 1.

Sincerely,

Optum360

LWCNY18R

2525 Lake Park Boulevard • Salt Lake City, UT 84120 • 800.464.3649 • Fax 801.982.4033

Assembly Instructions

Official New York State Workers' Compensation Medical Fee Schedule

Please follow these instructions to assemble your book. Insert the pages in the NEW Pages column. The OLD Pages should be retained for dates of service prior to January 1, 2020.

Tab Sections	Old Pages	New Pages
Medical Fee Schedule		
	Title/Disclaimer pages	Title/Disclaimer pages
Introduction and General Guidelines	3 – 8 11 – 16 19 – 20	3 – 8 11 – 16 19 – 20A
Evaluation and Management	27 – 28	27 – 28A
Surgery	59 – 66	59 – 66
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Pathology and Laboratory	279 – 282	279 – 282
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Behavioral Health Fee Schedule		
	Title/Disclaimer pages	Title/Disclaimer pages
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Introduction and General Guidelines	1 – 8	1 – 8
Chiropractic Fee Schedule		
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Medicine	17 – 18	17 – 18
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Podiatry Fee Schedule		
	Title/Disclaimer pages	Title/Disclaimer pages
Introduction and General Guidelines	3 – 8	3 – 8
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OFFICIAL

NEW YORK STATE WORKERS' COMPENSATION

MEDICAL FEE SCHEDULE

Effective 4/1/2019
Revisions Effective 1/1/2020

UWCNY18R2

NEW YORK STATE OF OPPORTUNITY.

Workers' Compensation Board

1.800.464.3649

Optum360 Notice

The *Official New York State Workers' Compensation Medical Fee Schedule* is designed to be an accurate and authoritative source of information about medical coding and reimbursement. Every reasonable effort has been made to verify its accuracy, and all information is believed reliable at the time of publication. Absolute accuracy, however, cannot be guaranteed.

Optum360 worked closely with the New York Workers' Compensation Board in the development, formatting, and production of this fee schedule. However, all decisions resulting in the final content of this schedule were made solely by the New York State Workers' Compensation Board.

This publication is made available with the understanding that the publisher is not engaged in rendering legal and other services that require a professional license.

For additional copies of this publication or other fee schedules, please call 1.800.464.3649.

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New York Workers' Compensation Board Filing Notice

The Medical Fee Schedule was duly filed in the Office of the Department of State, and constitutes Sections 329.1 and 329.3 of Title 12 of the Official Compilation of Codes, Rules, and Regulations of the State of New York.

Our Commitment to Accuracy

Optum360 is committed to producing accurate and reliable materials. To report corrections, please email accuracy@optum.com. You can also reach customer service by calling 1.800.464.3649, option 1.

Revised Printing

This revised printing contains revisions effective January 1, 2020.

FOREWORD

The Workers' Compensation Board is pleased to present the updated version of the *Official New York State Workers' Compensation Medical Fee Schedule*.

The revised fee schedule is an essential tool for health care providers and those paying the cost of health care services under the New York State Workers' Compensation system. This schedule provides comprehensive billing guides, which will allow health care providers to appropriately describe their services and minimize disputes over reimbursement. Also, this schedule includes many new procedures and coding changes that have taken place since the previously published fee schedule.

This fee schedule could not have been produced without the assistance of many individuals. The spirit of cooperation between the provider and payer communities is very much appreciated. The excellence of this schedule is due, in large part, to the commitment of many people in the workers' compensation community. We are grateful for their efforts.

Except where noted, this fee schedule is effective for medical services rendered on or after April 1, 2019, regardless of the date of accident. The fees established herein are payable to health care providers authorized or permitted to render care under the Workers' Compensation Law, Volunteer Firefighters' Benefit Law, and Volunteer Ambulance Workers' Benefit Law.

New York State Workers' Compensation Board

identify four circumstances where the usual follow-up days concept does not apply. These four circumstances are as follows:

MMM Describes services in uncomplicated maternity care. This includes antepartum, delivery, and postpartum care. The usual global surgery concept does not apply.

XXX Indicates that the global surgery concept does not apply.

YYY Indicates that the global period is to be established by report.

ZZZ Indicates that the service is an add-on service and, therefore, is treated in the global period of the primary procedure that is billed in conjunction with the ZZZ service. Do not bill these codes with modifier 51. Reimbursement should not be reduced.

PC/TC Split

The PC/TC Split column shows the percentage of the procedure that is professional or technical. A procedure with a relative value unit of 3.0 and a 40/60 in the PC/TC Split column would be calculated as follows: 40 percent of the value (3.0 x conversion factor x .40 = PC) is for the professional component of the service, and 60 percent of the value (3.0 x conversion factor x .60 = TC) represents the technical component of the service. The total component reimbursed should never be more than the professional and technical components combined.

Specialty Classifications

The "C" rating (Consultant in Specialty, e.g., CS—Consultant-Surgery) may be granted to physicians certified as specialists by a board recognized by the American Board of Medical Specialties and the American Osteopathic Association. Applicants, who are qualified but have not attained board-certified status as defined above, will be granted a specialty rating without the "C" prefix (e.g., IM, OS, and S).

The rating "OP-GP" is given to osteopathic physicians in general practice. The "OP" designation, when combined with one of the specialty ratings, indicates that the specialist is an osteopathic physician (e.g., OPOS, is the proper rating for an osteopathic physician who is a qualified specialist in orthopedic surgery. Upon obtaining Consultant status, as defined above, a physician may apply for an "OP-COS" rating). Please refer to the Board's website for a full listing of rating codes: http://www.wcb.ny.gov/.

Revised printing effective 1/1/2020

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Postal ZIP Codes by Region

Postal ZIP codes included in each region:

Region I

From	*Thru*	*From*	*Thru*
12007	12099	13601	13699
12106	12177	13730	13797
12184	12199	13801	13865
12401	12498	14001	14098
12701	12792	14101	14174
12801	12887	14301	14305
12901	12998	14410	14489
13020	13094	14501	14592
13101	13176	14701	14788
13301	13368	14801	14898
13401	13439	14901	14925
13450	13495		

Region II

From	*Thru*	*From*	*Thru*
12179	12183	13440	13449
12201	12288	13501	13599
12301	12345	13901	13905
12501	12594	14201	14280
12601	12614	14601	14694
13201	13290		

Region III

From	*Thru*	*From*	*Thru*
06390	06390	10801	10805
10501	10598	10901	10998
10601	10650	11901	11980
10701	10710		

Region IV

From	*Thru*	*From*	*Thru*
00501	00501	11101	11120
00544	00544	11201	11256
10001	10099	11301	11390
10100	10199	11401	11499
10200	10299	11501	11599
10301	10314	11601	11697
10401	10499	11701	11798
11001	11096	11801	11854

Numerical List of Postal ZIP Codes

From	*Thru*	*Region*	*From*	*Thru*	*Region*
00501	00501	IV	12401	12498	I
00544	00544	IV	12501	12594	II
06390	06390	III	12601	12614	II
10001	10099	IV	12701	12792	I
10100	10199	IV	12801	12887	I
10200	10299	IV	12901	12998	I
10301	10314	IV	13020	13094	I
10401	10499	IV	13101	13176	I
10501	10598	III	13201	13290	II
10601	10650	III	13301	13368	I
10701	10710	III	13401	13439	I
10801	10805	III	13440	13449	II
10901	10998	III	13450	13495	I
11001	11096	IV	13501	13599	II
11101	11120	IV	13601	13699	I
11201	11256	IV	13730	13797	I
11301	11390	IV	13801	13865	I
11401	11499	IV	13901	13905	II
11501	11599	IV	14001	14098	I
11601	11697	IV	14101	14174	I
11701	11798	IV	14201	14280	II
11801	11854	IV	14301	14305	I
11901	11980	III	14410	14489	I
12007	12099	I	14501	14592	I
12106	12177	I	14601	14694	II
12179	12183	II	14701	14788	I
12184	12199	I	14801	14898	I
12201	12288	II	14901	14925	I
12301	12345	II			

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Conversion Factors

Regional conversion factors for services rendered on or after April 1, 2019.

Section	Region I	Region II	Region III	Region IV
E/M	$12.11	$12.11	$13.85	$15.06
Medicine	$8.91	$8.91	$10.19	$11.07
Physical Medicine	$8.43	$8.43	$9.65	$10.48
Anesthesia	$23.88	$23.88	$27.34	$29.71
Surgery	$202.53	$202.53	$231.78	$251.94
Radiology	$46.77	$46.77	$53.53	$58.19
Pathology and Laboratory	$1.06	$1.06	$1.21	$1.31

Category III codes are subject to the conversion factor applicable to similar services. See the Category III Codes section for more information.

Calculating Fees Using Relative Values and Conversion Factors

Except as otherwise provided in this schedule, the maximum fee amount is calculated by multiplying the relative value by the applicable conversion factor. For example, the total fee for code 99213, performed in Region I or Region II, would be calculated as follows:

5.83 (Relative Value)
x $12.11 (E/M Section Conversion Factor for Region I or Region II)
= $70.60

New CPT Codes

The table below is a complete list of CPT codes that have been added since the June 1, 2012 fee schedule.

These codes are identified in the fee schedule with "■".

0308T 0312T 0313T 0314T 0315T 0316T
0317T 0329T 0330T 0331T 0332T 0333T
0335T 0337T 0338T 0339T 0341T 0342T
0345T 0346T 0347T 0348T 0349T 0350T
0351T 0352T 0353T 0354T 0355T 0356T
0357T 0358T 0359T 0360T 0361T 0362T
0363T 0364T 0365T 0366T 0367T 0368T
0369T 0370T 0371T 0372T 0373T 0374T
0375T 0376T 0377T 0378T 0379T 0380T
0381T 0382T 0383T 0384T 0385T 0386T
0387T 0388T 0389T 0390T 0391T 0394T
0395T 0396T 0397T 0398T 0399T 0400T
0401T 0402T 0403T 0404T 0405T 0406T
0407T 0408T 0409T 0410T 0411T 0412T
0413T 0414T 0415T 0416T 0417T 0418T
0419T 0420T 0421T 0422T 0423T 0424T
0425T 0426T 0427T 0428T 0429T 0430T
0431T 0432T 0433T 0434T 0435T 0436T
0437T 0439T 0440T 0441T 0442T 0443T
0444T 0445T 0446T 0447T 0448T 0449T
0450T 0451T 0452T 0453T 0454T 0455T
0456T 0457T 0458T 0459T 0460T 0461T
0462T 0463T 0464T 0465T 0466T 0467T
0468T 0469T 0470T 0471T 0472T 0473T
0474T 0475T 0476T 0477T 0478T 0479T
0480T 0481T 0482T 0483T 0484T 0485T
0486T 0487T 0488T 0489T 0490T 0491T
0492T 0493T 0494T 0495T 0496T 0497T
0498T 0499T 0500T 0501T 0502T 0503T
0504T 10030 10035 10036 15730 15733
19081 19082 19083 19084 19085 19086
19281 19282 19283 19284 19285 19286
19287 19288 19294 20604 20606 20611
20939 20983 21811 21812 21813 22510
22511 22512 22513 22514 22515 22586
22853 22854 22858 22859 22867 22868
22869 22870 23333 23334 23335 23473
23474 24370 24371 27197 27198 27279
28291 28295 31241 31253 31257 31259
31298 31551 31552 31553 31554 31572
31573 31574 31591 31592 31647 31648
31649 31651 31652 31653 31654 31660
31661 32554 32555 32556 32557 32701
32994 33270 33271 33272 33273 33340
33361 33362 33363 33364 33365 33366
33367 33368 33369 33390 33391 33418
33419 33477 33927 33928 33929 33946
33947 33948 33949 33951 33952 33953
33954 33955 33956 33957 33958 33959
33962 33963 33964 33965 33966 33969
33984 33985 33986 33987 33988 33989
33990 33991 33992 33993 34701 34702
34703 34704 34705 34706 34707 34708
34709 34710 34711 34712 34713 34714
34715 34716 34839 34841 34842 34843
34844 34845 34846 34847 34848 36221
36222 36223 36224 36225 36226 36227
36228 36456 36465 36466 36473 36474
36482 36483 36901 36902 36903 36904
36905 36906 36907 36908 36909 37197
37211 37212 37213 37214 37217 37218
37236 37237 37238 37239 37241 37242
37243 37244 37246 37247 37248 37249
37252 37253 38222 38243 38573 39401
39402 43180 43191 43192 43193 43194
43195 43196 43197 43198 43206 43210
43211 43212 43213 43214 43229 43233
43252 43253 43254 43266 43270 43274
43275 43276 43277 43278 43284 43285
43286 43287 43288 44381 44384 44401
44402 44403 44404 44405 44406 44407
44408 44705 45346 45347 45349 45350
45388 45389 45390 45393 45398 45399
46601 46607 47383 47531 47532 47533

47534 47535 47536 47537 47538 47539
47540 47541 47542 47543 47544 49185
49405 49406 49407 50430 50431 50432
50433 50434 50435 50606 50693 50694
50695 50705 50706 52287 52356 52441
52442 54437 54438 55874 58575 58674
61645 61650 61651 62302 62303 62304
62305 62320 62321 62322 62323 62324
62325 62326 62327 62380 64461 64462
64463 64486 64487 64488 64489 64615
64616 64617 64642 64643 64644 64645
64646 64647 64912 64913 65785 66179
66183 66184 69209 71045 71046 71047
71048 72081 72082 72083 72084 73501
73502 73503 73521 73522 73523 73551
73552 74018 74019 74021 74712 74713
76641 76642 76706 77061 77062 77063
77065 77066 77067 77085 77086 77293
77306 77307 77316 77317 77318 77385
77386 77387 77767 77768 77770 77771
77772 78012 78013 78014 78071 78072
78265 78266 80081 80155 80159 80163
80165 80169 80171 80175 80177 80180
80183 80199 80203 80305 80306 80307
80320 80321 80322 80323 80324 80325
80326 80327 80328 80329 80330 80331
80332 80333 80334 80335 80336 80337
80338 80339 80340 80341 80342 80343
80344 80345 80346 80347 80348 80349
80350 80351 80352 80353 80354 80355
80356 80357 80358 80359 80360 80361
80362 80363 80364 80365 80366 80367
80368 80369 80370 80371 80372 80373
80374 80375 80376 80377 81105 81106
81107 81108 81109 81110 81111 81112
81120 81121 81161 81162 81170 81175
81176 81201 81202 81203 81218 81219
81230 81231 81232 81235 81238 81246
81247 81248 81249 81252 81253 81254
81258 81259 81269 81272 81273 81276
81283 81287 81288 81311 81313 81314
81321 81322 81323 81324 81325 81326
81327 81328 81334 81335 81346 81361
81362 81363 81364 81410 81411 81412
81413 81414 81415 81416 81417 81420
81422 81425 81426 81427 81430 81431
81432 81433 81434 81435 81436 81437
81438 81439 81440 81442 81445 81448
81450 81455 81460 81465 81470 81471
81479 81490 81493 81500 81503 81504
81506 81507 81508 81509 81510 81511
81512 81519 81520 81521 81525 81528
81535 81536 81538 81539 81540 81541
81545 81551 81595 81599 82777 83006
84410 86008 86152 86153 86711 86794
86828 86829 86830 86831 86832 86833
86834 86835 87483 87505 87506 87507
87623 87624 87625 87631 87632 87633
87634 87661 87662 87806 87910 87912
88341 88344 88350 88364 88366 88369
88373 88374 88375 88377 89337 90587
90620 90621 90625 90630 90651 90653
90672 90673 90674 90682 90685 90686
90687 90688 90697 90739 90750 90756
90785 90791 90792 90832 90833 90834
90836 90837 90838 90839 90840 90863
91112 91200 92145 92242 92521 92522
92523 92524 92537 92538 92920 92921
92924 92925 92928 92929 92933 92934
92937 92938 92941 92943 92944 93050
93260 93261 93355 93582 93583 93590
93591 93592 93644 93653 93654 93655
93656 93657 93702 93792 93793 93895
94617 94618 94669 95017 95018 95076
95079 95249 95782 95783 95907 95908
95909 95910 95911 95912 95913 95924
95940 95941 95943 96127 96160 96161
96377 96573 96574 96931 96932 96933
96934 96935 96936 97127 97161 97162
97163 97164 97165 97166 97167 97168
97169 97170 97171 97172 97607 97608
97610 97763 99151 99152 99153 99155
99156 99157 99177 99184 99188 99415
99416 99446 99447 99448 99449 99483
99484 99485 99486 99487 99489 99490
99492 99493 99494 99495 99496 99497
99498

Changed Codes

Changed Values

The following table is a complete list of CPT and state-specific codes that have a relative value change, an FUD change, or a PC/TC split change since the June 1, 2012 fee schedule. Codes that have had a description change, are listed in a separate table below.

Revised printing effective 1/1/2020

Columns that are blank for any code either do not apply to the code or the code was not assigned a value on the current or previous (June 1, 2012) fee schedule.

For each code listed, the following information is included:

NY 2018 RVU. This is the current RVU for services rendered on or after April 1, 2019.

NY 2012 RVU. This is the RVU effective June 1, 2012.

NY 2018 FUD. This is the FUD for services rendered on or after April 1, 2019**.**

NY 2012 FUD. This is the FUD listed in the June 1, 2012 fee schedule.

NY 2018 PC/TC Split. This is the PC/TC split for services rendered on or after April 1, 2019. Only codes with distinct professional and technical components are assigned a PC/TC split; therefore, many codes will not have a value in this column.

NY 2012 PC/TC Split. This is the PC/TC split effective June 1, 2012.

These codes are identified in the fee schedule with "■."

CODE	NY 2018 RVU	NY 2012 RVU	NY 2018 FUD	NY 2012 FUD	NY 2018 PC/TC Split	NY 2012 PC/TC Split
0042T	15.44	BR	XXX	XXX		
0054T	2.47	BR	XXX	XXX		
0055T	3.23	BR	XXX	XXX		
0075T	18.68	BR	XXX	XXX		
0076T	17.50	BR	XXX	XXX		
0100T	16.22	BR	XXX	XXX		
0101T	2.78	BR	XXX	XXX		
0102T	2.78	BR	XXX	XXX		
0159T	0.83	BR	ZZZ	ZZZ		
0163T	17.56	BR	YYY	YYY		
0164T	3.25	BR	YYY	YYY		
0165T	3.61	BR	YYY	YYY		
0174T	0.60	BR	XXX	XXX		
0175T	0.60	BR	XXX	XXX		
0184T	6.22	BR	XXX	XXX		
0190T	1.87	BR	XXX	XXX		
0191T	6.40	BR	XXX	XXX		
0198T	9.99	BR	XXX	XXX		
0200T	8.70	BR	XXX	XXX		
0201T	11.98	BR	XXX	XXX		
0202T	15.40	BR	XXX	XXX		
0205T	0.53	BR	ZZZ	ZZZ		
0206T	37.42	BR	XXX	XXX		
0207T	3.76	BR	XXX	XXX		
0208T	5.20	BR	XXX	XXX		
0209T	9.65	BR	XXX	XXX		
0210T	6.43	BR	XXX	XXX		
0212T	8.14	BR	XXX	XXX		
0213T	1.19	BR	XXX	XXX		
0214T	0.60	BR	ZZZ	ZZZ		
0215T	0.61	BR	ZZZ	ZZZ		
0216T	1.07	BR	XXX	XXX		
0217T	0.54	BR	ZZZ	ZZZ		
0218T	0.55	BR	ZZZ	ZZZ		
0228T	1.75	BR	XXX	XXX		
0229T	0.83	BR	XXX	XXX		
0230T	1.60	BR	XXX	XXX		
0231T	0.70	BR	XXX	XXX		
0232T	0.37	BR	XXX	XXX		
0234T	11.12	BR	YYY	YYY		
0235T	10.84	BR	YYY	YYY		
0236T	9.27	BR	YYY	YYY		
0237T	4.62	BR	YYY	YYY		
0238T	6.28	BR	YYY	YYY		
0249T	3.08	BR	YYY	YYY		
0253T	7.12	BR	YYY	YYY		
0254T	7.74	BR	YYY	YYY		
0263T	2.67	BR	XXX	XXX		
0264T	1.19	BR	XXX	XXX		
0265T	0.19	BR	XXX	XXX		
0275T	BR	BR	XXX	YYY		
0295T	36.19	BR	XXX	XXX		
0296T	4.51	BR	XXX	XXX		
0297T	28.39	BR	XXX	XXX		
0298T	5.13	BR	XXX	XXX		
20240	1.71	1.71	000	010		
20245	2.90	2.90	000	010		
22505	0.00	0.94	010	010		
30140	3.47	3.47	000	090		
34812	2.02	2.46	ZZZ	000		
34820	3.45	4.16	ZZZ	000		
34833	3.95	3.84	ZZZ	000		

90827	90828	90829	90857	90862	92140
92506	92543	92980	92981	92982	92984
92995	92996	93651	93652	93965	93982
94620	95010	95015	95075	95900	95903
95904	95920	95934	95936	95973	97001
97002	97003	97004	97005	97006	97532
97762	99143	99144	99145	99148	99149
99150	99363	99364	99420		

General Ground Rules

1A. NYS Medical Treatment Guidelines

Treatment of work-related injuries should be in accordance with any applicable medical treatment guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the fee schedule ground rules and the medical treatment guidelines, the guidelines will prevail. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

1B. Multiple Procedures

It is appropriate to designate multiple procedures that are rendered on the same date by separate entries. For example, if a level three established patient office visit (99213) and an ECG (93000) are performed during the visit, it is appropriate to designate both the established patient office visit and the ECG. In this instance, both 99213 and 93000 would be reported.

2. Unlisted Service or Procedure

When an unlisted service or procedure is provided, the procedure should be identified and the value substantiated "by report" (see Rule 3 below). All sections will have an unlisted service or procedure code number, usually ending in "99."

3. Procedures Listed Without Specified Relative Value Units

By report (BR) items: "BR" in the Relative Value column represents services that are too variable in the nature of their performance to permit assignment of relative value units. Fees for such procedures need to be justified "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary, but sufficient information shall be submitted to permit a sound evaluation. It must be emphasized that reviews are based on records, hence the importance of documentation. The original official record, such as operative report and hospital chart, will be given far greater weight than supplementary reports formulated and submitted at later dates. For any procedure where the relative value unit is listed in the schedule as "BR," the physician shall establish a relative value unit consistent in relativity with other relative value units shown in the schedule. The insurer shall review all submitted "BR" relative value units to ensure that the relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items.

4. Materials Supplied by Provider: Pharmaceuticals and Durable Medical Equipment

A) **Pharmacy**

A prescriber cannot dispense more than a seventy-two hour supply of drugs with the exceptions of:

1. Persons practicing in hospitals as defined in section 2801 of the public health law;
2. The dispensing of drugs at no charge to their patients;
3. Persons whose practices are situated ten miles or more from a registered pharmacy;
4. The dispensing of drugs in a clinic, infirmary, or health service that is operated by or affiliated with a post-secondary institution;
5. The dispensing of drugs in a medical emergency as defined in subdivision 6 of section 6810 of the State Education Law.

For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070.

B) **Durable Medical Equipment**

Prior to the effective date of the 2020 Durable Medical Equipment Fee Schedule, for durable medical equipment administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional

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"handling" costs added to the total cost of the item. Bill using procedure code 99070.

Following the effective date of the 2020 Durable Medical Equipment Fee Schedule, all durable medical equipment supplied shall be billed and paid using the 2020 Durable Medical Equipment Fee Schedule. The 2020 Durable Medical Equipment Fee Schedule is/will be available on the Board's website. Any item identified as requiring prior authorization in the 2020 Durable Medical Equipment Fee Schedule or not listed in the 2020 Durable Medical Equipment Fee Schedule may not be billed without such prior authorization.

Do not bill for or report supplies that are customarily included in surgical packages, such as gauze, sponges, Steri-strips, and dressings; drug screening supplies; and hot and cold packs. These items are included in the fee for the medical services in which such supplies are used.

5. Separate Procedures

Certain procedures are an inherent portion of a procedure or service and, as such, do not warrant a separate charge. For example: multiple muscle strains, such as cervical and lumbar areas, extremity, etc., when treated by other than a specific descriptor listed in the Surgery section will be considered as an entity and not carry cumulative and/or additional charges; that is, the appropriate level of service for office, hospital, or home visits will apply. When such a procedure is carried out as a separate entity not immediately related to other services, the indicated value for "separate procedure" is applicable. See also Surgery Ground Rule 7.

6. Concurrent Care

When more than one physician treats a patient for the same condition during the same period of time, payment is made only to one physician, the one whose specialty is most relevant to the diagnosis. For example, if claims are received from both a cardiologist and a general practitioner for the treatment of a heart condition, or from both an orthopedist and a surgeon for the treatment of a back disorder, payment is due only to the cardiologist and orthopedist, respectively. Where the concurrent care involves overlapping or common services, the fees payable shall not be increased but prorated. Each physician shall submit separate bills but indicate if agreement has been reached on the proration. If no agreement between or among the physicians has been reached, the matter shall be referred to the Medical Arbitration Committee per Section 13-g of the Workers' Compensation Law.

When the condition of the patient requires the disparate skills of two or more physicians to treat different conditions which do not fall within the scope of other physicians treating the patient at the same time (e.g., management of diabetes mellitus in a surgical case), payment is due each physician who plays an active role in the treatment program. The services rendered by each physician shall be distinct, in different disciplines, identifiable, and adequately documented in the records and reports. (For consultations, see 99241–99255.)

7. Alternating Physicians

When physicians of similar skills alternate in the care of a patient (e.g., partners, groups, or same facility covering for another physician on weekends or vacation periods), each physician shall bill individually for the services each personally rendered and in accordance with the Medical Fee Schedule.

8. Proration of Scheduled Relative Value Unit Fee

When the schedule specifies a relative value unit fee for a definite treatment with an inclusive period of aftercare (follow-up days), and the patient is transferred from one physician to another physician, the employer (or carrier) is only responsible for the total amount listed in the schedule. Such amount is to be apportioned between the physicians. If the concerned physicians agree to the amounts to be prorated to each, they shall render separate bills accordingly. If no proration agreement is reached by them, the amounts payable to each party shall be settled by an arbitration committee appointed pursuant to Section 13-g of the Workers' Compensation Law, without cost to the contestants. When treatment is terminated by the departure of the patient from New York State before the expiration of the stated period of follow-up days, the fee shall be the portion of the appropriate fee having regard for the fact that usually the greater portion is earned at the time of the original operation or service. When treatment is terminated by the death of the patient before the expiration of follow-up days, the full fee is payable, subject to proration where applicable.

9. Home Visits

The necessity for such visits is infrequent in cases covered by the Workers' Compensation Law. When necessary, a statement setting forth the medical indications justifying such visits shall be submitted. Please refer to the Evaluation and Management section for coding of these services.

10. Medical Testimony

As provided in Part 301 of the Workers' Compensation regulations and following direction by the Board, whenever the attendance of the injured employee's treating or consultant physician or

podiatrist is required at a hearing or deposition, such physician or podiatrist shall be entitled to an attendance fee of $450. Fees for testimony shall be billed following a direction by the Board as to the fee amount using code 99075.

As provided in Part 301 of the Workers' Compensation regulations and following direction by the Board, whenever the attendance of the injured employee's treating or consultant chiropractor, psychologist, nurse practitioner, or licensed clinical social worker is required at a hearing or deposition, such provider shall be entitled to an attendance fee of $350. Fees for testimony shall be billed following a direction by the Board as to the fee amount using code 99075.

11. Ground Rules for Physician Assistants (PA) and Nurse Practitioners (NP)

Authorized Nurse Practitioners who render care and treatment in accordance with their scope of practice under State Education Law, and Physician Assistants who render treatment and care for ongoing temporary disability in accordance with the Workers' Compensation Law, shall report and bill using their individual authorization numbers and bills shall be payable at 80 percent of the fee available to physicians for such treatment code.

Note: This Ground Rule is not applicable to Surgery Ground Rule 12 (F), whereby the surgeon must be directly and personally supervising the surgical assistants and such surgeon (or when the NP or PA is employed by the facility where the service is performed, the facility representative) must submit the bill for the surgical assistant's services in accordance with that Ground Rule.

State-specific modifier 83 is used to identify assistant at surgery services provided by a physician assistant or nurse practitioner.

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12. Moderate (Conscious) Sedation

Sedation with or without analgesia is used to achieve a state of depressed consciousness while maintaining the patient's ability to control their own breathing as well as respond to stimulation. The use of these codes requires the presence of an independent trained observer to assist the physician in monitoring the patient's level of consciousness and physiological status.

Conscious sedation includes pre- and post-sedation evaluations, administration of the sedation, and monitoring of cardiorespiratory function.

Procedures that are integral to the moderate (conscious) sedation service and that should not be reported separately include:

- Assessment of the patient
- Establishment of IV access and provision of fluids to maintain patency
- Administration of sedation agents
- Maintenance of sedation
- Monitoring of oxygen saturation, heart rate, and blood pressure
- Recovery

Do not report minimal sedation (anxiolysis), deep sedation, or monitored anesthesia care with moderate (conscious) sedation codes.

Codes 99151–99153 identify moderate (conscious) sedation services provided by the same physician performing the diagnostic or therapeutic service that the sedation supports. CPT codes 99155–99157 identify moderate (conscious) sedation services provided by a second physician other than the health care professional performing the diagnostic or therapeutic service. When moderate (conscious) sedation services are provided by a second physician in a facility or nonfacility setting, the conscious sedation service may be billed separately.

13. Add-on Procedures

CPT identifies procedures that are always performed in addition to the primary procedure and designates them with a + in the CPT book. Add-on codes are never reported for stand-alone services but are reported secondarily in addition to the primary procedure. CPT uses specific language to identify add-on procedures such as "each additional" or "(List separately in addition to primary procedure)."

The same physician that performed the primary procedures/services must perform the add-on procedures. Add-on codes describe additional intra-service work associated with the primary procedure/service (e.g., additional digits, lesion, neurorrhaphy, vertebral segment, tendon, joint).

Add-on procedures are not subject to multiple procedure rules and, as such, modifier 51 does not apply. Fee schedule amounts for add-on codes are not subject to reduction and should be reimbursed at the lesser of 100 percent of the listed value or the billed amount. Do not append modifier 51 to a code identified as an add-on procedure.

The CPT codes currently designated as add-on codes are listed in Appendix D of *CPT 2018*.

14. Exempt From Modifier 51 Codes

As the description implies, modifier 51 exempt procedures are not subject to multiple procedure rules and, as such, modifier 51 does not apply. Fee schedule amounts for modifier 51 exempt codes are not subject to reduction and should be reimbursed at the lesser of 100 percent of the listed value or the billed amount.

The CPT book identifies these services with the (⊘) symbol.

Modifier 51 exempt services and procedures can be found in Appendix E of *CPT 2018*.

In addition to the codes noted in Appendix E, Optum360 has identified codes that are modifier 51 exempt according to CPT guidelines. The following additional modifier 51 exempt codes are identified in the data with the icon ⓫:

90281	90283	90284	90287	90288	90291
90296	90371	90375	90376	90378	90384
90385	90386	90389	90393	90396	90399
90476	90477	90581	90585	90586	90587
90620	90621	90625	90630	90632	90633
90634	90636	90644	90647	90648	90649
90650	90651	90653	90654	90655	90656
90657	90658	90660	90661	90662	90664
90666	90667	90668	90670	90672	90673
90674	90675	90676	90680	90681	90682
90685	90686	90687	90688	90690	90691
90696	90697	90698	90700	90702	90707
90710	90713	90714	90715	90716	90717
90723	90732	90733	90734	90736	90738
90739	90740	90743	90744	90746	90747
90748	90749	90750	90756	97010	97012
97014	97016	97018	97022	97024	97026
97028	97032	97033	97034	97035	97036
97110	97112	97113	97116	97124	97140
97150	97530	97533	97535	97537	97542

97545	97546	97597	97598	97602	97605
97606	97607	97608	97610	97750	97755
97760	97761	97763	99050	99051	99053
99056	99058	99060			

15. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code.

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

23 Unusual Anesthesia

Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.

24 Unrelated Evaluation and Management Services by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period

The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

26 Professional Component

Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component

Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

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27 ***Multiple Outpatient Hospital E/M Encounters on the Same Date***
(This CPT modifier is for use by Ambulatory Surgery Center (ASC) and Hospital Outpatient Settings Only.) For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (eg, hospital emergency department, clinic). **Note:** This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient evaluation and management services provided by the same physician on the same date and performed in multiple outpatient setting(s) (eg, hospital emergency department, clinic), see **Evaluation and Management, Emergency Department**, or **Preventive Medicine Services** codes.

32 ***Mandated Services***
Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

47 ***Anesthesia by Surgeon***
Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) **Note:** Modifier 47 would not be used as a modifier for the anesthesia procedures.

50 ***Bilateral Procedure***
Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5 digit code.

51 ***Multiple Procedures***
When multiple procedures, other than E/M services, physical medicine and rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D).

52 ***Reduced Services***
Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 ***Discontinued Procedure***
Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

54 ***Surgical Care Only***
When 1 physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701–86703 and 87389). The test does not require permanent dedicated space, hence by its design it may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of this modifier.

96 Habilitative Services

When a service or procedure that may be either habilitative or rehabilitative in nature is provided for habilitative purposes, the physician or other qualified health care professional may add modifier 96 to the service or procedure code to indicate that the service or procedure provided was a habilitative service. Habilitative services help an individual learn skills and functioning for daily living that the individual has not yet developed, and then keep and/or improve those learned skills. Habilitative services also help an individual keep, learn, or improve skills and functioning for daily living.

97 Rehabilitative Services

When a service or procedure that may be either habilitative or rehabilitative in nature is provided for rehabilitative purposes, the physician or other qualified health care professional may add modifier 97 to the service or procedure code to indicate that the service or procedure provided was a rehabilitative service. Rehabilitative services help an individual keep, get back, or improve skills and functioning for daily living that have been lost or impaired because the individual was sick, hurt, or disabled.

99 Multiple Modifiers

Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

1B∞ Behavioral Health Provider Enhanced Reimbursement

Provides a 20 percent reimbursement increase for E/M and Medicine services when rendered by providers with the following WCB assigned provider rating codes:

Rating Code	Description
PN-P	PSYCHIATRY
OPPN-P	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – PSYCHIATRY
CPN-P	PSYCHIATRY CONSULTANT
OPCPN-P	OSTEOPATHIC PSYCHIATRY
PN-ADP	ADDICTION PSYCHIATRY
OPPN-ADP	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – ADDICTION PSYCHIATRY
CPN-ADP	ADDICTION PSYCHIATRY CONSULTANT
OPCPN-ADP	OSTEOPATHIC ADDICTION PSYCHIATRY
PN-PM	PAIN MANAGEMENT
OPPN-PM	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – PAIN MANAGEMENT
CPN-PM	PAIN MANAGEMENT CONSULTANT
OPCPN-PM	OSTEOPATHIC PAIN MANAGEMENT
PSY	PSYCHOLOGY
LCSW	LICENSED CLINICAL SOCIAL WORKER
LCSW-R	LICENSED CLINICAL SOCIAL WORKER – PSYCHOTHERAPY
NP-P	NURSE PRACTITIONER IN PSYCHIATRY
PHYAS	PHYSICIAN ASSISTANT*

* A supervising physician needs to have a rating code eligible for the modifier 1B enhancement.

1D∞ Designated Provider Enhanced Reimbursement

Provides an additional 20 percent reimbursement increase for E/M services performed by providers with the following WCB assigned provider rating codes:

Rating Code	Description
FP	FAMILY PRACTICE
CFP	FAMILY PRACTICE CONSULTANT
OPFP	OSTEOPATHIC FAMILY PRACTICE
OPCFP	OSTEOPATHIC FAMILY PRACTICE CONSULTANT
GP	GENERAL PRACTICE
OPGP	OSTEOPATHIC GENERAL PRACTICE
IM	INTERNAL MEDICINE
CIM	INTERNAL MEDICINE CONSULTANT
OPIM	OSTEOPATHIC INTERNAL MEDICINE
OPCIM	OSTEOPATHIC INTERNAL MEDICINE CONSULTANT
FM	FAMILY MEDICINE
CFM	FAMILY MEDICINE CONSULTANT
OPFM	OSTEOPATHIC FAMILY MEDICINE

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Rating Code	Description
OPCFM	OSTEOPATHIC FAMILY MEDICINE CONSULTANT
NP-AC	NURSE PRACTITIONER IN ACUTE CARE
NP-AH	NURSE PRACTITIONER IN ADULT HEALTH
NP-COMH	NURSE PRACTITIONER IN COMMUNITY HEALTH
NP-FH	NURSE PRACTITIONER IN FAMILY HEALTH
NP-P	NURSE PRACTITIONER IN PSYCHIATRY
NP-WH	NURSE PRACTITIONER IN WOMEN'S HEALTH
PHYAS	PHYSICIAN ASSISTANT*

* A supervising physician needs to have a rating code eligible for the modifier 1D enhancement.

16. Treatment by Out-of-State Providers

Claimant lives outside of New York State—A claimant who lives outside of New York State may treat with a qualified out-of-state medical provider. The medical treatment shall conform to the Medical Treatment Guidelines and the Ground Rules included herein. Payment for medical treatment shall be at the Fee Schedule amount for work related injuries and illnesses as available in the state where treatment is rendered, or if there is no such fee schedule, then such charges shall be as prevail in the community for similar treatment. All fees shall be subject to the jurisdiction of the Board.

Claimant lives in New York State but treats outside of New York State—A claimant who lives in New York State may treat with a qualified or Board authorized out-of-state medical provider when such treatment conforms to the Workers' Compensation Law and regulations, the Medical Treatment Guidelines and the Medical Fee Schedule. Payment shall be made to the medical provider as set forth herein and using the regional conversion factor for the ZIP code where the claimant resides.

Out-of-state medical treatment that does not "further the economic and humanitarian objective" of Workers' Compensation Law may be denied by the Board.

A medical provider who has had a NYS WCB authorization suspended, revoked or surrendered shall not be qualified to treat out-of-state.

Permanency—The New York State guidelines on permanent impairment, pertaining to both the schedule loss of use and classification, apply regardless of whether claimant lives in or out of New York State.

17. Designated Provider Enhanced Reimbursement

In an effort to increase the number of Board authorized providers in the general medicine (Family Practice, General Practice and Internal Medicine) specialties available to render care and treatment to injured workers, the WCB has established WCB specific modifier 1D which will provide a 20 percent reimbursement increase to providers with WCB assigned rating codes for designated services. Modifier 1D provides an additional 20 percent reimbursement increase for E/M services performed by providers with the following WCB assigned provider rating codes:

Rating Code	Description
FP	FAMILY PRACTICE
CFP	FAMILY PRACTICE CONSULTANT
OPFP	OSTEOPATHIC FAMILY PRACTICE
OPCFP	OSTEOPATHIC FAMILY PRACTICE CONSULTANT
GP	GENERAL PRACTICE
OPGP	OSTEOPATHIC GENERAL PRACTICE
IM	INTERNAL MEDICINE
CIM	INTERNAL MEDICINE CONSULTANT
OPIM	OSTEOPATHIC INTERNAL MEDICINE
OPCIM	OSTEOPATHIC INTERNAL MEDICINE CONSULTANT
FM	FAMILY MEDICINE
CFM	FAMILY MEDICINE CONSULTANT
OPFM	OSTEOPATHIC FAMILY MEDICINE
OPCFM	OSTEOPATHIC FAMILY MEDICINE CONSULTANT
NP-AC	NURSE PRACTITIONER IN ACUTE CARE
NP-AH	NURSE PRACTITIONER IN ADULT HEALTH
NP-COMH	NURSE PRACTITIONER IN COMMUNITY HEALTH
NP-FH	NURSE PRACTITIONER IN FAMILY HEALTH
NP-P	NURSE PRACTITIONER IN PSYCHIATRY
NP-WH	NURSE PRACTITIONER IN WOMEN'S HEALTH
PHYAS	PHYSICIAN ASSISTANT*

* A supervising physician needs to have a rating code eligible for the modifier 1D enhancement.

18. Behavioral Health Provider Enhanced Reimbursement

In an effort to increase the number of Board authorized providers in behavioral health available to render care and treatment to injured workers, the WCB has established WCB specific modifier 1B which will provide a 20 percent reimbursement increase to providers with WCB assigned rating codes for designated services. Modifier 1B provides a 20 percent reimbursement increase for E/M and

Medicine services when rendered by providers with the following WCB assigned provider rating codes:

Rating Code	Description
PN-P	PSYCHIATRY
OPPN-P	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – PSYCHIATRY
CPN-P	PSYCHIATRY CONSULTANT
OPCPN-P	OSTEOPATHIC PSYCHIATRY
PN-ADP	ADDICTION PSYCHIATRY
OPPN-ADP	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – ADDICTION PSYCHIATRY
CPN-ADP	ADDICTION PSYCHIATRY CONSULTANT
OPCPN-ADP	OSTEOPATHIC ADDICTION PSYCHIATRY
PN-PM	PAIN MANAGEMENT
OPPN-PM	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – PAIN MANAGEMENT
CPN-PM	PAIN MANAGEMENT CONSULTANT
OPCPN-PM	OSTEOPATHIC PAIN MANAGEMENT
PSY	PSYCHOLOGY
LCSW	LICENSED CLINICAL SOCIAL WORKER
LCSW-R	LICENSED CLINICAL SOCIAL WORKER – PSYCHOTHERAPY
NP-P	NURSE PRACTITIONER IN PSYCHIATRY
PHYAS	PHYSICIAN ASSISTANT*

* A supervising physician needs to have a rating code eligible for the modifier 1B enhancement.

19. Use of Medical Fee Schedule Codes

There are separate and distinct fee schedules for use by Podiatrists (Podiatry Fee Schedule), Chiropractors (Chiropractic Fee Schedule), and Psychologists and licensed Clinical Social Workers (Behavioral Medicine Fee Schedule). A Podiatrist, Chiropractor, Psychologist, or licensed Clinical Social Worker may not use the CPT coding guidelines contained in this Medical Fee Schedule. Podiatrists, Chiropractors, Psychologists, and licensed Clinical Social Workers should consult the applicable fee schedule relevant for his or her scope of practice when submitting bills for treatment.

20. Non-Schedule and Schedule Permanency Evaluations

Non-schedule: Code 99245 is used for examinations and reports of non-schedule permanency evaluations performed by an authorized physician.

Schedule: Code 99243 is used for examinations and reports of schedule permanency evaluations performed by an authorized physician.

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setting are reported with 99339–99340. Care plan oversight services for patients under the care of a home health agency, hospice, or nursing facility are reported with 99374–99380. "The complexity and the approximate time of the care plan oversight services provided within a 30-day period determine the code selection."

"Only one individual may report services for a given period of time, to reflect the sole or predominant supervisory role with a particular patient. These codes should not be reported for supervision of patients in a nursing facility or under the care of home health agencies unless they require recurrent supervision of therapy."

Special Evaluation and Management Services (99450–99456)

This series of codes reports provider evaluations performed to establish baseline information for insurance certification and/or work-related or medical disability.

Special Instructions for Use of Codes 99455 and 99456

Please refer to the General Ground Rules for information regarding reimbursement for By Report (BR) designated CPT codes.

Other Evaluation and Management Services (99499)

This is an unlisted code to report services not specifically defined in the CPT book.

9. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Modifiers commonly used with E/M procedures are as follows:

24 Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period

The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for reasons unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the E/M service.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

27 Multiple Outpatient Hospital E/M Encounters on the Same Date

(This CPT modifier is for use by Ambulatory Surgery Center (ASC) and Hospital Outpatient Settings Only.) For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (eg, hospital emergency department, clinic). **Note:** This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient evaluation and management services provided by the same physician on the same date and performed in multiple outpatient setting(s) (eg, hospital emergency department, clinic), see **Evaluation and Management, Emergency Department,** or **Preventive Medicine Services** codes.

32 Mandated Services

Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

52 Reduced Services

Under certain circumstances, a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of modifier 52 signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

57 Decision for Surgery

An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

99 Multiple Modifiers

Under certain circumstances, 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

1B∞ Behavioral Health Provider Enhanced Reimbursement

Provides a 20 percent reimbursement increase for E/M and Medicine services when rendered by providers with the following WCB assigned provider rating codes:

Rating Code	Description
PN-P	PSYCHIATRY
OPPN-P	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – PSYCHIATRY
CPN-P	PSYCHIATRY CONSULTANT
OPCPN-P	OSTEOPATHIC PSYCHIATRY
PN-ADP	ADDICTION PSYCHIATRY
OPPN-ADP	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – ADDICTION PSYCHIATRY
CPN-ADP	ADDICTION PSYCHIATRY CONSULTANT
OPCPN-ADP	OSTEOPATHIC ADDICTION PSYCHIATRY
PN-PM	PAIN MANAGEMENT
OPPN-PM	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – PAIN MANAGEMENT
CPN-PM	PAIN MANAGEMENT CONSULTANT
OPCPN-PM	OSTEOPATHIC PAIN MANAGEMENT
PSY	PSYCHOLOGY
LCSW	LICENSED CLINICAL SOCIAL WORKER
LCSW-R	LICENSED CLINICAL SOCIAL WORKER – PSYCHOTHERAPY
NP-P	NURSE PRACTITIONER IN PSYCHIATRY
PHYAS	PHYSICIAN ASSISTANT*

* A supervising physician needs to have a rating code eligible for the modifier 1B enhancement.

1D∞ Designated Provider Enhanced Reimbursement

Provides an additional 20 percent reimbursement increase for E/M services performed by providers with the following WCB assigned provider rating codes:

Rating Code	Description
FP	FAMILY PRACTICE
CFP	FAMILY PRACTICE CONSULTANT
OPFP	OSTEOPATHIC FAMILY PRACTICE
OPCFP	OSTEOPATHIC FAMILY PRACTICE CONSULTANT
GP	GENERAL PRACTICE
OPGP	OSTEOPATHIC GENERAL PRACTICE
IM	INTERNAL MEDICINE
CIM	INTERNAL MEDICINE CONSULTANT
OPIM	OSTEOPATHIC INTERNAL MEDICINE
OPCIM	OSTEOPATHIC INTERNAL MEDICINE CONSULTANT
FM	FAMILY MEDICINE
CFM	FAMILY MEDICINE CONSULTANT
OPFM	OSTEOPATHIC FAMILY MEDICINE
OPCFM	OSTEOPATHIC FAMILY MEDICINE CONSULTANT
NP-AC	NURSE PRACTITIONER IN ACUTE CARE
NP-AH	NURSE PRACTITIONER IN ADULT HEALTH
NP-COMH	NURSE PRACTITIONER IN COMMUNITY HEALTH
NP-FH	NURSE PRACTITIONER IN FAMILY HEALTH
NP-P	NURSE PRACTITIONER IN PSYCHIATRY
NP-WH	NURSE PRACTITIONER IN WOMEN'S HEALTH
PHYAS	PHYSICIAN ASSISTANT*

* A supervising physician needs to have a rating code eligible for the modifier 1D enhancement.

10. Designated Provider Enhanced Reimbursement

In an effort to increase the number of Board authorized providers in the general medicine (Family

Practice, General Practice, and Internal Medicine) specialties available to render care and treatment to injured workers, the WCB has established WCB specific modifiers 1D which will provide a 20 percent reimbursement increase to providers with WCB assigned rating codes for designated services. Modifier 1D provides an additional 20 percent reimbursement increase for E/M services performed by providers with the following WCB assigned provider rating codes:

Rating Code	Description
FP	FAMILY PRACTICE
CFP	FAMILY PRACTICE CONSULTANT
OPFP	OSTEOPATHIC FAMILY PRACTICE
OPCFP	OSTEOPATHIC FAMILY PRACTICE CONSULTANT
GP	GENERAL PRACTICE
OPGP	OSTEOPATHIC GENERAL PRACTICE
IM	INTERNAL MEDICINE
CIM	INTERNAL MEDICINE CONSULTANT
OPIM	OSTEOPATHIC INTERNAL MEDICINE
OPCIM	OSTEOPATHIC INTERNAL MEDICINE CONSULTANT
FM	FAMILY MEDICINE
CFM	FAMILY MEDICINE CONSULTANT
OPFM	OSTEOPATHIC FAMILY MEDICINE
OPCFM	OSTEOPATHIC FAMILY MEDICINE CONSULTANT
NP-AC	NURSE PRACTITIONER IN ACUTE CARE
NP-AH	NURSE PRACTITIONER IN ADULT HEALTH
NP-COMH	NURSE PRACTITIONER IN COMMUNITY HEALTH
NP-FH	NURSE PRACTITIONER IN FAMILY HEALTH
NP-P	NURSE PRACTITIONER IN PSYCHIATRY
NP-WH	NURSE PRACTITIONER IN WOMEN'S HEALTH
PHYAS	PHYSICIAN ASSISTANT*

* A supervising physician needs to have a rating code eligible for the modifier 1D enhancement.

11. Behavioral Health Provider Enhanced Reimbursement

In an effort to increase the number of Board authorized providers in the behavioral health to render care and treatment to injured workers, the WCB has established WCB specific modifier 1B which will provide a 20 percent reimbursement increase to providers with WCB assigned rating codes for designated services. Modifier 1B provides a 20 percent reimbursement increase for E/M and Medicine services when rendered by providers with the following WCB assigned provider rating codes:

Rating Code	Description
PN-P	PSYCHIATRY
OPPN-P	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – PSYCHIATRY
CPN-P	PSYCHIATRY CONSULTANT
OPCPN-P	OSTEOPATHIC PSYCHIATRY
PN-ADP	ADDICTION PSYCHIATRY
OPPN-ADP	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – ADDICTION PSYCHIATRY
CPN-ADP	ADDICTION PSYCHIATRY CONSULTANT
OPCPN-ADP	OSTEOPATHIC ADDICTION PSYCHIATRY
PN-PM	PAIN MANAGEMENT
OPPN-PM	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – PAIN MANAGEMENT
CPN-PM	PAIN MANAGEMENT CONSULTANT
OPCPN-PM	OSTEOPATHIC PAIN MANAGEMENT
PSY	PSYCHOLOGY
LCSW	LICENSED CLINICAL SOCIAL WORKER
LCSW-R	LICENSED CLINICAL SOCIAL WORKER – PSYCHOTHERAPY
NP-P	NURSE PRACTITIONER IN PSYCHIATRY
PHYAS	PHYSICIAN ASSISTANT*

* A supervising physician needs to have a rating code eligible for the modifier 1B enhancement.

12. Non-Schedule and Schedule Permanency Evaluations

Non-schedule: Code 99245 is used for examinations and reports of non-schedule permanency evaluations performed by an authorized physician.

Schedule: Code 99243 is used for examinations and reports of schedule permanency evaluations performed by an authorized physician.

adequate summary of the history, physical findings, operative findings, and an accurate and complete description of the surgical procedures performed.

10. By Report (BR) Items

"BR" in the relative value column indicates that the value of this service is to be determined "by report" because the service is too unusual or variable to be assigned a relative value. Information concerning the nature, extent and need for the procedure or service, time, skill and equipment necessary, etc., is to be furnished using all of the following:

A) Diagnosis (postoperative), pertinent history, and physical findings.

B) Size, location, and number of lesions or procedures where appropriate.

C) A complete description of the major surgical procedure and the supplementary procedures.

D) When possible, list the closest similar procedure by code and relative value unit. The "BR" relative value unit shall be consistent in relativity with other relative value units in the schedule.

E) Estimated follow-up period, if not listed.

F) Operative time.

11. Unlisted Services or Procedures

Some services performed are not described by any CPT code. These services should be reported using an unlisted code and substantiating it by report as discussed in Surgery Ground Rule 10. The unlisted procedures and accompanying codes for surgery will be found at the end of the relevant section or subsection.

12. Concurrent Services by More Than One Provider

Charges for concurrent services of two or more providers may be warranted under the following circumstances:

A) **Identifiable medical services** provided prior to or during the surgical procedure or in the postoperative period (e.g., diabetic management, operative monitoring of cardiac or brain conditions, management of conditions not within the accepted scope of the primary surgeon) are to be billed for by the provider rendering the service. The services should be identified by the appropriate code and relative value unit. Such payable fees are unrelated to the surgeon's fees.

B) **Surgical Assistants:** Identify surgery performed by code number, appropriate modifier, and description of procedures. Assistants should bill at 16 percent of the code fee. The codes must coincide with those of the primary surgeon. Assistants' fees are not payable when the hospital provides intern or resident staff to assist at surgery.

C) **Two surgeons:** Under certain circumstances the skills of two surgeons (usually with different skills) may be required in the management of a specific surgical problem (e.g., urologist and a general surgeon in the creation of an ileal conduit). By prior agreement, the total value for the procedures may be apportioned by the providers in relation to the responsibility and work done. The total value may be increased by 25 percent in lieu of the assistant's charge. Under these circumstances, the services of each surgeon should be identified using the code number and appropriate modifier.

D) **Co-surgeons:** Under certain circumstances, two surgeons (usually with similar skills) may function simultaneously as primary surgeons performing distinct parts of a total surgical service (e.g., two surgeons simultaneously applying skin grafts to different parts of the body or two surgeons repairing different fractures in the same patient). By prior agreement, the total value may be apportioned by the providers in relation to the responsibility and work done. The total value for the procedures shall not, however, be increased but shall be prorated between the co-surgeons. Under these circumstances, the services of each surgeon should be identified using the code number and appropriate modifier.

In the event of no agreement between co-surgeons, the proration shall be determined by a WCB Medical Arbitration Committee.

E) **Surgical Team:** Under some circumstances highly complex procedures (e.g., open heart or organ transplant surgery) requiring the concomitant services of several providers, often of different specialties, plus other highly skilled, specially trained personnel, and various types of complex equipment are carried out under the "surgical team" concept with a single fee charged for the total service. The services covered vary widely and a single value cannot be assigned. These situations should be identified by the code and appropriate modifier. The value should be supported by a report to include itemization of the provider services, paramedical personnel, and equipment involved.

F) **Physician Assistants and Nurse Practitioners:** Services of physician assistants and nurse practitioners assisting during surgical procedures will be paid at two-thirds of the surgical assistant percentage (16.0 percent). Physician assistants will receive 10.7 percent of the total allowance for the surgical procedures. Payment will be made to the supervising physician performing the surgery. General Ground Rule 11 is not

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applicable to surgical assistants. The bill must be submitted by the supervising physician who performed the surgery where such assistance was rendered.

13. Surgery and Follow-up Care Provided by Different Providers

When one provider performs the surgical procedure itself and another provides the follow-up care, the value may be apportioned between them by agreement and in accordance with medical ethics. Use the appropriate modifier to identify and indicate whether the value is for the procedure or the follow-up care, rather than the whole. The "global fee" is not increased, but is prorated between the providers. If no agreement is reached by the providers involved, the apportionment shall be determined by the WCB Medical Arbitration Committee.

14. Repeat Procedure by Another Provider

A basic procedure performed by another provider may have to be repeated. Identify the repeated procedure using the appropriate modifier and submit an explanatory note.

15. Proration of Scheduled Relative Value Unit Fee

When the schedule specifies a relative value unit fee for a definite treatment with an inclusive period of aftercare (follow-up days), and the patient transferred from one provider to another provider, the employer (or carrier) is only responsible for the total amount listed in the schedule. Such amount is to be apportioned between the providers. If the concerned providers agree on the amounts to be prorated to each, they shall render separate bills accordingly. If no proration agreement is reached by them, the amounts payable to each party shall be settled by an arbitration committee appointed pursuant to Section 13-g of the Workers' Compensation Law, without cost to the contestants. When treatment is terminated by the departure of the patient from New York State before the expiration of the stated period of follow-up days, the fee shall be the portion of the appropriate fee having regard for the fact that usually the greater portion is earned at the time of the original operation or service. When treatment is terminated by the death of the patient before the expiration of follow-up days, the full fee is payable, subject to proration where applicable.

16. Materials Supplied by Provider: Pharmaceuticals and Durable Medical Equipment

A) **Pharmacy**

A prescriber cannot dispense more than a seventy-two hour supply of drugs with the exceptions of:

1. Persons practicing in hospitals as defined in section 2801 of the public health law;
2. The dispensing of drugs at no charge to their patients;
3. Persons whose practices are situated ten miles or more from a registered pharmacy;
4. The dispensing of drugs in a clinic, infirmary, or health service that is operated by or affiliated with a post-secondary institution;
5. The dispensing of drugs in a medical emergency as defined in subdivision 6 of section 6810 of the State Education Law.

For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070.

B) **Durable Medical Equipment**

Prior to the effective date of the 2020 Durable Medical Equipment Fee Schedule, for durable medical equipment administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070.

Following the effective date of the 2020 Durable Medical Equipment Fee Schedule, all durable medical equipment supplied shall be billed and paid using the 2020 Durable Medical Equipment Fee Schedule. The 2020 Durable Medical Equipment Fee Schedule is/will be available on the Board's website. Any item identified as requiring prior authorization in the 2020 Durable Medical Equipment Fee Schedule or not listed in the 2020 Durable Medical Equipment Fee Schedule may not be billed without such prior authorization.

Do not bill for or report supplies that are customarily included in surgical packages, such as gauze, sponges, Steri-strips, and dressings; drug screening supplies; and hot and cold packs. These items are included in the fee for the medical services in which such supplies are used.

17. Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting provider, such procedures are to be billed directly to the insurance carrier by the laboratory.

18. Surgical Destruction

Destruction or ablation of tissue is considered an inherent portion of surgical procedures and may be performed by any of the following methods used alone or in combination: electrosurgery, cryosurgery, laser, and chemical treatment. Unless specified by the CPT code description, destruction by any method does not change the selection of code to report the surgical service.

19. Fractures and Dislocations

The terms "closed" and "open" are used with reference to the type of procedure (e.g., fracture or dislocation) and to the type of reduction.

A) **Casting and Strapping Guidelines**
Application of casts and strapping codes are used to report replacement procedures during or after the period of follow-up care. These codes can also be used when the cast application or strapping is an initial service performed to stabilize or protect a fracture, injury, or dislocation without a restorative treatment or procedure. Restorative treatment or procedure rendered by another provider following the application of the initial cast, splint, or strap may be reported with a treatment of fracture or dislocation code.

Codes found in the application of casts and strapping section (29000–29799) should be reported separately when:

- The cast application or strapping is a replacement procedure used during or after the period of follow-up care.
- The cast application or strapping is an initial service performed without restorative treatment or procedures to stabilize or protect a fracture, injury, or dislocation, and to afford comfort to a patient.
- An initial casting or strapping when no other treatment or procedure is performed or will be performed by the same provider.
- A provider performs the initial application of a cast or strapping subsequent to another provider having performed a restorative treatment or procedure.

A provider who applies the initial cast, strap, or splint and also assumes all of the subsequent fracture, dislocation, or injury care cannot use the application of casts and strapping codes as an initial service. The first cast, splint, or strap application is included as a part of the service of the treatment of the fracture and dislocation codes. If no fracture care code is reported, for instance for a sprain, then it is appropriate to report the cast application.

B) **Re-reduction**
Re-reduction of a fracture and/or dislocation, performed by the primary provider, may warrant an additional payment when performed during the inclusive aftercare period. See Surgery Ground Rule 6.

C) **Bone, Cartilage, and Fascial Grafts**
Listed relative value units for most graft procedures include obtaining the graft. When a second surgeon obtains the graft, the relative value unit of the total procedure will not be increased but in accordance with Surgery Ground Rule 12-D, the relative value unit may be apportioned by the co-surgeons. Procedures 20900–20922 are NOT to be used with procedures which include the graft as part of the descriptor. Procedures 20900–20922 can be used in those unusual circumstances when a graft is used that is not included in the descriptor.

Unless separately listed, when an alloplastic implant or non-autogenous graft is used in a procedure which "includes obtaining graft," the relative value unit is to be the same as for using a local bone graft. The phrase "iliac or other autogenous bone graft" refers only to grafts obtained from an anatomical site distinct from the primary operative area and obtained through a separate incision. Plastic and/or metallic implant or non-autogenous graft materials are to be valued at the cost to the provider.

D) **Dislocations Complicated by a Fracture**
Increase the relative value unit of the fracture/dislocation by 50 percent. The additional charge is not applicable to ankle fractures/dislocations.

E) **Multiple Injuries**
For concurrent care of multiple injuries, not contiguous and not in the same hand or foot, and not otherwise specified, see Surgery Ground Rule 5. Superficial injuries not requiring extensive care do not carry cumulative or additional allowances.

20. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Modifiers

commonly used with surgical procedures are as follows:

22 Increased Procedural Services
When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

23 Unusual Anesthesia
Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.

24 Unrelated Evaluation and Management Services by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period
The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

26 Professional Component
Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component
Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

32 Mandated Services
Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

47 Anesthesia by Surgeon
Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) **Note:** Modifier 47 would not be used as a modifier for the anesthesia procedures.

50 Bilateral Procedure
Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate 5 digit code.

51 Multiple Procedures
When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This

modifier should not be appended to designated "add-on" codes (see Appendix D).

New York State Guideline: See Ground Rule 13 in the General Ground Rules in this fee schedule.

52 Reduced Services
Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 Discontinued Procedure
Under certain circumstances the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

54 Surgical Care Only
When 1 physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

55 Postoperative Management Only
When 1 physician or other qualified health care professional performs the postoperative management and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

56 Preoperative Management Only
When 1 physician or other qualified health care professional performed the preoperative care and evaluation and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

57 Decision for Surgery
An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

58 Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** For treatment of a problem that requires a return to the operating/procedure room (eg, unanticipated clinical condition), see modifier 78.

59 Distinct Procedural Service
Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should

modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

62 Two Surgeons
When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure[s]) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. **Note:** If a co-surgeon acts as an assistant in the performance of an additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

63 Procedure Performed on Infants less than 4 kg
Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure number. **Note:** Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20005–69990 code series. Modifier 63 should not be appended to any CPT codes listed in the **Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory**, or **Medicine** sections.

66 Surgical Team
Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians or other qualified health care professionals, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating individual with the addition of modifier 66 to the basic procedure number used for reporting services.

76 Repeat Procedure or Service by the Same Physician or Other Qualified Health Care Professional
It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service. **Note:** This modifier should not be appended to an E/M service.

77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional
It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

78 Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period
It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following the initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

80 Assistant Surgeon
Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

81 Minimum Assistant Surgeon
Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.

82 ***Assistant Surgeon (when qualified resident surgeon not available)***
The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).

83∞ ***Physician Assistant or Nurse Practitioner as Assistant Surgeon***
When a physician assistant or nurse practitioner performs services for assistants at surgery, identify the services by adding modifier 83 to the usual procedure code. Services of a physician assistant or nurse practitioner are reimbursed at 10.7 percent of the listed value of the surgical code and payable to the employing physician. This modifier is valid for surgery only. Please refer to Ground Rule 12 (F) and Surgery Ground Rule 12 for additional reimbursement guidelines.

90 ***Reference (Outside) Laboratory***
When laboratory procedures are performed by a party other than the treating or reporting physician or other qualified health care professional, the procedure may be identified by adding modifier 90 to the usual procedure number.

99 ***Multiple Modifiers***
Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

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SURGERY 10021–69990

Medical Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD	PC/TC Split
		10021	Fine needle aspiration; without imaging guidance	0.38	XXX	
		10022	Fine needle aspiration; with imaging guidance	0.56	XXX	
■		10030	Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous	3.55	000	
■		10035	Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; first lesion	3.26	000	
■	+	10036	Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; each additional lesion (List separately in addition to code for primary procedure)	2.86	ZZZ	
		10040	Acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)	0.18	010	
		10060	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single	0.29	010	
		10061	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple	0.90	010	
		10080	Incision and drainage of pilonidal cyst; simple	0.45	010	
		10081	Incision and drainage of pilonidal cyst; complicated	1.08	010	
		10120	Incision and removal of foreign body, subcutaneous tissues; simple	0.36	010	
		10121	Incision and removal of foreign body, subcutaneous tissues; complicated	1.08	010	
		10140	Incision and drainage of hematoma, seroma or fluid collection	0.54	010	
		10160	Puncture aspiration of abscess, hematoma, bulla, or cyst	0.29	010	
		10180	Incision and drainage, complex, postoperative wound infection	1.62	010	
		11000	Debridement of extensive eczematous or infected skin; up to 10% of body surface	0.25	000	
	+	11001	Debridement of extensive eczematous or infected skin; each additional 10% of the body surface, or part thereof (List separately in addition to code for primary procedure)	0.20	ZZZ	
		11004	Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum	3.41	000	
		11005	Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure	4.67	000	
		11006	Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia, perineum and abdominal wall, with or without fascial closure	4.31	000	
	+	11008	Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)	1.75	ZZZ	
		11010	Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin and subcutaneous tissues	1.10	010	
		11011	Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, and muscle	1.98	000	
		11012	Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle, and bone	2.42	000	
		11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less	1.10	000	
		11043	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less	1.98	000	
		11044	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less	2.42	000	

for each additional sheet of film or electronic media. These reproductions are not returnable to the provider. Copies of images produced by copiers (e.g., Xerox) shall not merit any additional payment and shall not be returnable to the provider; such copies should accompany the bill submitted for the particular imaging procedure. (The use of digital or photographic media and/or imaging is not reported separately but is considered to be a component of the basic procedure.) When recorded images are capable of electronic transmission, without creation of a physical copy of the film, CD or other physical reproduction, no fee may be charged for such electronic transmission.

In cases where the patient transfers from one provider to another, the original provider will promptly forward all images or copies of images to the new attending provider.

9. Materials Supplied by Provider

Pharmacy

A prescriber cannot dispense more than a seventy-two hour supply of drugs with the exceptions of:

1. Persons practicing in hospitals as defined in section 2801 of the public health law;
2. The dispensing of drugs at no charge to their patients;
3. Persons whose practices are situated ten miles or more from a registered pharmacy;
4. The dispensing of drugs in a clinic, infirmary, or health service that is operated by or affiliated with a post-secondary institution;
5. The dispensing of drugs in a medical emergency as defined in subdivision 6 of section 6810 of the State Education Law.

For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070.

Radiopharmaceutical or other radionuclide material cost: Listed relative value units in this section do not include these costs. List the name and dosage of radiopharmaceutical material and cost. Bill with code 99070.

10. Injection Procedures

Relative value units for injection procedures include all usual pre- and postinjection care specifically related to the injection procedure, necessary local anesthesia, placement of needle or catheter, and injection of contrast media.

Vascular injection procedures are listed in the cardiovascular section under procedure codes 36000–36299. Other injection procedures are listed in appropriate sections.

11. Contrast Enhanced Magnetic Resonance Imaging

Contrast materials provided by the provider over and above those usually included with the service, for image enhancement, may be charged for separately. Listed values in this section do not include the costs of contrast agents. When billing, list the name and dosage of the contrast material used and its cost. Payment shall not exceed the cost of the item to the provider.

12. Miscellaneous

A) Emergency services rendered between 10:00 p.m. and 7:00 a.m. in response to requests received during those hours or on Sundays or legal holidays, provided such services are not otherwise reimbursed, may warrant an additional payment of one-third of the applicable fee. Circumstances justifying the additional payment should be set forth in a statement accompanying the bill.

B) Relative value units for office, home and hospital visits, consultation, and other medical services are listed in the Evaluation and Management, Anesthesia, Surgery, Pathology and Laboratory, Medicine, and Physical Medicine sections.

C) When interpretation of radiologic procedures is performed, and a radiologist is not in house and is not available by teleradiography, the treating provider may render the interpretation and write the report. All radiology guidelines and requirements must be met, and the written report must be the official report in the medical records. The treating provider can bill for interpretation services using modifier 26 to identify the professional component of the procedure. The written report must accompany the bill.

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13. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Modifiers commonly used with radiology procedures are as follows:

22 Increased Procedure Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

26 Professional Component

Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component

Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

32 Mandated Services

Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

76 Repeat Procedure or Service by the Same Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

99 Multiple Modifiers

Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

6 Pathology and Laboratory

The relative value units in this section were determined uniquely for pathology and laboratory services. Use the pathology and laboratory conversion factor when determining fee amounts. The pathology and laboratory conversion factor is not applicable to any other section.

The fee for a procedure or service in this section is determined by multiplying the relative value by the pathology and laboratory conversion factor, subject to the ground rules, instructions, and definitions of the schedule. Conversion factors are located in the Introduction and General Guidelines section.

To ensure uniformity of billing when multiple services are rendered, each relative value unit is to be multiplied by the conversion factor separately. After which, charges for products may be added.

Pathology and Laboratory Ground Rules

Definitions and rules pertaining to pathology and laboratory services are as follows:

Note: Rules used by all providers in reporting their services are presented in the General Ground Rules in the Introduction and General Guidelines section.

1A. NYS Medical Treatment Guidelines

Treatment of work-related injuries should be in accordance with any applicable medical treatment guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the fee schedule ground rules and the medical treatment guidelines, the guidelines will prevail. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

1B. Attending Provider

The attending provider will not make a charge for obtaining and handling of specimen, except for spinal puncture and also routine venipuncture, or unless otherwise specified.

2. Materials Supplied by Provider

Pharmacy

A prescriber cannot dispense more than a seventy-two hour supply of drugs with the exceptions of:

1. Persons practicing in hospitals as defined in section 2801 of the public health law;
2. The dispensing of drugs at no charge to their patients;
3. Persons whose practices are situated ten miles or more from a registered pharmacy;
4. The dispensing of drugs in a clinic, infirmary, or health service that is operated by or affiliated with a post-secondary institution;
5. The dispensing of drugs in a medical emergency as defined in subdivision 6 of section 6810 of the State Education Law.

For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070.

3. Referral Laboratory

When the service or procedure is performed by other than the attending provider, be it hospital, commercial, or other laboratory, only the laboratory rendering the service may bill and such shall be submitted directly to the responsible payer.

4. Reports

No bill for services or procedures included in this section shall be considered properly rendered unless it is accompanied by a report that includes the findings and the interpretation of such findings. Where the service or procedure results in producing an image or graph, such shall be submitted together with the bill.

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5. By Report "BR"

"BR" in the Relative Value column indicates that the relative value unit of this service is to be determined "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary. See the Ground Rules in the Introduction and General Guidelines section for a complete explanation of "by report" procedures.

6. Indices or Ratios

Tests which produce an index or ratio based on mathematical calculations from two or more other results may not be billed as a separate independent test (e.g., A/G ratio, free thyroxine index).

7. Unlisted Service or Procedure

Specify the service by the last code number in the appropriate subdivision. Identify by name or description, and submit report (see Pathology and Laboratory Ground Rule 5).

8. Organ or Disease-Oriented Panels

Organ or disease-oriented panels (80047–80076), are used to confirm specific diagnoses. These panels are problem-oriented in scope. Each panel contains a list of the tests that must be included in order to use that particular code number. This is not meant to limit the number of tests performed or ordered if medically appropriate. Other tests performed that are not part of the panel may be separately reported. It is also inappropriate to separately report the components of a panel test if the full set of identified tests was performed.

Clinical information derived from results of laboratory data that are mathematically calculated is considered part of the test procedure and not separately coded. Please refer to CPT guidelines for a complete explanation of codes included in each panel.

9. Specific Billing Instructions

The relative value units listed in this section include recording the specimen, performing the test, and reporting the result. They do not include specimen collection, transfer, or individual patient administrative services. (For reporting collection and handling, see the 99000 series.)

The listed relative value units are total values that include both the professional and technical components. Utilization of the listed code without modifier 26 or TC implies that there will only be one charge, inclusive of the professional and technical components. The listed relative value units apply to provider.

The column designated PC/TC Split indicates the percent of the global fee (relative value unit) for the technical and professional components of the procedure.

A) **Professional Component**
The professional component represents the value of the professional pathology services of the physician. This includes examination of the patient, when indicated, interpretation and written report of the laboratory procedure, and consultation with the referring provider. (Report using modifier 26.)

B) **Technical Component**
The technical component includes the charges for performance and/or supervision of the procedure, personnel, materials, space, equipment, and other facilities. (Report using modifier TC.)

10. Collection and Handling

Relative value units assigned to each test represent only the cost of performing the individual test, be it manual or automated. The collection, handling, and patient administrative services have been assigned relative value units and separate code numbers.

Collection and handling procedures:

A) Report collection, handling, and patient administrative services separately, where applicable. For venipuncture, see procedure 36415; for capillary specimen, see procedure 36416; for handling, see procedures 99000–99001.

B) Only the provider or laboratory drawing the blood or obtaining the specimen is entitled to collection and handling fees.

C) Relative value units for specimen collection, handling, and patient administrative services are assigned in relation to the complexity of the process.

D) A collection and handling charge can be reported by the provider or laboratory performing the service even though there is no billing for the test itself. The test ordered and the name of the testing facility should be indicated.

E) When collection and handling is performed at the testing facility (laboratory), the laboratory may include separate charges for the services.

11. Review of Diagnostic Studies

When prior studies are reviewed in conjunction with a visit, consultation, record review, or other evaluation, no separate charge is warranted for the review by the medical practitioner or other medical personnel. Neither the professional component

(modifier 26) nor the pathology consultation codes (80500 and 80502) are reimbursable under this circumstance. The review of diagnostic tests is included in the evaluation and management codes.

12. Drug Screening

Drug screening may be required as part of the non-acute pain management treatment protocol.

Drug Testing—Urine Drug Testing (UDT) (or the testing of blood or any other body fluid) is a mandatory component of chronic opioid management, as part of the baseline assessment and ongoing re-assessment of opioid therapy. Baseline drug testing should be obtained on all transferring patients who are already using opioids or when a patient is being considered for ongoing opioid therapy. The table below offers guidance as to frequency of regular, random drug testing.

Risk Category (Score)	Random Drug Frequency
Low Risk	Periodic (At least once/year)
Moderate Risk	Regular (At least 2/year)
High Risk	Frequent (At least 3–4/year)
Aberrant Behavior	At time of visit

Random drug screening (urine or other method) should be performed at the point of care using a quick or rapid screening test method utilizing a stick/dip stick, cup or similar device. Reimbursement will be limited to 1 unit of 80305, 80306, or 80307. In addition, the provider may bill the appropriate evaluation and management code commensurate with the services rendered.

Drug Testing (urine or any other body fluid) by a laboratory—Drug testing performed by a laboratory (whether the lab is located at the point of care or not) should not be a regular part of the non-acute pain management treatment protocol, but rather shall be used as confirmatory testing upon receipt of unexpected or unexplained UDT results (Red Flags).

Red Flags include:

- Negative for opioid(s) prescribed
- Positive for amphetamine or methamphetamine
- Positive for cocaine or metabolites
- Positive for drug not prescribed (benzodiazepines, opioids, etc.)
- Positive for alcohol

Upon documentation of the Red Flag, the provider shall direct confirmatory testing using GCL, GC/MS or LC/MS. Such tests shall be billed using 1 unit of 80375 for 1–3 drugs; 1 unit of 80376 for 4–6 drugs; or 1 unit of 80377 for 7 or more drugs.

13. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Modifiers commonly used with pathology and laboratory procedures are as follows:

22 Increased Procedure Services
When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

26 Professional Component
Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component
Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

32 Mandated Services
Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

52 Reduced Services
Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing

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the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

90 Reference (Outside) Laboratory
When laboratory procedures are performed by a party other than the treating or reporting physician or other qualified health care professional, the procedure may be identified by adding modifier 90 to the usual procedure number.

91 Repeat Clinical Diagnostic Laboratory Test
In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number with the addition of modifier 91. **Note:** This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

92 Alternative Laboratory Platform Testing
When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701–86703 and 87389). The test does not require permanent dedicated space; hence by its design it may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of this modifier.

99 Multiple Modifiers
Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

- Rib cage region
- Abdomen and viscera region

7. Moderate (Conscious) Sedation

Sedation with or without analgesia is used to achieve a state of depressed consciousness while maintaining the patient's ability to control their own breathing as well as respond to stimulation. The use of these codes requires the presence of an independent trained observer to assist the provider in monitoring the patient's level of consciousness and physiological status.

Conscious sedation includes pre- and postsedation evaluations, administration of the sedation, and monitoring of cardiorespiratory function.

Codes 99151–99153 identify moderate (conscious) sedation services provided by the same provider performing the diagnostic or therapeutic service that the sedation supports. CPT codes 99155–99157 identify moderate (conscious) sedation services provided by a second provider other than the health care professional performing the diagnostic or therapeutic service. When moderate (conscious) sedation services are provided by a second provider in a facility setting or nonfacility setting, the conscious sedation service may be billed separately.

Procedures that include moderate (conscious) sedation are addressed in General Ground Rule 12. See General Ground Rule 12 for additional guidelines related to reporting of moderate (conscious) sedation.

8. Use of Code 97127 and 97533

Please see Ground Rule 7 of the Behavioral Health Fee Schedule for guidelines related to the use of code 97127 and 97533.

9. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Modifiers commonly used with medicine procedures are as follows:

22 Increased Procedure Services
When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

26 Professional Component
Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component
Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

32 Mandated Services
Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

52 Reduced Services
Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

76 Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional
It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

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77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional
It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

90 Reference (Outside) Laboratory
When laboratory procedures are performed by a party other than the treating or reporting physician or other qualified health care professional, the procedure may be identified by adding modifier 90 to the usual procedure number.

91 Repeat Clinical Diagnostic Laboratory Test
In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number with the addition of modifier 91. **Note:** This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (eg, glucose tolerance tests , evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

99 Multiple Modifiers
Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

1B∞ Behavioral Health Provider Enhanced Reimbursement
Provides a 20 percent reimbursement increase for E/M and Medicine services when rendered by providers with the following WCB assigned provider rating codes:

Rating Code	Description
PN-P	PSYCHIATRY
OPPN-P	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – PSYCHIATRY
CPN-P	PSYCHIATRY CONSULTANT
OPCPN-P	OSTEOPATHIC PSYCHIATRY
PN-ADP	ADDICTION PSYCHIATRY
OPPN-ADP	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – ADDICTION PSYCHIATRY
CPN-ADP	ADDICTION PSYCHIATRY CONSULTANT
OPCPN-ADP	OSTEOPATHIC ADDICTION PSYCHIATRY
PN-PM	PAIN MANAGEMENT
OPPN-PM	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – PAIN MANAGEMENT
CPN-PM	PAIN MANAGEMENT CONSULTANT
OPCPN-PM	OSTEOPATHIC PAIN MANAGEMENT
PSY	PSYCHOLOGY
LCSW	LICENSED CLINICAL SOCIAL WORKER
LCSW-R	LICENSED CLINICAL SOCIAL WORKER – PSYCHOTHERAPY
NP-P	NURSE PRACTITIONER IN PSYCHIATRY
PHYAS	PHYSICIAN ASSISTANT*

* A supervising physician needs to have a rating code eligible for the modifier 1B enhancement.

10. Behavioral Health Provider Enhanced Reimbursement

In an effort to increase the number of Board authorized providers in the behavioral health to render care and treatment to injured workers, the WCB has established WCB specific modifier 1B which will provide a 20 percent reimbursement increase to providers with WCB assigned rating codes for designated services. Modifier 1B provides a 20 percent reimbursement increase for E/M and Medicine services when rendered by providers with the following WCB assigned provider rating codes:

Rating Code	Description
PN-P	PSYCHIATRY
OPPN-P	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – PSYCHIATRY
CPN-P	PSYCHIATRY CONSULTANT
OPCPN-P	OSTEOPATHIC PSYCHIATRY

Rating Code	Description
PN-ADP	ADDICTION PSYCHIATRY
OPPN-ADP	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – ADDICTION PSYCHIATRY
CPN-ADP	ADDICTION PSYCHIATRY CONSULTANT
OPCPN-ADP	OSTEOPATHIC ADDICTION PSYCHIATRY
PN-PM	PAIN MANAGEMENT
OPPN-PM	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – PAIN MANAGEMENT
CPN-PM	PAIN MANAGEMENT CONSULTANT
OPCPN-PM	OSTEOPATHIC PAIN MANAGEMENT
PSY	PSYCHOLOGY
LCSW	LICENSED CLINICAL SOCIAL WORKER
LCSW-R	LICENSED CLINICAL SOCIAL WORKER – PSYCHOTHERAPY
NP-P	NURSE PRACTITIONER IN PSYCHIATRY
PHYAS	PHYSICIAN ASSISTANT*

* A supervising physician needs to have a rating code eligible for the modifier 1B enhancement.

11. EDX (Codes 95907-95913)

EDX is only recommended where there is failure of suspected radicular pain to resolve or plateau after waiting 4 to 6 weeks (to provide for sufficient time to develop EMG abnormalities as well as time for conservative treatment to resolve the problems), equivocal imaging findings, e.g., on CT or MRI studies, and suspicion by history and physical examination that a neurologic condition other than radiculopathy may be present instead of or in addition to radiculopathy. When such testing is recommended, the provider shall select from codes 95907–95913 using 1 unit of the 1 code that most closely represents the nerve(s) tested. Requests for repeat testing require approval from the carrier.

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8 Physical Medicine

The relative value units in this section were determined uniquely for physical medicine services. Use the physical medicine conversion factor when determining fee amounts. The physical medicine conversion factor is not applicable to any other section.

The fee for a procedure or service in this section is determined by multiplying the relative value unit by the physical medicine conversion factor, subject to the ground rules, instructions, and definitions of the schedule. Conversion factors are located in the Introduction and General Guidelines section.

To ensure uniformity of billing when multiple services are rendered, each relative value unit is to be multiplied by the conversion factor separately. After which, charges for products may be added.

Physical Medicine Ground Rules

The fees for physical medicine and physical or occupational therapy services are payable when services are rendered by a physician. When physical medicine treatment is rendered in the follow-up period of surgical or fracture care procedures, the treatment is not considered part of the global surgical fee. Physical medicine services are separately covered procedures when rendered during the follow-up period of any surgical service. When a patient is seen by a provider other than the surgeon prior to and during the implementation of a physical medicine program, and a history and physical examination is performed, a fee for an office visit is permitted. Definitions and rules pertaining to physical medicine services are as follows:

Note: Rules used by all provider in reporting their services are presented in the General Ground Rules in the Introduction and General Guidelines section.

1A. NYS Medical Treatment Guidelines

The recommendations of the NYS Medical Treatment Guidelines supersede the ground rule frequency limitation for services rendered to body parts covered by the NYS Medical Treatment Guidelines. The maximum reimbursement limitations per patient per day per accident or illness for modalities is 12.0 RVUs, re-evaluation plus modalities is 15.0 RVUs, and initial evaluation plus modalities is 18.0 RVUs for all providers combined. Treatment of work-related injuries should be in accordance with any applicable medical treatment guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the fee schedule ground rules and the medical treatment guidelines, the guidelines will prevail. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

1B. Referral and Prescription by Physician, Nurse Practitioner, Physician Assistant or Podiatrist

Occupational and physical therapy services must be rendered only upon the prescription or referral of an authorized physician, nurse practitioner, physician assistant or podiatrist. The referring or prescribing provider should also oversee the written instructions for treatment for a given diagnosis. Written instructions should include precautions, goals, frequency, and modalities to be used.

2. Physical Medicine Utilization

Physical medicine services in excess of 12 treatments or after 45 days from the first treatment, require documentation that includes provider certification of medical necessity for continued treatment, progress notes, and treatment plans. This documentation should be submitted to the insurance carrier as part of the claim.

3. Physical Medicine and Rehabilitation Program

If the provider deems that the patient's condition warrants a physical medicine and rehabilitation program and the referral is made during the follow-up period, no preauthorization from the insurance carrier is required for the referral.

4. Home Treatment

When treatment is rendered in a patient's home by a provider or a therapist, add 50 percent to the listed value. Documentation explaining the necessity of

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home treatment instead of an office or outpatient treatment setting is required with the bill to the insurance carrier.

5. Referral and Authorization

A provider referring patients to a duly licensed and registered physical therapist (PT) or occupational therapist (OT) may include a directive indicating the treatment plan and duration but should not exceed 12.0 RVUs per patient per day.

6. Report Requirements

Authorized physical and occupational therapists shall submit reports of treatment in the electronic format prescribed by the Chair.

7. Postoperative Procedures by a Physical Therapist or Occupational Therapist

Physical or occupational therapists that render therapy during the follow-up period for fractures, dislocations, or other postoperative procedures shall be reimbursed for therapy during and after the follow-up period in accordance with the Acupuncture and Physical and Occupational Therapy Fee Schedules.

8. Initial Evaluation and Re-evaluation by a Physician, Nurse Practitioner, or Physician Assistant

Physicians, nurse practitioners, and physician assistants may bill for an initial evaluation using CPT codes 97161–97163 and 97165–97167, respectively. The maximum number of RVUs (including treatment) per patient per day per accident or illness when billing for an initial evaluation shall be limited to 18.0. The following codes represent the treatments subject to this rule:

97010	97012	97014	97016	97018	97022
97024	97026	97028	97032	97033	97034
97035	97036	97039	97110	97112	97113
97116	97124	97139	97140	97150	97530
97535	97537	97542	97760	97761	97763

Evaluations shall include the following elements: history, examination, clinical testing, interpretation of data, clinical presentation, clinical decision making, and development of the plan of care with defined goals, appropriate interventions, and recommendations.

The maximum number of RVUs (including treatment) per person per day per accident or illness when billing for a re-evaluation shall be limited to 15.0. Re-evaluations using CPT codes 97164 (PT) and 97168 (OT) may be billed when any of the following applies:

A) If following discharge (for whatever reason), the patient is referred again for treatment with the same or similar condition of the same body part.

B) If there is a significant change in the patient's condition that warrants a revision of the treatment goals, intervention and/or the plan of care.

C) If it is medically necessary to provide re-evaluation services over and above those normally included during therapeutic treatment.

D) If the patient's status becomes stationary and it is not likely that significant improvement will occur with further treatment.

E) If at the conclusion of the current episode of therapy care, re-evaluation is indicated for any of the following reasons:

- Satisfactory goal achievement with present functional status defined including a home program and follow-up services, as necessary.
- Patient declines to continue care.
- The patient is unable to continue to work toward goals due to medical or psychosocial complications.

Please note, however, that re-evaluations may be billed only in instances where such evaluation is therapeutically necessary, and in any event, not more than once in a 30-day period.

9. Employed Physical Therapists and Occupational Therapists

Physical therapists and occupational therapists employed by physicians must bill separately from the physician-employer using the Acupuncture and Physical and Occupational Therapy Fee Schedules.

10. Hospital-based EMG

When electro-diagnostic testing is performed in a hospital setting using hospital-owned equipment and hospital-employed technicians, the hospital may bill for the technical portion of the service.

11. Multiple Physical Medicine Procedures and Modalities

When multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 12.0 RVUs per patient per accident or illness or the amount billed, whichever is less. **Note:** When a patient receives physical medicine procedures and/or modalities from more than one provider, the patient may not receive

more than 12.0 RVUs per day per accident or illness from all providers combined. The following codes represent the physical medicine procedures and modalities subject to this rule:

97010	97012	97014	97016	97018	97022
97024	97026	97028	97032	97033	97034
97035	97036	97039	97110	97112	97113
97116	97124	97139	97140	97150	97530
97535	97537	97542	97760	97761	97763

12. Tests and Measurements

Codes 97760–97763 training and management for orthotic/prosthetic use, shall not be billed on the same day as an office visit.

13. Work Hardening Rules

Work hardening programs are interdisciplinary, goal-specific, vocationally-driven treatment programs designed to maximize the likelihood of return to work through functional, behavioral, and vocational management.

Not all claimants require these programs to reach a level of function that will allow successful return to work.

Only those programs that meet all of the specific guidelines will be defined as work hardening programs.

Programs will be reimbursed per the fee schedule after meeting all other requirements.

Pre-Admission Criteria

All claimants must complete a preprogram assessment including a Functional Capacity Evaluation (FCE) and Vocational Evaluation.

The goal of the program is return to work, therefore, for all anticipated returns to previous employment or placement with a new employer, the following must be provided:

A) Specific written critical job demands and/or job site analysis

B) Verified written employment opportunities

Evaluation Process

Initial screening evaluation is performed by the treatment team consisting of:

A) Physical Therapy and/or Occupational Therapy

PLUS

B) Psychology/Psychiatry and/or Vocational Rehabilitation, Chiropractor, or other providers suitable by scope of practice as determined in the State Education Law

The outcome of this evaluation will be:

A) Recommendation of release to return to work

B) Acceptance into the program with an Individual Written Rehabilitation Plan stating specific goals and recommended services

C) Rejection from program for specific reasons

D) Referral back to provider for medical evaluation

E) Recommendation of vocational rehabilitation, either by referral to and acceptance by Adult Career and Continuing Education Services—Vocational Rehabilitation (ACCES-VR), or by other providers if approved by the carrier

Claimants must be referred by a physician, nurse practitioner, physician assistant or podiatrist authorized by the NYSWCB to provide care to injured claimants, who will provide a written referral for evaluation and treatment.

Programs and Providers

Claimants will be provided with the availability of the following providers as determined by the needs of the claimant:

A) A minimum of two (2) of the following: Physical Therapist, Occupational Therapist, Vocational Rehabilitation Counselor, Psychologist/Psychiatrist, licensed Clinical Social Worker, Chiropractor, or other provider suitable by scope of practice as determined in the State Education Law; in addition to a Case Manager, either internal or external to the program.

B) Providers who can provide initial medical evaluation, participation in the development of the treatment plan, and coordination of work restrictions and discharge planning with the recommendation of specialists in Physical Medicine and Rehabilitation.

Discharge Criteria

Discharge criteria must be provided to all claimants in writing prior to initiation of treatment at the time program goals are determined.

Voluntary discharge is achieved by:

A) Meeting program goals

B) Early return to work

C) Acute or worsening medical conditions

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D) The claimant declining further treatment

Non-voluntary discharge may be necessary in cases of:

A) Failure to comply with program policies

B) Absenteeism

C) Lack of demonstrable benefit from treatment

Non-voluntary discharge requires written documentation of prior and repeated counseling of the claimant, and immediate notification of the employer, insurer, case manager, and referring and attending (if different) provider.

Under all circumstances of voluntary and non-voluntary discharge, the claimant will return to the referring attending provider for release from the program.

The attending provider must sign a release to return to work when the program goals are achieved.

Program Evaluation

Programs are subject to disclosure and evaluation as permitted by local and state health care agencies and other appropriate individuals or groups in the State of New York, including issues of:

A) Written policies and procedures

B) Program implementation

C) Maintenance of medical records

D) Outcomes achieved

E) Site design and equipment

F) Affiliations with non-site-based providers

G) Admission and discharge criteria

Programs must provide insurers and referring providers with:

A) Initial interdisciplinary team evaluation report

B) Proposed treatment plan

C) Progress reports at weekly intervals

D) Opportunity to attend team meetings

E) Final discharge summary report

F) Any information described in sections above

Integration of Vocation Rehabilitation Services

Work hardening programs are vocationally directed and driven rehabilitation services. The vocational rehabilitation counselor serves to:

A) Coordinate efforts between the claimant, program, and employer

B) Obtain job descriptions and critical job demands from the employer

C) Gather and provide information to the treatment team

D) Educate employers toward work tasks and work-site design

E) Assist claimants toward appropriate employment opportunities within their safe maximal capabilities

Programs that do not retain the services of vocational rehabilitation counselors on a full time basis may utilize private rehabilitation agencies, specialists provided by insurance carriers, or ACCES-VR. These individuals are required to make continuous on-site contact with claimants and program providers, including participation in team meetings.

The qualifications for serving as a vocational rehabilitation counselor with respect to work hardening programs shall be determined by the Director of Rehabilitation and Social Services of the State of New York Workers' Compensation Board. Vocational rehabilitation counselors should be reimbursed at the usual and customary rate currently paid by insurers in each region.

Program Duration

Work hardening programs will be provided on the following time schedule:

A) Daily treatment, full or partial days, with fee differential

B) Minimum of ten (10) treatment days and maximum of thirty (30) treatment days subject to carrier prior approval

C) Treatment to be completed within six (6) consecutive weeks

D) Any additional treatment days beyond thirty (30) upon approval by the carrier

Fee Schedule

Fees for work hardening programs will be paid in accordance with the medical fee schedule, with written prior approval by the carrier, utilizing the following guidelines:

A) In all cases, for both voluntary and non-voluntary discharge, payment is for the actual duration of treatment provided.

B) Payment differential for partial and full day program.

C) CPT codes 97545 and 97546 will be reimbursed for work hardening programs only as described above.

D) Non-multidisciplinary "work conditioning" programs will be reimbursed utilizing existing PT, OT, and physical medicine codes.

E) Behavioral health services as requested in the Individual Written Rehabilitation Plan and approved by the carrier will be billed separately from codes 97545 and 97546, in accordance with the appropriate fee schedules.

F) Payment for external case managers and vocational rehabilitation counselors will be the responsibility of the carrier, exclusive of program codes 97545 and 97546.

G) Billing will not exceed eight (8) hours for any given treatment day.

14. Functional Capacity Evaluations (FCE)

Indications

The FCE is utilized for the following purposes:

A) To determine the level of safe maximal function at the time of maximal medical improvement.

B) To provide a prevocational baseline of functional capabilities to assist in the vocational rehabilitation process.

C) To objectively set restrictions and guidelines for return to work.

D) To determine whether specific job tasks can be safely performed by modification of technique, equipment, or by further training.

E) To determine whether additional treatment or referral to a work hardening program is indicated.

F) To assess outcome at the conclusion of a work hardening program.

General Requirements

A) The FCE may be prescribed only by an authorized physician, nurse practitioner, physician assistant, or podiatrist, or may be requested by the carrier when indicated.

B) The FCE does not require prior authorization by the carrier.

C) The prescribing provider must justify the indication for each at the request of the carrier (see Eligibility Criteria).

D) The FCE shall be performed by a physical or occupational therapist currently holding a valid license in New York state, or other licensed provider qualified by scope of practice. Constant supervision by the licensed provider is required.

Specific Requirements

A) The FCE, when medically necessary and indicated, may be performed only at the point of maximum medical improvement in the opinion of the attending provider.

B) The FCE should not be prescribed prior to three (3) months post-injury unless there is a significant documented change in the claimant's status which justifies earlier utilization.

C) At least one of the following eligibility criteria is required for all claimants:

1) Claimant is preparing to return to previous job.

2) Claimant has been offered a new job (verified).

3) Claimant is working with a rehabilitation provider and a vocational objective is established.

4) Claimant is expected to be classified with a non-schedule permanent partial disability.

D) Reports will include the following information:

1) Patient demographics including work history.

2) Indication for evaluation.

3) Type of evaluation performed.

4) Raw and tabulated data.

5) Normative data values.

6) Narrative cover sheet with recommendations.

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E) The bill for services provided must be attached to the report to be processed by the carrier.

F) All evaluation tools must be standardized, and normative data and interpretive guidelines must be attached to the report.

NYS Allowable for FCE

∞*97800 Functional Capacity Evaluation:*

Region I	$496.00	**Region II**	$496.00
Region III	$564.00	**Region IV**	$614.00

15. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Modifiers commonly used with physical medicine procedures are as follows:

22 Increased Procedure Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

51 Multiple Procedures

When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D).

96 Habilitative Services

When a service or procedure that may be either habilitative or rehabilitative in nature is provided for habilitative purposes, the physician or other qualified health care professional may add modifier 96 to the service or procedure code to indicate that the service or procedure provided was a habilitative service. Habilitative services help an individual learn skills and functioning for daily living that the individual has not yet developed, and then keep and/or improve those learned skills. Habilitative services also help an individual keep, learn, or improve skills and functioning for daily living.

97 Rehabilitative Services

When a service or procedure that may be either habilitative or rehabilitative in nature is provided for rehabilitative purposes, the physician or other qualified health care professional may add modifier 97 to the service or procedure code to indicate that the service or procedure provided was a rehabilitative service. Rehabilitative services help an individual keep, get back, or improve skills and functioning for daily living that have been lost or impaired because the individual was sick, hurt, or disabled.

99 Multiple Modifiers

Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

16. Supplies and Materials: Durable Medical Equipment

Prior to the effective date of the 2020 Durable Medical Equipment Fee Schedule, for durable medical equipment administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070.

Following the effective date of the 2020 Durable Medical Equipment Fee Schedule, all durable medical equipment supplied shall be billed and paid using the 2020 Durable Medical Equipment Fee Schedule. The 2020 Durable Medical Equipment Fee Schedule is/will be available on the Board's website. Any item identified as requiring prior authorization in the 2020 Durable Medical Equipment Fee Schedule or not listed in the 2020 Durable Medical Equipment Fee Schedule may not be billed without such prior authorization.

Do not bill for or report supplies that are customarily included in surgical packages, such as gauze, sponges, Steri-strips, and dressings; drug screening supplies; and hot and cold packs. These items are included in the fee for the medical services in which such supplies are used.

OFFICIAL

NEW YORK STATE WORKERS' COMPENSATION

BEHAVIORAL HEALTH FEE SCHEDULE

Effective 4/1/2019
Revisions Effective 1/1/2020

NEW YORK STATE OF OPPORTUNITY.
Workers' Compensation Board

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The *Official New York State Workers' Compensation Behavioral Health Fee Schedule* is designed to be an accurate and authoritative source of information about medical coding and reimbursement. Every reasonable effort has been made to verify its accuracy, and all information is believed reliable at the time of publication. Absolute accuracy, however, cannot be guaranteed.

Optum360 worked closely with the New York Workers' Compensation Board in the development, formatting, and production of this fee schedule. However, all decisions resulting in the final content of this schedule were made solely by the New York Workers' Compensation Board.

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New York Workers' Compensation Board Filing Notice

The Behavioral Health Fee Schedule was duly filed in the Office of the Department of State, and constitutes Sections 333.1 and 333.2 of Title 12 of the Official Compilation of Codes, Rules and Regulations of the State of New York.

Our Commitment to Accuracy

Optum360 is committed to producing accurate and reliable materials. To report corrections, please email accuracy@optum.com. You can also reach customer service by calling 1.800.464.3649, option 1.

Revised Printing

This revised printing contains revisions effective January 1, 2020.

Foreword

The Workers' Compensation Board is pleased to present the updated version of the *New York State Workers' Compensation Behavioral Health Fee Schedule*.

The revised fee schedule is an essential tool for health care providers and those paying the cost of health care services under the New York State Workers' Compensation system. This schedule provides comprehensive billing guides, which will allow health care providers to appropriately describe their services and minimize disputes over reimbursement. Also, this schedule includes many new procedures and coding changes that have taken place since the previously published fee schedule.

This fee schedule could not have been produced without the assistance of many individuals. The spirit of cooperation between the provider and payer communities is very much appreciated. The excellence of this schedule is due, in large part, to the commitment of many people in the workers' compensation community. We are grateful for their efforts.

Except where noted, this fee schedule is effective for medical services rendered on or after April 1 2019, regardless of the date of accident. The fees established herein are payable to health care providers authorized or permitted to render care under the Workers' Compensation Law, Volunteer Firefighters' Benefit Law, and Volunteer Ambulance Workers' Benefit Law.

New York State Workers' Compensation Board

Contents

Introduction and General Guidelines

The *Official New York State Workers' Compensation Behavioral Health Fee Schedule* shows behavioral health services and their relative value units. The services are listed by *Current Procedural Terminology* (CPT®) codes. The relative value unit set for each CPT service is based on comparative magnitude among various services and procedures. The relative value units within each section apply only to that section. CPT is a registered trademark of the American Medical Association (AMA).

The accompanying instructions and ground rules explain the application of these procedure descriptors and relative value units.

Because the Behavioral Health Fee Schedule is applicable to all of New York State, a large and diverse geographical area, the relative value units contained herein do not necessarily reflect the charges of any individual medical provider or the pattern of charges in any specific area of New York State.

A primary purpose of the schedule is to provide a precise description and coding of the services provided by authorized psychologists, psychiatric nurse practitioners, licensed clinical social workers, and physicians in the care of workers' compensation covered patients and ensure the proper payment for such services by assuring that they are specifically identifiable. The Behavioral Health Fee Schedule is for use by these medical providers delivering behavioral health services and treatment to injured workers covered under Workers' Compensation Law. Physicians and psychiatric nurse practitioners can use the full version of the *Official New York State Workers' Compensation Medical Fee Schedule* and the codes and conversion factors therein. Psychologists and licensed clinical social workers are to bill for services listed in this section of the fee schedule as appropriate.

An attempt has been made to adhere as closely as possible to the terminology and coding of the American Medical Association's *CPT 2018*.

To ensure uniformity of billing, when multiple services are rendered, each relative value unit is to be multiplied by the conversion factor separately, and then the products are to be added.

Format

The *Official New York State Workers' Compensation Behavioral Health Fee Schedule* consists of one section, which uses the psychology conversion factor.

Introductory Information

The introductory ground rules that precede the data include definitions, references, prohibitions, and dire ctions for proper use. It cannot be emphasized too strongly that the introductory ground rules be read and understood before using the data in this schedule.

Regions

The Workers' Compensation Board has established four regions within New York State based on the difference in the cost of maintaining a practice in different localities of the state. The Board has defined each such region by use of the U.S. Postal Service ZIP codes for the state of New York, based upon the relative cost factors which are compatible to that region.

The fees payable for behavioral health services shall be determined by the region in which the services were rendered.

How To Interpret the Fee Schedule Data

The columns used in the Behavioral Health Fee Schedule vary by section throughout the schedule.

Icons

The following icons are included in the Behavioral Health Fee Schedule:

■ New and changed codes—Codes that are new, changed description, or changed value from June 1, 2012.

+ Add-on service—Add-on codes have been designated in the CPT book as being additional or supplemental procedures that are carried out in addition to the primary procedure.

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⊘ Modifier 51 exempt service—Modifier 51 exempt codes have not been identified as add-on services but are exempt from modifier 51 when performed in conjunction with other services.

⓫ Optum360 identified modifier 51 exempt service—Additional modifier 51 exempt codes identified by Optum360 based upon CPT language are exempt from modifier 51 when performed in conjunction with other services.

® Altered CPT codes—Services listed have been altered from the official CPT code description.

∞ State-specific codes—Where a CPT code does not currently exist to describe a service there may be a state-specific code number assigned to describe the service. RVU's are state assigned or gap filled.

Code

The Code column lists the American Medical Association's (AMA) CPT code. *CPT 2018* is used by arrangement with the AMA. Any altered CPT codes are identified with the registered trademark symbol (®). State-specific codes are identified with the infinity symbol (∞).

Description

This manual lists full 2018 CPT code descriptions.

Relative Value

The Relative Value column lists the relative value units used to calculate the fee amount for a service. Except as otherwise provided in this schedule, the maximum fee amount is calculated by multiplying the relative value units by the applicable conversion factor. Conversion factors are listed later in this chapter.

Relative values are used to calculate fees using the following formula:

Relative Value
x Applicable Conversion Factor
= Fee

For example, the fee for code 96110, performed by a psychologist in Region I or Region II, would be calculated as follows:

17.00 (Relative Value)
x $7.94 (Psychology Conversion Factor for Region I and Region II)
= $134.98

BR

Some services do not have a relative value unit because they are too variable or new. These by report services are identified with a "BR."

Postal ZIP Codes by Region

Postal ZIP codes included in each region:

Region I

From	*Thru*	*From*	*Thru*
12007	12099	13601	13699
12106	12177	13730	13797
12184	12199	13801	13865
12401	12498	14001	14098
12701	12792	14101	14174
12801	12887	14301	14305
12901	12998	14410	14489
13020	13094	14501	14592
13101	13176	14701	14788
13301	13368	14801	14898
13401	13439	14901	14925
13450	13495		

Region II

From	*Thru*	*From*	*Thru*
12179	12183	13440	13449
12201	12288	13501	13599
12301	12345	13901	13905
12501	12594	14201	14280
12601	12614	14601	14694
13201	13290		

Region III

From	*Thru*	*From*	*Thru*
06390	06390	10801	10805
10501	10598	10901	10998
10601	10650	11901	11980
10701	10710		

Region IV

From	*Thru*	*From*	*Thru*
00501	00501	11101	11120
00544	00544	11201	11256
10001	10099	11301	11390
10100	10199	11401	11499
10200	10299	11501	11599
10301	10314	11601	11697
10401	10499	11701	11798
11001	11096	11801	11854

Numerical List of Postal ZIP Codes

From	*Thru*	*Region*	*From*	*Thru*	*Region*
00501	00501	IV	12401	12498	I
00544	00544	IV	12501	12594	II
06390	06390	III	12601	12614	II
10001	10099	IV	12701	12792	I
10100	10199	IV	12801	12887	I
10200	10299	IV	12901	12998	I
10301	10314	IV	13020	13094	I

From	*Thru*	*Region*	*From*	*Thru*	*Region*
10401	10499	IV	13101	13176	I
10501	10598	III	13201	13290	II
10601	10650	III	13301	13368	I
10701	10710	III	13401	13439	I
10801	10805	III	13440	13449	II
10901	10998	III	13450	13495	I
11001	11096	IV	13501	13599	II
11101	11120	IV	13601	13699	I
11201	11256	IV	13730	13797	I
11301	11390	IV	13801	13865	I
11401	11499	IV	13901	13905	II
11501	11599	IV	14001	14098	I
11601	11697	IV	14101	14174	I
11701	11798	IV	14201	14280	II
11801	11854	IV	14301	14305	I
11901	11980	III	14410	14489	I
12007	12099	I	14501	14592	I
12106	12177	I	14601	14694	II
12179	12183	II	14701	14788	I
12184	12199	I	14801	14898	I
12201	12288	II	14901	14925	I
12301	12345	II			

Conversion Factors

Regional conversion factors for services rendered on or after April 1, 2019.

Section	Region I	Region II	Region III	Region IV
Psychology	$7.94	$7.94	$9.08	$9.86

Physicians and psychiatric nurse practitioners can bill codes from other sections of the *Official New York State Workers' Compensation Medical Fee Schedule* as appropriate (such as E/M, Medicine, etc.) and should determine their fees using the corresponding conversion factors listed in that manual's Introduction and General Guidelines section. Nurse practitioners and licensed clinical social workers should use appropriate modifiers and bill in accordance with General Ground Rules 9 and 12 herein.

New CPT Codes

The table below is a complete list of CPT codes that have been added to the Behavioral Health Fee Schedule since the June 1, 2012 fee schedule.

These codes are identified in the fee schedule with "■".

90785 90791 90792 90832 90833 90834
90836 90837 90838 90839 90840 97127

Changed Codes

Changed Values

The following table is a list of CPT and state-specific codes applicable to the Behavioral Health Fee Schedule that have a relative value change, an FUD change, or a PC/TC split change since the June 1, 2012 fee schedule. Codes that have had a description change are listed in a separate table below.

Columns that are blank for any code, either do not apply to the code or the code was not assigned a value on the current or previous (June 1, 2012) fee schedule.

For each code listed, the following information is included:

NY 2018 RVU. This is the current RVU for services rendered on or after April 1, 2019.

NY 2012 RVU. This is the RVU effective June 1, 2012.

NY 2018 FUD. This is the FUD for services rendered on or after April 1, 2019.

NY 2012 FUD. This is the FUD listed in the June 1, 2012 fee schedule.

NY 2018 PC/TC Split. This is the PC/TC split for services rendered on or after April 1, 2019. Only codes with distinct professional and technical components are assigned a PC/TC split; therefore, many codes will not have a value in this column.

NY 2012 PC/TC Split. This is the PC/TC split effective June 1, 2012.

These codes are identified in the fee schedule with "■."

CODE	NY 2018 RVU	NY 2012 RVU	NY 2018 FUD	NY 2012 FUD	NY 2018 PC/TC Split	NY 2012 PC/TC Split
99075	$350.00	$400.00				

Changed Descriptions

The table below is a list of CPT codes applicable to the Behavioral Health Fee Schedule that have had a description change since the June 1, 2012 fee schedule.

90846 90847 90875 90876 90889 96110
97533

Deleted CPT Codes

The table below is a list of CPT codes that have been deleted from the Behavioral Health Fee Schedule since the June 1, 2012 fee schedule.

90801 90802 90804 90806 90808 90810
90812 90814 90816 90818 90821 90823
90826 90828 90857 97532

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Behavioral Health Services Provided by Physicians, Psychiatric Nurse Practitioners, Psychologists and Licensed Clinical Social Workers

Behavioral health services will be rendered by a New York State Workers' Compensation Board (NYS WCB) authorized psychiatrist or a NYS WCB authorized physician with a rating code of PN-ADP (Addiction Medicine) or PN-PM (Pain Management), an authorized psychiatric nurse practitioner, psychologist or licensed clinical social worker. A physician, psychiatric nurse practitioner, psychologist or licensed clinical social worker who is not Board authorized may not provide treatment.

All reports and bills shall be submitted in the format prescribed by the Chair by the treating authorized provider. Fees shall be paid at the following rates:

- Psychiatric nurse practitioners shall bill at 80 percent of the applicable medical treatment code and conversion factor available to physicians
- Psychologists shall bill using the applicable behavioral health treatment code and conversion factor
- Licensed clinical social workers shall bill at 80 percent of the applicable medical treatment code and conversion factor for psychologists

Behavioral Health Ground Rules

1A. NYS Medical Treatment Guidelines

Treatment of work-related injuries should be in accordance with any applicable medical treatment guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the fee schedule ground rules and the medical treatment guidelines, the guidelines will prevail. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

1B. Biofeedback

Biofeedback is a form of behavioral medicine that helps patients learn self-awareness and self-regulation skills for the purpose of gaining greater control of their physiology. Electronic instrumentation is used to monitor the targeted physiology and then displayed or fed back to the patient through visual, auditory or tactile means, with coaching by a biofeedback specialist. Treatment is individualized to the patient's work-related diagnosis and needs. Home practice of skills is required for mastery and may be facilitated by the use of home training tapes. The ultimate goal of biofeedback treatment is the transfer of learned skills to the workplace and daily life. Candidates for biofeedback therapy or training must be motivated to learn and practice biofeedback and self-regulation techniques.

Biofeedback is not appropriate for individuals suffering from acute pain or acute injury. It may be appropriate for non-acute pain when combined with a program including functional restoration.

- Time to Produce Effect: 3 to 4 sessions.
- Frequency: 1 to 2 times per week.
- Optimum Duration: 5 to 6 sessions.
- Maximum Duration: 10 to 12 sessions.

When more than one treatment is performed on the same day, the maximum reimbursement will be limited to the highest single relative value.

2. Testing

Psychological tests should not be used routinely. When appropriate, documentation should include the specific indication for each test and overlapping and/or duplicate testing should be avoided. Tests, when administered, must be used in correlation with clinical interview data to monitor a patient's condition and progress. Repeat testing is not necessary or indicated when the clinical documentation supports improved outcomes.

Reimbursement for testing is limited to 11 hours of testing in any 12-month period.

3. Procedures Listed Without Specified Relative Value Units

By report (BR) items: "BR" in the Relative Value column represents services that are too variable in the nature of their performance to permit assignment of relative value units. Fees for such procedures need to be justified "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, skill, and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary, but sufficient information shall be submitted to permit a sound evaluation. It must be emphasized that reviews are based on records; hence the importance of documentation. The original official record, such as the chart notes will be given far greater weight than supplementary reports formulated and submitted at later dates. For any procedure where the relative value unit is listed in the schedule as "BR," the authorized medical provider shall establish a relative value unit consistent in relativity with other unit values shown in the schedule. The insurer shall review all submitted "BR" relative value units to ensure that the relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items.

4. Medical Testimony

As provided in Part 301 of the Workers' Compensation regulations and following direction by the Board, whenever the attendance of the injured employee's treating or consultant authorized physician is required at a hearing or deposition, such physician shall be entitled to an attendance fee of $450. Fees for testimony shall be billed following a direction by the Board as to the fee amount using code 99075.

As provided in Part 301 of the Workers' Compensation regulations and following direction by the Board, whenever the attendance of the injured employee's treating or consultant authorized psychologist, psychiatric nurse practitioner, or licensed clinical social worker is required at a hearing or deposition, such psychologist, nurse practitioner, or social worker shall be entitled to an attendance fee of $350. Fees for testimony shall be billed following a direction by the Board as to the fee amount using code 99075.

5. Evaluation and Management

Evaluation and management services may be reported by physicians and psychiatric nurse practitioners with codes 90833, 90836, and 90838 when both services are performed and documented.

6. Central Nervous System Assessments/Tests (e.g., Neuro-cognitive, Mental Status, Speech Testing) (96101–96127)

CPT codes 96101–96127 are used to report the services provided during testing of the cognitive function of the central nervous system. The testing of cognitive processes, visual motor responses, and abstractive abilities is accomplished by the combination of several types of testing procedures. It is expected that the administration of these tests will generate material that will be formulated into a report. Qualifications of the "technicians" and "qualified health care professionals" referenced in these procedure codes must satisfy the requirements as provided for in Article 153 of the State Education Law.

7. Use of code 97127 and 97533

Reimbursement for code 97127 is limited to a maximum of 1 unit per day. Code 97533 may be reported a maximum of 2 units per day and is limited to 1 unit per day when reported on the same date with code 97127. Both services must be performed face-to-face.

When billing code 97127, an initial report must be submitted containing:

A) Outline of the claimant's current cognitive skill level

B) Proposed treatment plan

C) Expected goals

Thereafter, a progress report should be filed at least every four weeks that updates:

A) The claimant's current cognitive skill level

B) The treatment plan

C) Claimant's progress towards expected goals

All reporting requirements are inclusive in the fee for the service.

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8. Health and Behavior Assessment/Intervention

Assessment and intervention codes are reported for patients with physical health problems where the focus is not on mental health, but emotional and social factors contributing to the individual's well-being. When psychiatric services are performed during the same encounter, the dominating service should be reported, but not both services.

Information obtained through the assessment testing is interpreted and a written report is generated. The interpretation and report are included in the service.

Codes 96150–96155 describe services associated with an acute or chronic illness (not meeting criteria for psychiatric diagnosis), prevention of a physical illness or disability, and maintenance of health, not meeting criteria for a psychiatric diagnosis, or representing a preventive medicine service.

For patients that require psychiatric services (90785–90899) as well as health and behavior assessment/intervention (96150–96155), report the predominant service performed. Do not report codes 96150–96155 in addition to codes 90785–90899 on the same date.

9. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Modifiers commonly used in the Medicine section are:

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

51 Multiple Procedures

When multiple procedures, other than E/M services, physical medicine and rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D).

99 Multiple Modifiers

Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

1B∞ Behavioral Health Provider Enhanced Reimbursement

Provides a 20 percent reimbursement increase for E/M and Medicine Behavioral Health services when rendered by Licensed Clinical Social Workers and the providers with the following WCB assigned provider rating codes:

Rating Code	Description
PN-P	PSYCHIATRY
OPPN-P	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – PSYCHIATRY
CPN-P	PSYCHIATRY CONSULTANT
OPCPN-P	OSTEOPATHIC PSYCHIATRY
PN-ADP	ADDICTION PSYCHIATRY
OPPN-ADP	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – ADDICTION PSYCHIATRY
CPN-ADP	ADDICTION PSYCHIATRY CONSULTANT
OPCPN-ADP	OSTEOPATHIC ADDICTION PSYCHIATRY
PN-PM	PAIN MANAGEMENT
OPPN-PM	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – PAIN MANAGEMENT
CPN-PM	PAIN MANAGEMENT CONSULTANT
OPCPN-PM	OSTEOPATHIC PAIN MANAGEMENT
PSY	PSYCHOLOGY

* A supervising physician needs to have a rating code eligible for the modifier 1B enhancement.

Rating Code	Description
LCSW	LICENSED CLINICAL SOCIAL WORKER
LCSW-R	LICENSED CLINICAL SOCIAL WORKER – PSYCHOTHERAPY
NP-P	NURSE PRACTITIONER IN PSYCHIATRY
PHYAS	PHYSICIAN ASSISTANT*

* A supervising physician needs to have a rating code eligible for the modifier 1B enhancement.

10. Treatment by Out-of-State Providers

Claimant lives outside of New York State—A claimant who lives outside of New York State may treat with a qualified out-of-state medical provider. The medical treatment shall conform to the Medical Treatment Guidelines and the Ground Rules included herein. Payment for medical treatment shall be at the Fee Schedule for work related injuries and illnesses as available in the state where treatment is rendered, or if there is no such fee schedule, then such charges shall be as prevail in the community for similar treatment. All fees shall be subject to the jurisdiction of the Board.

Claimant lives in New York State but treats outside of New York State—A claimant who lives in New York State may treat with a qualified or Board authorized out-of-state medical provider when such treatment conforms to the Workers' Compensation Law and regulations, the Medical Treatment Guidelines and the Medical Fee Schedule. Payment shall be made to the medical provider as set forth herein and using the regional conversion factor for the ZIP code where the claimant resides.

Out-of-state medical treatment that does not "further the economic and humanitarian objectives" of Workers' Compensation Law may be denied by the Board.

A medical provider who has had a NYSWCB authorization suspended, revoked or surrendered shall not be qualified to treat out-of-state.

Permanency—The New York State guidelines on permanent impairment, pertaining to both the schedule loss of use and classification, apply regardless of whether claimant lives in or out of New York State.

11. Non-Schedule Permanency Evaluations

Code 99243 is used to report a non-scheduled permanency evaluation. Codes 99455–99456 may not be used for this purpose.

12. Behavioral Health Provider Enhanced Reimbursement

In an effort to increase the number of Board-authorized providers in behavioral health to render care and treatment to injured workers, the WCB has established WCB-specific modifier 1B which will provide a 20 percent reimbursement increase to providers with WCB assigned rating codes for designated services. Modifier 1B provides a 20 percent reimbursement increase for E/M and Medicine Behavioral Health services when rendered by licensed clinical social workers and the providers with the following WCB assigned provider rating codes:

Rating Code	Description
PN-P	PSYCHIATRY
OPPN-P	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – PSYCHIATRY
CPN-P	PSYCHIATRY CONSULTANT
OPCPN-P	OSTEOPATHIC PSYCHIATRY
PN-ADP	ADDICTION PSYCHIATRY
OPPN-ADP	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – ADDICTION PSYCHIATRY
CPN-ADP	ADDICTION PSYCHIATRY CONSULTANT
OPCPN-ADP	OSTEOPATHIC ADDICTION PSYCHIATRY
PN-PM	PAIN MANAGEMENT
OPPN-PM	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – PAIN MANAGEMENT
CPN-PM	PAIN MANAGEMENT CONSULTANT
OPCPN-PM	OSTEOPATHIC PAIN MANAGEMENT
PSY	PSYCHOLOGY
LCSW	LICENSED CLINICAL SOCIAL WORKER
LCSW-R	LICENSED CLINICAL SOCIAL WORKER – PSYCHOTHERAPY
NP-P	NURSE PRACTITIONER IN PSYCHIATRY
PHYAS	PHYSICIAN ASSISTANT*

* A supervising physician needs to have a rating code eligible for the modifier 1B enhancement.

13. Codes in the Behavioral Health Fee Schedule

An authorized psychologist and licensed clinical social worker may only use CPT codes contained in the Behavioral Health Fee Schedule for billing of treatment. A psychologist and social worker may not use codes that do not appear in the Behavioral Health Fee Schedule.

Revised printing effective 1/1/2020

BEHAVIORAL HEALTH 90785–99499

Behavioral Health Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD
■	+	**90785**	Interactive complexity (List separately in addition to the code for primary procedure)	2.80	ZZZ
■		**90791**	Psychiatric diagnostic evaluation	25.84	XXX
■		**90792**	Psychiatric diagnostic evaluation with medical services	27.75	XXX
■		**90832**	Psychotherapy, 30 minutes with patient	12.59	XXX
■	+	**90833**	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	13.13	ZZZ
■		**90834**	Psychotherapy, 45 minutes with patient	16.83	XXX
■	+	**90836**	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	16.55	ZZZ
■		**90837**	Psychotherapy, 60 minutes with patient	25.24	XXX
■	+	**90838**	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	21.89	ZZZ
■		**90839**	Psychotherapy for crisis; first 60 minutes	26.34	XXX
■	+	**90840**	Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)	12.59	ZZZ
		90845	Psychoanalysis	16.43	XXX
■		**90846**	Family psychotherapy (without the patient present), 50 minutes	16.91	XXX
■		**90847**	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	20.42	XXX
		90849	Multiple-family group psychotherapy	5.42	XXX
		90853	Group psychotherapy (other than of a multiple-family group)	5.42	XXX
■		**90875**	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 30 minutes	11.01	XXX
■		**90876**	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 45 minutes	17.55	XXX
		90880	Hypnotherapy	20.26	XXX
		90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions	13.36	XXX
		90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	8.93	XXX
		90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	13.72	XXX
■		**90889**	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers	NC	XXX
		90899	Unlisted psychiatric service or procedure	BR	XXX
		90901	Biofeedback training by any modality	9.81	000
		90911	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry	16.91	000
		96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	24.52	XXX
		96102	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face	11.16	XXX
		96103	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report	7.10	XXX
		96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	18.50	XXX

OFFICIAL

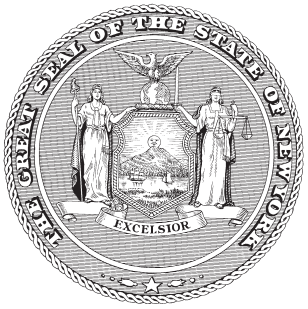
NEW YORK STATE WORKERS' COMPENSATION

CHIROPRACTIC FEE SCHEDULE

Effective 4/1/2019
Revisions Effective 1/1/2020

Workers' Compensation Board

Made in the USA



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Optum360 worked closely with the New York Workers' Compensation Board in the development, formatting, and production of this fee schedule. However, all decisions resulting in the final content of this schedule were made solely by the New York Workers' Compensation Board.

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The Chiropractic Fee Schedule was duly filed in the Office of the Department of State, and constitutes Sections 348.1 and 348.2 of Title 12 of the Official Compilation of Codes, Rules, and Regulations of the State of New York.

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Revised Printing

This revised printing contains revisions effective January 1, 2020.

FOREWORD

The Workers' Compensation Board is pleased to present the updated version of the *New York State Workers' Compensation Chiropractic Fee Schedule*.

The revised fee schedule is an essential tool for health care providers and those paying the cost of health care services under the New York State Workers' Compensation system. This schedule provides comprehensive billing guides, which will allow health care providers to appropriately describe their services and minimize disputes over reimbursement. Also, this schedule includes many new procedures and coding changes that have taken place since the previously published fee schedule.

This fee schedule could not have been produced without the assistance of many individuals. The spirit of cooperation between the provider and payer communities is very much appreciated. The excellence of this schedule is due, in large part, to the commitment of many people in the workers' compensation community. We are grateful for their efforts.

Except where noted, this fee schedule is effective for medical services rendered on or after April 1, 2019, regardless of the date of accident. The fees established herein are payable to health care providers authorized or permitted to render care under the Workers' Compensation Law, Volunteer Firefighters' Benefit Law, and Volunteer Ambulance Workers' Benefit Law.

New York State Workers' Compensation Board

Region II

From	*Thru*	*From*	*Thru*
12179	12183	13440	13449
12201	12288	13501	13599
12301	12345	13901	13905
12501	12594	14201	14280
12601	12614	14601	14694
13201	13290		

Region III

From	*Thru*	*From*	*Thru*
06390	06390	10801	10805
10501	10598	10901	10998
10601	10650	11901	11980
10701	10710		

Region IV

From	*Thru*	*From*	*Thru*
00501	00501	11101	11120
00544	00544	11201	11256
10001	10099	11301	11390
10100	10199	11401	11499
10200	10299	11501	11599
10301	10314	11601	11697
10401	10499	11701	11798
11001	11096	11801	11854

Numerical List of Postal ZIP Codes

From	*Thru*	*Region*	*From*	*Thru*	*Region*
00501	00501	IV	12401	12498	I
00544	00544	IV	12501	12594	II
06390	06390	III	12601	12614	II
10001	10099	IV	12701	12792	I
10100	10199	IV	12801	12887	I
10200	10299	IV	12901	12998	I
10301	10314	IV	13020	13094	I
10401	10499	IV	13101	13176	I
10501	10598	III	13201	13290	II
10601	10650	III	13301	13368	I
10701	10710	III	13401	13439	I
10801	10805	III	13440	13449	II
10901	10998	III	13450	13495	I
11001	11096	IV	13501	13599	II
11101	11120	IV	13601	13699	I
11201	11256	IV	13730	13797	I
11301	11390	IV	13801	13865	I
11401	11499	IV	13901	13905	II
11501	11599	IV	14001	14098	I
11601	11697	IV	14101	14174	I
11701	11798	IV	14201	14280	II
11801	11854	IV	14301	14305	I
11901	11980	III	14410	14489	I
12007	12099	I	14501	14592	I
12106	12177	I	14601	14694	II
12179	12183	II	14701	14788	I
12184	12199	I	14801	14898	I
12201	12288	II	14901	14925	I
12301	12345	II			

Conversion Factors

Regional conversion factors for services rendered on or after April 1, 2019 except as noted below.

Section	Region I	Region II	Region III	Region IV
E/M	$6.37	$6.37	$7.29	$7.92
Medicine	$6.09	$6.09	$6.97	$7.57
Physical Medicine				
(eff. 04/01/2019-12/31/2019)	$5.77	$5.77	$6.60	$7.17
(eff. 01/01/2020)	$7.69	$7.69	$8.79	$9.55
Radiology	$32.01	$32.01	$36.63	$39.82

Calculating Fees Using Relative Values and Conversion Factors

Except as otherwise provided in this schedule, the maximum fee amount is calculated by multiplying the relative value by the applicable conversion factor. For example, the total fee for code 99201, performed in Region I or Region II, would be calculated as follows:

5.83 (Relative Value)
x $6.37 (Chiropractic E/M Section Conversion Factor for Region I or Region II)
= $37.14

New CPT Codes

The table below is a complete list of CPT codes that have been added to the Chiropractic Fee Schedule since the June 1, 2012 fee schedule.

These codes are identified in the fee schedule with "■".

72081	72082	72083	72084	73501	73502
73503	73521	73522	73523	73551	73552
95885	95886	95887	95907	95908	95909
95910	95911	95912	95913	97763	

Changed Codes

Changed Values

The following table is a list of CPT and state-specific codes applicable to the Chiropractic Fee Schedule that have a

relative value change, an FUD change, or a PC/TC split change since the June 1, 2012 fee schedule. Codes that have had a description change, are listed in a separate table below.

Columns that are blank for any code either do not apply to the code or the code was not assigned a value on the current or previous (June 1, 2012) fee schedule.

For each code listed, the following information is included:

NY 2018 RVU. This is the current RVU for services rendered on or after April 1, 2019.

NY 2012 RVU. This is the RVU effective June 1, 2012.

NY 2018 FUD. This is the FUD for services rendered on or after April 1, 2019.

NY 2012 FUD. This is the FUD listed in the June 1, 2012 fee schedule.

NY 2018 PC/TC Split. This is the PC/TC split for services rendered on or after April 1, 2019. Only codes with distinct professional and technical components are assigned a PC/TC split; therefore, many codes will not have a value in this column.

NY 2012 PC/TC Split. This is the PC/TC split effective June 1, 2012.

These codes are identified in the fee schedule with "■."

CODE	NY 2018 RVU	NY 2012 RVU	NY 2018 FUD	NY 2012 FUD	NY 2018 PC/TC Split	NY 2012 PC/TC Split
97010	0.55	2.37	XXX	XXX		
97750	0.00	5.41	XXX	XXX		
99075	$350.00	$400.00				

Changed Descriptions

The table below is a complete list of CPT codes that have had a description change in the Chiropractic Fee Schedule since the June 1, 2012 fee schedule.

72040	72050	72052	72080	95930	97530
99070	99201	99202	99203	99204	99212

Deleted CPT Codes

The table below is a list of CPT codes that have been deleted from the Chiropractic Fee Schedule since the June 1, 2012 fee schedule.

72010	72069	72090	73500	73510	73520
73550	95900	95903	95904	95934	95936
97762					

General Ground Rules

1A. NYS Medical Treatment Guidelines

The recommendations of the NYS Medical Treatment Guidelines supersede the ground rule frequency limitation for services rendered to body parts covered by the NYS Medical Treatment Guidelines. Treatment of work-related injuries should be in accordance with any applicable medical treatment guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the fee schedule ground rules and the medical treatment guidelines, the guidelines will prevail. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

1B. Unlisted Service or Procedure

When an unlisted service or procedure is provided the procedure should be identified and the value substantiated "by report" (see Ground Rule 2 below). All sections will have an unlisted service or procedure code number, usually ending in "99."

2. Procedures Listed Without Specified Relative Value Units

By report (BR) items: "BR" in the relative value column represents services that are too variable in the nature of their performance to permit assignment of relative value units. Fees for such procedures need to be justified "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary, but sufficient information shall be submitted to permit a sound evaluation. It must be emphasized that reviews are based on records; hence the importance of documentation. The original official record, such as operative report and hospital chart, will be given far greater weight than supplementary reports formulated and submitted at later dates. For any procedure where the relative value unit is listed in the schedule as "BR," the chiropractor shall establish a relative value unit consistent in relativity with other relative value units shown in the schedule. The insurer shall review all submitted "BR" unit values to ensure that the relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items.

3. Materials Supplied by Chiropractor

Durable Medical Equipment Fee Schedule

Prior to the effective date of the 2020 Durable Medical Equipment Fee Schedule, for durable medical equipment administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070.

Following the effective date of the 2020 Durable Medical Equipment Fee Schedule, all durable medical equipment supplied shall be billed and paid using the 2020 Durable Medical Equipment Fee Schedule. The 2020 Durable Medical Equipment Fee Schedule is/will be available on the Board's website. Any item identified as requiring prior authorization in the 2020 Durable Medical Equipment Fee Schedule or not listed in the 2020 Durable Medical Equipment Fee Schedule may not be billed without such prior authorization.

Do not bill for or report supplies that are customarily included in surgical packages, such as gauze, sponges, Steri-strips, and dressings; drug screening supplies; and hot and cold packs. These items are included in the fee for the medical services in which such supplies are used.

4. Miscellaneous

When reporting services in which the relativity is predicated on the basis of time, information concerning the amount of time spent should be indicated.

5. Medical Testimony

As provided in Part 301 of the Workers' Compensation regulations and following direction by the Board, whenever the attendance of the injured employee's treating or consultant chiropractor is required at a hearing or deposition, such chiropractor shall be entitled to an attendance fee of $350. Fees for testimony shall be billed following a direction by the Board as to the fee amount using code 99075.

6. Chiropractic Manipulative Treatment (CMT)

Chiropractic manipulative treatment (CMT) is a form of manual spinal treatment performed by a chiropractor. Please see procedure codes 98940–98943.

The CMT codes include charges for standard premanipulation assessment. Evaluation and management services can be reported separately by adding modifier 25, if the condition of a patient requires a significantly separate E/M service, beyond the usual pre- and postservice associated with the procedure.

Per *CPT 2018* the five spinal regions for CMT are:

- Cervical region includes atlanto-occipital joint
- Thoracic region—includes the costovertebral and costotransverse joints
- Lumbar region
- Sacral region
- Pelvic region—includes sacro-iliac joint

7. Periodic Re-evaluation

Code 99212 may be used to bill for a periodic re-evaluation consisting of documentation of: (1) an interim history describing the patient's response to the current treatment regimen (i.e., efficacy of the treatment/modality), (2) objective findings on physical examination, and (3) the future treatment plan and goals. If there is a positive patient response, functional gains must be objectively measured (including but not limited to improvement in positional tolerances, range of motion, strength, endurance) and documented. If the patient has not demonstrated a positive response, the treatment regimen should be modified or discontinued. The provider should re-evaluate the efficacy of the treatment or modality 2–3 weeks after the initial visit and every 3–4 weeks thereafter. The maximum number of RVUs (including treatment) per person per day per accident or illness when billing for a re-evaluation shall be limited to 15.0.

8. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of a Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M

service to be reported (see **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in the decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

26 Professional Component
Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component
Certain procedures are a combination of a professional component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

50 Bilateral Procedure
Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5 digit code.

59 Distinct Procedural Service
Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

76 Repeat Procedure or Service by the Same Physician or Other Qualified Health Care Professional
It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional
It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

99 Multiple Modifiers
Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

9. Treatment by Out-of-State Providers

Claimant lives outside of New York State—A claimant who lives outside of New York State may treat with a qualified out-of-state medical provider. The medical treatment shall conform to the Medical Treatment Guidelines and the Ground Rules included herein. Payment for medical treatment shall be at the Fee Schedule amount for work related injuries and illnesses as available in the state where treatment is rendered, or if there is no such fee schedule, then such charges shall be as prevail in the community for similar treatment. All fees shall be subject to the jurisdiction of the Board.

Claimant lives in New York State but treats outside of New York State—A claimant who lives in New York State may treat with a qualified or Board authorized out-of-state medical provider when such treatment conforms to the Workers' Compensation Law and regulations, the Medical Treatment Guidelines and the Medical Fee Schedule. Payment shall be made to the

medical provider as set forth herein and using the regional conversion factor for the ZIP code where the claimant resides.

Out-of-state medical treatment that does not "further the economic and humanitarian objective" of Workers' Compensation Law may be denied by the Board.

A medical provider who has had a NYS WCB authorization suspended, revoked or surrendered shall not be qualified to treat out-of-state.

Permanency—The New York State guidelines on permanent impairment, pertaining to both the schedule loss of use and classification, apply regardless of whether claimant lives in or out of New York State.

10. Codes in the Chiropractic Fee Schedule

A chiropractor may only use CPT codes contained in the Chiropractic Fee Schedule for billing of treatment. A chiropractor may not use codes that do not appear in the Chiropractic Fee Schedule.

11. Moxibustion and Other Complementary Integrative Medicine Techniques

Moxibustion and other complementary integrative medicine techniques are often combined with acupuncture. No additional reimbursement will be provided for acupuncture combined with moxibustion or other similar adjunctive procedures.

4 Medicine

The relative values listed in this section have been determined on an entirely different basis than those in other sections. A conversion factor applicable to this section is not applicable to any other section. The relative value units listed in this section reflect the relativity of charges for procedures within this section only. The fee for a particular procedure or service in this section is determined by multiplying the listed relative value unit by the current dollar conversion factor applicable to this section, subject to the ground rules, instructions, and definitions of the schedule. To ensure uniformity of billing, when multiple services are rendered, each relative value unit is to be multiplied by the conversion factor separately, and then the products are to be added.

Medicine Ground Rules

Rules used by all chiropractors in reporting their services are presented in the Introduction and General Guidelines section preceding the Medicine section. Definitions and rules pertaining to Medicine services are as follows:

1A. NYS Medical Treatment Guidelines

The recommendations of the NYS Medical Treatment Guidelines supersede the ground rule frequency limitation for services rendered to body parts covered by the NYS Medical Treatment Guidelines. The maximum reimbursement limitations per patient per day per accident or illness for modalities is 12.0 RVUs, re-evaluation plus modalities is 15.0 RVUs, and initial evaluation plus modalities is 18.0 RVUs for all providers combined. Treatment of work-related injuries should be in accordance with any applicable medical treatment guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the fee schedule ground rules and the medical treatment guidelines, the guidelines will prevail. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

1B. Special Services and Reports

Charges for services generally provided as an adjunct to common medical services should be made only when circumstances clearly warrant an additional charge over and above the scheduled charges for basic services.

2. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Modifiers commonly used with medicine procedures are as follows:

26 ***Professional Component***
Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

51 ***Multiple Procedures***
When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D).

TC ***Technical Component***
Certain procedures are a combination of a professional component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number

3. EDX (Codes 95907–95913)

EDX is only recommended where there is failure of suspected radicular pain to resolve or plateau after waiting 4 to 6 weeks (to provide for sufficient time to develop EMG abnormalities as well as time for

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conservative treatment to resolve the problems), equivocal imaging findings, e.g., on CT or MRI studies, and suspicion by history and physical examination that a neurologic condition other than radiculopathy may be present instead of or in addition to radiculopathy. When such testing is recommended, the provider shall select from codes 95907–95913 using 1 unit of the 1 code that most closely represents the nerve(s) tested. Requests for repeat testing require approval from the carrier.

5 Physical Medicine

The relative values in this section were determined uniquely for physical medicine services. Use the physical medicine conversion factor when determining fee amounts. The physical medicine conversion factor is not applicable to any other section. The fee for a procedure or service in this section is determined by multiplying the relative value by the physical medicine conversion factor, subject to the ground rules, instructions, and definitions of the schedule. Conversion factors are located in the Introduction and General Guidelines section. To ensure uniformity of billing when multiple services are rendered, each relative value unit is to be multiplied by the conversion factor separately. After which, charges for products may be added.

Physical Medicine Ground Rules

The fees for physical medicine services are payable when services are rendered by a chiropractor. When physical medicine treatment is rendered in the follow-up period of surgical or fracture care procedures, the treatment is not considered part of the global surgical fee. Physical medicine services are separately covered procedures when rendered during the follow-up period of any surgical service. When a patient is seen by a chiropractor prior to and during the implementation of a physical medicine program, and a history and physical examination is performed, a fee for an office visit is permitted. Definitions and rules pertaining to physical medicine services are as follows:

Note: Rules used by a chiropractor in reporting services are presented in the General Ground Rules in the Introduction and General Guidelines section.

1A. NYS Medical Treatment Guidelines

The recommendations of the NYS Medical Treatment Guidelines supersede the ground rule frequency limitation for services rendered to body parts covered by the medical treatment guidelines. The maximum reimbursement limitations per patient per day per accident or illness for modalities is 12.0 RVUs, re-evaluation plus modalities is 15.0 RVUs, and initial evaluation plus modalities is 18.0 RVUs for all providers combined. Treatment of work-related injuries should be in accordance with any applicable medical treatment guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the fee schedule ground rules and the medical treatment guidelines, the guidelines will prevail. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

2. Initial Evaluation and Re-evaluation

Chiropractors may bill for an initial evaluation using CPT codes 99201–99204. Evaluations shall include the following elements: history, clinical testing, and interpretation of data and development of the plan of care with defined goals, appropriate interventions, and recommendations.

The maximum number of relative value units (including treatment) per patient per day when billing for an initial evaluation shall be limited to 18.0 RVUs. The maximum number of relative value units (including treatment) per patient per day when billing for a re-evaluation shall be limited to 15.0 RVUs.

The following codes represent the treatments subject to this rule:

97010	97012	97014	97024	97026	97028
97032	97033	97034	97035	97036	97039
97110	97112	97113	97116	97124	97139
97140	97530	97810	97811	97813	97814
98940	98941	98942			

Re-evaluations may be billed using CPT code 99212 when any of the following applies:

A) If following discharge (for whatever reason), the patient is referred again for treatment with the same or similar condition of the same body part.

B) If there is a significant change in the patient's condition that warrants a revision of the treatment goals, intervention and/or the plan of care.

C) If it is medically necessary to provide re-evaluation services over and above those normally included during therapeutic treatment.

D) If the patient's status becomes stationary and it is not likely that significant improvement will occur with further treatment.

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E) If at the conclusion of the current episode of therapy care, re-evaluation is indicated for any of the following reasons:

- Satisfactory goal achievement with present functional status defined including a home program and follow-up services, as necessary.
- Patient declines to continue care
- The patient is unable to continue to work toward goals due to medical or psychosocial complications

3. Multiple Physical Medicine Procedures and Modalities

When multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 12.0 RVUs per patient per day per accident or illness or the amount billed, whichever is less. **Note:** When a patient receives physical medicine procedures, acupuncture and/or chiropractic modalities from more than one provider, the patient may not receive more than 12.0 RVUs per day per accident or illness from all providers combined. The following codes represent the physical medicine procedures and modalities subject to this rule:

97010	97012	97014	97024	97026	97028
97032	97033	97034	97035	97036	97039
97110	97112	97113	97116	97124	97139
97140	97530	97810	97811	97813	97814
98940	98941	98942			

4. Tests and Measurements

Code 97763 training and management for orthotic/prosthetic use, shall not be billed on the same day as an office visit.

5. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Modifiers commonly used with physical medicine procedures are as follows:

22 Increased Procedure Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

51 Multiple Procedures

When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D).

99 Multiple Modifiers

Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

OFFICIAL

NEW YORK STATE WORKERS' COMPENSATION

PODIATRY FEE SCHEDULE

Effective 4/1/2019
Revisions Effective 1/1/2020

Workers' Compensation Board

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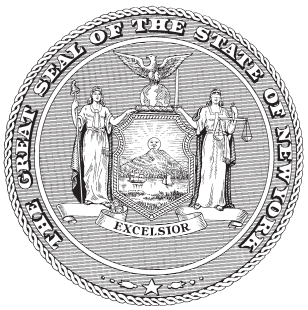

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Optum360 worked closely with the New York Workers' Compensation Board in the development, formatting, and production of this fee schedule. However, all decisions resulting in the final content of this schedule were made solely by the New York Workers' Compensation Board.

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The Podiatry Fee Schedule was duly filed in the Office of the Department of State, and constitutes Sections 343.1 and 343.2 of Title 12 of the Official Compilation of Codes, Rules, and Regulations of the State of New York.

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Revised Printing

This revised printing contains revisions effective January 1, 2020.

FOREWORD

The Workers' Compensation Board is pleased to present the updated version of the *New York State Workers' Compensation Podiatry Fee Schedule*.

The revised fee schedule is an essential tool for health care providers and those paying the cost of health care services under the New York State Workers' Compensation system. This schedule provides comprehensive billing guides, which will allow health care providers to appropriately describe their services and minimize disputes over reimbursement. Also, this schedule includes many new procedures and coding changes that have taken place since the previously published fee schedule.

This fee schedule could not have been produced without the assistance of many individuals. The spirit of cooperation between the provider and payer communities is very much appreciated. The excellence of this schedule is due, in large part, to the commitment of many people in the workers' compensation community. We are grateful for their efforts.

Except where noted, this fee schedule is effective for medical services rendered on or after April 1, 2019, regardless of the date of accident. The fees established herein are payable to health care providers authorized or permitted to render care under the Workers' Compensation Law, Volunteer Firefighters' Benefit Law, and Volunteer Ambulance Workers' Benefit Law.

New York State Workers' Compensation Board

From	*Thru*	*From*	*Thru*
13301	13368	14801	14898
13401	13439	14901	14925
13450	13495		

Region II

From	*Thru*	*From*	*Thru*
12179	12183	13440	13449
12201	12288	13501	13599
12301	12345	13901	13905
12501	12594	14201	14280
12601	12614	14601	14694
13201	13290		

Region III

From	*Thru*	*From*	*Thru*
06390	06390	10801	10805
10501	10598	10901	10998
10601	10650	11901	11980
10701	10710		

Region IV

From	*Thru*	*From*	*Thru*
00501	00501	11101	11120
00544	00544	11201	11256
10001	10099	11301	11390
10100	10199	11401	11499
10200	10299	11501	11599
10301	10314	11601	11697
10401	10499	11701	11798
11001	11096	11801	11854

Numerical List of Postal ZIP Codes

From	*Thru*	*Region*	*From*	*Thru*	*Region*
00501	00501	IV	12401	12498	I
00544	00544	IV	12501	12594	II
06390	06390	III	12601	12614	II
10001	10099	IV	12701	12792	I
10100	10199	IV	12801	12887	I
10200	10299	IV	12901	12998	I
10301	10314	IV	13020	13094	I
10401	10499	IV	13101	13176	I
10501	10598	III	13201	13290	II
10601	10650	III	13301	13368	I
10701	10710	III	13401	13439	I
10801	10805	III	13440	13449	II
10901	10998	III	13450	13495	I
11001	11096	IV	13501	13599	II
11101	11120	IV	13601	13699	I
11201	11256	IV	13730	13797	I
11301	11390	IV	13801	13865	I
11501	11599	IV	14001	14098	I
11601	11697	IV	14101	14174	I
11701	11798	IV	14201	14280	II
11801	11854	IV	14301	14305	I
11901	11980	III	14410	14489	I
12007	12099	I	14501	14592	I
12106	12177	I	14601	14694	II
12179	12183	II	14701	14788	I
12184	12199	I	14801	14898	I
12201	12288	II	14901	14925	I
12301	12345	II			

Conversion Factors

Regional conversion factors are for services rendered on or after April 1, 2019.

Section	Region I	Region II	Region III	Region IV
E/M	$12.11	$12.11	$13.85	$15.06
Medicine	$8.91	$8.91	$10.19	$11.07
Surgery	$202.53	$202.53	$231.78	$251.94
Radiology	$46.77	$46.77	$53.53	$58.19
Pathology and Laboratory	$1.06	$1.06	$1.21	$1.31
Appliances and Prostheses	$17.18	$17.18	$17.18	$17.18

New CPT Codes

The table below is a list of CPT codes applicable to the Podiatry Fee Schedule that have been added since the June 1, 2012 fee schedule.

These codes are identified in the fee schedule with "■".

28291

Changed Codes

Changed Values

The following table is a list of CPT and state-specific codes applicable to the Podiatry Fee Schedule that have a relative value change, an FUD change, or a PC/TC split change since the June 1, 2012 fee schedule. Codes that have had a description change, are listed in a separate table below.

Columns that are blank for any code either do not apply to the code or the code was not assigned a value on the current or previous (June 1, 2012) fee schedule.

For each code listed, the following information is included:

NY 2018 RVU. This is the current RVU for services rendered on or after April 1, 2019.

NY 2012 RVU. This is the RVU effective June 1, 2012.

NY 2018 FUD. This is the FUD for services rendered on or after April 1, 2019.

NY 2012 FUD. This is the FUD listed in the June 1, 2012 fee schedule.

NY 2018 PC/TC Split. This is the PC/TC split for services rendered on or after April 1, 2019. Only codes with distinct professional and technical components are assigned a PC/TC split; therefore, many codes will not have a value in this column.

NY 2012 PC/TC Split. This is the PC/TC split effective June 1, 2012.

These codes are identified in the fee schedule with "■."

CODE	NY 2018 RVU	NY 2012 RVU	NY 2018 FUD	NY2012 FUD	NY 2018 PC/TC Split	NY 2012 PC/TC Split
77002	2.81	2.81	ZZZ	XXX	34/66	34/66
99075	$450.00	$400.00				

Changed Descriptions

The table below is a list of CPT codes applicable to the Podiatry Fee Schedule that have had a description change since the June 1, 2012 fee schedule.

11623	15777	17250	20600	20605	20610
20665	27615	27616	28046	28047	28292
28296	28297	28298	28299	28890	76881
76882	77002	95004	95024	99205	99211
99213	99214	99215	99217	99218	99219
99220	99221	99222	99223	99224	99225
99226	99231	99232	99233	99234	99235
99236	99241	99242	99243	99244	99245
99251	99252	99253	99254	99255	99281
99282	99283	99284	99285	99304	99305
99306	99307	99308	99309	99310	99318
99324	99325	99326	99327	99328	99334
99335	99336	99337	99341	99342	99343
99344	99345	99347	99348	99349	99350
99354	99355	99375			

Deleted CPT Codes

The table below is a list of CPT codes applicable to the Podiatry Fee Schedule that have been deleted since the June 1, 2012 fee schedule.

11752	28290	28293	28294	29582	29590
95015					

General Ground Rules

1A. NYS Medical Treatment Guidelines

Treatment of work-related injuries should be in accordance with any applicable medical treatment guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the fee schedule ground rules and the medical treatment guidelines, the guidelines will prevail. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

1B. Multiple Procedures

It is appropriate to designate multiple procedures that are rendered on the same date by separate entries.

2. Unlisted Service or Procedure

Some services performed are not described by any CPT code. These services should be reported using an unlisted code and substantiating it by report as discussed in Rule 3 below. All sections will have an unlisted service or procedure code number, usually ending in "99."

3. Procedures Listed Without Specified Unit Values: By Report (BR) Items

"BR" in the unit value column represents services that are too variable in the nature of their performance to permit assignment of relative value units. Fees for such procedures need to be justified "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary, but sufficient information shall be submitted to permit a sound evaluation. It must be emphasized that reviews are based on records; hence the importance of documentation. The original official record, such as operative report and hospital chart, will be given far greater weight than supplementary reports formulated and submitted at later dates. For any procedure where the relative value unit is listed in the Schedule as "BR," the podiatrist shall establish a relative value unit consistent in relativity with other relative value units shown in the Schedule. The insurer shall review all submitted "BR" relative value units to ensure that the relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items.

4. Materials Supplied by Podiatrist: Pharmaceuticals and Durable Medical Equipment

A) **Pharmacy**

A prescriber cannot dispense more than a seventy-two hour supply of drugs with the exceptions of:

1. Persons practicing in hospitals as defined in section 2801 of the public health law;
2. The dispensing of drugs at no charge to their patients;
3. Persons whose practices are situated ten miles or more from a registered pharmacy;
4. The dispensing of drugs in a clinic, infirmary, or health service that is operated by or affiliated with a post-secondary institution;
5. The dispensing of drugs in a medical emergency as defined in subdivision six of section 6810 of the State Education Law.

For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070.

B) **Durable Medical Equipment**

Prior to the effective date of the 2020 Durable Medical Equipment Fee Schedule, for durable medical equipment administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070.

Following the effective date of the 2020 Durable Medical Equipment Fee Schedule, all durable medical equipment supplied shall be billed and paid using the 2020 Durable Medical Equipment Fee Schedule. The 2020 Durable Medical Equipment Fee Schedule is/will be available on the Board's website. Any item identified as requiring prior authorization in the 2020 Durable Medical Equipment Fee Schedule or not listed in the 2020 Durable Medical Equipment Fee Schedule may not be billed without such prior authorization.

Do not bill for or report supplies that are customarily included in surgical packages, such as gauze, sponges, Steri-strips, and dressings; drug screening supplies; and hot and cold packs. These items are included in the fee for the medical services in which such supplies are used.

5. Separate Procedures

Certain procedures are an inherent portion of a procedure or service, and, as such, do not warrant a separate charge. For example: multiple muscle strains, such as cervical and lumbar areas, extremity, etc., when treated by other than a specific descriptor listed in the Surgery section will be considered as an entity and not carry cumulative and/or additional charges; that is, the appropriate level of service for office, hospital, or home visits will apply. When such a procedure is carried out as a separate entity not immediately related to other services, the indicated value for "separate procedure" is applicable. See also Surgery Ground Rule 7.

6. Concurrent Care

When more than one provider treats a patient for the same condition during the same period of time, payment is made only to one provider. Where the concurrent care involves overlapping or common services, the fees payable shall not be increased but prorated. Each provider shall submit separate bills but indicate if agreement has been reached on the proration. If no agreement has been reached, the matter shall be referred to a Medical Arbitration Committee.

7. Alternating Providers

When providers of similar skills alternate in the care of a patient (e.g., partners, groups, or same facility covering for another provider on weekends or vacation periods), each provider shall bill individually for the services they personally rendered and in accordance with the fee schedule.

8. Proration of Scheduled Relative Value Unit Fee

When the schedule specifies a relative value unit fee for a definite treatment with an inclusive period of aftercare (follow-up days), and the patient is transferred from one provider to another provider, the employer (or carrier) is only responsible for the total amount listed in the schedule. Such amount is to be apportioned between the providers. If the concerned providers agree to the amounts to be prorated to each, they shall render separate bills accordingly. If no proration agreement is reached by them, the amounts payable to each party shall be settled by an arbitration committee, without cost to the contestants. When treatment is terminated by the departure of the patient from New York State before the expiration of the stated follow-up days, the fee shall be the portion of the appropriate fee having regard for the fact that usually the greater portion is earned at the time of the

original operation or service. When treatment is terminated by the death of the patient before the expiration of the follow-up days, the full fee is payable, subject to proration where applicable.

9. Home Visits

The necessity for such visits is infrequent in cases covered by the Workers' Compensation Law. When necessary, a statement setting forth the medical indications justifying such visits shall be submitted. Please refer to the Evaluation and Management section for coding of these services.

10. Referrals/Direct Care

A fee is payable for the examination of a patient who seeks the care of a podiatrist either directly or by a referral from another provider or another podiatrist, in instances when it is incumbent upon the podiatrist to examine the patient in order to make a proper diagnosis, prognosis, and to decide on the necessity and type of treatment to be rendered. This fee is in addition to the unit fee prescribed for the operation or treatment subsequently rendered by the podiatrist except that where the therapeutic procedure or treatment is of a minor character and the fee for the procedure or treatment is in excess of the fee for the office visit, the greater fee (not both fees) is payable. Similarly, if the fee for the minor procedure or treatment is less than the fee for the office visit, the fee for the office visit alone is payable.

11. Multiple Services

Where a fee for an office therapeutic procedure or treatment is in excess of the fee for an ordinary office visit (e.g., a fee for a minor operation), the greater fee, not both, shall be payable.

12. Miscellaneous

A) Listings and relativities for other diagnostic, therapeutic, surgical, anesthetic, x-ray, and laboratory procedures may be found within the Surgery, Radiology and Nuclear Medicine, Pathology, and Appliances and Prostheses sections.

B) When reporting services in which the relativity is predicated on the basis of time, information concerning the amount of time spent should be indicated.

C) Reference (Outside) Laboratory: When laboratory procedures are performed by a party other than the treating or reporting provider, such procedures are to be billed directly to the insurance carrier by the laboratory.

13. Medical Testimony

As provided in Part 301 of the Workers' Compensation regulations and following direction by the Board, whenever the attendance of the injured employee's treating or consultant podiatrist is required

at a hearing or deposition, such podiatrist shall be entitled to an attendance fee of $450.00. Fees for testimony shall be billed following a direction by the Board as to the fee amount using code 99075.

14. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. If more than one modifier is needed, place modifier 99 after the procedure code to indicate that two or more modifiers will follow.

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

24 Unrelated Evaluation and Management Services by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period

The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the

procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

26 Professional Component
Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component
Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

27 Multiple Outpatient Hospital E/M Encounters on the Same Date
(This CPT modifier is for use by Ambulatory Surgery Center (ASC) and Hospital Outpatient Settings Only.) For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (eg, hospital emergency department, clinic). **Note:** This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient evaluation and management services provided by the same physician on the same date and performed in multiple outpatient setting(s) (eg, hospital emergency department, clinic), see **Evaluation and Management, Emergency Department,** or **Preventive Medicine Services** codes.

32 Mandated Services
Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

47 Anesthesia by Surgeon
Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) **Note:** Modifier 47 would not be used as a modifier for the anesthesia procedures.

50 Bilateral Procedure
Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5 digit code.

51 Multiple Procedures
When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D).

52 Reduced Services
Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73

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and 74 (see modifiers approved for ASC hospital outpatient use).

54 Surgical Care Only
When 1 physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

55 Postoperative Management Only
When 1 physician or other qualified health care professional performs the postoperative management and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

56 Preoperative Management Only
When 1 physician or other qualified health care professional performed the preoperative care and evaluation and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

57 Decision for Surgery
An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

58 Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** For treatment of a problem that requires a return to the operating/procedure room (eg, unanticipated clinical condition), see modifier 78.

59 Distinct Procedural Service
Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

62 Two Surgeons
When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure[s]) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. **Note:** If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

63 Procedure Performed on Infants less than 4 kg
Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure number. **Note:** Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20005–69990 code series. Modifier 63 should not be appended to any CPT codes listed in the **Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory,** or **Medicine** sections.

10. By Report (BR) Items

"BR" in the Relative Value column indicates that the value of this service is to be determined "by report" because the service is too unusual or variable to be assigned a relative value unit. Pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary, etc., is to be furnished, using any of the following as indicated:

A) Diagnosis (postoperative), pertinent history and physical findings.

B) Size, location, and number of lesion(s) or procedure(s) where appropriate.

C) Major surgical procedure with supplementary procedure(s).

D) Whenever possible, list the closest similar procedure by number and relative value unit. The "BR" relative value units shall be consistent in relativity with other relative value units in the schedule.

E) Estimated follow-up period, if not listed.

F) Operative time.

11. Unlisted Services or Procedures

Some services performed are not described by any CPT code. These services should be reported using an unlisted code and substantiated by report as discussed in Surgery Ground Rule 10 above. The unlisted procedures and accompanying codes for surgery will be found at the end of the relevant section or subsection.

12. Concurrent Services by More Than One Podiatrist

Charges for concurrent services of two or more podiatrists may be warranted under the following circumstances:

A) **Identifiable medical services** provided prior to or during the surgical procedure or in the postoperative period are to be charged for by the podiatrist rendering the service identified by the appropriate code and relative value units. Such payable fees are unrelated to the surgeon's fee.

B) **Surgical assistants:** Identify surgery performed by code number, appropriate modifier, description of procedures, and bill at 16 percent of the code fee. The code must coincide with those of the primary surgeon. Assistants' fees are not payable when the hospital provides intern or resident staff to assist at surgery.

C) **Two surgeons:** Under certain circumstances the skills of two surgeons (usually with different skills) may be required in the management of a specific surgical problem. By prior agreement, the total value for the procedures may be apportioned in relation to the responsibility and work done. The total value may be increased by 25 percent in lieu of the assistant's charge. Under these circumstances, the services of each surgeon should be identified. Identify surgery performed by code number, appropriate modifier, and description of procedures.

D) **Co-surgeons:** Under certain circumstances, two surgeons (usually with similar skills) may function simultaneously as primary surgeons performing distinct parts of a total surgical service. By prior agreement, the total value may be apportioned in relation to the responsibility and work done. The total value for the procedure shall not, however, be increased but shall be prorated between the co-surgeons. Identify surgery performed by code number, appropriate modifier, and description of procedures.

In the event of no agreement between co-surgeons, the proration shall be determined by an Arbitration Committee.

E) **Surgical team:** Under some circumstances highly complex procedures requiring the concomitant services of several providers, often of different specialties, plus other highly skilled, specially trained personnel, and various types of complex equipment are carried out under the "surgical team" concept with a single fee charged for the total service. The services covered vary widely and a single value cannot be assigned. These situations should be identified. The value should be supported by a report to include itemization of the provider services, paramedical personnel, and equipment involved.

13. Surgery and Follow-up Care Provided by Different Providers

When one provider performs the surgical procedure itself and another provides the follow-up care, the value may be apportioned between them by agreement and in accordance with medical ethics. Identify and indicate whether the value is for the procedure or the follow-up care, rather than the whole. The "global fee" is not increased, but prorated between the providers. If no agreement is reached by the providers involved, the apportionment shall be determined by arbitration.

14. Repeat Procedure by Another Provider

A basic procedure performed by another provider may have to be repeated. Identify and submit an explanatory note.

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15. Proration of a Scheduled Relative Value Unit Fee

When the schedule specifies a relative value unit fee for a definite treatment with an inclusive period of aftercare (follow-up days), and the patient transferred from one provider to another provider, the employer (or carrier) is only responsible for the total amount listed in the schedule. Such amount is to be apportioned between the providers. If the concerned providers agree to the amounts to be prorated to each, they shall render separate bills accordingly. If no proration agreement is reached by them, the amounts payable to each party shall be settled by an arbitration committee, without cost to the contestants. When treatment is terminated by the departure of the patient from New York State before the expiration of the stated follow-up days, the fee shall be the portion of the appropriate fee having regard for the fact that usually the greater portion is earned at the time of the original operation or service. When treatment is terminated by the death of the patient before the expiration of the follow-up days, the full fee is payable, subject to proration where applicable.

16. Materials Supplied by Podiatrist: Pharmaceuticals and Durable Medical Equipment

A) **Pharmacy**

A prescriber cannot dispense more than a seventy-two hour supply of drugs with the exceptions of:

1) Persons practicing in hospitals as defined in section 2801 of the public health law;
2) The dispensing of drugs at no charge to their patients;
3) Persons whose practices are situated ten miles or more from a registered pharmacy;
4) The dispensing of drugs in a clinic, infirmary, or health service that is operated by or affiliated with a post-secondary institution;
5) The dispensing of drugs in a medical emergency as defined in subdivision six of section 6810 of the State Education Law.

For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070..

B) **Durable Medical Equipment**

Prior to the effective date of the 2020 Durable Medical Equipment Fee Schedule, for durable medical equipment administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070.

Following the effective date of the 2020 Durable Medical Equipment Fee Schedule, all durable medical equipment supplied shall be billed and paid using the 2020 Durable Medical Equipment Fee Schedule. The 2020 Durable Medical Equipment Fee Schedule is/will be available on the Board's website. Any item identified as requiring prior authorization in the 2020 Durable Medical Equipment Fee Schedule or not listed in the 2020 Durable Medical Equipment Fee Schedule may not be billed without such prior authorization.

Do not bill for or report supplies that are customarily included in surgical packages, such as gauze, sponges, Steri-strips, and dressings; drug screening supplies; and hot and cold packs. These items are included in the fee for the medical services in which such supplies are used.

17. Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting podiatrist, such procedures are to be billed directly to the insurance carrier by the laboratory.

18. Surgical Destruction

Destruction or ablation of tissue is considered an inherent portion of surgical procedures and may be by any of the following methods used alone or in combination: electrosurgery, cryosurgery, laser, and chemical treatment. Unless specified by the CPT code description, destruction by any method does not change the selection of code to report the surgical service.

19. Fractures and Dislocations

The terms "closed" and "open" are used with reference to the type of procedure (e.g., fracture or dislocation) and to the type of reduction.

A) **Casting and Strapping Guidelines**

Application of casts and strapping codes are used to report replacement procedures during or after the period of follow-up care. These codes can also be used when the cast application or strapping is an initial service performed to stabilize or protect a fracture, injury, or dislocation without a restorative treatment or procedure. Restorative treatment or procedure rendered by another provider following the application of the initial cast, splint, or strap may

be reported with a treatment of fracture or dislocation codes.

Codes found in the application of casts and strapping section (29000–29799) should be reported separately when:

- The cast application or strapping is a replacement procedure used during or after the period of follow-up care.
- The cast application or strapping is an initial service performed without restorative treatment or procedures to stabilize or protect a fracture, injury, or dislocation, and to afford comfort to a patient.
- An initial casting or strapping when no other treatment or procedure is performed or will be performed by the same provider.
- A provider performs the initial application of a cast or strapping subsequent to another provider having performed a restorative treatment or procedure.

A provider who applies the initial cast, strap, or splint and also assumes all of the subsequent fracture, dislocation, or injury care cannot use the application of casts and strapping codes as an initial service. The first cast, splint, or strap application is included as a part of the service of the treatment of the fracture and dislocation codes. If no fracture care code is reported, for instance for a sprain, then it is appropriate to report the cast application.

B) **Re-reduction**
Re-reduction of a fracture and/or dislocation, performed by the primary podiatrist may warrant an additional payment when performed during the inclusive follow-up period; see Surgery Ground Rule 6, Follow-up or Aftercare.

C) **Bone, Cartilage, and Fascial Grafts**
Listed values for most graft procedures include obtaining the graft. When a second surgeon obtains the graft, the value of the total procedure will not be increased but in accordance with Surgery Ground Rule 12-D, the value may be apportioned between the surgeons. Procedure 20900 is NOT to be used with procedures that include the graft as part of the descriptor. Procedure 20900 can be used in those unusual circumstances when a graft is used that is not included in the descriptor.

Unless separately listed, when an alloplastic implant or non-autogenous graft is used in a procedure which "includes obtaining graft," the value is to be the same as for using a local bone graft. The phrase "iliac or other autogenous bone graft" refers only to grafts obtained from an anatomical site distinct from the primary operative area and obtained through a separate incision. Plastic and/or metallic implant or non-autogenous graft materials are to be valued at the cost to the podiatrist.

D) **Dislocations Complicated by a Fracture**
Increase the unit value of the fracture/dislocation by 50 percent. The additional charge is not applicable to ankle fractures/dislocations.

E) **Multiple Injuries**
For concurrent care of multiple injuries, not contiguous and not in the same foot, and not otherwise specified, see Surgery Ground Rule 5, Multiple or Bilateral Procedures. Superficial injuries not requiring extensive care do not carry cumulative or additional allowances.

20. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Modifiers commonly used in surgery are as follows:

22 Increased Procedural Services
When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

32 Mandated Services
Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

47 Anesthesia by Surgeon
Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) **Note:** Modifier 47 would not be used as a modifier for the anesthesia procedures.

50 Bilateral Procedure
Unless otherwise identified in the listings, bilateral procedures that are performed at the

same session should be identified by adding modifier 50 to the appropriate 5 digit code.

51 Multiple Procedures
When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D).

52 Reduced Services
Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

54 Surgical Care Only
When 1 physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

57 Decision for Surgery
An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

58 Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** For treatment of a problem that requires a return to the operating/procedure room (eg, unanticipated clinical condition), see modifier 78.

59 Distinct Procedural Service
Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

62 Two Surgeons
When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure[s]) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. **Note:** If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

66 Surgical Team
Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians or other qualified health care professionals, often of different specialties,

plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating individual with the addition of modifier 66 to the basic procedure number used for reporting services.

76 Repeat Procedure or Service by the Same Physician or Other Qualified Health Care Professional
It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional
It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

78 Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period
It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

80 Assistant Surgeon
Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

81 Minimum Assistant Surgeon
Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.

82 Assistant Surgeon (when qualified resident surgeon not available)
The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).

99 Multiple Modifiers
Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

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SURGERY 10060–64911

Podiatry Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	10060	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single	0.29	010	
	10061	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple	0.90	010	
	10120	Incision and removal of foreign body, subcutaneous tissues; simple	0.36	010	
	10121	Incision and removal of foreign body, subcutaneous tissues; complicated	1.08	010	
	10140	Incision and drainage of hematoma, seroma or fluid collection	0.54	010	
	10160	Puncture aspiration of abscess, hematoma, bulla, or cyst	0.29	010	
	10180	Incision and drainage, complex, postoperative wound infection	1.62	010	
	11010	Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin and subcutaneous tissues	1.10	010	
	11011	Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, and muscle	1.98	000	
	11012	Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle, and bone	2.42	000	
	11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less	1.10	000	
	11043	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less	1.98	000	
	11044	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less	2.42	000	
+	**11045**	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	0.18	ZZZ	
+	**11046**	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	0.45	ZZZ	
+	**11047**	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	0.90	ZZZ	
	11055	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion	0.18	000	
	11056	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions	0.22	000	
	11057	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than 4 lesions	0.36	000	
	11100	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion	0.34	000	
+	**11101**	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; each separate/additional lesion (List separately in addition to code for primary procedure)	0.25	ZZZ	
	11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions	0.31	010	
+	**11201**	Removal of skin tags, multiple fibrocutaneous tags, any area; each additional 10 lesions, or part thereof (List separately in addition to code for primary procedure)	0.25	ZZZ	
	11420	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less	0.47	010	
	11421	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm	0.61	010	
	11422	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm	0.76	010	
	11423	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm	1.12	010	

7. Materials Supplied by Podiatrist

Pharmacy

A prescriber cannot dispense more than a seventy-two hour supply of drugs with the exceptions of:

1. Persons practicing in hospitals as defined in section 2801 of the public health law;
2. The dispensing of drugs at no charge to their patients;
3. Persons whose practices are situated ten miles or more from a registered pharmacy;
4. The dispensing of drugs in a clinic, infirmary, or health service that is operated by or affiliated with a post-secondary institution;
5. The dispensing of drugs in a medical emergency as defined in subdivision six of section 6810 of the State Education Law.

For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070.

Radiopharmaceutical or other radionuclide material cost: listed relative value units in this section do not include these costs. List the name and dosage of radiopharmaceutical material and cost. Bill with code 99070.

Appliances and prostheses as listed within this fee schedule can be billed separately and do not apply to the supply rules as listed here.

8. Injection Procedures

Relative value units for injection procedures include all usual pre- and postinjection care specifically related to the injection procedure, necessary local anesthesia, placement of needle or catheter, and injection of contrast media.

9. Miscellaneous

A) Emergency services rendered between 10 p.m. and 7 a.m. in response to requests received during those hours or on Sundays or legal holidays, provided such services are not otherwise reimbursed, may warrant an additional payment of one-third of the applicable fee. Submit report (see Medicine Ground Rule 1B).

B) Relative value units for office, home and hospital visits, consultation, and other medical services, surgical and laboratory procedures are listed in the Evaluation and Management, Medicine, Surgery, and Pathology and Laboratory sections.

10. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. If more than one modifier is needed, place modifier 99 after the procedure code to indicate that two or more modifiers will follow. Modifiers commonly used with radiology procedures are as follows:

22 Increased Procedural Services
When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required).
Note: This modifier should not be appended to an E/M service.

26 Professional Component
Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component
Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

32 Mandated Services
Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

51 Multiple Procedures
When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by

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appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D).

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

62 Two Surgeons

When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure[s]) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. **Note:** If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

76 Repeat Procedure or Service by the Same Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

99 Multiple Modifiers

Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

5 Pathology and Laboratory

The relative value units in this section were determined uniquely for pathology and laboratory services. Use the pathology and laboratory conversion factor when determining fee amounts. The pathology and laboratory conversion factor is not applicable to any other section.

The fee for a procedure or service in this section is determined by multiplying the relative value by the pathology and laboratory conversion factor, subject to the ground rules, instructions, and definitions of the schedule.

To ensure uniformity of billing when multiple services are rendered, each relative value unit is to be multiplied by the conversion factor separately. After which, charges for products may be added.

Fees for pathology items are for podiatrists who perform their own laboratory work. All serological procedures are to be performed by registered pathologists or laboratories.

Items used by all podiatrists in reporting their services are presented in the Introduction and General Guidelines section under General Ground Rules.

Pathology and Laboratory Ground Rules

1A. NYS Medical Treatment Guidelines

Treatment of work-related injuries should be in accordance with any applicable medical treatment guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the fee schedule ground rules and the medical treatment guidelines, the guidelines will prevail. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

1B. Attending Podiatrist

The attending podiatrist will not make a charge for obtaining and handling of specimens.

2. Materials Supplied by Provider

Pharmacy

A prescriber cannot dispense more than a seventy-two hour supply of drugs with the exceptions of:

1. Persons practicing in hospitals as defined in section 2801 of the public health law;
2. The dispensing of drugs at no charge to their patients;
3. Persons whose practices are situated ten miles or more from a registered pharmacy;
4. The dispensing of drugs in a clinic, infirmary, or health service that is operated by or affiliated with a post-secondary institution;
5. The dispensing of drugs in a medical emergency as defined in subdivision six of section 6810 of the State Education Law.

For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070.

3. Referral Laboratory

When the service or procedure is performed by other than the attending podiatrist, be it hospital, commercial, or other laboratory, only the laboratory rendering the service may bill and such shall be submitted directly to the responsible payer.

4. Reports

No bill for services or procedures included in this section shall be considered properly rendered unless it is accompanied by a report that includes the findings and the interpretation of such findings. Where the service or procedure results in producing an image or graph, such shall be submitted together with the bill.

5. By Report "(BR)"

"BR" in the Relative Value column indicates that the relative value unit of this service is to be determined "by report." Pertinent information concerning the

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nature, extent, and need for the procedure or service, the time, skill, and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary. See the General Ground Rules for an explanation of "BR" procedures.

6. Indices or Ratios

Tests which produce an index or ratio based on mathematical calculations from two or more other results may not be billed as a separate independent test (e.g., A/G ratio, free thyroxine index).

7. Unlisted Service or Procedure

Specify the service by the last code number in the appropriate subdivision. Identify by name or description, and submit report (see Pathology and Laboratory Ground Rule 5 above).

8. Organ or Disease-Oriented Panels

Organ or disease-oriented panels (80047–80076), are used to confirm specific diagnoses. These panels are problem-oriented in scope. Each panel contains a list of the tests that must be included in order to use that particular code number. This is not meant to limit the number of tests performed or ordered if medically appropriate. Other tests performed that are not part of the panel may be separately reported. It is also inappropriate to separately report the components of a panel test if the full set of identified tests was performed. Please refer to CPT guidelines for a complete explanation of codes included in each panel.

9. Specific Billing Instructions

The relative value units listed in this section include recording the specimen, performance of the test, and reporting of the result. They do not include specimen collection, transfer, or individual patient administrative services. (For reporting collection and handling, see the 99000 series)

The listed relative value units are total values that include both the professional and technical components. Utilization of the listed code without modifier 26 or TC implies that there will only be one charge, inclusive of the professional and technical components. The listed relative value units apply to podiatrists, podiatrist-owned laboratories, commercial laboratories, and hospital laboratories.

The column designated PC/TC Split indicates the percent of the global fee (relative value) for the technical and professional components of the procedure.

A) **Professional Component**
The professional component represents the value of the professional pathology services of the podiatrist. This includes examination of the patient, when indicated, interpretation and written report of the laboratory procedure, and consultation with the referring podiatrist. (Report using modifier 26.)

B) **Technical Component**
The technical component includes the charges for performance and/or supervision of the procedure, personnel, materials, space, equipment, and other facilities. (Report using modifier TC.)

10. Collection and Handling

Relative value units assigned to each test represent only the cost of performing the individual test, be it manual or automated. The collection, handling, and patient administrative services have been assigned relative value units and separate code numbers.

11. Review of Diagnostic Studies

When prior studies are reviewed in conjunction with a visit, consultation, record review, or other evaluation, no separate charge is warranted for the review by the medical practitioner or other medical personnel. Neither the professional component modifier 26 nor the pathology consultation codes (80500 and 80502) are reimbursable under this circumstance. The review of diagnostic tests is included in the evaluation and management codes.

12. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Modifiers commonly used with surgical procedures are as follows:

22 Increased Procedural Services
When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

26 Professional Component
Certain procedures are a combination of a physician or other qualified health care

professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component
Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

32 Mandated Services
Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

52 Reduced Services
Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

90 Reference (Outside) Laboratory
When laboratory procedures are performed by a party other than the treating or reporting physician or other qualified health care professional, the procedure may be identified by adding modifier 90 to the usual procedure number.

91 Repeat Clinical Diagnostic Laboratory Test
In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number with the addition of modifier 91. **Note:** This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

99 Multiple Modifiers
Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

13. Drug Screening

Drug screening may be required as part of the non-acute pain management treatment protocol.

Drug Testing—Urine Drug Testing (UDT) (or the testing of blood or any other body fluid) is a mandatory component of chronic opioid management, as part of the baseline assessment and ongoing re-assessment of opioid therapy. Baseline drug testing should be obtained on all transferring patients who are already using opioids or when a patient is being considered for ongoing opioid therapy. The table below offers guidance as to frequency of regular, random drug testing.

Risk Category (Score)	Random Drug Frequency
Low Risk	Periodic (At least once/year)
Moderate Risk	Regular (At least 2/year)
High Risk	Frequent (At least 3–4/year)
Aberrant Behavior	At time of visit

Random drug screening (urine or other method) should be performed at the point of care using a quick or rapid screening test method utilizing a stick/dip stick, cup or similar device. Reimbursement will be limited to 1 unit of 80305, 80306, or 80307. In addition, the provider may bill the appropriate evaluation and management code commensurate with the services rendered.

Drug Testing (urine or any other body fluid) by a laboratory—Drug testing performed by a laboratory (whether the lab is located at the point of care or not) should not be a regular part of the non-acute pain management treatment protocol, but rather shall be used as confirmatory testing upon receipt of unexpected or unexplained UDT results (Red Flags).

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Red Flags include:

- Negative for opioid(s) prescribed
- Positive for amphetamine or methamphetamine
- Positive for cocaine or metabolites
- Positive for drug not prescribed (benzodiazepines, opioids, etc.)
- Positive for alcohol

Upon documentation of the Red Flag, the provider shall direct confirmatory testing using GLC, GC/MS or LC/MS. Such tests shall be billed using 1 unit of 80375 for 1–3 drugs; 1 unit of 80376 for 4–6 drugs; or 1 unit of 80377 for 7 or more drugs.