OFFICIAL

NEW YORK STATE WORKERS' COMPENSATION

ACUPUNCTURE AND PHYSICAL & OCCUPATIONAL THERAPY FEE SCHEDULES

Effective xx/xx/2026

NEW YORK STATE OF OPPORTUNITY
Workers' Compensation Board

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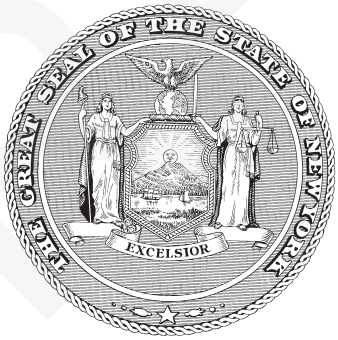

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NEW YORK WORKERS' COMPENSATION BOARD FILING NOTICE

The Acupuncture and Physical Therapy & Occupational Therapy Fee Schedules were duly filed in the Office of the Department of State, and constitutes Part 329-4 of Title 12 of the Official Compilation of Codes, Rules, and Regulations of the State of New York.

OUR COMMITMENT TO ACCURACY

RefMed is committed to producing accurate and reliable materials. To report corrections, please visit marketplace.refmed.com or call 863.222.4071.

FOREWORD

The Workers' Compensation Board is pleased to present the updated version of the *Official New York State Workers' Compensation Acupuncture and Physical & Occupational Therapy Fee Schedules.*

The fee schedules are 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.

These fee schedules 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.

These fee schedules are effective for services rendered on or after [Insert Date], 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

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OFFICIAL

NEW YORK STATE WORKERS' COMPENSATION

SECTION 1: ACUPUNCTURE FEE SCHEDULES

1 Introduction and General Guidelines

The Acupuncture section of the *Official New York Workers' Compensation Acupuncture and Physical & Occupational Therapy Fee Schedules* shows acupuncture 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 values 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 in the acupuncture practice.

Because the Acupuncture 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 acupuncturist or the pattern of charges in any specific area of New York.

A primary purpose of the schedule is to provide a precise description and coding of the services provided by New York acupuncturists in the care of workers' compensation covered patients and ensures the proper payment for such services by assuring that they are specifically identifiable.

This edition of the *Official New York Workers' Compensation Acupuncture and Physical & Occupational Therapy Fee Schedules* uses CPT procedure codes, modifiers, and descriptions. Please refer to the CPT book for an explanation of coding rules and regulations not listed in this schedule.

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

Inclusion of a code in this Fee Schedule does not guarantee reimbursement. All codes billed should be based on medical necessity and be in alignment with all applicable Medical Treatment Guidelines and Fee Schedule Ground Rules, as further discussed herein. Reimbursement may be dependent on multiple factors, including but not necessarily limited to, causal relationship, clinical necessity and appropriateness of the fees submitted.

Format

The Acupuncture section of the *Official New York Workers' Compensation Acupuncture and Physical & Occupational Therapy Fee Schedules* consists of two sections, Evaluation and Management and Medicine. Each section has instructions which precede the codes, descriptions, and values.

The sections are organized according to type of service and the variations of overhead expense ratios for providing the services. Therefore, each section uses a single conversion factor.

Introductory Information

The introductory ground rules that precede the data in each section include definitions, references, prohibitions, and directions 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 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 Acupuncture services shall be determined by the region in which the services were rendered.

How To Interpret The Fee Schedule Data

There are five columns used throughout the Acupuncture Fee Schedule. The columns vary by section throughout the schedule.

Icons

The following icons are included in the Acupuncture Fee Schedule:

- ■ New and changed codes - Codes that are new, changed description, or changed value from the 2020 Fee Schedule.

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

Code

The Code column lists the American Medical Association's (AMA) CPT code. *CPT 2024* 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 *CPT 2024* 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.

FUD

The FUD column lists the follow-up days included in a surgical procedure's global charge. In counting follow-up days, day one is the day of surgery, not the discharge day. The State of New York has determined the number of follow-up days in this schedule and these follow-up days are consistent with those found in the Medicare Physician Fee Schedule. Follow-up days will be designated as 000 (0 follow-up days), 010 (10 follow-up days), or 090 (90 follow-up days). Medicare also uses letter designations to 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.

Postal ZIP Codes by Region

See Appendix A.

Acupuncture Conversion Factors

Regional conversion factors for services rendered on or after January 1, 2026.

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

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 99202, performed in Region I or Region II, would be calculated as follows:

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

		Relative Value
	x	Applicable Conversion Factor
	=	Fee
	7.27	(Relative Value)
x	$6.37	(Acupuncture E/M Section Conversion Factor for Region I or II)
=	$46.31	

New and Deleted CPT Codes

See Appendix A.

General Ground Rules

1A. NYS Medical Treatment Guidelines

Treatment of work-related injuries should be in accordance with any currently published, 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. Treatment that correctly applies the recommendations of the Medical

Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.

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

Services may be rendered by an authorized acupuncturist upon the referral or prescription of an authorized physician, nurse practitioner, physician assistant or, if applicable, podiatrist. Such referring 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. Acupuncture Utilization

Acupuncture 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. Narrative Reports

A detailed narrative report must be submitted with all services provided. Narrative report must include the following element in a highly visible location: Work Status. Providers are strongly encouraged to use the narrative template format found on the WCB webpage CMS 1500 Requirements.

Additional narrative information should include the history of the injury/illness, any objective findings based on the clinical evaluation, plan of care and your diagnosis(es)/ assessment of the patient.

Time must be documented whenever the CPT code definition is based on time spent with patient, or if necessary to justify a higher or additional code billed.

All entries in the medical record must be legible to another reader.

4. 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. This includes obtaining any required Prior Authorization (PAR).

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. Out-of-state providers are required to use only those CPT codes listed in the current applicable New York State WCB fee schedules.

Presence of a CPT code in this fee schedule does not imply medical necessity which is determined by the NYS Medical Treatment Guidelines.

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.

5. Billing for Acupuncture Needles

The cost of needles is included in the Acupuncture service and will be denied if submitted in addition to the Acupuncture service.

6. 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.

7. Codes in the Acupuncture Fee Schedule

A licensed acupuncturist may only use CPT® codes contained in the Acupuncture Fee Schedule for billing of treatment. A licensed acupuncturist may not use codes that do not appear in the Acupuncture Fee Schedule. Chiropractors who are licensed acupuncturists should use the Chiropractic Fee Schedule when performing acupuncture services.

Physicians should use the Medical Fee Schedule when performing acupuncture services.

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 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.

9. Multiple Case Numbers

If a claimant has more than one WCB claim/number, it is permissible to bill services for both claims on the same date of service. Separate bills should be submitted for each claim/visit. However the total time billed for each claim number should not exceed the actual face- to face time spent with the patient. The visits need to be scheduled and documented as two distinct and sequential office visits, with two distinct and separate office visit notes.

10. Electronic Billing:

Providers may offset the cost of using an electronic submission partner by using code 99080 as a "By Report" (BR) code, up to a maximum value of one dollar. The code should be placed on the same CMS 1500 form for which the billable services payment and the electronic submission costs are being requested. The price listed by the provider for code 99080 should accurately reflect the actual cost incurred by the provider for the electronic submission of the individual bill, up to a maximum of one dollar.

Please see any current guidance on the WCB webpage.

2 Evaluation and Management (E/M)

The relative value units 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 products are to be added.

Conversion Factors

Regional conversion factors for services rendered on or after January 1, 2026.

Section	Region I	Region II	Region III	Region IV
E/M	$6.37	$6.37	$7.29	$7.92

Evaluation and Management Ground Rules

Visits, examinations, consultations, and similar services as listed in this section reflect the wide variations in time and skills required in the diagnosis and treatment of illness or injury. The listed relativities apply only when these services are performed by an authorized licensed acupuncturist unless otherwise stated. Please refer to the CPT® guidelines for a full explanation of the proper use of the Evaluation and Management codes.

When exact text of the AMA CPT® guidelines is used, the text is either in quotations or is preceded by the phrase "CPT guidelines state."

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

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. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside/in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.

1B. New and Established Patient Service

Several code subcategories in the Evaluation and Management section are based on the patient's status; new or established. The Evaluation and Management code for initial visits is 99202. E/M established visit code 99212 may be used to bill for a periodic re-evaluation consisting of a thorough examination and report documenting diagnosis, thorough interim history, clinical findings, and future course of treatment. The maximum number of RVUs (including treatment) per patient per day per WCB case number when billing for an initial evaluation shall be limited to 18.0. The following codes represent the treatments subject to this rule:

99202, 99212

CPT 2024 guidelines define new and established patients. The patient definitions have been expanded from *CPT 2024* for the New York Fee Schedule (this text will be in italics).

New Patient

A new patient is one who has not received any professional services from the *acupuncturist, or another acupuncturist* who belongs to the same group practice, within the past three years.

Established Patient

An established patient *shall also be considered one who has been treated for the same injury by any acupuncturist* who belongs to the same group practice. *Because initial records such as history and physical are available within the group's*

facility, an initial new patient visit would not be indicated. The maximum number of RVUs (including treatment) per person per day per WCB case number when billing for a re-evaluation shall be limited to 15.0.

The new versus established patient guidelines also clarify the situation in which an acupuncturist is on call or covering for another acupuncturist. In this instance, classify the patient encounter the same as if it were for the acupuncturist who is unavailable.

2. 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.

3. Narrative Reports

A detailed narrative report must be submitted with all services provided. Narrative report must include the following element in a highly visible location: Work Status. Providers are strongly encouraged to use the narrative template format found on the WCB webpage CMS 1500 Requirements.

Additional narrative information should include the history of the injury/illness, any objective findings based on the clinical evaluation, plan of care and your diagnosis(es)/assessment of the patient.

Time must be documented whenever the CPT code definition is based on time spent with patient, or if necessary to justify a higher or additional code billed.

All entries in the medical record must be legible to another reader.

4. 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. Appendixes referenced in the modifier descriptions are found in the CPT 2024 book. Modifiers commonly used with E/M procedures are as follows:

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.

Evaluation and Management

99201, 99212

Acupuncture Fee Schedule

Effective January 1, 2026

	Code	Description	Relative Value	FUD
■	**99202**	Initial E/M	7.27	XXX
	99212	Re-Evaluation	4.57	XXX

~ Established Patient Visits ® Altered CPT Code ✚ Add-on Procedure

■ New code, changed description, or changed value from 2020

3 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.

Conversion Factors

Regional conversion factors for services rendered on or after January 1, 2026.

Section	Region I	Region II	Region III	Region IV
Medicine	$6.09	$6.09	$6.97	$7.57

Medicine Ground Rules

Rules used by all acupuncturists 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 WCB case number 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. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.

1B. Multiple Acupuncture Procedures

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

97810, 97811, 97813, 97814

2. Narrative Reports

A detailed narrative report must be submitted with all services provided. Narrative report must include the following element in a highly visible location: Work Status. Providers are strongly encouraged to use the narrative template format found on the WCB webpage CMS 1500 Requirements.

Additional narrative information should include the history of the injury/illness, any objective findings based on the clinical evaluation, plan of care and your diagnosis(es)/ assessment of the patient.

Time must be documented whenever the CPT code definition is based on time spent with patient, or if necessary to justify a higher or additional code billed.

All entries in the medical record must be legible to another reader.

97810-97814, 99080

MEDICINE

Effective January 1, 2026

Acupuncture Fee Schedule

	Code	Description	Relative Value	FUD
	97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	3.55	XXX
+	**97811**	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)	3.04	ZZZ
	97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	3.89	XXX
+	**97814**	Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)	3.38	ZZZ
■	**99080**	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form	BR	XXX

Appendix A

New CPT Codes

The table below is a list of CPT codes applicable to the Acupuncture Fee Schedule that have been added since the 2020 Fee Schedule.

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

99080 99202

Deleted CPT Codes

The table below is a list of CPT codes that have been deleted from the Acupuncture Fee Schedule since the 2020 Fee Schedule.

99201

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

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OFFICIAL

NEW YORK STATE WORKERS' COMPENSATION

SECTION 2: PHYSICAL & OCCUPATIONAL THERAPY FEE SCHEDULES

1 Introduction and General Guidelines

The Physical and Occupational Therapy section of the *Official New York Workers' Compensation Acupuncture and Physical & Occupational Therapy Fee Schedules* shows physical and occupational therapy 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 values within each section apply only to that section. CPT is a registered trademark of the American Medical Association.

The accompanying instructions and ground rules explain the application of these procedure descriptors and relative value units in the physical and occupational therapy practice.

Because the Physical and Occupational Therapy Fee Schedule is applicable to all of New York State (NYS), a large and diverse geographical area, the relative value units contained herein do not necessarily reflect the charges of any individual therapist or the pattern of charges in any specific area of New York State.

A primary purpose of the fee schedule is to provide a precise description and coding of the services provided by New York physical and occupational therapists in the care of workers' compensation covered patients and ensures the proper payment for such services by assuring that they are specifically identifiable.

This edition of the *Official New York Workers' Compensation Acupuncture and Physical & Occupational Therapy Fee Schedules* uses CPT procedure codes, modifiers, and descriptions. Please refer to the CPT book for an explanation of coding rules and regulations not listed in this schedule.

Inclusion of a code in this Fee Schedule does not guarantee reimbursement. All codes billed should be based on medical necessity and be in alignment with all applicable Medical Treatment Guidelines and Fee Schedule Ground Rules, as further discussed herein. Reimbursement may be dependent on multiple factors, including but not necessarily limited to, causal relationship, clinical necessity and appropriateness of the fees submitted.

Format

The Physical and Occupational Therapy section of the *Official New York Workers' Compensation Acupuncture and Physical & Occupational Therapy Fee Schedules* consists of two sections, Physical Medicine and Appendix. This section has instructions which precede the codes, descriptions, and values.

The section is organized according to type of service and the variations of overhead expense ratios for providing the services. The Physical and Occupational Therapy Fee Schedule uses a single physical/occupational therapy conversion factor with the amount varying by region.

Introductory Information

The introductory ground rules that precede the data include definitions, references, prohibitions, and directions 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 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 Physical and Occupational therapy services shall be determined by the region in which the services were rendered.

How to Interpret Fee Schedule Data

There are five columns used throughout the Physical and Occupational Therapy Fee Schedule. The columns vary by section throughout the schedule.

Icons

The following icons are included in the Physical and Occupational Therapy Fee Schedule:

- ■ New and changed codes - Codes that are new, changed description, or changed value from the 2020 Fee Schedule.
- + 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.

⃠ 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.

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

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

∞ State-specific codes or modifiers—Where a CPT code or modifier does not currently exist to describe a service there may be a state-specific code number assigned to describe the service. Relative value units (RVUs) are state assigned or gap filled.

Code

The Code column lists the American Medical Association's (AMA) *CPT® 2024* 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 *CPT 2024* 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 total fee for code 97161, performed in Region I or Region II, would be calculated as follows:

	9.47	(Relative Value)
x	$7.69	(Physical Medicine Section Conversion Factor for Region I or II)
=	$72.82	

FUD

The FUD column lists the follow-up days included in a surgical procedure's global charge. In counting follow-up days, day one is the day of surgery, not the discharge day. The State of New York has determined the number of follow-up days in this schedule and these follow-up days are consistent with those found in the Medicare Physician Fee Schedule. Follow-up days will be designated as 000 (0 follow-up days), 010 (10 follow-up days), or 090 (90 follow-up days). Medicare also uses letter designations to 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.

Postal ZIP Codes by Region

See Appendix B.

Physical and Occupational Therapy Conversion Factors

Regional conversion factors for services rendered on or after January 1, 2026.

Region 1

Section	Region I	Region II	Region III	Region IV
Physical Medicine	$7.69	$7.69	$8.79	$9.55

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 97161, performed in Region I or Region II, would be calculated as follows:

	9.47	(Relative Value)
x	$7.69	(Physical Medicine Section Conversion Factor for Region I or II)
=	$72.82	

New, Changed, and Deleted CPT Codes

See Appendix B.

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. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.

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. Narrative Reports

A detailed narrative report must be submitted with all services provided. Narrative report must include the following element in a highly visible location: Work Status. Providers are strongly encouraged to use the narrative template format found on the WCB webpage CMS 1500 Requirements.

Additional narrative information should include the history of the injury/illness, any objective findings based on the clinical evaluation, plan of care and your diagnosis(es)/ assessment of the patient.

Time must be documented whenever the CPT code definition is based on time spent with patient, or if necessary to justify a higher or additional code billed.

Any ordered medications, durable medical equipment, tests, or procedures should be thoroughly explained.

All entries in the medical record must be legible to another reader.

4. 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. This includes obtaining any required Prior Authorization (PAR).

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. Out-of-state providers are required to use only those CPT codes listed in the current applicable New York State WCB fee schedules.

Presence of a CPT code in this fee schedule does not imply medical necessity which is determined by the NYS Medical Treatment Guidelines.

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.

5. Codes in the Physical and Occupational Therapy Fee Schedule

A physical or occupational therapist may only use CPT codes contained in the Physical and Occupational Therapy Fee Schedule for billing of treatment. A physical or occupational therapist may not use codes that do not appear in the Physical and Occupational Therapy Fee Schedule.

6. Employed Physical Therapists and Occupational Therapists

All NYS Physical and Occupational Therapists, whether self-employed or part of a physician practice, must submit their own medical reports and bill independently under their own authorization number, and not through a supervising physician.

See WCB webpage for more information on Expanded Provider Law: www.wcb.ny.gov

A hospital/ambulatory surgery center facility may bill for PT/OT services only when services are rendered during an inpatient admission or for an immediate post operative evaluation needed for safe discharge.

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.

8. Multiple Case Numbers

If a claimant has more than one WCB claim/number, it is permissible to bill services for both claims on the same date of service. Separate bills should be submitted for each claim/visit. However the total time billed for each claim number should not exceed the actual face to face time spent with the patient. The visits need to be scheduled and documented as two distinct and sequential office visits, with two distinct and separate office visit notes.

9. Physical Therapy Assistants (PTAs) and Occupational Therapy Assistants (OTAs):

PTA and OTAs must be directly supervised by an authorized Physical Therapist (PT) or authorized Occupational Therapist (OT) respectively.

PTAs and OTAs may not become authorized, provide treatment, or bill for services independently. Only the supervising PT/OT provider may bill for these services.

Modifier CQ indicates the codes performed by the PTA. Modifier CO indicates the codes performed by the OTA Also see Physical Medicine Modifiers.

Services billed using the modifiers CQ or CO should be billed and reimbursed at 85 percent of the amount payable to authorized PTs/OTs for such services.

Clinical notes by PTAs/OTAs must be cosigned by the supervising PT/OT.

The maximum numbers of billable RVUs for physical therapy and occupational therapy on any given date of service, as outlined elsewhere in the fee schedule remain the same and are not increased or otherwise changed based on whether the services are provided by PTs, OTs, PTAs or OTAs.

If a PT/OT and PTA/OTA provide services on the same day/session, the services provided by the PT/OT will be prioritized towards the daily RVU limits.

All care should be within the appropriate NYS Scope of Practice parameters.

PTAs and OTAs may not perform Functional Capacity Evaluations (FCEs) for NYS WCB claimants.

Please see any current guidelines published on the WCB webpage.

10. Electronic Billing:

Providers may offset the cost of using an electronic submission partner by using code 99080 as a "By Report" (BR) code, up to a maximum value of one dollar. The code should be placed on the same CMS 1500 form for which the billable services payment and the electronic submission costs are being requested. The price listed by the provider for code 99080 should accurately reflect the actual cost incurred by the provider for the electronic submission of the individual bill, up to a maximum of one dollar.

Please see any current guidance on the WCB webpage.

11. Miscellaneous and By Report Codes

1. Providers should only use codes listed in the Fee Schedule. When billing a service or procedure, select the CPT code from the WCB Fee schedule that accurately identifies the service or procedure performed. If no such code is available, report the service or procedure using the closest appropriate ***Miscellaneous*** code in the Fee Schedule (often ending in -99). These codes may also be titled "Unlisted," "Unspecified," or "Not Otherwise Specified".

2. By Report (BR) in the Relative Value (RVU) column represents services that too variable to permit assignment of RVUs. Fees for such procedures need to be justified with additional information.

    - The inclusion of a miscellaneous or by report code in this Fee Schedule does not guarantee reimbursement. All codes billed should be based on medical necessity and be in alignment with all applicable Medical Treatment Guidelines and Fee Schedule Ground Rules. Reimbursement may be dependent on multiple factors, including but not necessarily limited to, causal relationship, clinical necessity and appropriateness of the fees submitted.
    - It is the responsibility of the provider to ensure all information required to process a miscellaneous or by report procedure is included with the bill. If required information is missing, or if there is a valid code that describes the procedure, then the code may not be reimbursed.
    - Nearly all miscellaneous and by report codes, require prior authorization (PAR). If a procedure or item is not recommended or not addressed in an applicable WCB Medical Treatment Guideline (MTG), then prior authorization is always required. If the procedure or item involves a body part or condition for which there is no MTG and costs over $1,000 then prior authorization must be obtained.
    - While emergency procedures/items do not require prior authorization, the circumstances must be identified and explained in the procedure record. The codes billed may be subject to review and non-payment.
    - When a miscellaneous or by report code is used, the actual service/item should be identified on the bill, narrative note, and in an additional attached report.
    - The price billed must be substantiated by indicating the closest comparable code found in the current fee schedule and/or with a manufacturer's invoice.
    - Documentation should include: any decision making, medical necessity and explanation why an existing fee schedule code could not be used.
    - Any PARs including identification numbers should also be submitted with bills.
    - Miscellaneous and by report codes should not be billed merely to describe a proprietary product or procedure, when an existing fee schedule code adequately describes the procedure or item.
    - Surgical miscellaneous or by report codes may require additional documentation including: time, skill, equipment necessary, diagnosis, pertinent history, and physical findings, size/location/number of lesions or procedures.

12. 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 current CPT books.

In addition to the codes noted in CPT book, Optum has identified codes that are modifier 51 exempt according to CPT guidelines. The additional Optum modifier 51 exempt codes are identified in the data with the icon ⑤①. See Appendix.

2 Physical Medicine

Physical Medicine Ground Rules

1. Home Treatment

When treatment is rendered in a patient's home by an authorized occupational or physical therapist, add 50 percent to the listed value. Documentation explaining the necessity of home treatment instead of an office or outpatient treatment setting is required with the bill to the insurance carrier.

2. Initial Evaluation and Re-evaluation by a Physical or Occupational Therapist

Authorized physical therapists (PT) and occupational therapists (OT) may bill for an initial evaluation using CPT codes 97161–97163 and 97165–97167, respectively.

The maximum number of relative value units (including treatment) 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

Re-evaluations using CPT codes 97164 (PT) and 97168 (OT) may be billed in addition to the modalities rendered 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.

The maximum number of relative value units (including treatment) when billing for a re-evaluation shall be limited to 15.0.

3. Multiple Physical Medicine Procedures and Modalities

When multiple physical therapy or occupational therapy procedures and/or modalities are performed on the same day, reimbursement is limited to 12.0 RVUs per patient per WCB case number or the amount billed, whichever is less. Note: When a patient receives acupuncture, chiropractic, physical or occupational therapy procedures or modalities from more than one provider, the patient may not receive more than 12.0 RVUs per day per WCB case number from all providers. 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

4. Tests and Measurements

Orthotic Training

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

5. 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 New York State Workers' Compensation Board 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/Psychiatric Nurse Practitioner/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

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 Chair of the State of New York, Workers' Compensation Board, in consultation with the Medical Director's Office 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.

6. 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.

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	**$546.00**	**Region IV**	**$614.00**

7. 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. Appendixes referenced in the modifier descriptions are found in the CPT 2024 book. Modifiers commonly used with physical or occupational therapy services are as follows:

CO Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant.

CQ Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant.

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.

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 ***[occupational or physical therapist]*** 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 ***[occupational or physical therapist]*** 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.

8. Durable Medical Equipment (DME) Fee Schedule

All durable equipment supplies shall be billed and paid using the WCB DME Fee Schedule available on the Board's webpage. Any item identified as requiring prior authorization in the WCB DME Fee Schedule or not listed in the WCB DME Fee Schedule may not be billed without such prior authorization.

Medical necessity should be documented for all prescribed DME. Prescription or order form must be completed by the provider and accurately describe the item needed.

Appropriate HCPCS codes should be billed for items. All miscellaneous/unspecified codes, or codes without a listed price require Prior Authorization (PAR) and manufacture's invoice.

Also see Surgery Ground Rules regarding post procedure casting/splinting DME.

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.

9. Narrative Reports

A detailed narrative report must be submitted with all services provided. Narrative report must include the following element in a highly visible location: Work Status. Providers are strongly encouraged to use the narrative template format found on the WCB webpage CMS 1500 Requirements.

Additional narrative information should include the history of the injury/illness, any objective findings based on the clinical evaluation, plan of care and your diagnosis(es)/ assessment of the patient.

Time must be documented whenever the CPT code definition is based on time spent with patient, or if necessary to justify a higher or additional code billed.

Any ordered medications, durable medical equipment, tests, or procedures should be thoroughly explained.

All entries in the medical record must be legible to another reader.

95851-99080

Physical Medicine

Effective January 1, 2026

Physical and Occupational Therapy Fee Schedule

	Code	Description	Relative Value	FUD
	95851	Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)	0.00	XXX
	95852	Range of motion measurements and report (separate procedure); hand, with or without comparison with normal side	0.00	XXX
(51)	97010	Application of a modality to 1 or more areas; hot or cold packs	0.55	XXX
(51)	97012	Application of a modality to 1 or more areas; traction, mechanical	2.71	XXX
(51)	97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)	2.66	XXX
(51)	97016	Application of a modality to 1 or more areas; vasopneumatic devices	3.30	XXX
(51)	97018	Application of a modality to 1 or more areas; paraffin bath	2.71	XXX
(51)	97022	Application of a modality to 1 or more areas; whirlpool	2.62	XXX
(51)	97024	Application of a modality to 1 or more areas; diathermy (eg, microwave)	2.71	XXX
(51)	97026	Application of a modality to 1 or more areas; infrared	2.54	XXX
(51)	97028	Application of a modality to 1 or more areas; ultraviolet	2.54	XXX
(51)	97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes	2.45	XXX
(51)	97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes	3.55	XXX
(51)	97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes	2.37	XXX
(51)	97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes	2.41	XXX
(51)	97036	Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes	3.89	XXX
	97039	Unlisted modality (specify type and time if constant attendance)	BR	XXX
(51)	97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	3.97	XXX
(51)	97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	3.89	XXX
(51)	97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises	4.40	XXX
(51)	97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)	3.51	XXX
(51)	97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	2.62	XXX
	97139	Unlisted therapeutic procedure (specify)	2.89	XXX
(51)	97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	4.23	XXX
(51)	97150	Therapeutic procedure(s), group (2 or more individuals)	3.63	XXX

Physical Medicine

95851-99080

Physical and Occupational Therapy Fee Schedule **Effective January 1, 2026**

		Code	Description	Relative Value	FUD
■	(51)	**97161**	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.	9.47	XXX
■	(51)	**97162**	Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.	9.47	XXX
■	(51)	**97163**	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.	9.47	XXX
■	(51)	**97164**	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.	4.00	XXX
■	(51)	**97165**	Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.	9.47	XXX

95851-99080

Physical Medicine

Effective January 1, 2026

Physical and Occupational Therapy Fee Schedule

			Code	Description	Relative Value	FUD
■	(51)		97166	Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.	9.47	XXX
■	(51)		97167	Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.	9.47	XXX
■	(51)		97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.	4.00	XXX
	(51)		97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	2.87	XXX
	(51)		97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes	3.38	XXX
	(51)		97537	Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes	3.38	XXX
	(51)		97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes	2.37	XXX
	(51)	®	97545	Work hardening/conditioning; initial 2 hours	28.00	XXX
+	(51)	®	97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)	3.30	ZZZ
	(51)		97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes	0.00	XXX

Physical Medicine

95851-99080

Physical and Occupational Therapy Fee Schedule **Effective January 1, 2026**

		Code	Description	Relative Value	FUD
	(51)	**97755**	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes	NC	XXX
	(51)	**97760**	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes	4.23	XXX
	(51)	**97761**	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes	4.23	XXX
	(51)	**97763**	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes	3.55	XXX
	∞	**97800**	Functional Capacity Evaluation-See Rules	Refer to Rules	
■		**99080**	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form	BR	XXX

Appendix B

New CPT Codes

The table below is a list of CPT codes applicable to the Physical and Occupational Therapy Fee Schedules that have been added since the 2020 Fee Schedule.

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

99080

Optum Exempt From Modifier 51 Codes (51)

97010	97012	97014	97016	97018	97022
97024	97026	97028	97032	97033	97034
97035	97036	97110	97112	97013	97116
97124	97140	97150	97161	97162	97163
97164	97165	97166	97167	97168	97530
97535	97537	97542	97545	97546	97750
97755	97760	97761	97763		

Changed Codes

Changed Values

The following table is a list of CPT and state-specific codes applicable to the Physical and Occupational Therapy Fee Schedule that have a relative value change, an FUD change, a PC/TC split change, an Add-on change, or modifier 51 exempt change since the 2020 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 (2020) fee schedules.

For each code listed, the following information is included:

NY 2024 RVU. This is the current RVU for services rendered on or after January 1, 2026.

NY 2020 RVU. This is the RVU effective in the 2020 Fee Schedule.

NY 2024 FUD. This is the FUD for services rendered on or after January 1, 2026.

NY 2020 FUD. This is the FUD listed in the 2020 Fee Schedule.

NY 2024 PC/TC Split. This is the PC/TC split for services rendered on or after January 1, 2026. 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 2020 PC/TC Split. This is the PC/TC split effective in the 2020 Fee Schedules.

NY 2024 Add-On. This is the Add-on status for services rendered on or after January 1, 2026.

NY 2020 Add-On. This is the Add-on status in the 2020 Fee Schedule.

NY 2024 Mod51 Exempt. This is the modifier 51 exempt status for services rendered on or after January 1, 2026

NY 2020 Mod51 Exempt. This is the modifier 51 exempt status in the 2020 Fee Schedule.

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

CODE	2020 Units	2024 Units	2020 FUD	2024 FUD	2020 PC/ TC	2024 PC/ TC	2020 Add On	2024 Add On	2020 Mod51 Exempt	2024 Mod51 Exempt
97161	9.47	9.47	XXX	XXX						(51)
97162	9.47	9.47	XXX	XXX						(51)
97163	9.47	9.47	XXX	XXX						(51)
97164	4.00	4.00	XXX	XXX						(51)
97165	9.47	9.47	XXX	XXX						(51)
97166	9.47	9.47	XXX	XXX						(51)
97167	9.47	9.47	XXX	XXX						(51)
97168	4.00	4.00	XXX	XXX						(51)

Deleted CPT Codes

The table below is a list of CPT codes that have been deleted from the Physical and Occupational Therapy Fee Schedules since the 2020 Fee Schedule.

95831 95832 95833 95834

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