OFFICIAL

NEW YORK STATE WORKERS' COMPENSATION

BEHAVIORAL HEALTH FEE SCHEDULE

Effective xx/xx/2026

NEW YORK STATE OF OPPORTUNITY

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.

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FOREWORD

The Workers' Compensation Board is pleased to present the updated version of the *Official 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 [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

Contents

1 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 must 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.

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.

An attempt has been made to adhere as closely as possible to the terminology and coding of the American Medical Association's *CPT 2024*.

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 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 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 since the 2018/2020 Fee Schedules

✚ 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 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 2024 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 90832, performed in Region I or Region II, would be calculated as follows:

	12.59	(Relative Value)
x	$7.94	(Psychology Conversion Factor for Region I and II)
=	$99.96	

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."

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.

Conversion Factors

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

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.

New, Changed, or Deleted CPT Codes

See Appendix.

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

Behavioral health services may be rendered by providers that are New York State Workers' Compensation Board (NYS WCB) authorized (unless an exception applies) and are:

A. Licensed Psychiatrist

B. Licensed Physician with a specialty classification code for Psychiatry & Neurology from American Board of Psychiatry & Neurology as published on the WCB webpage

C. Board Certified psychiatric nurse practitioner

D. Licensed psychologist

E. Licensed clinical social worker

F. Appropriately certified Physician Assistant with eligible Supervising Physician

Physicians, physician assistants, and psychiatric nurse practitioners must use the full version of the Official New York State Workers' Compensation Medical Fee Schedule and the codes and conversion factors therein. 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 and physician assistants 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 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. Biofeedback

When more than one treatment is performed on the same day, the maximum reimbursement will be limited to the highest single relative value. All applicable Medical Treatment Guidelines must be followed.

2. Psychological, Behavioral, and Neuro-cognitive Testing

Reimbursement for Psychological, Behavioral, and Neuro-cognitive testing is limited to **11 hours in any 12-month period.**

Psychological, Behavioral, and Neuro-cognitive testing 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 generally not necessary or indicated, particularly when the clinical documentation supports improved outcomes or stable condition. Ongoing documentation should include updates to treatment plans, efficacy of medications and/or treatments, and overall progress towards expected goals. 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. All applicable Medical Treatment Guidelines must be followed.

Reimbursement for CPT codes **97129** and **97130 for Cognitive Testing** is limited to one unit of each code per day. All applicable Medical Treatment Guidelines should be followed.

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 97129. Both services must be performed face-to-face.

3. 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.

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. If psychometric testing is indicated by findings in the initial encounter, time for such testing should not exceed an additional three hours of professional time.

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

See Ground Rule #2 above for **Psychological, Behavioral, and Neuro-cognitive Testing.**

7. Use of codes 97129, 97130, and 97533

See Ground Rule #2 above for **Psychological, Behavioral, and Neuro-cognitive Testing.**

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 96156-96170 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 who require psychiatric services as well as health and behavior assessment/intervention, do not report both services on the same date of service; report only the predominant service.

Evaluation and management services including counseling risk-factor reduction and behavior change services should not be reported on the same date of service when provided by the same provider.

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. Appendixes referenced in the modifier descriptions are found in the CPT 2024 book. Modifiers commonly used in the Medicine section are:

1B∞ Behavioral Health Provider Enhanced Reimbursement

- Provides a 20 percent reimbursement increase for certain E/M and psychotherapy services.
- The following types of codes may not be appended with modifier 1B: diagnostic testing codes, procedural codes, and E/M visit codes 99202-99205, and 99211-99215.
- Behavioral Health consultation codes may use modifier 1B.
- ** Modifier 1B may be used by psychologists and LCSWs with the appropriate telehealth codes.
- May only be used by the following WCB authorized Behavioral Health providers:
  a. Licensed psychiatrist
  b. Licensed physician with a specialty rating code from American Board of Psychiatry & Neurology as published on the WCB webpage
  c. Board certified psychiatric nurse practitioner (NP)
  d. Appropriately certified physician assistant (PA) with eligible supervising physician
  e. Licensed psychologist
  f. Licensed clinical social worker

** See current Telehealth Ground Rule and webpage: https://www.wcb.ny.gov/telehealth/

See **Appendix** for Behavioral Health Provider Enhanced Rating Codes.

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 CPT Book Appendix D).

93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System

Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located away at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.

95® Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System

Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.

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.

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

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. 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 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.

- Provides a 20 percent reimbursement increase for certain E/M and psychotherapy services.
- The following types of codes may not be appended with modifier 1B: diagnostic testing codes, procedural codes, and E/M visit codes 99202-99205, and 99211-99215.
- Behavioral Health consultation codes may use modifier 1B.
- ** Modifier 1B may be used by psychologists and LCSWs with the appropriate telehealth codes.
- May only be used by the following WCB authorized Behavioral Health providers:
    a. Licensed psychiatrist
    b. Licensed physician with a specialty rating code from American Board of Psychiatry & Neurology as published on the WCB webpage

c. Board certified psychiatric nurse practitioner (NP)

d. Appropriately certified physician assistant (PA) with eligible supervising physician

e. Licensed psychologist

f. Licensed clinical social worker

** See current Telehealth Ground Rule and webpage: https://www.wcb.ny.gov/telehealth/

See **Appendix** for Behavioral Health Provider Enhanced Rating Codes.

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.

14. Telehealth

Effective July 11, 2023, the NYS Workers' Compensation Board adopted ***permanent*** regulations for telehealth appointments in certain situations. Telemedicine is not available to all provider types.

Treatment may be rendered by telehealth when medically appropriate and subject to the restrictions contained in the currently published regulations.

1. *Behavioral Health* Psychiatrists, Psych PAs, Psych NPs may bill:
   - E/M codes **99202-99204, 99212**
   - Psychotherapy/Combination/crisis codes: 9**0832-90834, 90836-90840**
   - Group therapy: **90853**
2. Psychologists and LCSWs may bill:
   - Psychotherapy/ crisis codes: **90832, 90834, 90837,90839, 90840**
   - Group therapy: **90853**
3. All eligible provider types should use:
   - Modifier **95** for two-way Audio and Visual communication
   - Modifier **93** for Audio only
   - Place of service (POS) code **10** for patient located in their home
   - POS code **02** for patient located in a healthcare setting that is not their home
4. Modifier **1B** may ***not*** be used with E/M codes but may be billed with applicable psychotherapy/group therapy telehealth codes.

Updates or modifications to WCB Telemedicine regulations may supersede the content published in this edition of the WCB Fee Schedule.

All current rules and restrictions for telehealth are found on the WCB webpage: https://www.wcb.ny.gov/telehealth/

15. Narrative Reports

A detailed narrative report must be submitted with all services provided. Narrative report must include the following elements in a highly visible location: Work Status, Casual Relationship & Temporary Impairment Percentage. 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.

16. 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.

17. 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.

18. 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 ⓫. See Appendix.

Behavioral Health

90785-99499

Behavioral Health Fee Schedule

Effective January 1, 2026

	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
	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	18.5	XXX

+ Add-on Procedure ∞ State Specific Code ® Altered CPT Code
⃠ Modifier 51 Exempt (51) Optum Mod 51 Exempt
■ New code, changed description, or changed value from 2018/2020

		Code	Description	Relative Value	FUD
		96110	Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument	17.00	XXX
■		96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour	25.57	XXX
■	+	96113	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)	10.74	ZZZ
■		96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour	27.39	XXX
■	+	96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)	14.64	ZZZ
■		96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	23.62	XXX
■	+	96131	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)	16.66	ZZZ
■		96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	25.18	XXX
■	+	96133	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)	18.81	ZZZ
■		96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes	8.20	XXX

Behavioral Health

90785-99499

Behavioral Health Fee Schedule

Effective January 1, 2026

			Code	Description	Relative Value	FUD
■	+		**96137**	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)	7.22	ZZZ
■			**96138**	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes	6.77	XXX
■	+		**96139**	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)	6.77	ZZZ
■			**96146**	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	0.46	XXX
■			**96156**	Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)	19.91	XXX
■			**96158**	Health behavior intervention, individual, face-to-face; initial 30 minutes	13.67	XXX
■	+		**96159**	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	4.69	ZZZ
■			**96164**	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes	2.08	XXX
■	+		**96165**	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	0.98	ZZZ
■			**96167**	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes	14.51	XXX
■	+		**96168**	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	5.21	ZZZ
■			**96170**	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes	15.10	XXX
■	+		**96171**	Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	5.47	ZZZ
■			**96202**	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes	4.69	XXX
■	+		**96203**	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); each additional 15 minutes (List separately in addition to code for primary service)	1.17	ZZZ
■		⓫	**97129**	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes	4.36	XXX
■	+	⓫	**97130**	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)	4.16	ZZZ

+ Add-on Procedure ∞ State Specific Code ® Altered CPT Code
⃠ Modifier 51 Exempt ⓫ Optum Mod 51 Exempt
■ New code, changed description, or changed value from 2018/2020

90785-99499

Behavioral Health

Effective January 1, 2026

Behavioral Health Fee Schedule

				Code	Description	Relative Value	FUD
	(51)			**97533**	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes	5.55	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
				99075	Medical testimony	Refer to Rules	XXX
■				**99080**	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form	BR	XXX
■				**99243**	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	16.49	XXX
				99499	Unlisted evaluation and management service	BR	XXX

Appendix

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 2018/2020 Fee Schedules.

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

96112	96113	96121	96130	96131	96132
96133	96136	96137	96138	96139	96146
96156	96158	96159	96164	96165	96167
96168	96170	96171	96202	96203	97129
97130	99080				

Changed Codes

Changed Values

There were no relative value changes, FUD changes, PC/TC split changes, Add-on changes or modifier 51 exempt changes to CPT or state-specific codes in the Behavioral Health Fee Schedule since the 2018/2020 Fee Schedules.

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 2018/2020 Fee Schedules.

96116	99243

Deleted CPT Codes

The table below is a list of CPT codes that have been deleted from the Behavioral Health Fee Schedule since the 2018/2020 Fee Schedules.

90911	96101	96102	96103	96111	96118
96119	96120	96150	96151	96152	96153
96154	96155	97127			

Optum Exempt From Modifier 51 Codes (51)

97129	97130	97533	97545	97546

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

Behavioral Health Provider Enhanced Rating Codes

Rating Code	Description
CPN-ADP	ADDICTION PSYCHIATRY
OPCPN-ADP	ADDICTION PSYCHIATRY
OPPN-ADP	ADDICTION PSYCHIATRY
PN-ADP	ADDICTION PSYCHIATRY
CPN-CLP	CONSULTATION-LIAISON PSYCHIATRY
OPCPN-CLP	CONSULTATION-LIAISON PSYCHIATRY
OPPN-CLP	CONSULTATION-LIAISON PSYCHIATRY
PN-CLP	CONSULTATION-LIAISON PSYCHIATRY
CPN-FPSY	FORENSIC PSYCHIATRY
OPCPN-FPSY	FORENSIC PSYCHIATRY
OPPN-FPSY	FORENSIC PSYCHIATRY
PN-FPSY	FORENSIC PSYCHIATRY
CPN-GER	GERIATRIC PSYCHIATRY
OPCPN-GER	GERIATRIC PSYCHIATRY
OPPN-GER	GERIATRIC PSYCHIATRY
PN-GER	GERIATRIC PSYCHIATRY
CPN-P	PSYCHIATRY
OPCPN-P	PSYCHIATRY
OPPN-P	PSYCHIATRY
PN-P	PSYCHIATRY
OPPN	PSYCHIATRY/NEUROLOGY
PN	PSYCHIATRY/NEUROLOGY
CPN-BIM	PSYCHIATRY AND NEUROLOGY - BRAIN INJURY MEDICINE
OPCPN-BIM	PSYCHIATRY AND NEUROLOGY -BRAIN INJURY MEDICINE
OPPN-BIM	PSYCHIATRY AND NEUROLOGY -BRAIN INJURY MEDICINE
PN-BIM	PSYCHIATRY AND NEUROLOGY -BRAIN INJURY MEDICINE
LCSW	LICENSED CLINICAL SOCIAL WORKER
LCSW-R	LICENSED CLINICAL SOCIAL WORKER PSYCHOTHERAPY
NP-P	NURSE PRACTITIONER IN PSYCHIATRY
PHYAS	PHYSICIAN ASSISTANT **
PSY	PSYCHOLOGY

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