OFFICIAL

NEW YORK STATE WORKERS' COMPENSATION

CHIROPRACTIC FEE SCHEDULE

Effective xx/xx/2026

NEW YORK STATE OF OPPORTUNITY
Workers' Compensation Board

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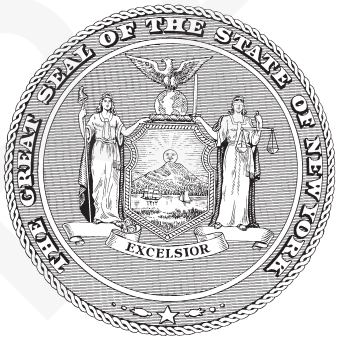

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NEW YORK WORKERS' COMPENSATION BOARD FILING NOTICE

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

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FOREWORD

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

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

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

Except where noted, this fee schedule is effective for medical services rendered on or after [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

The *Official New York State Workers' Compensation Chiropractic Fee Schedule*

1 Introduction and General Guidelines

The *Official New York State Workers' Compensation Chiropractic Fee Schedule* shows chiropractic 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.

Because the Chiropractic 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 chiropractor 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 New York State chiropractors 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 State Workers' Compensation Chiropractic Fee Schedule 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.

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

Format

The *Official New York State Workers' Compensation Chiropractic Fee Schedule* consists of five sections. Each section has instructions which precede the codes, descriptions, and values. The sections in this schedule are: Evaluation and Management, Radiology, Medicine, Physical Medicine, and Appendix.

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 Chiropractic services shall be determined by the region in which the services were rendered.

How To Interpret The Fee Schedule Data

There are six columns used throughout the Chiropractic Fee Schedule. The columns vary by section throughout the schedule.

Icons

The following icons are included in the Chiropractic Fee Schedule:

- New and changed codes—Codes that are new, changed description, or changed value from 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 *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 fee for code 99243, performed in Region I or Region II, would be calculated as follows:

	16.49	(Relative Value)
x	$6.37	(Chiropractic E/M Section Conversion Factor for Region I or II)
=	$105.04	

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.

PC/TC Split

The Relative Value column lists the relative value units used to calculate the fee amount for a service. Except, as otherwise provided in this fee schedule, the maximum fee amount is calculated by multiplying the relative value unit by the applicable conversion factor. Conversion factors are listed in this fee schedule. The PC/TC column shows the percentage of the procedure that is professional or technical. A procedure with a relative value of 3.0 RVUs and a 40/60 in the PC/TC column would be calculated as follows: 40 percent of the value (3.0 x conversion factor x .40 = PC) is for the professional component and 60 percent of the value (3.0 x conversion factor x .60 = TC) represents the technical component. The total component reimbursed should never be more than the professional component plus the technical component combined.

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
E/M	$6.37	$6.37	$7.29	$7.92
Medicine	$6.09	$6.09	$6.97	$7.57
Physical Medicine	$7.69	$7.69	$8.79	$9.55
Radiology	$32.01	$32.01	$36.63	$39.82

Calculating Fees Using Relative Values and Conversion Factors

Except as otherwise provided in this schedule, the maximum fee amount is calculated by multiplying the relative value by the applicable conversion factor. For example, the total fee for code 99243, performed in Region I or Region II, would be calculated as follows:

	16.49	(Relative Value)
x	$6.37	(Chiropractic E/M Section Conversion Factor for Region I or II)
=	$105.04	

New, Changed, and Deleted CPT Codes

See Appendix.

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. Multiple Procedures

In extremely limited circumstances, if an acute problem arises during a routine visit, additional procedures may be reported on the same bill.

2. 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 are 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.

3. Materials Supplied by Chiropractor

Durable Medical Equipment Fee Schedule

All durable medical equipment (DME) supplied shall be billed and paid using the current published Durable Medical Equipment Fee Schedule. The WCB Durable Medical Equipment Fee Schedule is available on the Board's website. Any item identified as requiring prior authorization in the WCB DME Fee Schedule or not listed in the DME Fee Schedule may not be billed without such prior authorization.

All DME prescriptions must follow any applicable Medical Treatment Guidelines. 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.

4. Miscellaneous

When reporting services in which the relativity is predicated on the basis of time, information concerning the amount of time spent should be indicated. See also Narrative Reports Ground Rule.

5. Medical Testimony

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

6. Chiropractic Manipulative Treatment (CMT)

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

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

Per CPT 2024 the five spinal regions for CMT are:

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

7. Periodic Re-evaluation

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

8. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Appendixes referenced in the modifier descriptions are found in the CPT 2024 book.

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

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

26 Professional Component

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

TC Technical Component

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

50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5 digit code. **Note:** This modifier should not be appended to designated 'add-on' codes (see Appendix D).

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances.

Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

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

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

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

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

99 Multiple Modifiers

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

9. Treatment by Out-of-State Providers

Claimant lives outside of New York State—A claimant who lives outside of New York State may treat with a qualified out-of-state medical provider. The medical treatment shall conform to the Medical Treatment Guidelines and the Ground Rules included herein. 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.

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

10. Codes in the Chiropractic Fee Schedule

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

11. 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.

12. 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.

13. 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.

14. Exempt From Modifier 51 Codes

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

The CPT book identifies these services with the ⊘ symbol.

Modifier 51 exempt services and procedures can be found in 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 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 chiropractor 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 chiropractors 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 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. New and Established Patient Service

Several code subcategories in the Evaluation and Management section are based on the patient's status; new or established. Evaluation and Management codes for initial visits are 99202–99204. 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. Chiropractors may also report CPT code 99243 for office consultations for a new or established patient. 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 99203 99204 99212 99243

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

New Patient

A new patient is one who has not received any professional services *from the chiropractor, or another chiropractor* 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 chiropractor* 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 a chiropractor is on call or covering for another chiropractor. In this instance, classify the patient encounter the same as if it were for the chiropractor who is unavailable.

2. Referral

A referral is the transfer of the total or specific care of a patient from one chiropractor to another and does not constitute a consultation. (Initial evaluations and subsequent services are designated as listed in E/M services.)

3. Clinical Examples

The codes for E/M services are provided to assist chiropractors in understanding the meaning of the descriptors and selecting the correct code for the services they have rendered. It is important to note that the same problem, when seen by different specialists, may involve different amounts of work. Therefore, the appropriate level of encounter should be reported using the descriptions as outlined for explanation of E/M services in the CPT book and this fee schedule rather than the examples. For more examples please refer to CPT guidelines.

4. 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.

5. 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.

6. 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..

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

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

7. Non-Schedule Permanency Evaluations

Code 99243 is used for examination and reports of a non-schedule permanency evaluation.

Evaluation and Management 99202-99456

Chiropractic Fee Schedule **Effective January 1, 2026**

	Code	Description	Relative Value	FUD
■	**99202**	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.	7.27	XXX
■	**99203**	Office or other outpatient visit for the evaluation and management of a new 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.	9.47	XXX
■	**99204**	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.	13.53	XXX
■	**99212**	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.	4.57	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
	99455	Work related or medical disability examination by the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.	BR	XXX
	99456	Work related or medical disability examination by other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.	BR	XXX

3 Radiology

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 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
Radiology	$32.01	$32.01	$36.63	$39.82

Radiology Ground Rules

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

X-rays of any portion of the skeletal system are permitted if the x-rays are necessary to diagnose problems arising in the vertebral column.

1A. NYS Medical Treatment Guidelines

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

1B. Duplication of X-Rays

Every attempt should be made to minimize the number of x-rays taken. The attending doctor or any other person or institution having possession of x-rays which pertain to the patient that are deemed to be needed for diagnostic or treatment purposes should make these x-rays available upon request. No payments shall be made for additional x-rays when recent x-rays are available except when supported by adequate information. The use of digital or photographic media and/or imaging is not reported separately but is considered to be a component of the basic procedure, and shall not merit any additional payment.

When a diagnostic procedure in conjunction with clinical information provides sufficient information to establish an accurate diagnosis, the second procedure will be redundant if performed only for diagnostic purposes. At the same time, a subsequent diagnostic procedure can be a complementary diagnostic procedure if the first or preceding procedures in conjunction with clinical information cannot provide an accurate diagnosis.

1C. Review of Diagnostic Studies

When prior studies are reviewed in conjunction with a visit, consultation, record review, or other evaluation, no separate charge is warranted for the review by the medical practitioner or other medical personnel. Neither the professional component (modifier 26) nor technical component are reimbursable under this circumstance. The review of diagnostic tests is included in the evaluation and management codes.

2. Multiple Diagnostic Procedures

The following adjustments apply to all diagnostic radiology procedures (Chiropractic Fee Schedule codes 70100–76999) including MRI:

A. For two contiguous parts, the charge shall be the greater fee plus 50 percent of the lesser fee.

B. For two remote parts, the charge shall be the greater fee plus 75 percent of the lesser fee. Bilateral procedures are considered remote parts.

C. For three or more parts, whether contiguous or remote, the charge shall be the greatest fee plus 75 percent of the total of the lesser fees.

D. Where more than one part is included in a single line item, it shall be charged for as a single line item. Any additional item examined shall be considered under rules 2A–2C above, whichever pertains.

E. No charge shall be made for comparative x-rays except when such x-rays are specifically authorized by the carrier or the Chairman. Comparative x-rays specifically authorized shall be subject to fees for contiguous and remote parts as provided in this formula as provided in rules 2A–2D above.

F. X-rays/imaging studies of different areas taken within 7 days of the first x-rays/imaging studies and related to the injury or problem necessitating the first x-ray/imaging studies, and which could have reasonably been performed at one time, shall be subject to rules 2A–2E above.

3. Specific Billing Instructions

The total relative value includes professional services plus expenses for personnel, materials (including usual contrast media), space, equipment, and other facilities. Supplies and materials provided by the chiropractor over and above those usually included with or necessitated by the services rendered may be charged for separately; in these instances, list items individually on the bill. Payment shall not exceed the cost of the item(s) to the chiropractor.

The listed values are for technical and professional components. Total reimbursement for the professional and technical components shall not exceed the listed value for the total procedure, regardless of the site where services are rendered. Use of codes 70010–79999 without modifier 26 or TC implies that the charge is inclusive of both the professional and technical components. To report either the professional or technical component separately, use modifier 26 or TC, respectively. When either the professional or technical component is billed separately, the listed percent of the total value is apportioned as indicated in the PC/TC column of the fee schedule.

4. Reports and Custody of X-rays and Other Recorded Images

A written report of the findings must be submitted as prescribed by the Chair.

Films or other recorded images shall be preserved in accordance with New York State Department of Health retention requirements. They (or satisfactory reproductions) shall be made available to the attending chiropractor, insurance carrier, or self-insured employer. When requested, carriers and self-insured employers shall return original films to the chiropractor within 20 days of their receipt.

When a carrier or self-insured employer requests x-rays, MRI's, or other recorded images and satisfactory reproductions including electronic media are furnished in lieu of the original films, a fee of $5.00 may be charged for the first sheet of duplicating film or for reproduction on an electronic media (e.g., digital images copied to a CD) regardless of the number of images contained on the media, and $3.00 for each additional sheet of film or electronic media. When recorded images are capable of electronic transmission, without creation of a physical copy of the film, CD, or other physical reproduction, no fee may be charged for such electronic transmission.

These reproductions are not returnable to the chiropractor. Copies of images produced by copiers (e.g., Xerox) shall not merit any additional payment and shall not be returnable to the chiropractor; such copies should accompany the bill submitted for the particular imaging procedure. (The use of digital or photographic media and/or imaging is not reported separately but is considered to be a component of the basic procedure.) In cases where the patient transfers from one chiropractor to another, the original chiropractor will promptly forward all images or copies of images to the new attending chiropractor.

5. Miscellaneous

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

B. Relative value units for office visits are listed in the Evaluation and Management and Medicine sections.

6. 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.

26 Professional Component

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

50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5 digit code. **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D).

TC Technical Component

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

7. 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.

70100-76999 RADIOLOGY

Effective January 1, 2026 **Chiropractic Fee Schedule**

	Code	Description	Relative Value	FUD	PC/TC Split
	70100	Radiologic examination, mandible; partial, less than 4 views	1.15	XXX	40/60
	70110	Radiologic examination, mandible; complete, minimum of 4 views	1.94	XXX	40/60
	70120	Radiologic examination, mastoids; less than 3 views per side	1.15	XXX	40/60
	70130	Radiologic examination, mastoids; complete, minimum of 3 views per side	2.17	XXX	40/60
	70134	Radiologic examination, internal auditory meati, complete	2.50	XXX	40/60
	70140	Radiologic examination, facial bones; less than 3 views	1.66	XXX	40/60
	70150	Radiologic examination, facial bones; complete, minimum of 3 views	2.04	XXX	40/60
	70160	Radiologic examination, nasal bones, complete, minimum of 3 views	1.28	XXX	40/60
	70170	Dacryocystography, nasolacrimal duct, radiological supervision and interpretation	1.99	XXX	35/65
	70190	Radiologic examination; optic foramina	1.63	XXX	40/60
	70200	Radiologic examination; orbits, complete, minimum of 4 views	2.07	XXX	40/60
	70210	Radiologic examination, sinuses, paranasal, less than 3 views	1.40	XXX	40/60
	70220	Radiologic examination, sinuses, paranasal, complete, minimum of 3 views	2.30	XXX	40/60
	70240	Radiologic examination, sella turcica	1.40	XXX	40/60
■	**70250**	Radiological examination, skull; less than 4 views	1.66	XXX	40/60
	70260	Radiologic examination, skull; complete, minimum of 4 views	2.30	XXX	40/60
	70328	Radiologic examination, temporomandibular joint, open and closed mouth; unilateral	2.09	XXX	40/60
	70330	Radiologic examination, temporomandibular joint, open and closed mouth; bilateral	3.06	XXX	40/60
	71100	Radiologic examination, ribs, unilateral; 2 views	1.68	XXX	40/60
	71101	Radiologic examination, ribs, unilateral; including posteroanterior chest, minimum of 3 views	1.94	XXX	40/60
	71110	Radiologic examination, ribs, bilateral; 3 views	2.04	XXX	40/60
	71111	Radiologic examination, ribs, bilateral; including posteroanterior chest, minimum of 4 views	2.42	XXX	40/60
	71120	Radiologic examination; sternum, minimum of 2 views	1.48	XXX	40/60
	71130	Radiologic examination; sternoclavicular joint or joints, minimum of 3 views	1.79	XXX	40/60
	72020	Radiologic examination, spine, single view, specify level	1.28	XXX	40/60
	72040	Radiologic examination, spine, cervical; 2 or 3 views	1.82	XXX	40/60
	72050	Radiologic examination, spine, cervical; 4 or 5 views	2.32	XXX	40/60
	72052	Radiologic examination, spine, cervical; 6 or more views	2.75	XXX	40/60
	72070	Radiologic examination, spine; thoracic, 2 views	1.76	XXX	40/60
	72072	Radiologic examination, spine; thoracic, 3 views	1.89	XXX	40/60
	72074	Radiologic examination, spine; thoracic, minimum of 4 views	2.17	XXX	40/60
	72080	Radiologic examination, spine; thoracolumbar junction, minimum of 2 views	1.84	XXX	40/60
	72081	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); one view	1.61	XXX	35/65
	72082	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); 2 or 3 views	2.60	XXX	26/74

RADIOLOGY 70100-76999

Chiropractic Fee Schedule Effective January 1, 2026

	Code	Description	Relative Value	FUD	PC/TC Split
	72083	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); 4 or 5 views	3.13	XXX	25/75
	72084	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); minimum of 6 views	3.64	XXX	25/75
	72100	Radiologic examination, spine, lumbosacral; 2 or 3 views	1.66	XXX	40/60
	72110	Radiologic examination, spine, lumbosacral; minimum of 4 views	2.42	XXX	40/60
	72114	Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views	3.06	XXX	40/60
	72170	Radiologic examination, pelvis; 1 or 2 views	1.45	XXX	40/60
	72190	Radiologic examination, pelvis; complete, minimum of 3 views	1.84	XXX	40/60
	72200	Radiologic examination, sacroiliac joints; less than 3 views	1.53	XXX	40/60
	72220	Radiologic examination, sacrum and coccyx, minimum of 2 views	1.56	XXX	40/60
	73000	Radiologic examination; clavicle, complete	1.58	XXX	40/60
	73010	Radiologic examination; scapula, complete	1.66	XXX	40/60
	73020	Radiologic examination, shoulder; 1 view	1.40	XXX	40/60
	73030	Radiologic examination, shoulder; complete, minimum of 2 views	1.79	XXX	40/60
	73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	1.58	XXX	40/60
	73060	Radiologic examination; humerus, minimum of 2 views	1.48	XXX	40/60
	73070	Radiologic examination, elbow; 2 views	1.33	XXX	40/60
	73080	Radiologic examination, elbow; complete, minimum of 3 views	1.48	XXX	40/60
	73090	Radiologic examination; forearm, 2 views	1.28	XXX	40/60
	73100	Radiologic examination, wrist; 2 views	1.17	XXX	40/60
	73110	Radiologic examination, wrist; complete, minimum of 3 views	1.33	XXX	40/60
	73120	Radiologic examination, hand; 2 views	1.20	XXX	40/60
	73130	Radiologic examination, hand; minimum of 3 views	1.33	XXX	40/60
	73140	Radiologic examination, finger(s), minimum of 2 views	1.01	XXX	40/60
	73501	Radiologic examination, hip, unilateral, with pelvis when performed; 1 view	1.25	XXX	32/68
	73502	Radiologic examination, hip, unilateral, with pelvis when performed; 2-3 views	1.73	XXX	27/73
	73503	Radiologic examination, hip, unilateral, with pelvis when performed; minimum of 4 views	2.15	XXX	28/72
	73521	Radiologic examination, hips, bilateral, with pelvis when performed; 2 views	1.56	XXX	30/70
	73522	Radiologic examination, hips, bilateral, with pelvis when performed; 3-4 views	2.04	XXX	31/69
	73523	Radiologic examination, hips, bilateral, with pelvis when performed; minimum of 5 views	2.36	XXX	29/71
	73551	Radiologic examination, femur; 1 view	1.17	XXX	30/70
	73552	Radiologic examination, femur; minimum 2 views	1.37	XXX	29/71
	73560	Radiologic examination, knee; 1 or 2 views	1.40	XXX	40/60
	73562	Radiologic examination, knee; 3 views	1.66	XXX	40/60

70100-76999

RADIOLOGY

Effective January 1, 2026

Chiropractic Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	73564	Radiologic examination, knee; complete, 4 or more views	1.86	XXX	40/60
	73565	Radiologic examination, knee; both knees, standing, anteroposterior	1.40	XXX	40/60
	73590	Radiologic examination; tibia and fibula, 2 views	1.53	XXX	40/60
	73600	Radiologic examination, ankle; 2 views	1.38	XXX	40/60
	73610	Radiologic examination, ankle; complete, minimum of 3 views	1.48	XXX	40/60
	73620	Radiologic examination, foot; 2 views	1.43	XXX	40/60
	73630	Radiologic examination, foot; complete, minimum of 3 views	1.48	XXX	40/60
	73650	Radiologic examination; calcaneus, minimum of 2 views	1.28	XXX	40/60
	73660	Radiologic examination; toe(s), minimum of 2 views	1.12	XXX	40/60
	76080	Radiologic examination, abscess, fistula or sinus tract study, radiological supervision and interpretation	2.35	XXX	35/65
■	**76999**	Unlisted ultrasound procedure (eg, diagnostic, interventional)	0.00	XXX	

4 Medicine

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

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

1A. NYS Medical Treatment Guidelines

The recommendations of the NYS Medical Treatment Guidelines supersede the ground rule frequency limitation for services rendered to body parts covered by the NYS Medical Treatment Guidelines.

The maximum reimbursement limitations per patient per day 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 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. Special Services and Reports

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

2. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Appendixes referenced in the modifier descriptions are found in the CPT 2024 book. Modifiers commonly used with medicine procedures are as follows:

26 Professional Component

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

51 Multiple Procedures

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

TC Technical Component

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

3. EDX (Codes 95907–95913)

EDX testing must comply with all applicable Medical Treatment Guidelines (unless there is an approved prior authorization request), including provider qualifications. When such testing is recommended and/or approved, the provider shall bill 1 unit of the single code that most closely represents the nerve(s) tested.

4. 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.

5. 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.

MEDICINE

Chiropractic Fee Schedule

95860-97814, 99050-99080

Effective January 1, 2026

	Code	Description	Relative Value	FUD	PC/TC Split
	95860	Needle electromyography; 1 extremity with or without related paraspinal areas	21.98	XXX	80/20
	95861	Needle electromyography; 2 extremities with or without related paraspinal areas	28.58	XXX	80/20
	95863	Needle electromyography; 3 extremities with or without related paraspinal areas	37.20	XXX	80/20
	95864	Needle electromyography; 4 extremities with or without related paraspinal areas	48.36	XXX	80/20
	95867	Needle electromyography; cranial nerve supplied muscle(s), unilateral	22.83	XXX	80/20
	95868	Needle electromyography; cranial nerve supplied muscles, bilateral	39.91	XXX	80/20
	95869	Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)	16.91	XXX	80/20
	95870	Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters	16.91	XXX	80/20
+	**95885**	Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)	11.66	ZZZ	32/68
+	**95886**	Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure)	18.27	ZZZ	54/46
+	**95887**	Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)	16.28	ZZZ	48/52
	95907	Nerve conduction studies; 1-2 studies	19.02	XXX	55/45
	95908	Nerve conduction studies; 3-4 studies	24.63	XXX	54/46
	95909	Nerve conduction studies; 5-6 studies	29.35	XXX	54/46
	95910	Nerve conduction studies; 7-8 studies	38.65	XXX	54/46
	95911	Nerve conduction studies; 9-10 studies	46.11	XXX	57/43
	95912	Nerve conduction studies; 11-12 studies	51.17	XXX	61/39
	95913	Nerve conduction studies; 13 or more studies	59.03	XXX	62/38
	95925	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs	35.76	XXX	80/20
	95926	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs	35.76	XXX	80/20
	95927	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head	35.76	XXX	80/20
	95930	Visual evoked potential (VEP) checkerboard or flash testing, central nervous system except glaucoma, with interpretation and report	16.91	XXX	50/50
	95933	Orbicularis oculi (blink) reflex, by electrodiagnostic testing	14.37	XXX	80/20

+ 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

95860-97814, 99050-99080

MEDICINE

Effective January 1, 2026

Chiropractic Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	95937	Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method	13.36	XXX	80/20
	95999	Unlisted neurological or neuromuscular diagnostic procedure	BR	XXX	
	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	
(51)	**99050**	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service	3.55	XXX	
(51)	**99051**	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service	BR	XXX	
(51)	**99053**	Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service	BR	XXX	
(51)	**99056**	Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service	3.38	XXX	
(51)	**99058**	Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service	4.23	XXX	
(51)	**99060**	Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service	4.73	XXX	
	99070	Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	Refer to Rules	XXX	
	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	

5 Physical Medicine

The relative values in this section were determined uniquely for physical medicine services. Use the physical medicine conversion factor when determining fee amounts. The physical medicine conversion factor is not applicable to any other section. The fee for a procedure or service in this section is determined by multiplying the relative value by the physical medicine conversion factor, subject to the ground rules, instructions, and definitions of the schedule.

Conversion factors are located in the Introduction and General Guidelines section. To ensure uniformity of billing when multiple services are rendered, each relative value unit is to be multiplied by the conversion factor separately. After which, charges for products may be added.

Conversion Factors

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

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

Physical Medicine Ground Rules

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

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

1. NYS Medical Treatment Guidelines

The recommendations of the NYS Medical Treatment Guidelines supersede the ground rule frequency limitation for services rendered to body parts covered by the medical treatment guidelines.

The maximum reimbursement limitations per patient per day per 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.

2. Initial Evaluation and Re-evaluation

Chiropractors may bill for an initial evaluation using CPT codes 99202–99204. Evaluations shall include the following elements: history, clinical testing, and interpretation of data and development of the plan of care with defined goals, appropriate interventions, and recommendations.

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

The following codes represent the treatments subject to this rule:

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

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

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

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

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

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

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

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

3. Multiple Physical Medicine Procedures and Modalities

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

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

4. Tests and Measurements

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

5. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Appendixes referenced in the modifier descriptions are found in the CPT 2024 book. Modifiers commonly used with physical medicine procedures are as follows:

22 Increased Procedure Services

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

51 Multiple Procedures

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

99 Multiple Modifiers

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

6. Physical and Occupational Therapists Billing

All providers who can be authorized by the NYS Workers' Compensation Board, must be Board-authorized in order to treat injured workers.

All Physical and Occupational Therapists, whether self-employed or part of another practice, must submit their own medical reports and bill independently in their own name, and must bill using the NYS WCB Physical and Occupational Therapy Fee Schedule and not through a supervising provider. Some exceptions may include:

PT/OT performed in a hospital inpatient setting or ambulatory surgery setting may be billed by the facility. See WCB webpage for more information on Expanded Provider Law: www.wcb.ny.gov.

Chiropractors may not bill for (incident to) physical/occupational therapists that are performing the patient's therapy.

7. 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.

97010-97763, 98940-98943

Physical Medicine

Effective January 1, 2026

Chiropractic Fee Schedule

		Code	Description	Relative Value	FUD
	(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)	**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)	**97530**	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	2.87	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
	(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
		98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions	4.57	000
		98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions	6.00	000
		98942	Chiropractic manipulative treatment (CMT); spinal, 5 regions	7.10	000
		98943	Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions	NC	XXX

Appendix

New CPT Codes

The table below is a complete list of CPT codes that have been added to the Chiropractic Fee Schedule since the 2018/2020 Fee Schedules.

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

99080

Optum Exempt From Modifier 51 (51)

99050	99051	99053	99056	99058	99060
97010	97012	97014	97024	97026	97028
97032	97033	97034	97035	97036	97110
97112	97113	97116	97124	97140	97530
97545	97750	97763			

Changed Codes

Changed Values

The following table is a list of CPT and state-specific codes applicable to the Chiropractic Fee Schedule that have a relative value change, an FUD change, a PC/TC split change, an Add-on change, or modifier 51 exempt change since the 2018/2020 Fee Schedules. 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 (2018/2020) 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 2018/2020 RVU. This is the RVU effective in the 2018/2020 fee schedules.

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

NY 2018/2020 FUD. This is the FUD listed in the 2018/2020 fee schedules.

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 2018/2020 PC/TC Split. This is the PC/TC split effective in the 2018/2020 fee schedules.

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

NY 2018/2020 Add-On. This is the Add-on status in the 2018/2020 fee schedules.

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

NY 2018/2020 Mod51 Exempt. This is the modifier 51 exempt status in the 2018/2020 fee schedules.

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

CODE	NY 2018/2020 RVU	NY 2024 RVU	NY 2018/2020 FUD	NY 2024 FUD	NY 2018/2020 PC/TC Split	NY 2024 PC/TC Split	NY 2018/2020 Add-On	NY 2024 Add-On	NY 2018/2020 Mod 51 Exempt	NY 2024 Mod 51 Exempt
76999	BR	0	XXX	XXX						

Changed Descriptions

The table below is a complete list of CPT codes that have had a description change in the Chiropractic Fee Schedule since the 2018/2020 Fee Schedules.

70250	99202	99203	99204	99212	99243

Deleted CPT Codes

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

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