OFFICIAL

NEW YORK STATE WORKERS' COMPENSATION

PODIATRY FEE SCHEDULE

Effective xx/xx/2026

NEW YORK STATE OF OPPORTUNITY

Workers' Compensation Board

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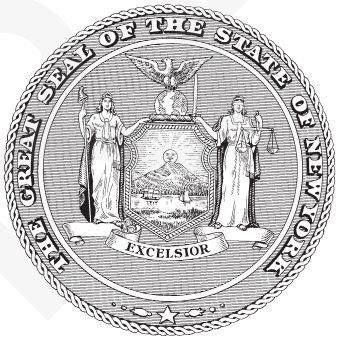

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NEW YORK WORKERS' COMPENSATION BOARD FILING NOTICE

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

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FOREWORD

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

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

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

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

New York State Workers' Compensation Board

Contents

1 Introduction and General Guidelines

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

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

Because the Podiatry 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 podiatrist 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 podiatrists in the care of workers' compensation covered patients and ensure the proper payment for such services by assuring that they are specifically identifiable.

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 Podiatry Fee Schedule has seven major sections—Evaluation and Management, Surgery, Radiology, Pathology and Laboratory, Medicine, Appliances and Prostheses, and Appendix. Each section has specific instructions which precede it. Organization according to these sections stems from the types of services which each contains. Furthermore, the separation into these sections reflects the variations which exist in the overhead expense ratios for providing these services. Thus, separation provides the capability of merely changing the conversion factor (the dollar value to apply to a unit) in one section as economic factors affect the cost of providing services.

The introduction material, known as Ground Rules, precedes each section. These ground rules contain general information and instructions, and a list of general rules with which the user of each section must be acquainted before undertaking to use the section. Familiarity with these general rules, which include definitions, references, prohibitions, and directions for their proper employment, is necessary for all who use the Schedule.

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 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 Podiatry Fee Schedule. The columns vary by section throughout the schedule.

Icons

The following icons are included in the Podiatry Fee Schedule:

- ■ New and changed codes—Codes that are new, changed description, or changed value since the 2018/2020 Fee Schedules.
- + Add-on service—Add-on codes have been designated in the CPT book as being additional or supplemental procedures that are carried out in addition to the primary procedure.

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

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

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

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

Code

The Code column lists the American Medical Association's CPT codes. *CPT 2024* is used by arrangement with the AMA. Any altered CPT codes are identified with the registered trademark symbol (®). State-specific codes or codes used only in New York State are identified with an infinity symbol (∞).

Description

This manual lists full 2024 CPT code descriptions.

Relative Value

The Relative Value column lists the relative value units (RVUs) 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 unit 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 10121, performed in Region I or Region II, would be calculated as follows:

	1.08	(Relative Value)
x	$202.53	(Surgery Section Conversion Factor for Region I or II)
=	$218.73	

BR

Some services do not have a relative value unit assigned 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 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 PC/TC Split column shows the percentage of the procedure that is professional or technical. A procedure with a relative value unit of 3.0 and a 40/60 in the PC/TC Split column would be calculated as follows: 40 percent of the value (3.0 x conversion factor x .40 = PC) is for the professional portion of the service and 60 percent of the value (3.0 x conversion factor x .60 = TC) represents the technical portion of the service. The total component reimbursed should never be more than the professional and technical portions 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	$12.11	$12.11	$13.85	$15.06
Medicine	$8.91	$8.91	$10.19	$11.07
Surgery	$202.53	$202.53	$231.78	$251.94
Radiology	$46.77	$46.77	$53.53	$58.19
Pathology and Laboratory	$1.06	$1.06	$1.21	$1.31
Appliances and Prosthesis	$17.18	$17.18	$17.18	$17.18

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

WCB Authorized Nurse Practitioners (NP) and Physician Assistants (PA) who render care within their scope of practice under NYS Education Law, and in accordance with their delineation of activities in Workers' Compensation Law, shall bill and be reimbursed for their services at **80 percent** of the corresponding Podiatry Fee Schedule rate. See currently published information on Expanded Provider Legislation available on the WCB webpage. This Ground Rule does not apply to bills for assistance during surgeries. Also see Surgery Ground Rule for Concurrent Services, and also Modifier 83 information. State-specific modifier 83 is used to identify assistant at surgery services provided by a physician assistant or nurse practitioner.

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

A. Pharmacy

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

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

For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070. Except in emergencies, any medications must follow all WCB Formulary and applicable Medical Treatment Guidelines. Any variations require or Prior Authorization (PAR).

B. Durable Medical Equipment

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

5. Separate Procedures

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

See also information in Surgery section and under other Ground Rules for "Modifiers". Also refer to any currently published WCB policies and/or guidance.

6. Concurrent Care

When more than one provider treats a patient for the same condition during the same period of time, payment is made only to one provider. Where the concurrent care involves overlapping or common services, the fees payable shall not be increased but prorated. Each provider shall submit

separate bills but indicate if agreement has been reached on the proration. The services rendered by each physician shall be distinct, in different disciplines, identifiable, and adequately documented in the records and reports.

6a. 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 spent with the patient should be prorated such that the time billed on each visit does not exceed the total 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.

7. Alternating Providers

When providers of similar skills alternate in the care of a patient (e.g., partners, groups, or same facility covering for another provider on weekends or vacation periods), each provider shall bill individually for the services they personally rendered and in accordance with the fee schedule. Each billing physician/provider must be WCB authorized, as applicable . If a provider wishes to perform a procedure for which a Prior Authorization (PAR) was granted to a different provider, the subsequent provider should seek express written authorization from the payer, ideally as a new PAR, or as otherwise approved in writing by the payer.

8. Proration of Scheduled Relative Value Unit Fee

When the schedule specifies a relative value unit fee for a definite treatment with an inclusive period of aftercare (follow-up days), and the patient is transferred from one provider to another provider, the employer (or carrier) is only responsible for the total amount listed in the schedule. Such amount is to be apportioned between the providers. If the concerned providers agree to the amounts to be prorated to each, they shall render separate bills accordingly. When treatment is terminated by the departure of the patient from New York State before the expiration of the stated follow-up days, the fee shall be the portion of the appropriate fee having regard for the fact that usually the greater portion is earned at the time of the original operation or service. When treatment is terminated by the death of the patient before the expiration of the follow-up days, the full fee is payable, subject to proration where applicable.

9. Home Visits

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

10. Referrals/Direct Care

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

11. Multiple Services

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

12. Miscellaneous

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

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

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

13. Medical Testimony

As provided in Part 301 of the Workers' Compensation regulations and following direction by the Board, whenever the attendance of the injured employee's treating or consultant podiatrist is required at a hearing or deposition, such podiatrist shall be entitled to an attendance fee of $450.00. Fees for testimony shall be billed following a direction by the Board as to the fee amount using code 99075.

14. Modifiers

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

will follow. Appendixes referenced in the modifier descriptions are found in the CPT 2024 book.

1R∞ Non-surgical services provided by residents and fellows.

Billed and payable at the same applicable rate as the WCB authorized, supervising podiatrist. 1R can be used for E/M codes, such as office visits, as well as for standalone procedures not performed during a surgery i.e., injections. This modifier is not used for a surgery assistant. See Modifier 84.

22 Increased Procedural Services

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

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

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

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

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

26 Professional Component

Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number. ***For intra-operative imaging, this modifier should not be used on the same code by two providers during the same procedure.***

TC Technical Component

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

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

(This CPT modifier is for use by Ambulatory Surgery Center (ASC) and Hospital Outpatient Settings Only.)

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

32 Mandated Services

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

47 Anesthesia by Surgeon

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

50 Bilateral Procedure

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

51 Multiple Procedures

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

52 Reduced Services

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

54 Surgical Care Only

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

55 Post-operative Management Only

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

56 Preoperative Management Only

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

57 Decision for Surgery

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

58 Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

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

59 Distinct Procedural Service

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

62 Two Surgeons

When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each

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

66 Surgical Team

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

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

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

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

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

78 Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Post-operative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Post-operative Period

The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

80 Assistant Surgeon

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

81 Minimum Assistant Surgeon

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

82 Assistant Surgeon (when qualified resident surgeon not available)

The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).

83∞ Services of Physician Assistants (PA) and Nurse Practitioners (NP) assisting during surgical procedures

The operating podiatrist must bill at 10.7 percent of the total podiatry fee schedule allowance for the surgical procedures performed by the PA/NP. Identify the services by adding Modifier 83 to the specific procedure codes done by the NP/PA. Payment will be made to the supervising podiatrist performing the surgery. This modifier is valid for surgery only. NPs and PAs cannot bill for surgery independently.

84∞ Assistance at surgery provided by residents and fellows.

This modifier should be appended to the individual codes representing work actually performed by the resident/fellow while assisting the WCB authorized, supervising podiatrist. This modifier should not be used for E/M codes or for procedures not performed during a surgery i.e., injections. See Modifier 1R.

90 Reference (Outside) Laboratory

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

91 Repeat Clinical Diagnostic Laboratory Test

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

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

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

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

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

99 Multiple Modifiers

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

15. 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.

16. Codes in the Podiatry Fee Schedule

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

17. Telehealth

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

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

1. Podiatrists may only bill:
    - E/M code **99212**
2. All eligible provider types should use:
    - Modifier **95** for two-way *Audio and Visual* communication
    - Modifier **93** for *Audio only*
    - Place of service (POS) code **10** for patient located in their home
    - POS code **02** for patient located in a ***healthcare setting*** that is not their home

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

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

18. 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.

19. 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.

20. Billing for Residents and Fellows

Treatment rendered by residents and fellows can only be billed by the Board authorized supervising podiatrist. Non-surgical service codes should be appended with modifier **1R.** Services with modifier 1R must be billed and reimbursed at the same amount payable to the authorized supervising podiatrist.

Assistant-at-surgery codes should be appended with modifier **84.** Surgery codes with modifier 84 must be billed and reimbursed at **16 percent** of the applicable podiatrist code fee. All Fee Schedule Ground Rules for multiple procedures apply. Also see WCB webpage and any current bulletins for additional guidance.

A. Podiatrists cannot additionally bill for supervision of the resident.

B. If the supervising podiatrist bills for a resident/fellow assisting at surgery, only one additional assistant (PA/NP-Modifier 83) may be billed and only if documentation supports the necessity of the additional assistance.

C. When applicable, Modifier 84 should be appended to the individual codes of the surgery.

D. All codes billed should accurately reflect work performed by the resident/fellow. Documentation in the operative/procedure report should include all details. Payment may be decided based on review of documentation, as well as the usual and customary standards of CPT/CMS billing guidelines for allowance of assistants at surgery.

E. Non-Authorized Out-of-State Podiatrists may not bill for residents/fellows.

F. Podiatrists should not bill for services performed by a resident/fellow that would not normally be billed by another type of assistant at surgery.

G. Payment shall not be made for observation, or for simple assistance such as closing basic surgical fields or work typically performed by nursing/technical staff.

H. The name of the resident/fellow does not need to be documented on the CMS 1500 form.

I. All CMS 1500 Narrative requirements do apply to any bills submitted. https://www.wcb.ny.gov/CMS-1500/

21. Exempt From Modifier 51 Codes

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

The CPT book identifies these services with the ⃠ symbol.

Modifier 51 exempt services and procedures can be found in current CPT books.

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

2 Evaluation and Management (E/M)

The relative value units in this section were determined uniquely for evaluation and management services. Use the E/M conversion factor when determining fee amounts.

The relative value units listed in this section reflect the relativity of charges for procedures within this section only.

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

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

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 or under the responsible and direct supervision of a podiatrist unless otherwise stated. Please refer to CPT guidelines for a full explanation of the proper use of the evaluation and management codes.

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	$12.11	$12.11	$13.85	$15.06

Evaluation and Management 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. Emergency Room

Podiatrists shall bill for services rendered in a hospital emergency room in accordance with the provisions of this schedule. If the treatment rendered is covered by a line item in sections other than office and hospital visits, the fees applicable to the appropriate code shall be payable. (See Surgery section Ground Rule *Emergency Situations* for preoperative hospital visits and services.)

2. New and Established Patient Service

Several code subcategories in the E/M section are based on the patient's status as being either new or established. The new versus established patient guidelines also clarify the situation in which one podiatrist is on call or covering for another podiatrist. In this instance, classify the patient encounter the same as if it were for the podiatrist who is unavailable.

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 podiatrist, or another podiatrist* who belongs to the same group practice, within the past three years.

Established Patient

An established patient is one who has received professional services from the *podiatrist, or another podiatrist* who belongs to the same group practice, within the past three years. *Because initial records such as history and physical are available within the group's facility, an initial new patient visit would not be warranted.*

3. Modifiers

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

1R∞ Non-surgical services provided by residents and fellows

Billed and payable at the same applicable rate as the WCB authorized, supervising podiatrist. 1R can be used for E/M codes, such as office visits, as well as for standalone procedures not performed during a surgery i.e., injections. This modifier is not used for a surgery assistant. See Modifier 84.

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

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

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

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

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

(This CPT modifier is for use by Ambulatory Surgery Center (ASC) and Hospital Outpatient Settings Only.)

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

32 Mandated Services

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

52 Reduced Services

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

57 Decision for Surgery

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

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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. Billing for Residents and Fellows

Treatment rendered by residents and fellows can only be billed by the Board authorized supervising podiatrist. Non-surgical service codes should be appended with modifier **1R.** Services with modifier 1R must be billed and reimbursed at the same amount payable to the authorized supervising podiatrist. Also see WCB webpage and any current bulletins for additional guidance.

A. Podiatrists cannot additionally bill for supervision of the resident.

B. All codes billed should accurately reflect work performed by the resident/fellow. Documentation in the operative/procedure report should include all details. Payment may be decided based on review of documentation, as well as the usual and customary standards of CPT/CMS billing guidelines for allowance of assistants at surgery.

C. Non-Authorized out-of-state podiatrists may not bill for residents/fellows.

D. Podiatrists should not bill for services performed by a resident/fellow that would not normally be billed by another type of assistant. Payment shall not be made for observation, or for simple assistance or work typically performed by nursing/technical staff.

E. The name of the resident/fellow does not need to be documented on the CMS 1500 form.

F. All CMS 1500 Narrative requirements do apply to any bills submitted. https://www.wcb.ny.gov/CMS-1500/

6. Telehealth

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

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

1. Podiatrists may only bill:
   - E/M code **99212**
2. All eligible provider types should use:
   - Modifier **95** for two-way *Audio and Visual* communication
   - Modifier **93** for Audio only
   - Place of service (POS) code **10** for patient located in their home
   - POS code **02** for patient located in a *healthcare setting* that is not their home

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

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

7. Schedule Permanency Evaluations

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

Evaluation and Management 99202-99456

Podiatry 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
■	**99205**	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.	18.26	XXX
■	**99211**	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional	3.21	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
■	**99213**	Office or other outpatient visit for the evaluation and management of an 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, 20 minutes must be met or exceeded.	5.83	XXX
■	**99214**	Office or other outpatient visit for the evaluation and management of an established 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, 30 minutes must be met or exceeded.	8.46	XXX
■	**99215**	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.	13.53	XXX
■	**99221**	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.	14.12	XXX
■	**99222**	Initial hospital inpatient or observation care, per day, for the evaluation and management of a 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, 55 minutes must be met or exceeded.	19.02	XXX
■	**99223**	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.	23.34	XXX

+ Add-on Procedure

■ New code, changed description, or changed value from 2018/2020

99202-99456

Evaluation and Management

Effective January 1, 2026

Podiatry Fee Schedule

	Code	Description	Relative Value	FUD
■	**99231**	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.	7.44	XXX
■	**99232**	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a 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, 35 minutes must be met or exceeded.	10.15	XXX
■	**99233**	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.	14.97	XXX
■	**99234**	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low 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.	13.95	XXX
■	**99235**	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, 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, 70 minutes must be met or exceeded.	18.94	XXX
■	**99236**	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 85 minutes must be met or exceeded.	23.84	XXX
■	**99238**	Hospital inpatient or observation discharge day management; 30 minutes or less on the date of the encounter	8.79	XXX
■	**99239**	Hospital inpatient or observation discharge day management; more than 30 minutes on the date of the encounter	10.99	XXX
■	**99242**	Office or other outpatient consultation for a new or 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, 20 minutes must be met or exceeded.	12.94	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
■	**99244**	Office or other outpatient consultation for a new or established 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, 40 minutes must be met or exceeded.	21.56	XXX
■	**99245**	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.	27.23	XXX

Evaluation and Management 99202-99456

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

	Code	Description	Relative Value	FUD
■	**99252**	Inpatient or observation consultation for a new or 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, 35 minutes must be met or exceeded.	15.39	XXX
■	**99253**	Inpatient or observation 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, 45 minutes must be met or exceeded.	18.94	XXX
■	**99254**	Inpatient or observation consultation for a new or established 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, 60 minutes must be met or exceeded.	23.67	XXX
■	**99255**	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 80 minutes must be met or exceeded.	29.76	XXX
■	**99281**	Emergency department visit for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional	6.59	XXX
■	**99282**	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making	8.88	XXX
■	**99283**	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making	13.36	XXX
■	**99284**	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making	19.95	XXX
■	**99285**	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making	29.76	XXX
■	**99304**	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.	8.46	XXX
■	**99305**	Initial nursing facility care, per day, for the evaluation and management of a 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, 35 minutes must be met or exceeded.	11.84	XXX
■	**99306**	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.	14.37	XXX
■	**99307**	Subsequent nursing facility care, per day, for the evaluation and management of a 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.	4.73	XXX
■	**99308**	Subsequent nursing facility care, per day, for the evaluation and management of a 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, 20 minutes must be met or exceeded.	6.43	XXX

✚ Add-on Procedure

■ New code, changed description, or changed value from 2018/2020

99202-99456 EVALUATION AND MANAGEMENT

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

	Code	Description	Relative Value	FUD
■	**99309**	Subsequent nursing facility care, per day, for the evaluation and management of a 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, 30 minutes must be met or exceeded.	9.30	XXX
■	**99310**	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high 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.	12.68	XXX
■	**99315**	Nursing facility discharge management; 30 minutes or less total time on the date of the encounter	8.79	XXX
■	**99316**	Nursing facility discharge management; more than 30 minutes total time on the date of the encounter	10.99	XXX
■	**99341**	Home or residence 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.	7.69	XXX
■	**99342**	Home or residence 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.	9.64	XXX
■	**99344**	Home or residence 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, 60 minutes must be met or exceeded.	17.76	XXX
■	**99345**	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.	24.01	XXX
■	**99347**	Home or residence 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, 20 minutes must be met or exceeded.	6.00	XXX
■	**99348**	Home or residence visit for the evaluation and management of an 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.	7.69	XXX
■	**99349**	Home or residence visit for the evaluation and management of an established 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, 40 minutes must be met or exceeded.	11.16	XXX
■	**99350**	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.	17.84	XXX
	99358	Prolonged evaluation and management service before and/or after direct patient care; first hour	18.60	XXX
+	**99359**	Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)	9.30	ZZZ

Evaluation and Management 99202-99456

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

	Code	Description	Relative Value	FUD
	99375	Supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more	NC	XXX
■ +	**99417**	Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management service)	5.99	ZZZ
	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

+ Add-on Procedure

■ New code, changed description, or changed value from 2018/2020

3 Surgery

The relative value units in this section were determined uniquely for surgery services. Use the surgery conversion factor when determining fee amounts. The surgery conversion factor 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 procedure or service in this section is determined by multiplying the relative value units by the surgery conversion factor, subject to the ground rules, instructions, and definitions of the schedule.

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

Items used by all podiatrists in reporting their services are presented in the Introduction and General Guidelines section under General Ground Rules.

Conversion Factors

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

Section	Region I	Region II	Region III	Region IV
Surgery	$202.53	$202.53	$231.78	$251.94

Surgery 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. Package or Global Fee Concept

Listed values for all surgical procedures include the surgery, local infiltration, digital or regional block, and/or topical anesthesia when used and the normal follow-up care for the period indicated in days in the column headed "FUD." (For preoperative visits, see Ground Rule 2, below). Payment is for the procedure coded and described, irrespective of the method or appliance used to perform the procedure.

2. Immediate Preoperative Visits and Other Services by the Surgeon

Under most circumstances, including ordinary referrals, the immediate preoperative visit in the hospital or elsewhere necessary to examine the patient, complete the hospital records, and initiate the treatment program is included in the listed value for the surgical procedure.

Additional charges may be warranted for preoperative services under the following circumstances:

A. When the preoperative visit is the initial visit (e.g., an emergency) and prolonged detention or evaluation is required to prepare the patient or to establish the need for and type of surgical procedure.

B. When procedures not usually part of the basic surgical procedure are provided during the immediate preoperative period.

3. Emergency Situations

When a surgical procedure is performed in an emergency situation between the hours of 10:00 p.m. and 7:00 a.m., or on Sunday or legal holidays and is in response to calls received during those hours or on those days, an additional charge of one-third of the applicable fee, or one-third of the highest fee where multiple services or procedures are performed, may be warranted. The additional fee is not applicable in a standard case situation unless an emergency situation exists or arises. For example, it will not apply when the procedure is performed early or late for the convenience of the patient, podiatrist, or hospital.

Circumstances justifying the additional payment should be set forth in a statement accompanying the bill.

4. Follow-up Care for Diagnostic Procedures

Follow-up care for diagnostic procedures (e.g., endoscopy, injection procedures for radiography) includes only that care related to recovery from the diagnostic procedure itself. Care of the condition for which the diagnostic procedure was performed or of other concomitant conditions is not included and may be charged for in accordance with the services rendered.

5. Multiple or Bilateral Procedures/Add On Codes

When multiple procedures unrelated to the major procedure and adding significant time or complexity are provided at the same operative session, payment is for the procedure with the highest allowance plus half of the lesser procedures. The same rule applies for bilateral procedures when such are not specifically identified in the schedule.

It is appropriate to designate multiple procedures that are rendered on the same date by separate entries. This can be reported by using the multiple procedure modifier 51.

Multiple related procedures shall not warrant any additional fees. Related procedures are those without which the principle procedure cannot be adequately performed. Codes denoted as "each additional" are valued as listed and are not subject to the 50 percent reduction of the multiple procedures calculation.

Example: Related Procedures

A. **Open Reduction of a Fracture:** The excision of previous scars, the incision of fascia and muscles, the identification and retraction of nerves, muscles and area structures, and the closure of the wound, irrespective of type of closure, are all related to the principle procedure of the bone repair and merit no additional fee. If more than one podiatrist is involved in performing such related procedures, they will be considered as co-surgeons and the applicable fee for the principle procedure will apply and be prorated.

B. **Repair of a Tendon:** The skin incision and closure, irrespective of type, as well as the identification, incision and retraction of adjacent or overlying structures are related to the principle procedure and merit no additional fees.

C. **Each Additional Codes:** Within the fee schedule are procedures that are inherently related to each other due to additional levels or areas that are performed after a primary procedure. These procedures are identified with the + symbol and are not subject to the multiple procedure reductions. For example: When procedure code 15100 (split graft 100 sq. cm) is billed in conjunction with procedure code 15101 (each additional 100 sq. cm), each procedure will be reimbursed its full value.

6. Follow-up or Aftercare

A. Normal postoperative care is included with all services assigned follow-up days of 0, 10, or 90. Uncommon or unusual complications, recurrence, or the presence of other diseases or injuries requiring significant additional services concurrent with the procedures or during the listed period of follow-up care, may warrant additional charges. Additional charges must be substantiated by report.

B. When an additional surgical procedure is performed during the follow-up period and it is related to the previously performed procedure, but is not an intrinsic part of the latter, the additional procedure will be paid at one-half the allowed fee. In these instances, the follow-up periods will continue concurrently.

C. When multiple procedures and/or services are performed concurrently or sequentially within the same operative or treatment setting, the longest follow-up period will apply to all as one item.

7. Separate or Independent Procedures

Certain procedures are an inherent portion of a procedure or service, and, as such, do not warrant a separate charge. When such a procedure is carried out as a separate entity not immediately related to other services, the indicated value for "separate procedure" is applicable. Therefore, when a procedure is ordinarily a component of a larger procedure and is performed alone for a specific purpose, it may be considered a separate procedure. If a CPT code description includes the term "separate procedure," the CPT code may not be used with a related procedure in an anatomically related region, often through the same skin incision, or surgical approach.

Also refer to any currently published WCB policies and/or guidance.

8. Primary, Secondary, or Delayed Procedures

A primary procedure refers to one that is attempted or performed for the first time, irrespective of the time relationship to the date of the injury or the onset of the condition being treated subsequently. For example, where a tendon is lacerated and it is elected to close the laceration without suturing the tendon, the first direct repair of the tendon would constitute a delayed but primary repair. In this example, if the first repair is unsuccessful, any subsequent repair of the tendon would be a secondary procedure. Delayed procedures have the same values as primary procedures.

9. 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.

The podiatrist must submit all codes, including those for any NP/PA, Residents/Fellows, surgical assistants, on the same bill.

If multiple pages are submitted for one procedure, the total charge should appear on the last page.

10. 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.

11. Billing for Residents and Fellows

Treatment rendered by residents and fellows can only be billed by the Board authorized supervising podiatrist.

Non-surgical service codes should be appended with modifier 1R. Services with modifier 1R must be billed and reimbursed at the same amount payable to the authorized supervising physician.

Assistant-at-surgery codes should be appended with modifier **84.** Surgery codes with modifier 84 must be billed and reimbursed at **16 percent** of the applicable podiatrist code fee. All Fee Schedule Ground Rules for multiple procedures apply. Also see WCB webpage and any current bulletins for additional guidance.

A. Podiatrists cannot additionally bill for supervision of the resident.

B. If the supervising podiatrist bills for a resident/fellow assisting at surgery, only one additional assistant (NP/PA-Modifier 83) may be billed and only if documentation supports the necessity of the additional assistance.

C. When applicable, Modifier 84 should be appended to the individual codes of the surgery.

D. All codes billed should accurately reflect work performed by the resident/fellow. Documentation in the operative/procedure report should include all details. Payment may be decided based on review of documentation, as well as the usual and customary standards of CPT/CMS billing guidelines for allowance of assistants at surgery.

E. Non-Authorized out-of-state podiatrists may not bill for residents/fellows.

F. Podiatrists should not bill for services performed by a resident/fellow that would not normally be billed by another type of assistant at surgery. Payment shall not be made for observation, or for simple assistance such as closing basic surgical fields or work typically performed by nursing/technical staff.

G. The name of the resident/fellow does not need to be documented on the CMS 1500 form.

H. All CMS 1500 Narrative requirements do apply to any bills submitted. https://www.wcb.ny.gov/CMS-1500/

12. Concurrent Services by More Than One Podiatrist

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

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

B. Surgical assistants (Modifier 80): Identify surgery performed by code number, appropriate modifier, description of procedures, and bill at 16 percent of the code fee. The code must coincide with those of the primary surgeon. Assistants' fees are not payable when the hospital provides intern or resident staff to assist at surgery.

C. Two surgeons (Modifier 62): Under certain circumstances the skills of two surgeons (usually with different skills) may be required in the management of a specific surgical problem. By prior agreement, the total value for the procedures may be apportioned in relation to the responsibility and work done. The total value may be increased by 25 percent in lieu of the assistant's charge. Under these circumstances, the services of each surgeon should be identified. Identify surgery performed by code number, appropriate modifier, and description of procedures.

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

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

F. Services of Physician Assistants (PA) and Nurse Practitioners (NP) assisting during surgical procedures (Modifier 83): The operating podiatrist should bill at 10.7 percent of the total podiatrist fee schedule allowance for the surgical procedures performed by the NP/PA. Identify the services by adding modifier 83 to the specific procedure codes done by the NP/PA. Payment will be made to the supervising podiatrist performing the surgery. This modifier is valid for surgery only. NPs and PAs cannot bill for surgery independently. Modifier 83 is not used for NP/PA independently billing non-surgical services.

G. Assistance at surgery provided by residents and fellows. Surgery codes with modifier 84 must only be billed by the Board authorized supervising podiatrist and will be reimbursed at 16 percent of the applicable podiatrist code fee. See Ground Rule and Modifier descriptions for further details.

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

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

14. Repeat Procedure by Another Provider

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

15. Proration of a Scheduled Relative Value Unit Fee

When the schedule specifies a relative value unit fee for a definite treatment with an inclusive period of aftercare (follow-up days), and the patient transferred from one provider to another provider, the employer (or carrier) is only responsible for the total amount listed in the schedule. Such amount is to be apportioned between the providers. If the concerned providers agree to the amounts to be prorated to each, they shall render separate bills accordingly. When treatment is terminated by the departure of the patient from New York State before the expiration of the stated follow-up days, the fee shall be the portion of the appropriate fee having regard for the fact that usually the greater portion is earned at the time of the original operation or service. When treatment is terminated by the death of the patient before the expiration of the follow-up days, the full fee is payable, subject to proration where applicable.

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

A. Pharmacy

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

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

For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070. Except in emergencies, any medications must follow all WCB Formulary and applicable Medical Treatment Guidelines. Any variations require or Prior Authorization (PAR).

B. Durable Medical Equipment

All durable medical equipment (DME) supplied shall be billed and paid using the current published WCB 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 Durable Medical Equipment Fee Schedule or not listed in the WCB Durable Medical Equipment Fee Schedule may not be billed without such prior authorization. All DME must be prescribed according to 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/unlisted codes, or codes without a listed price require prior authorization (PAR) and manufacturer'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.

17. Reference (Outside) Laboratory

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

18. Surgical Destruction

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

19. Fractures and Dislocations

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

A. Casting and Strapping Guidelines

Application of casts and strapping codes are used to report replacement procedures during or after the period of follow-up care. These codes can also

be used when the cast application or strapping is an initial service performed to stabilize or protect a fracture, injury, or dislocation without a restorative treatment or procedure. Restorative treatment or procedure rendered by another provider following the application of the initial cast, splint, or strap may be reported with a treatment of fracture or dislocation codes.

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

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

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

B. Re-reduction

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

C. Bone, Cartilage, and Fascial Grafts

Listed values for most graft procedures include obtaining the graft. When a second surgeon obtains the graft, the value of the total procedure will not be increased but in accordance with Surgery Ground Rule 12-D, the value may be apportioned between the surgeons. Procedure 20900 is NOT to be used with procedures that include the graft as part of the descriptor.

Procedure 20900 can be used in those unusual circumstances when a graft is used that is not included in the descriptor.

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

D. Dislocations Complicated by a Fracture

Increase the unit value of the fracture/dislocation by 50 percent. The additional charge is not applicable to ankle fractures/dislocations.

E. Multiple Injuries

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

20. Modifiers

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

1R∞ Non-surgical services provided by residents and fellows

Billed and payable at the same applicable rate as the WCB authorized, supervising physician. 1R can be used for E/M codes, such as office visits, as well as for stand-alone procedures not performed during a surgery i.e., injections. This modifier is not used for assistance at surgery. See modifier 84.

22 Increased Procedural Services

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

32 Mandated Services

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

47 Anesthesia by Surgeon

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

50 Bilateral Procedure

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

51 Multiple Procedures

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

52 Reduced Services

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

54 Surgical Care Only

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

57 Decision for Surgery

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

58 Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

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

59 Distinct Procedural Service

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

62 Two Surgeons

When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure[s]) are performed during the same surgical session, separate

code(s) may also be reported with modifier 62 added. **Note:** If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

66 Surgical Team

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

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

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

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

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

78 Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/ procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

80 Assistant Surgeon

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

81 Minimum Assistant Surgeon

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

82 Assistant Surgeon (when qualified resident surgeon not available)

The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).

83∞ Services of Physician Assistants (PA) and Nurse Practitioners (NP) assisting during surgical procedures

The operating podiatrist must bill at 10.7 percent of the total physician fee schedule allowance for the surgical procedures performed by the NP/PA.

Identify the services by adding Modifier 83 to the specific procedure codes done by the NP/PA. Payment will be made to the supervising podiatrist performing the surgery. This modifier is valid for surgery only. NPs and PAs cannot bill for surgery independently.

84∞ Assistance at surgery provided by residents and fellows

This modifier should be appended to the individual codes representing work actually performed by the resident/fellow while assisting the WCB authorized, supervising podiatrist.

This modifier should not be used for E/M codes or for procedures not performed during a surgery i.e., injections. See Modifier 1R.

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.

Surgery

10060-64911

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Effective January 1, 2026

	Code	Description	Relative Value	FUD	PC/TC Split
	10060	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single	0.29	010	
	10061	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple	0.90	010	
	10120	Incision and removal of foreign body, subcutaneous tissues; simple	0.36	010	
	10121	Incision and removal of foreign body, subcutaneous tissues; complicated	1.08	010	
	10140	Incision and drainage of hematoma, seroma or fluid collection	0.54	010	
	10160	Puncture aspiration of abscess, hematoma, bulla, or cyst	0.29	010	
	10180	Incision and drainage, complex, postoperative wound infection	1.62	010	
	11010	Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin and subcutaneous tissues	1.10	010	
	11011	Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, and muscle	1.98	000	
	11012	Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle, and bone	2.42	000	
	11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less	1.10	000	
	11043	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less	1.98	000	
	11044	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less	2.42	000	
+	**11045**	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	0.18	ZZZ	
+	**11046**	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	0.45	ZZZ	
+	**11047**	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	0.90	ZZZ	
	11055	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion	0.18	000	
	11056	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions	0.22	000	
	11057	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than 4 lesions	0.36	000	
■	**11102**	Tangential biopsy of skin (eg, shave, scoop, saucerize, curette); single lesion	0.64	000	
■ +	**11103**	Tangential biopsy of skin (eg, shave, scoop, saucerize, curette); each separate/additional lesion (List separately in addition to code for primary procedure)	0.32	ZZZ	
■	**11104**	Punch biopsy of skin (including simple closure, when performed); single lesion	0.80	000	

+ 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

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	Code	Description	Relative Value	FUD	PC/TC Split
■ +	11105	Punch biopsy of skin (including simple closure, when performed); each separate/additional lesion (List separately in addition to code for primary procedure)	0.38	ZZZ	
■	11106	Incisional biopsy of skin (eg, wedge) (including simple closure, when performed); single lesion	0.99	000	
■ +	11107	Incisional biopsy of skin (eg, wedge) (including simple closure, when performed); each separate/additional lesion (List separately in addition to code for primary procedure)	0.45	ZZZ	
	11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions	0.31	010	
+	11201	Removal of skin tags, multiple fibrocutaneous tags, any area; each additional 10 lesions, or part thereof (List separately in addition to code for primary procedure)	0.25	ZZZ	
	11420	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less	0.47	010	
	11421	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm	0.61	010	
	11422	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm	0.76	010	
	11423	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm	1.12	010	
	11424	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm	1.44	010	
	11426	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm	1.98	010	
	11620	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less	0.99	010	
	11621	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm	1.17	010	
	11622	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm	1.39	010	
	11623	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm	1.71	010	
	11624	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm	2.15	010	
	11626	Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm	2.69	010	
	11719	Trimming of nondystrophic nails, any number	0.18	000	
	11720	Debridement of nail(s) by any method(s); 1 to 5	0.16	000	
	11721	Debridement of nail(s) by any method(s); 6 or more	0.24	000	
	11730	Avulsion of nail plate, partial or complete, simple; single	0.34	000	

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	Code	Description	Relative Value	FUD	PC/TC Split
+	11732	Avulsion of nail plate, partial or complete, simple; each additional nail plate (List separately in addition to code for primary procedure)	0.25	ZZZ	
	11740	Evacuation of subungual hematoma	0.27	000	
	11750	Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal;	1.21	010	
	11755	Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)	0.54	000	
	11760	Repair of nail bed	1.48	010	
	11762	Reconstruction of nail bed with graft	2.15	010	
	11765	Wedge excision of skin of nail fold (eg, for ingrown toenail)	0.81	010	
	11900	Injection, intralesional; up to and including 7 lesions	0.22	000	
	11901	Injection, intralesional; more than 7 lesions	0.34	000	
	12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less	0.39	000	
	12002	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm	0.50	000	
	12004	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm	0.66	000	
	12005	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm	0.81	000	
	12006	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 20.1 cm to 30.0 cm	0.99	000	
	12007	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); over 30.0 cm	1.78	000	
	12041	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less	0.68	010	
	12042	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm	0.86	010	
	12044	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 7.6 cm to 12.5 cm	1.13	010	
	12045	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 12.6 cm to 20.0 cm	1.49	010	
	12046	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 20.1 cm to 30.0 cm	1.94	010	
	12047	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; over 30.0 cm	2.29	010	
	13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm	1.35	010	
	13132	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm	3.50	010	

+ 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

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	Code	Description	Relative Value	FUD	PC/TC Split
+	13133	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)	1.21	ZZZ	
	14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less	5.20	090	
	14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm	6.70	090	
	14350	Filleted finger or toe flap, including preparation of recipient site	3.99	090	
	15004	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children	2.24	000	
+	15005	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)	0.72	ZZZ	
	15040	Harvest of skin for tissue cultured skin autograft, 100 sq cm or less	1.66	000	
	15050	Pinch graft, single or multiple, to cover small ulcer, tip of digit, or other minimal open area (except on face), up to defect size 2 cm diameter	2.00	090	
	15100	Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)	5.21	090	
+	15101	Split-thickness autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	1.39	ZZZ	
	15110	Epidermal autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children	5.03	090	
+	15111	Epidermal autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	0.83	ZZZ	
	15115	Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children	4.89	090	
+	15116	Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	1.10	ZZZ	
	15120	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)	5.12	090	
+	15121	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	1.80	ZZZ	
	15130	Dermal autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children	3.97	090	

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	Code	Description	Relative Value	FUD	PC/TC Split
+	15131	Dermal autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	0.67	ZZZ	
	15135	Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children	5.07	090	
+	15136	Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	0.63	ZZZ	
	15150	Tissue cultured skin autograft, trunk, arms, legs; first 25 sq cm or less	4.00	090	
+	15151	Tissue cultured skin autograft, trunk, arms, legs; additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure)	0.88	ZZZ	
+	15152	Tissue cultured skin autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	1.08	ZZZ	
	15155	Tissue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 25 sq cm or less	4.02	090	
+	15156	Tissue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure)	1.17	ZZZ	
+	15157	Tissue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	1.35	ZZZ	
	15240	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less	5.30	090	
	15271	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	0.66	000	
+	15272	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	0.13	ZZZ	
	15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	1.58	000	
+	15274	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	0.33	ZZZ	
	15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	0.77	000	
+	15276	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	0.19	ZZZ	

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		Code	Description	Relative Value	FUD	PC/TC Split
		15277	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	1.64	000	
	+	**15278**	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	0.41	ZZZ	
		15574	Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet	5.75	090	
		15620	Delay of flap or sectioning of flap (division and inset); at forehead, cheeks, chin, neck, axillae, genitalia, hands, or feet	5.40	090	
		15756	Free muscle or myocutaneous flap with microvascular anastomosis	18.09	090	
		15757	Free skin flap with microvascular anastomosis	21.28	090	
		15758	Free fascial flap with microvascular anastomosis	23.43	090	
■		**15769**	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)	3.89	090	
■		**15773**	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate	3.91	090	
■	+	**15774**	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)	1.22	ZZZ	
	+	**15777**	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)	1.62	ZZZ	
		15782	Dermabrasion; regional, other than face	2.50	090	
		15786	Abrasion; single lesion (eg, keratosis, scar)	0.36	010	
	+	**15787**	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)	0.20	ZZZ	
		15792	Chemical peel, nonfacial; epidermal	1.00	090	
		15793	Chemical peel, nonfacial; dermal	1.51	090	
■		**15851**	Removal of sutures or staples requiring anesthesia (ie, general anesthesia, moderate sedation)	0.31	000	
		15852	Dressing change (for other than burns) under anesthesia (other than local)	0.35	000	
■	+	**15853**	Removal of sutures or staples not requiring anesthesia (List separately in addition to E/M code)	0.07	ZZZ	
■	+	**15854**	Removal of sutures and staples not requiring anesthesia (List separately in addition to E/M code)	0.09	ZZZ	
		15860	Intravenous injection of agent (eg, fluorescein) to test vascular flow in flap or graft	0.90	000	
		16000	Initial treatment, first degree burn, when no more than local treatment is required	0.25	000	

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	Code	Description	Relative Value	FUD	PC/TC Split
	16020	Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)	0.38	000	
	16025	Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (eg, whole face or whole extremity, or 5% to 10% total body surface area)	0.61	000	
	16030	Dressings and/or debridement of partial-thickness burns, initial or subsequent; large (eg, more than 1 extremity, or greater than 10% total body surface area)	0.90	000	
	17000	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion	0.26	010	
+	**17003**	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion)	0.13	ZZZ	
■	**17004**	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions	1.08	010	
	17110	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions	0.27	010	
	17111	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions	BR	010	
	17250	Chemical cauterization of granulation tissue (ie, proud flesh)	0.22	000	
	17340	Cryotherapy (CO2 slush, liquid N2) for acne	0.15	010	
	20200	Biopsy, muscle; superficial	0.70	000	
	20205	Biopsy, muscle; deep	1.40	000	
	20206	Biopsy, muscle, percutaneous needle	0.25	000	
	20220	Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs)	0.80	000	
	20500	Injection of sinus tract; therapeutic (separate procedure)	0.25	010	
	20501	Injection of sinus tract; diagnostic (sinogram)	0.25	000	
	20520	Removal of foreign body in muscle or tendon sheath; simple	0.60	010	
	20525	Removal of foreign body in muscle or tendon sheath; deep or complicated	2.60	010	
	20550	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	0.44	000	
	20551	Injection(s); single tendon origin/insertion	0.44	000	
	20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)	0.47	000	
	20553	Injection(s); single or multiple trigger point(s), 3 or more muscles	0.52	000	
■	**20560**	Needle insertion(s) without injection(s); 1 or 2 muscle(s)	0.25	XXX	
■	**20561**	Needle insertion(s) without injection(s); 3 or more muscles	0.36	XXX	
	20600	Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance	0.28	000	

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SURGERY

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	Code	Description	Relative Value	FUD	PC/TC Split
	20605	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance	0.31	000	
	20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance	0.25	000	
	20612	Aspiration and/or injection of ganglion cyst(s) any location	0.31	000	
	20615	Aspiration and injection for treatment of bone cyst	0.80	010	
	20650	Insertion of wire or pin with application of skeletal traction, including removal (separate procedure)	0.70	010	
	20660	Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)	2.00	000	
	20665	Removal of tongs or halo applied by another individual	0.20	010	
	20670	Removal of implant; superficial (eg, buried wire, pin or rod) (separate procedure)	0.35	010	
	20680	Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)	2.40	090	
	20696	Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; initial and subsequent alignment(s), assessment(s), and computation(s) of adjustment schedule(s)	7.25	090	
⊘	**20697**	Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; exchange (ie, removal and replacement) of strut, each	8.59	000	
	20900	Bone graft, any donor area; minor or small (eg, dowel or button)	1.60	000	
	20924	Tendon graft, from a distance (eg, palmaris, toe extensor, plantaris)	2.17	090	
⊘	**20975**	Electrical stimulation to aid bone healing; invasive (operative)	4.14	000	
	20979	Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)	2.59	000	
+	**20985**	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)	0.83	ZZZ	
	20999	Unlisted procedure, musculoskeletal system, general	BR	YYY	
	27600	Decompression fasciotomy, leg; anterior and/or lateral compartments only	6.47	090	
	27601	Decompression fasciotomy, leg; posterior compartment(s) only	6.04	090	
	27602	Decompression fasciotomy, leg; anterior and/or lateral, and posterior compartment(s)	7.77	090	
	27603	Incision and drainage, leg or ankle; deep abscess or hematoma	3.67	090	
	27604	Incision and drainage, leg or ankle; infected bursa	3.67	090	
	27605	Tenotomy, percutaneous, Achilles tendon (separate procedure); local anesthesia	3.45	010	
	27606	Tenotomy, percutaneous, Achilles tendon (separate procedure); general anesthesia	3.45	010	
	27607	Incision (eg, osteomyelitis or bone abscess), leg or ankle	5.18	090	

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27610	Arthrotomy, ankle, including exploration, drainage, or removal of foreign body	6.47	090	
27612	Arthrotomy, posterior capsular release, ankle, with or without Achilles tendon lengthening	7.33	090	
27613	Biopsy, soft tissue of leg or ankle area; superficial	3.23	010	
27614	Biopsy, soft tissue of leg or ankle area; deep (subfascial or intramuscular)	3.88	090	
27615	Radical resection of tumor (eg, sarcoma), soft tissue of leg or ankle area; less than 5 cm	6.47	090	
27616	Radical resection of tumor (eg, sarcoma), soft tissue of leg or ankle area; 5 cm or greater	10.56	090	
27618	Excision, tumor, soft tissue of leg or ankle area, subcutaneous; less than 3 cm	3.23	090	
27619	Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm	3.88	090	
27620	Arthrotomy, ankle, with joint exploration, with or without biopsy, with or without removal of loose or foreign body	6.47	090	
27625	Arthrotomy, with synovectomy, ankle;	9.06	090	
27626	Arthrotomy, with synovectomy, ankle; including tenosynovectomy	9.06	090	
27630	Excision of lesion of tendon sheath or capsule (eg, cyst or ganglion), leg and/or ankle	3.23	090	
27632	Excision, tumor, soft tissue of leg or ankle area, subcutaneous; 3 cm or greater	2.48	090	
27634	Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); 5 cm or greater	5.80	090	
27635	Excision or curettage of bone cyst or benign tumor, tibia or fibula;	7.77	090	
27637	Excision or curettage of bone cyst or benign tumor, tibia or fibula; with autograft (includes obtaining graft)	9.49	090	
27638	Excision or curettage of bone cyst or benign tumor, tibia or fibula; with allograft	8.20	090	
27640	Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); tibia	7.90	090	
27641	Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); fibula	4.32	090	
27645	Radical resection of tumor; tibia	12.07	090	
27646	Radical resection of tumor; fibula	9.49	090	
27647	Radical resection of tumor; talus or calcaneus	8.63	090	
27648	Injection procedure for ankle arthrography	0.40	000	
27650	Repair, primary, open or percutaneous, ruptured Achilles tendon;	7.77	090	
27652	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	9.49	090	
27654	Repair, secondary, Achilles tendon, with or without graft	9.92	090	
27656	Repair, fascial defect of leg	3.95	090	
27658	Repair, flexor tendon, leg; primary, without graft, each tendon	5.18	090	
27659	Repair, flexor tendon, leg; secondary, with or without graft, each tendon	6.47	090	

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	27664	Repair, extensor tendon, leg; primary, without graft, each tendon	3.45	090	
	27665	Repair, extensor tendon, leg; secondary, with or without graft, each tendon	3.23	090	
	27675	Repair, dislocating peroneal tendons; without fibular osteotomy	6.47	090	
	27676	Repair, dislocating peroneal tendons; with fibular osteotomy	7.77	090	
	27680	Tenolysis, flexor or extensor tendon, leg and/or ankle; single, each tendon	3.26	090	
	27681	Tenolysis, flexor or extensor tendon, leg and/or ankle; multiple tendons (through separate incision[s])	3.95	090	
	27685	Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure)	6.04	090	
	27686	Lengthening or shortening of tendon, leg or ankle; multiple tendons (through same incision), each	6.04	090	
	27687	Gastrocnemius recession (eg, Strayer procedure)	4.64	090	
	27690	Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)	6.04	090	
	27691	Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)	7.33	090	
+	**27692**	Transfer or transplant of single tendon (with muscle redirection or rerouting); each additional tendon (List separately in addition to code for primary procedure)	1.73	ZZZ	
	27695	Repair, primary, disrupted ligament, ankle; collateral	6.62	090	
	27696	Repair, primary, disrupted ligament, ankle; both collateral ligaments	9.19	090	
	27698	Repair, secondary, disrupted ligament, ankle, collateral (eg, Watson-Jones procedure)	9.19	090	
	27700	Arthroplasty, ankle;	7.77	090	
	27704	Removal of ankle implant	9.19	090	
	27705	Osteotomy; tibia	12.07	090	
	27707	Osteotomy; fibula	5.18	090	
	27709	Osteotomy; tibia and fibula	14.66	090	
	27712	Osteotomy; multiple, with realignment on intramedullary rod (eg, Sofield type procedure)	11.36	090	
	27715	Osteoplasty, tibia and fibula, lengthening or shortening	15.81	090	
	27720	Repair of nonunion or malunion, tibia; without graft, (eg, compression technique)	12.94	090	
	27722	Repair of nonunion or malunion, tibia; with sliding graft	14.24	090	
	27724	Repair of nonunion or malunion, tibia; with iliac or other autograft (includes obtaining graft)	15.53	090	
	27725	Repair of nonunion or malunion, tibia; by synostosis, with fibula, any method	15.53	090	
	27726	Repair of fibula nonunion and/or malunion with internal fixation	9.63	090	
	27730	Arrest, epiphyseal (epiphysiodesis), open; distal tibia	5.18	090	
	27732	Arrest, epiphyseal (epiphysiodesis), open; distal fibula	4.14	090	
	27734	Arrest, epiphyseal (epiphysiodesis), open; distal tibia and fibula	7.25	090	

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	27745	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, tibia	8.69	090	
	27760	Closed treatment of medial malleolus fracture; without manipulation	2.27	090	
	27762	Closed treatment of medial malleolus fracture; with manipulation, with or without skin or skeletal traction	4.32	090	
	27766	Open treatment of medial malleolus fracture, includes internal fixation, when performed	7.77	090	
	27767	Closed treatment of posterior malleolus fracture; without manipulation	1.55	090	
	27768	Closed treatment of posterior malleolus fracture; with manipulation	2.59	090	
	27769	Open treatment of posterior malleolus fracture, includes internal fixation, when performed	5.18	090	
	27780	Closed treatment of proximal fibula or shaft fracture; without manipulation	1.88	090	
	27781	Closed treatment of proximal fibula or shaft fracture; with manipulation	3.23	090	
	27784	Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed	5.24	090	
	27786	Closed treatment of distal fibular fracture (lateral malleolus); without manipulation	1.98	090	
	27788	Closed treatment of distal fibular fracture (lateral malleolus); with manipulation	4.32	090	
	27792	Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed	7.77	090	
	27808	Closed treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli or medial and posterior malleoli); without manipulation	2.59	090	
	27810	Closed treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli or medial and posterior malleoli); with manipulation	3.88	090	
	27814	Open treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli), includes internal fixation, when performed	8.63	090	
	27816	Closed treatment of trimalleolar ankle fracture; without manipulation	2.37	090	
	27818	Closed treatment of trimalleolar ankle fracture; with manipulation	5.18	090	
	27822	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; without fixation of posterior lip	9.92	090	
	27823	Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip	12.07	090	
	27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	5.18	090	
	27840	Closed treatment of ankle dislocation; without anesthesia	1.73	090	
	27842	Closed treatment of ankle dislocation; requiring anesthesia, with or without percutaneous skeletal fixation	4.32	090	
	27846	Open treatment of ankle dislocation, with or without percutaneous skeletal fixation; without repair or internal fixation	7.90	090	

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	27848	Open treatment of ankle dislocation, with or without percutaneous skeletal fixation; with repair or internal or external fixation	7.90	090	
	27860	Manipulation of ankle under general anesthesia (includes application of traction or other fixation apparatus)	3.23	010	
	27870	Arthrodesis, ankle, open	12.07	090	
	27871	Arthrodesis, tibiofibular joint, proximal or distal	11.36	090	
	27888	Amputation, ankle, through malleoli of tibia and fibula (eg, Syme, Pirogoff type procedures), with plastic closure and resection of nerves	11.21	090	
	27889	Ankle disarticulation	11.21	090	
	27892	Decompression fasciotomy, leg; anterior and/or lateral compartments only, with debridement of nonviable muscle and/or nerve	5.18	090	
	27893	Decompression fasciotomy, leg; posterior compartment(s) only, with debridement of nonviable muscle and/or nerve	5.18	090	
	27894	Decompression fasciotomy, leg; anterior and/or lateral, and posterior compartment(s), with debridement of nonviable muscle and/or nerve	7.77	090	
	27899	Unlisted procedure, leg or ankle	BR	YYY	
■	**28001**	Incision and drainage, bursa, foot	3.23	000	
■	**28002**	Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space	3.67	000	
■	**28003**	Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas	3.67	000	
	28005	Incision, bone cortex (eg, osteomyelitis or bone abscess), foot	4.74	090	
	28008	Fasciotomy, foot and/or toe	3.23	090	
	28010	Tenotomy, percutaneous, toe; single tendon	3.23	090	
	28011	Tenotomy, percutaneous, toe; multiple tendons	3.23	090	
	28020	Arthrotomy, including exploration, drainage, or removal of loose or foreign body; intertarsal or tarsometatarsal joint	5.18	090	
	28022	Arthrotomy, including exploration, drainage, or removal of loose or foreign body; metatarsophalangeal joint	3.23	090	
	28024	Arthrotomy, including exploration, drainage, or removal of loose or foreign body; interphalangeal joint	3.23	090	
	28035	Release, tarsal tunnel (posterior tibial nerve decompression)	5.24	090	
	28039	Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater	3.42	090	
	28041	Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); 1.5 cm or greater	4.14	090	
	28043	Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm	3.23	090	
	28045	Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1.5 cm	3.67	090	
	28046	Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; less than 3 cm	14.32	090	
	28047	Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; 3 cm or greater	8.07	090	
	28050	Arthrotomy with biopsy; intertarsal or tarsometatarsal joint	3.95	090	
	28052	Arthrotomy with biopsy; metatarsophalangeal joint	3.23	090	

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28054	Arthrotomy with biopsy; interphalangeal joint	3.23	090	
28055	Neurectomy, intrinsic musculature of foot	3.31	090	
28060	Fasciectomy, plantar fascia; partial (separate procedure)	4.74	090	
28062	Fasciectomy, plantar fascia; radical (separate procedure)	6.04	090	
28070	Synovectomy; intertarsal or tarsometatarsal joint, each	3.95	090	
28072	Synovectomy; metatarsophalangeal joint, each	3.23	090	
28080	Excision, interdigital (Morton) neuroma, single, each	3.88	090	
28086	Synovectomy, tendon sheath, foot; flexor	4.15	090	
28088	Synovectomy, tendon sheath, foot; extensor	3.26	090	
28090	Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (eg, cyst or ganglion); foot	3.23	090	
28092	Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (eg, cyst or ganglion); toe(s), each	3.23	090	
28100	Excision or curettage of bone cyst or benign tumor, talus or calcaneus;	4.74	090	
28102	Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with iliac or other autograft (includes obtaining graft)	5.18	090	
28103	Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with allograft	4.74	090	
28104	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus;	3.62	090	
28106	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus; with iliac or other autograft (includes obtaining graft)	5.18	090	
28107	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus; with allograft	5.18	090	
28108	Excision or curettage of bone cyst or benign tumor, phalanges of foot	4.10	090	
28110	Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)	3.23	090	
28111	Ostectomy, complete excision; first metatarsal head	4.64	090	
28112	Ostectomy, complete excision; other metatarsal head (second, third or fourth)	3.23	090	
28113	Ostectomy, complete excision; fifth metatarsal head	3.23	090	
28114	Ostectomy, complete excision; all metatarsal heads, with partial proximal phalangectomy, excluding first metatarsal (eg, Clayton type procedure)	7.90	090	
28116	Ostectomy, excision of tarsal coalition	6.04	090	
28118	Ostectomy, calcaneus;	6.47	090	
28119	Ostectomy, calcaneus; for spur, with or without plantar fascial release	6.91	090	
28120	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus	4.32	090	
28122	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus	4.32	090	
28124	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); phalanx of toe	3.23	090	

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28126	Resection, partial or complete, phalangeal base, each toe	3.67	090	
28130	Talectomy (astragalectomy)	12.07	090	
28140	Metatarsectomy	4.74	090	
28150	Phalangectomy, toe, each toe	3.23	090	
28153	Resection, condyle(s), distal end of phalanx, each toe	3.23	090	
28160	Hemiphalangectomy or interphalangeal joint excision, toe, proximal end of phalanx, each	3.23	090	
28171	Radical resection of tumor; tarsal (except talus or calcaneus)	10.77	090	
28173	Radical resection of tumor; metatarsal	6.91	090	
28175	Radical resection of tumor; phalanx of toe	5.18	090	
28190	Removal of foreign body, foot; subcutaneous	3.23	010	
28192	Removal of foreign body, foot; deep	3.67	090	
28193	Removal of foreign body, foot; complicated	4.10	090	
28200	Repair, tendon, flexor, foot; primary or secondary, without free graft, each tendon	3.95	090	
28202	Repair, tendon, flexor, foot; secondary with free graft, each tendon (includes obtaining graft)	4.91	090	
28208	Repair, tendon, extensor, foot; primary or secondary, each tendon	3.23	090	
28210	Repair, tendon, extensor, foot; secondary with free graft, each tendon (includes obtaining graft)	3.23	090	
28220	Tenolysis, flexor, foot; single tendon	3.26	090	
28222	Tenolysis, flexor, foot; multiple tendons	3.95	090	
28225	Tenolysis, extensor, foot; single tendon	3.23	090	
28226	Tenolysis, extensor, foot; multiple tendons	3.23	090	
28230	Tenotomy, open, tendon flexor; foot, single or multiple tendon(s) (separate procedure)	3.23	090	
28232	Tenotomy, open, tendon flexor; toe, single tendon (separate procedure)	3.23	090	
28234	Tenotomy, open, extensor, foot or toe, each tendon	3.23	090	
28238	Reconstruction (advancement), posterior tibial tendon with excision of accessory tarsal navicular bone (eg, Kidner type procedure)	4.66	090	
28240	Tenotomy, lengthening, or release, abductor hallucis muscle	3.23	090	
28250	Division of plantar fascia and muscle (eg, Steindler stripping) (separate procedure)	3.26	090	
28260	Capsulotomy, midfoot; medial release only (separate procedure)	5.24	090	
28261	Capsulotomy, midfoot; with tendon lengthening	5.93	090	
28262	Capsulotomy, midfoot; extensive, including posterior talotibial capsulotomy and tendon(s) lengthening (eg, resistant clubfoot deformity)	9.19	090	
28264	Capsulotomy, midtarsal (eg, Heyman type procedure)	7.90	090	
28270	Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, each joint (separate procedure)	3.23	090	
28272	Capsulotomy; interphalangeal joint, each joint (separate procedure)	3.23	090	
28280	Syndactylization, toes (eg, webbing or Kelikian type procedure)	4.10	090	

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	28285	Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)	3.23	090	
	28286	Correction, cock-up fifth toe, with plastic skin closure (eg, Ruiz-Mora type procedure)	3.23	090	
	28288	Ostectomy, partial, exostectomy or condylectomy, metatarsal head, each metatarsal head	3.23	090	
■	**28289**	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant	3.52	090	
	28291	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant	5.24	090	
■	**28292**	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with resection of proximal phalanx base, when performed, any method	5.18	090	
■	**28296**	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with distal metatarsal osteotomy, any method	7.77	090	
■	**28297**	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with first metatarsal and medial cuneiform joint arthrodesis, any method	6.21	090	
■	**28298**	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with proximal phalanx osteotomy, any method	5.61	090	
■	**28299**	Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with double osteotomy, any method	7.56	090	
	28300	Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation	6.91	090	
	28302	Osteotomy; talus	5.93	090	
	28304	Osteotomy, tarsal bones, other than calcaneus or talus;	5.24	090	
	28305	Osteotomy, tarsal bones, other than calcaneus or talus; with autograft (includes obtaining graft) (eg, Fowler type)	5.93	090	
	28306	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal	4.64	090	
	28307	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal with autograft (other than first toe)	5.18	090	
	28308	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each	3.45	090	
	28309	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; multiple (eg, Swanson type cavus foot procedure)	6.47	090	
	28310	Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)	3.23	090	
	28312	Osteotomy, shortening, angular or rotational correction; other phalanges, any toe	3.23	090	
	28313	Reconstruction, angular deformity of toe, soft tissue procedures only (eg, overlapping second toe, fifth toe, curly toes)	3.23	090	
	28315	Sesamoidectomy, first toe (separate procedure)	3.23	090	
	28320	Repair, nonunion or malunion; tarsal bones	4.32	090	
	28322	Repair, nonunion or malunion; metatarsal, with or without bone graft (includes obtaining graft)	4.32	090	

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28340	Reconstruction, toe, macrodactyly; soft tissue resection	5.80	090	
28341	Reconstruction, toe, macrodactyly; requiring bone resection	6.93	090	
28344	Reconstruction, toe(s); polydactyly	3.43	090	
28345	Reconstruction, toe(s); syndactyly, with or without skin graft(s), each web	4.87	090	
28360	Reconstruction, cleft foot	11.02	090	
28400	Closed treatment of calcaneal fracture; without manipulation	1.94	090	
28405	Closed treatment of calcaneal fracture; with manipulation	2.59	090	
28406	Percutaneous skeletal fixation of calcaneal fracture, with manipulation	4.32	090	
28415	Open treatment of calcaneal fracture, includes internal fixation, when performed;	9.49	090	
28420	Open treatment of calcaneal fracture, includes internal fixation, when performed; with primary iliac or other autogenous bone graft (includes obtaining graft)	10.35	090	
28430	Closed treatment of talus fracture; without manipulation	1.51	090	
28435	Closed treatment of talus fracture; with manipulation	2.67	090	
28436	Percutaneous skeletal fixation of talus fracture, with manipulation	3.67	090	
28445	Open treatment of talus fracture, includes internal fixation, when performed	7.77	090	
28446	Open osteochondral autograft, talus (includes obtaining graft[s])	7.76	090	
28450	Treatment of tarsal bone fracture (except talus and calcaneus); without manipulation, each	1.28	090	
28455	Treatment of tarsal bone fracture (except talus and calcaneus); with manipulation, each	2.15	090	
28456	Percutaneous skeletal fixation of tarsal bone fracture (except talus and calcaneus), with manipulation, each	3.45	090	
28465	Open treatment of tarsal bone fracture (except talus and calcaneus), includes internal fixation, when performed, each	4.10	090	
28470	Closed treatment of metatarsal fracture; without manipulation, each	1.48	090	
28475	Closed treatment of metatarsal fracture; with manipulation, each	2.37	090	
28476	Percutaneous skeletal fixation of metatarsal fracture, with manipulation, each	3.23	090	
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each	3.95	090	
28490	Closed treatment of fracture great toe, phalanx or phalanges; without manipulation	0.69	090	
28495	Closed treatment of fracture great toe, phalanx or phalanges; with manipulation	0.69	090	
28496	Percutaneous skeletal fixation of fracture great toe, phalanx or phalanges, with manipulation	3.23	090	
28505	Open treatment of fracture, great toe, phalanx or phalanges, includes internal fixation, when performed	3.23	090	
28510	Closed treatment of fracture, phalanx or phalanges, other than great toe; without manipulation, each	0.64	090	
28515	Closed treatment of fracture, phalanx or phalanges, other than great toe; with manipulation, each	0.86	090	

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Effective January 1, 2026

Code	Description	Relative Value	FUD	PC/TC Split
28525	Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each	3.23	090	
28530	Closed treatment of sesamoid fracture	1.03	090	
28531	Open treatment of sesamoid fracture, with or without internal fixation	3.23	090	
28540	Closed treatment of tarsal bone dislocation, other than talotarsal; without anesthesia	1.08	090	
28545	Closed treatment of tarsal bone dislocation, other than talotarsal; requiring anesthesia	3.23	090	
28546	Percutaneous skeletal fixation of tarsal bone dislocation, other than talotarsal, with manipulation	3.88	090	
28555	Open treatment of tarsal bone dislocation, includes internal fixation, when performed	3.88	090	
28570	Closed treatment of talotarsal joint dislocation; without anesthesia	1.08	090	
28575	Closed treatment of talotarsal joint dislocation; requiring anesthesia	3.23	090	
28576	Percutaneous skeletal fixation of talotarsal joint dislocation, with manipulation	3.88	090	
28585	Open treatment of talotarsal joint dislocation, includes internal fixation, when performed	4.74	090	
28600	Closed treatment of tarsometatarsal joint dislocation; without anesthesia	0.49	090	
28605	Closed treatment of tarsometatarsal joint dislocation; requiring anesthesia	3.23	090	
28606	Percutaneous skeletal fixation of tarsometatarsal joint dislocation, with manipulation	4.10	090	
28615	Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed	4.74	090	
28630	Closed treatment of metatarsophalangeal joint dislocation; without anesthesia	0.86	010	
28635	Closed treatment of metatarsophalangeal joint dislocation; requiring anesthesia	3.23	010	
28636	Percutaneous skeletal fixation of metatarsophalangeal joint dislocation, with manipulation	4.10	010	
28645	Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed	4.10	090	
28660	Closed treatment of interphalangeal joint dislocation; without anesthesia	0.40	010	
28665	Closed treatment of interphalangeal joint dislocation; requiring anesthesia	0.94	010	
28666	Percutaneous skeletal fixation of interphalangeal joint dislocation, with manipulation	3.23	010	
28675	Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed	3.23	090	
28705	Arthrodesis; pantalar	13.80	090	
28715	Arthrodesis; triple	12.07	090	
28725	Arthrodesis; subtalar	8.63	090	
28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;	7.77	090	
28735	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; with osteotomy (eg, flatfoot correction)	7.77	090	

✚ 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

10060-64911

Surgery

Effective January 1, 2026

Podiatry Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	28737	Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal navicular-cuneiform (eg, Miller type procedure)	6.21	090	
	28740	Arthrodesis, midtarsal or tarsometatarsal, single joint	3.67	090	
	28750	Arthrodesis, great toe; metatarsophalangeal joint	4.64	090	
	28755	Arthrodesis, great toe; interphalangeal joint	3.45	090	
	28760	Arthrodesis, with extensor hallucis longus transfer to first metatarsal neck, great toe, interphalangeal joint (eg, Jones type procedure)	5.18	090	
	28800	Amputation, foot; midtarsal (eg, Chopart type procedure)	7.77	090	
	28805	Amputation, foot; transmetatarsal	7.77	090	
	28810	Amputation, metatarsal, with toe, single	5.18	090	
■	**28820**	Amputation, toe; metatarsophalangeal joint	3.67	000	
■	**28825**	Amputation, toe; interphalangeal joint	3.23	000	
	28890	Extracorporeal shock wave, high energy, performed by a physician or other qualified health care professional, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia	2.79	090	
	28899	Unlisted procedure, foot or toes	BR	YYY	
	29345	Application of long leg cast (thigh to toes);	0.64	000	
	29355	Application of long leg cast (thigh to toes); walker or ambulatory type	0.84	000	
	29358	Application of long leg cast brace	0.84	000	
	29365	Application of cylinder cast (thigh to ankle)	0.41	000	
	29405	Application of short leg cast (below knee to toes);	0.49	000	
	29425	Application of short leg cast (below knee to toes); walking or ambulatory type	0.59	000	
	29435	Application of patellar tendon bearing (PTB) cast	0.74	000	
	29440	Adding walker to previously applied cast	0.20	000	
	29450	Application of clubfoot cast with molding or manipulation, long or short leg	0.30	000	
	29505	Application of long leg splint (thigh to ankle or toes)	0.44	000	
	29515	Application of short leg splint (calf to foot)	0.35	000	
	29540	Strapping; ankle and/or foot	0.21	000	
	29550	Strapping; toes	0.13	000	
	29580	Strapping; Unna boot	0.29	000	
	29581	Application of multi-layer compression system; leg (below knee), including ankle and foot	0.44	000	
	29700	Removal or bivalving; gauntlet, boot or body cast	0.25	000	
	29730	Windowing of cast	0.15	000	
	29740	Wedging of cast (except clubfoot casts)	0.20	000	
	29750	Wedging of clubfoot cast	0.20	000	
	29799	Unlisted procedure, casting or strapping	BR	YYY	
	29891	Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect	10.45	090	

Surgery

10060-64911

Podiatry Fee Schedule

Effective January 1, 2026

	Code	Description	Relative Value	FUD	PC/TC Split
	29892	Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)	12.27	090	
	29893	Endoscopic plantar fasciotomy	2.56	090	
	29894	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with removal of loose body or foreign body	7.51	090	
	29895	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; synovectomy, partial	7.11	090	
	29897	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, limited	7.11	090	
	29898	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive	7.77	090	
	29899	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle arthrodesis	9.83	090	
	29904	Arthroscopy, subtalar joint, surgical; with removal of loose body or foreign body	8.07	090	
	29905	Arthroscopy, subtalar joint, surgical; with synovectomy	8.80	090	
	29906	Arthroscopy, subtalar joint, surgical; with debridement	8.80	090	
	29907	Arthroscopy, subtalar joint, surgical; with subtalar arthrodesis	9.32	090	
	29999	Unlisted procedure, arthroscopy	BR	YYY	
■	**64450**	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	0.35	000	
■	**64455**	Injection(s), anesthetic agent(s) and/or steroid; plantar common digital nerve(s) (eg, Morton's neuroma)	0.23	000	
	64632	Destruction by neurolytic agent; plantar common digital nerve	0.82	010	
	64640	Destruction by neurolytic agent; other peripheral nerve or branch	0.82	010	
	64702	Neuroplasty; digital, 1 or both, same digit	2.73	090	
	64704	Neuroplasty; nerve of hand or foot	3.27	090	
	64722	Decompression; unspecified nerve(s) (specify)	4.18	090	
	64726	Decompression; plantar digital nerve	1.82	090	
	64727	Internal neurolysis, requiring use of operating microscope (List separately in addition to code for neuroplasty) (Neuroplasty includes external neurolysis)	2.80	ZZZ	
	64774	Excision of neuroma; cutaneous nerve, surgically identifiable	2.09	090	
	64776	Excision of neuroma; digital nerve, 1 or both, same digit	2.18	090	
+	**64778**	Excision of neuroma; digital nerve, each additional digit (List separately in addition to code for primary procedure)	0.89	ZZZ	
	64782	Excision of neuroma; hand or foot, except digital nerve	2.91	090	
+	**64783**	Excision of neuroma; hand or foot, each additional nerve, except same digit (List separately in addition to code for primary procedure)	1.45	ZZZ	
+	**64787**	Implantation of nerve end into bone or muscle (List separately in addition to neuroma excision)	3.18	ZZZ	
	64788	Excision of neurofibroma or neurolemmoma; cutaneous nerve	3.27	090	
	64831	Suture of digital nerve, hand or foot; 1 nerve	3.41	090	

+ 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

10060-64911

Surgery

Effective January 1, 2026

Podiatry Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
+	**64832**	Suture of digital nerve, hand or foot; each additional digital nerve (List separately in addition to code for primary procedure)	2.27	ZZZ	
	64834	Suture of 1 nerve; hand or foot, common sensory nerve	3.73	090	
+	**64837**	Suture of each additional nerve, hand or foot (List separately in addition to code for primary procedure)	2.27	ZZZ	
	64890	Nerve graft (includes obtaining graft), single strand, hand or foot; up to 4 cm length	5.91	090	
	64891	Nerve graft (includes obtaining graft), single strand, hand or foot; more than 4 cm length	7.27	090	
	64895	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; up to 4 cm length	8.91	090	
	64896	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; more than 4 cm length	10.91	090	
+	**64901**	Nerve graft, each additional nerve; single strand (List separately in addition to code for primary procedure)	2.95	ZZZ	
+	**64902**	Nerve graft, each additional nerve; multiple strands (cable) (List separately in addition to code for primary procedure)	4.45	ZZZ	
	64910	Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve	4.55	090	
	64911	Nerve repair; with autogenous vein graft (includes harvest of vein graft), each nerve	5.36	090	

4 Radiology

The relative value units in this section were determined uniquely for radiology services. Use the radiology conversion factor when determining fee amounts. The radiology 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 radiology conversion factor, subject to the ground rules, instructions, and definitions of the schedule.

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

Fees for radiology items are for podiatrists who perform their own radiology work.

Items used by all podiatrists in reporting their services are presented in the Introduction and General Guidelines section under General Ground Rules.

Conversion Factors

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

Section	Region I	Region II	Region III	Region IV
Radiology	$46.77	$46.77	$53.53	$58.19

Radiology 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. 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 regarding the need to re-x-ray.

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.

2. Multiple Diagnostic Procedures

The following adjustments apply to all diagnostic radiology procedures including MRI (Podiatry Fee Schedule codes 73600–76499, 76881–76882, 77002):

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 rule 2A–C 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 Chair of the Workers' Compensation Board. Comparative x-rays specifically authorized shall be subject to fees for contiguous and remote parts as provided in 2A–D above.

F. X-rays/imaging studies of different areas taken within 7 days of the initial 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 rule 2A–E above.

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

3. Xeroradiography

Imaging performed by this process shall have the identical values listed for conventional x-ray procedures of the same area and views.

4. Multiple Services Other Than Diagnostic Radiology

When multiple or bilateral procedures or services are provided at the same session, payment is for the procedure with the highest allowance plus half of the lesser procedures up to a total maximum allowance of twice the highest fee.

5. Specific Billing Instructions

The total relative value unit includes professional services plus expenses for personnel, materials - including usual contrast media and drugs - space, equipment, and other facilities. Values for injection procedures include all usual pre- and postinjection care specifically related to the injection procedure, necessary local anesthesia, placement of needle or catheter, and injection of contrast media. Supplies and materials provided by the podiatrist (e.g., sterile trays, radioisotopes) 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 items to the podiatrist.

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 sites 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 Split column of the fee schedule.

A. Professional Component

The professional component represents the value of the professional radiological services of the podiatrist. This includes examination of the patient, when indicated, interpretation and written report of the examination, and consultation with the referring podiatrist. (Report using modifier 26.) The same radiology code should not be used by two providers during the same procedure. Codes billed with modifier 26 for the PC split, cannot be billed by two providers during the same procedure.

B. Technical Component

The technical component includes the charges for performance and/or supervision of the procedure, personnel, materials (including usual contrast media and drugs), film or xerography, space, equipment and other facilities, but excludes the cost of radioisotopes and nonionic contrast media such as the use of gadolinium in MRI procedures. (Report using modifier TC.)

C. 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.

When this section of the schedule is used in connection with a conversion factor to establish fees, it must be emphasized that the conversion factor should be applied to the total relative value units. The professional component and the technical component are percentages of this total. Podiatrists who determine their fees by application of conversion factors to the relative value units in this section must use the percentage of the total relative value units for the professional and technical values as listed in the schedule.

Fees are for a competent diagnosis by image, expert interpretation, and opinion. Size and number of films are not relevant except as indicated by the minimum number listed for respective procedures.

6. 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 podiatrist, insurance carrier, or self-insured employer.

When requested, carriers and self-insured employers shall return original films to the podiatrist within 20 days of their receipt.

When a carrier or self-insured employer requests x-rays and satisfactory reproductions 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. These reproductions are not returnable to the podiatrist.

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

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

7. Materials Supplied by Podiatrist

Radiopharmaceutical or other radionuclide material cost: listed relative value units in this section do not include these costs. List the name and dosage of radiopharmaceutical material and cost. Bill with code 99070. Except in emergencies, any medications must follow all WCB Formulary and applicable Medical Treatment Guidelines. Any variations require or Prior Authorization (PAR).

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

8. Injection Procedures

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

9. Miscellaneous

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

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

10. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. If more than one modifier is needed, place modifier 99 after the procedure code to indicate that two or more modifiers will follow. Appendixes referenced in the modifier descriptions are found in the CPT 2024 book. Modifiers commonly used with radiology procedures are as follows:

22 Increased Procedural Services

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

26 Professional Component

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

TC Technical Component

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

32 Mandated Services

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

51 Multiple Procedures

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

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

52 Reduced Services

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

62 Two Surgeons

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

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

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

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

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

99 Multiple Modifiers

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

11. Miscellaneous and By Report Codes

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

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

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

    - It is the responsibility of the provider to ensure all information required to process a miscellaneous or by report procedure is included with the bill. If required information is missing, or if there is a valid code that describes the procedure, then the code may not be reimbursed.

    - Nearly all miscellaneous and by report codes, require prior authorization (PAR). If a procedure or item is not recommended or not addressed in an applicable WCB Medical Treatment Guideline (MTG), then prior authorization is always required. If the procedure or item involves a body part or condition for which there is no MTG and costs over $1,000 then prior authorization must be obtained.

- While emergency procedures/items do not require prior authorization, the circumstances must be identified and explained in the procedure record. The codes billed may be subject to review and non-payment.
- When a miscellaneous or by report code is used, the actual service/item should be identified on the bill, narrative note, and in an additional attached report.
- The price billed must be substantiated by indicating the closest comparable code found in the current fee schedule and/or with a manufacturer's invoice.
- Documentation should include: any decision making, medical necessity and explanation why an existing fee schedule code could not be used.
- Any PARs including identification numbers should also be submitted with bills.
- Miscellaneous and by report codes should not be billed merely to describe a proprietary product or procedure, when an existing fee schedule code adequately describes the procedure or item.
- Surgical miscellaneous or by report codes may require additional documentation including: time, skill, equipment necessary, diagnosis, pertinent history, and physical findings, size/location/number of lesions or procedures.

73600-77002 RADIOLOGY

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

	Code	Description	Relative Value	FUD	PC/TC Split
	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
	73615	Radiologic examination, ankle, arthrography, radiological supervision and interpretation	4.69	XXX	35/65
	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
	76499	Unlisted diagnostic radiographic procedure	BR	XXX	
	76881	Ultrasound, complete joint (ie, joint space and peri-articular soft tissue structures) real-time with image documentation	4.46	XXX	25/75
■	**76882**	Ultrasound, limited, joint or focal evaluation of other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft-tissue mass[es]), real-time with image documentation	1.28	XXX	51/49
+	**77002**	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)	2.81	ZZZ	34/66

5 Pathology and Laboratory

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

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

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

Fees for pathology items are for podiatrists who perform their own laboratory work. All serological procedures are to be performed by registered pathologists or laboratories.

Items used by all podiatrists in reporting their services are presented in the Introduction and General Guidelines section under General Ground Rules.

Conversion Factors

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

Section	Region I	Region II	Region III	Region IV
Pathology and Laboratory	$1.06	$1.06	$1.21	$1.31

Pathology and Laboratory Ground Rules

1. 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.

2. Materials Supplied by Provider

Pharmacy

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

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

For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070. Except in emergencies, any medications must follow all WCB Formulary and applicable Medical Treatment Guidelines. Any variations require or Prior Authorization (PAR).

3. Referral Laboratory

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

4. 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.

6. Indices or Ratios

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

7. Attending Podiatrist

The attending podiatrist will not make a charge for obtaining and handling of specimens.

8. Organ or Disease-Oriented Panels

The CPT Professional assigns CPT codes to organ or disease-oriented panels consisting of groups of specified tests. If all tests of a CPT-defined panel are performed, the provider/supplier shall bill the panel code. The panel codes shall be used when the tests are ordered as that panel. For example, if the individually ordered tests are cholesterol

(code 82465), triglycerides (84478), and HDL cholesterol (83718), the service should be reported as a lipid panel (80061).

9. Specific Billing Instructions

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

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

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

A. Professional Component

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

B. Technical Component

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

10. Collection and Handling

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

11. Review of Diagnostic Studies

When prior studies are reviewed in conjunction with a visit, consultation, record review, or other evaluation, no separate charge is warranted for the review by the medical practitioner or other medical personnel. Neither the professional component modifier 26 nor the pathology consultation codes (80500 and 80502) are reimbursable under this circumstance. The review of diagnostic tests is included in the evaluation and management codes.

12. Modifiers

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

22 Increased Procedural Services

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

26 Professional Component

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

TC Technical Component

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

32 Mandated Services

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

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/ service that is partially reduced or cancelled as a

result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

90 Reference (Outside) Laboratory

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

91 Repeat Clinical Diagnostic Laboratory Test

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

99 Multiple Modifiers

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

13. Drug Screening

Drug screening may be required for long term pain management. The clinical recommendations provided in the most recently adopted version of any applicable Medical Treatment Guideline shall take precedence over any guidance in any of the Fee Schedule Ground Rules.

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

Low Risk	Periodic (At least once/year)
Moderate Risk	Regular (At least 2/year)
High Risk	Frequent (At least 3-4/year)
Aberrant Behavior	At time of visit

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

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

Red Flags include:

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

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

Confidentiality and Reporting UDT Results (from Medical Treatment Guidelines)

- UDT results are not to be released to the carrier, employer or the Board. However, the treating podiatrist must certify the patient's adherence to or noncompliance with the Patient Understanding for Opioid Treatment Form in the medical record.
- Noncompliance would include (but not necessarily be limited to) evidence that patient is taking any non-prescribed drug(s) or not taking those drugs prescribed as part of treatment.
- Noncompliance can also be a refusal to undergo UDT, as noted above.
- Please also see any applicable Medical Treatment Guidelines.

Pathology and Laboratory

Podiatry Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	80305	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; capable of being read by direct optical observation only (eg, utilizing immunoassay [eg, dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service	11.96	XXX	0/100
	80306	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; read by instrument assisted direct optical observation (eg, utilizing immunoassay [eg, dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service	16.16	XXX	0/100
	80307	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; by instrument chemistry analyzers (eg, utilizing immunoassay [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service	30.00	XXX	
	80375	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 1-3	43.26	XXX	0/100
	80376	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 4-6	64.89	XXX	0/100
	80377	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 7 or more	86.52	XXX	0/100
	81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy	7.09	XXX	0/100
	81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy	5.54	XXX	0/100
	81005	Urinalysis; qualitative or semiquantitative, except immunoassays	4.93	XXX	0/100
	82310	Calcium; total	8.01	XXX	0/100
	82435	Chloride; blood	8.01	XXX	0/100
	82465	Cholesterol, serum or whole blood, total	8.32	XXX	0/100
	82565	Creatinine; blood	8.01	XXX	0/100
	82945	Glucose, body fluid, other than blood	26.49	XXX	0/100
	82947	Glucose; quantitative, blood (except reagent strip)	8.01	XXX	0/100
	82948	Glucose; blood, reagent strip	6.16	XXX	0/100
	82951	Glucose; tolerance test (GTT), 3 specimens (includes glucose)	22.80	XXX	0/100
+	**82952**	Glucose; tolerance test, each additional beyond 3 specimens (List separately in addition to code for primary procedure)	6.16	XXX	0/100
	84100	Phosphorus inorganic (phosphate);	8.01	XXX	0/100
	84132	Potassium; serum, plasma or whole blood	8.01	XXX	0/100
	84520	Urea nitrogen; quantitative	8.01	XXX	0/100
	84525	Urea nitrogen; semiquantitative (eg, reagent strip test)	6.16	XXX	0/100
	84550	Uric acid; blood	8.01	XXX	0/100
	85002	Bleeding time	12.94	XXX	0/100
	85004	Blood count; automated differential WBC count	9.24	XXX	0/100

80305-80307, 80375-80377, 81000-89051

Pathology and Laboratory

Effective January 1, 2026

Podiatry Fee Schedule

	Code	Description	Relative Value	FUD	PC/TC Split
	85007	Blood count; blood smear, microscopic examination with manual differential WBC count	7.39	XXX	0/100
	85008	Blood count; blood smear, microscopic examination without manual differential WBC count	4.93	XXX	0/100
	85009	Blood count; manual differential WBC count, buffy coat	7.39	XXX	0/100
	85013	Blood count; spun microhematocrit	5.54	XXX	0/100
	85014	Blood count; hematocrit (Hct)	5.54	XXX	0/100
	85018	Blood count; hemoglobin (Hgb)	5.54	XXX	0/100
	85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	11.40	XXX	0/100
	85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	10.78	XXX	0/100
	85032	Blood count; manual cell count (erythrocyte, leukocyte, or platelet) each	9.24	XXX	0/100
	85041	Blood count; red blood cell (RBC), automated	8.63	XXX	0/100
	85044	Blood count; reticulocyte, manual	9.24	XXX	0/100
	85045	Blood count; reticulocyte, automated	8.63	XXX	0/100
	85048	Blood count; leukocyte (WBC), automated	8.63	XXX	0/100
	85049	Blood count; platelet, automated	8.63	XXX	0/100
	85345	Coagulation time; Lee and White	6.16	XXX	0/100
	85347	Coagulation time; activated	6.16	XXX	0/100
	85651	Sedimentation rate, erythrocyte; non-automated	7.70	XXX	0/100
	86430	Rheumatoid factor; qualitative	11.71	XXX	0/100
	87181	Susceptibility studies, antimicrobial agent; agar dilution method, per agent (eg, antibiotic gradient strip)	10.47	XXX	0/100
	87205	Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types	8.01	XXX	0/100
	87206	Smear, primary source with interpretation; fluorescent and/or acid fast stain for bacteria, fungi, parasites, viruses or cell types	14.17	XXX	0/100
	89050	Cell count, miscellaneous body fluids (eg, cerebrospinal fluid, joint fluid), except blood;	9.86	XXX	0/100
	89051	Cell count, miscellaneous body fluids (eg, cerebrospinal fluid, joint fluid), except blood; with differential count	11.71	XXX	0/100

6 Medicine

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 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	$8.91	$8.91	$10.19	$11.07

Medicine 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. Special Services and Reports

The procedures with code numbers 99000–99075 provide the reporting podiatrist with the means of identifying the completion of special reports and services that are adjunct to the basic services rendered. The specific number assigned indicates the special circumstances under which a basic procedure is performed.

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. Billing for Residents and Fellows

Treatment rendered by residents and fellows can only be billed by the Board authorized supervising podiatrist. Non-surgical service codes should be appended with modifier 1R. Services with modifier 1R must be billed and reimbursed at the same amount payable to the authorized supervising podiatrist.

A. Podiatrists cannot additionally bill for supervision of the resident.

B. All codes billed should accurately reflect work performed by the resident/fellow. Documentation in the operative/procedure report should include all details. Payment may be decided based on review of documentation, as well as the usual and customary standards of CPT/CMS billing guidelines for allowance of assistants.

C. Non-Authorized out-of-state podiatrists may not bill for residents/fellows.

D. Podiatrists should not bill for services performed by a resident/fellow that would not normally be billed by another type of assistant. Payment shall not be made for observation, simple assistance or work typically performed by nursing/technical staff.

E. The name of the resident/fellow does not need to be documented on the CMS 1500 form.

F. All CMS 1500 narrative requirements do apply to any bills submitted. https://www.wcb.ny.gov/CMS-1500/

3. Modifiers

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

1R∞ Non-surgical services provided by residents or fellows

Billed and payable at the same applicable rate as the WCB authorized, supervising podiatrist. 1R can be used for E/M codes, such as office visits, as well as for standalone procedures not performed during a surgery i.e., injections. This modifier is not used for assistance at surgery. See Modifier 84.

26 Professional Component

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

TC Technical Component

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

32 Mandated Services

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

51 Multiple Procedures

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

52 Reduced Services

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

58 Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

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

59 Distinct Procedural Service

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

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

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.

79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

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.

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

Podiatry Fee Schedule

95004-99080

Effective January 1, 2026

			Code	Description	Relative Value	FUD
			95004	Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests	0.42	XXX
			95024	Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests	0.72	XXX
			95028	Intracutaneous (intradermal) tests with allergenic extracts, delayed type reaction, including reading, specify number of tests	1.23	XXX
			95044	Patch or application test(s) (specify number of tests)	1.65	XXX
			95052	Photo patch test(s) (specify number of tests)	2.20	XXX
			95199	Unlisted allergy/clinical immunologic service or procedure	BR	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)		**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

+ Add-on Procedure ∞ State Specific Code ® Altered CPT Code
⦸ Modifier 51 Exempt (51) Optum360 Mod 51 Exempt
■ New code, changed description, or changed value from January 1, 2020

7 Appliances and Prosthesis

The relative value units 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 units 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
Appliances and Prosthesis	$17.18	$17.18	$17.18	$17.18

Appliances and Prosthesis Ground Rules

1. 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.

Podiatric Appliances and Prosthesis

Fees allowed include cost of materials.

09006-∞09053 Appliances and Prosthesis

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

	Code	Description	Relative Value
∞	**09006**	Foot Molds (Pair)	4.25
∞	**09007**	Functional Rigid Appliance (Pair)	4.00
∞	**09008**	Shoes (Pair)	4.50
∞	**09009**	Heel Cup, Single	1.20
∞	**09010**	Heel Cup, Pair	1.50
∞	**09011**	Bunion Or Bunionette Jacket, Single	1.20
∞	**09012**	Bunion Or Bunionette Jacket, Multiple	1.50
∞	**09013**	Missing Parts (Toes, Forefoot, Etc.)	BR
∞	**09021**	Toe Jacket, Single	1.30
∞	**09022**	Toe Jacket, Multiple (Adjacent Toes)	1.50
∞	**09023**	Toe Jacket, Multiple (Nonadjacent Toes)	1.80
∞	**09024**	Silicone Toe Crest (One (Foot)	1.60
∞	**09025**	Silicone Toe Crest (Both Feet)	2.35
∞	**09026**	Silicone Toe Crest (One Foot) With Dorsal Retainer (One Toe)	1.80
∞	**09027**	Silicone Toe Crest (Both Feet) With Dorsal Retainer (One Toe)	2.55
∞	**09028**	Silicone Toe Crest (One Foot) With Dorsal Retainer (Multiple Toes)	2.00
∞	**09029**	Silicone Toe Crest (Both Feet) With Dorsal Retainer (Multiple Toes)	2.75
∞	**09030**	Silicone Toe Crest With Hallux Wedge (One Foot)	2.00
∞	**09031**	Silicone Toe Crest With Hallux Wedge (Both Feet)	2.75
∞	**09032**	Moulded Polyurethane Toe Device, (One Or More Lesser Toes, One Foot)	2.00
∞	**09033**	Moulded Polyurethane Toe Device, (One Or More Lesser Toes, Both Feet)	3.00
∞	**09034**	Moulded Polyurethane Toe Device, Hallux Only (One Foot)	2.25
∞	**09035**	Moulded Polyurethane Toe Device, Hallux Only (Both Feet)	3.25
∞	**09036**	Moulded Polyurethane Toe Device, Hallux And Lesser Toes (One Foot)	2.80
∞	**09037**	Moulded Polyurethane Toe Device, Hallux And Lesser Toes (Both Feet)	3.80
∞	**09038**	Moulded Polyurethane Toe Device With Plantar Extension (One or More Lesser Toes, One Foot)	2.80
∞	**09039**	Moulded Polyurethane Toe Device With Plantar Extension (One or More Lesser Toes, Both Feet)	3.80
∞	**09040**	Moulded Polyurethane Toe Device Including Hallux With Plantar Extension (One or More Lesser Toes, One Foot)	3.00
∞	**09041**	With Plantar Extension (One Or More Lesser Toes, Both Feet)	4.00
∞	**09042**	Bunion Or Bunionette Jacket, Single	1.50
∞	**09043**	Bunion Or Bunionette Jacket, Multiple (One Foot or Both Feet)	2.00
∞	**09044**	Orthodigital Splint (One Or More Toes, One Foot)	2.00
∞	**09045**	Orthodigital Splint (One Or More Toes, Both Feet)	3.00
∞	**09046**	Foot Moulds, Balance Inlays, Supports, Etc. (Pair)	7.00
∞	**09047**	Functional Rigid Appliance, Custom Made (Pair)	11.50
∞	**09052**	Shoes	BR
∞	**09053**	Missing Parts	BR

Appendix

New CPT Codes

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

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

11102	11103	11104	11105	11106	11107
15769	15773	15774	15853	15854	20560
20561	28289	99080	99417		

Changed Codes

Changed Values

The following table is a list of CPT and state-specific codes applicable to the Podiatry Fee Schedule that have a relative value change, an FUD change, 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 Mod51 Exempt	NY 2024 Mod51
17004	1.08	1.08	010	010					⊘	
28001	3.23	3.23	010	000						
28002	3.67	3.67	010	000						
28003	3.67	3.67	090	000						
28820	3.67	3.67	090	000						
28825	3.23	3.23	090	000						

Changed Descriptions

The table below is a list of CPT codes applicable to the Podiatry Fee Schedule that have had a description change since the 2018/2020 Fee Schedules.

15851	28292	28296	28297	28298	28299
64450	64455	76882	99202	99203	99204
99205	99211	99212	99213	99214	99215
99221	99222	99223	99231	99232	99233
99234	99235	99236	99238	99239	99242
99243	99244	99245	99252	99253	99254
99255	99281	99282	99283	99284	99285
99304	99305	99306	99307	99308	99309
99310	99315	99316	99341	99342	99344
99345	99347	99348	99349	99350	

Deleted CPT Codes

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

11100	11101	15850	20005	20926	99201
99217	99218	99219	99220	99224	99225
99226	99241	99251	99318	99324	99325
99326	99327	99328	99334	99335	99336
99337	99339	99340	99343	99354	99355
99356	99357				

Optum Exempt From Modifier 51 Codes (51)

97545	97546	99050	99051	99053	99056
99058	99060				

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