# NYS Official Workers' Compensation Acupuncture Fee Schedule Ground Rules

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| **Introduction & General Guidelines** | Page 1 | | 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. | disclaimer paragraph added |
| | Page 2 | **Relative Value**<br>The Relative Value column lists the relative value units used to calculate the fee amount for a service. Except as otherwise provided in this schedule, the maximum fee amount is calculated by multiplying the relative value units by the applicable conversion factor. Conversion factors are listed later in this chapter. Relative values are used to calculate fees using the following formula:<br>Relative Value x applicable conversion factor = fee.<br>For example, the fee for code 99201, performed in Region I or Region II, would be calculated as follows:<br>5.83 (Relative Value) x $6.37 (Acupuncture E/M Section Conversion Factor for Region I or II) = $37.14 | **Relative Value**<br>The Relative Value column lists the relative value units used to calculate the fee amount for a service. Except as otherwise provided in this schedule, the maximum fee amount is calculated by multiplying the relative value units by the applicable conversion factor. Conversion factors are listed later in this chapter. | updated code and deleted duplicate calculation example |

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| | Page 2 | | **FUD**<br>The FUD column lists the follow-up days included in a surgical procedure's global charge. In counting follow-up days, day one is the day of surgery, not the discharge day. The State of New York has determined the number of follow-up days in this schedule and these follow-up days are consistent with those found in the Medicare Physician Fee Schedule. Followup 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 YYY ZZZ Indicates that the global surgery concept does not apply. Indicates that the global period is to be established by report. 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. | included to be consistent with other fee schedules |
| | Page 2 | **POSTAL ZIP CODES BY REGION** | Moved to Appendix A | |
| | Page 2 | **Numerical List of Zip Codes** | Deleted as duplicative | |
| | Page 2 | **CALCULATING FEES USING RELATIVE VALUES AND CONVERSION FACTORS**<br>Except as otherwise provided in this schedule, the maximum fee amount is calculated by multiplying the relative value by the applicable conversion factor. For example, the total fee for code 99201, performed in Region I or Region II, would be calculated as follows:<br>Relative values are used to calculate fees using the following formula: Relative Value x = Applicable Conversion Factor Fee. 5.83 (Relative Value) x $6.37 (Acupuncture E/M Section Conversion Factor for Region I or Region II) = $37.14 | **CALCULATING FEES USING RELATIVE VALUES AND CONVERSION FACTORS**<br>Except as otherwise provided in this schedule, the maximum fee amount is calculated by multiplying the relative value by the applicable conversion factor. For example, the total fee for code 99202, performed in Region I or Region II, would be calculated as follows:<br>Relative Value x Applicable Conversion Factor = 7.27 x $6.37 Fee (Relative Value) (Acupuncture E/M Section Conversion Factor for Region I or II) = $46.31 | updated code for example calculation |
| | Page 2 | **NEW AND DELETED CPT CODES** | Moved to Appendix A | |

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| | 1A | **NYS Medical Treatment Guidelines**<br>The recommendations of the New York State (NYS) Medical Treatment Guidelines supersede the ground rule frequency limitation for services rendered to body parts covered by the NYS Medical Treatment Guidelines. Treatment of work-related injuries should be in accordance with any applicable medical treatment guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the fee schedule ground rules and the medical treatment guidelines, the guidelines will prevail. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance. | **NYS Medical Treatment Guidelines**<br>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. | updated to include PAR information |
| | 3 | **Report Requirements**<br>Authorized acupuncturists shall provide reports of treatment in the electronic format prescribed by the Chair of the Workers' Compensation Board. | **Narrative Reports**<br>A detailed narrative report must be submitted with all services provided. Narrative report must include the following element in a highly visible location: Work Status. Providers are strongly encouraged to use the narrative template format found on the WCB webpage CMS 1500 Requirements. Additional narrative information should include the history of the injury/illness, any objective findings based on the clinical evaluation, plan of care and your diagnosis(es)/ assessment of the patient. Time must be documented whenever the CPT code definition is based on time spent with patient, or if necessary to justify a higher or additional code billed. All entries in the medical record must be legible to another reader. | Enhanced GR with CMS1500 documentation guidelines |

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| | 4 | **Treatment by Out of State Providers**<br>Claimant lives outside of New York State—A claimant who lives outside of New York State may treat with a qualified out-of-state medical provider. The medical treatment shall conform to the Medical Treatment Guidelines and the Ground Rules included herein. Payment for medical treatment shall be at the Fee Schedule amount for work related injuries and illnesses as available in the state where treatment is rendered, or if there is no such fee schedule, then such charges shall be as prevail in the community for similar treatment. All fees shall be subject to the jurisdiction of the Board.<br>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. | **Treatment by Out-of-State Providers**<br>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.<br>Presence of a CPT code in this fee schedule does not imply medical necessity which is determined by the NYS Medical Treatment Guidelines.<br>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. | Updates including PAR information, use of NY fee schedule codes |
| | 9 | | **Multiple Case Numbers**<br>If a claimant has more than one WCB claim/number, it is permissible to bill services for both claims on the same date of service. Separate bills should be submitted for each claim/visit. However, the total time billed for each claim number should not exceed the actual face- to face time spent with the patient. The visits need to be scheduled and documented as two distinct and sequential office visits, with two distinct and separate office visit notes. | New GR 6A. Explaining practice for claimants with multiple WCB Case numbers |

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| | 10 | | **Electronic Billing:**<br>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. | New GR for electronic billing codes and cost offset |
| **Evaluation and Management** | | | **CONVERSION FACTORS** chart | Copy of conversion factor chart applicable to this section. No changes in values from previous fee schedule. |
| | 1A | NYS Medical Treatment Guidelines The recommendations of the NYS Medical Treatment Guidelines supersede the ground rule frequency limitation for services rendered to body parts covered by the NYS Medical Treatment Guidelines. Treatment of work-related injuries should be in accordance with any applicable medical treatment guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the fee schedule ground rules and the medical treatment guidelines, the guidelines will prevail. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance. | NYS Medical Treatment Guidelines Treatment of work-related injuries should be in accordance with any applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the fee schedule ground rules and the Medical Treatment Guidelines, the guidelines will prevail. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside/ in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization. | updated as in Intro section |

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| | 1B | **New and Established Patient Service**<br>Several code subcategories in the Evaluation and Management section are based on the patient's status; new or established. The Evaluation and Management code for initial visits is 99201. E/M established visit code 99212 may be used to bill for a periodic re-evaluation consisting of a thorough examination and report documenting diagnosis, thorough interim history, clinical findings, and future course of treatment. The maximum number of RVUs (including treatment) per patient per day per accident or illness when billing for an initial evaluation shall be limited to 18.0. The following codes represent the treatments subject to this rule: 99201, 99212.<br>CPT 2018 guidelines define new and established patients. The patient definitions have been expanded from CPT 2018 for the New York Fee Schedule (this text will be in italics). New Patient- A new patient is one who has not received any professional services from the acupuncturist, or another acupuncturist who belongs to the same group practice, within the past three years.<br>Established Patient- An established patient shall also be considered one who has been treated for the same injury by any acupuncturist who belongs to the same group practice. Because initial records such as history and physical are available within the group's facility, an initial new patient visit would not be indicated. The maximum number of RVUs (including treatment) per person per day per accident or illness when billing for a re-evaluation shall be limited to 15.0. The procedure codes that exclusively represent established patient visits are identified in the fee schedule with the tilde (~) symbol. The new versus established patient guidelines also clarify the situation in which an acupuncturist is on call or covering for another acupuncturist. In this instance, classify the patient encounter the same as if it were for the acupuncturist who is unavailable. | **New and Established Patient Service**<br>Several code subcategories in the Evaluation and Management section are based on the patient's status; new or established. The Evaluation and Management code for initial visits is 99202. E/M established visit code 99212 may be used to bill for a periodic re-evaluation consisting of a thorough examination and report documenting diagnosis, thorough interim history, clinical findings, and future course of treatment. The maximum number of RVUs (including treatment) per patient per day per WCB case number when billing for an initial evaluation shall be limited to 18.0. The following codes represent the treatments subject to this rule: 99202, 99212 CPT 2024 guidelines define new and established patients. The patient definitions have been expanded from CPT 2024 for the New York Fee Schedule (this text will be in italics).<br>New Patient- A new patient is one who has not received any professional services from the acupuncturist, or another acupuncturist who belongs to the same group practice, within the past three years.<br>Established Patient- An established patient shall also be considered one who has been treated for the same injury by any acupuncturist who belongs to the same group practice. Because initial records such as history and physical are available within the group's facility, an initial new patient visit would not be indicated. The maximum number of RVUs (including treatment) per person per day per WCB case number when billing for a re-evaluation shall be limited to 15.0. The new versus established patient guidelines also clarify the situation in which an acupuncturist is on call or covering for another acupuncturist. In this instance, classify the patient encounter the same as if it were for the acupuncturist who is unavailable. | updated codes |

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| | 3 | **Periodic Re-evaluation**<br>Code 99212 may be used to bill for a periodic re-evaluation consisting of documentation of: (1) an interim history describing the patient's response to the current treatment regimen (i.e., efficacy of the treatment/modality), (2) objective findings on physical examination, and (3) the future treatment plan and goals. If there is a positive patient response, functional gains must be objectively measured (including but not limited to improvement in positional tolerances, range of motion, strength, endurance) and documented. If the patient has not demonstrated a positive response, the treatment regimen should be modified or discontinued. The provider should re-evaluate the efficacy of the treatment or modality 2–3 weeks after the initial visit and every 3–4 weeks thereafter. | **Periodic Re-evaluation**<br>Code 99212 may be used to bill for a periodic re-evaluation consisting of documentation of: (1) an interim history describing the patient's response to the current treatment regimen (i.e., efficacy of the treatment/modality), (2) objective findings on physical examination, and (3) the future treatment plan and goals. If there is a positive patient response, functional gains must be objectively measured (including but not limited to improvement in positional tolerances, range of motion, strength, endurance) and documented. If the patient has not demonstrated a positive response, the treatment regimen should be modified or discontinued. The provider should re-evaluate the efficacy of the treatment or modality 2–3 weeks after the initial visit and every 3–4 weeks thereafter. | Old GR 3 becomes new GR 2. Correcting previous numbering error |
| | 4 | **Narrative Reports**<br>A detailed narrative report must be submitted with the bill for the following procedures: 99201 and 99212. | **Narrative Reports**<br>A detailed narrative report must be submitted with all services provided. Narrative report must include the following element in a highly visible location: Work Status. Providers are strongly encouraged to use the narrative template format found on the WCB webpage CMS 1500 Requirements. Additional narrative information should include the history of the injury/illness, any objective findings based on the clinical evaluation, plan of care and your diagnosis(es)/ assessment of the patient. Time must be documented whenever the CPT code definition is based on time spent with patient, or if necessary to justify a higher or additional code billed. All entries in the medical record must be legible to another reader. | Old GR 4 becomes new GR 3- correcting numbering error. Also enhanced information from CMS1500. |

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| | 4 (new) | | **Modifiers**<br>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.<br>Appendixes referenced in the modifier descriptions are found in the CPT 2024 book.<br>Modifiers commonly used with E/M procedures are as follows:<br>**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<br>It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/ or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59. | New GR 4- added for consistency with other fee schedules |
| **Medicine** | Page 9 | | **CONVERSION FACTORS** chart | Copy of conversion factor chart applicable to this section. No changes in values from previous fee schedule. |

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| | 1A | **NYS Medical Treatment Guidelines**<br>The recommendations of the NYS Medical Treatment Guidelines supersede the ground rule frequency limitation for services rendered to body parts covered by the NYS Medical Treatment Guidelines. The maximum reimbursement limitations per patient per day per accident or illness for modalities is 12.0 RVUs, re-evaluation plus modalities is 15.0 RVUs, and initial evaluation plus modalities is 18.0 RVUs for all providers combined. Treatment of work-related injuries should be in accordance with any applicable medical treatment guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the fee schedule ground rules and the medical treatment guidelines, the guidelines will prevail. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance. | **NYS Medical Treatment Guidelines**<br>The recommendations of the NYS Medical Treatment Guidelines supersede the ground rule frequency limitation for services rendered to body parts covered by the NYS Medical Treatment Guidelines. The maximum reimbursement limitations per patient per day per WCB case number for modalities is 12.0 RVUs, re-evaluation plus modalities is 15.0 RVUs, and initial evaluation plus modalities is 18.0 RVUs for all providers combined. Treatment of work-related injuries should be in accordance with any applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the fee schedule ground rules and the Medical Treatment Guidelines, the guidelines will prevail. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization. | Updated as in Intro section. Also clarified wording "per patient per day **per accident or illness** " to "per patient per day **per WCB case numbe**r" |
| | 2 | N/A | **Narrative Reports**<br>A detailed narrative report must be submitted with all services provided. Narrative report must include the following element in a highly visible location: Work Status. Providers are strongly encouraged to use the narrative template format found on the WCB webpage CMS 1500 Requirements. Additional narrative information should include the history of the injury/illness, any objective findings based on the clinical evaluation, plan of care and your diagnosis(es)/ assessment of the patient. Time must be documented whenever the CPT code definition is based on time spent with patient, or if necessary to justify a higher or additional code billed. All entries in the medical record must be legible to another reader. | New GR 2 with updated CMS1500 info |
| **Appendix A** | Page 11 | | **Appendix** | New, Changed, Deleted Code lists, Zip Codes by Region |