NYS Official Workers' Compensation Behavioral Health Fee Schedule Ground Rules

Section	Ground Rule Number	2018-2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
Introduction & General Guidelines	Page 6		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 7	**Relative Value** The Relative Value column lists the relative value units used to calculate the fee amount for a service. Except as otherwise provided in this schedule, the maximum fee amount is calculated by multiplying the relative value units by the applicable conversion factor. Conversion factors are listed later in this chapter. Relative values are used to calculate fees using the following formula: Relative Value x Applicable Conversion Factor = Fee For example, the fee for code 96110, performed by a psychologist in Region I or Region II, would be calculated as follows: 17.00 (Relative Value) x $7.94 (Psychology Conversion Factor for Region I and Region II) = $134.98 BR Some services do not have a relative value unit because they are too variable or new. These by report services are identified with a "BR."	**Relative Value** The Relative Value column lists the relative value units used to calculate the fee amount for a service. Except as otherwise provided in this schedule, the maximum fee amount is calculated by multiplying the relative value units by the applicable conversion factor. Conversion factors are listed later in this chapter. Relative values are used to calculate fees using the following formula: Relative Value x Applicable Conversion Factor = Fee For example, the fee for code 90832, performed in Region I or Region II, would be calculated as follows: 12.59 (Relative Value) x $7.94 (Psychology Conversion Factor for Region I and II) = $99.96 BR Some services do not have a relative value unit because they are too variable or new. These by report services are identified with a "BR."	updated example

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	Page 7		**FUD** The FUD column lists the follow-up days included in a surgical procedure's global charge. In counting follow-up days, day one is the day of surgery, not the discharge day. The State of New York has determined the number of follow-up days in this schedule and these follow-up days are consistent with those found in the Medicare Physician Fee Schedule. Follow-up days will be designated as 000 (0 follow-up days), 010 (10 follow-up days), or 090 (90 follow-up days). Medicare also uses letter designations to identify four circumstances where the usual follow-up days concept does not apply. These four circumstances are as follows: MMM Describes services in uncomplicated maternity care. This includes antepartum, delivery, and postpartum care. The usual global surgery concept does not apply. XXX 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.	added for consistency with other fee schedules
	Page 7	POSTAL ZIP CODES BY REGION	Moved to Appendix	
	Page 7	**CONVERSION FACTORS** Regional conversion factors for services rendered on or after April 1, 2019. Physicians and psychiatric nurse practitioners can bill codes from other sections of the Official New York State Workers' Compensation Medical Fee Schedule as appropriate (such as E/M, Medicine, etc.) and should determine their fees using the corresponding conversion factors listed in that manual's Introduction and General Guidelines section. Nurse practitioners and licensed clinical social workers should use appropriate modifiers and bill in accordance with General Ground Rules 9 and 12 herein.	**CONVERSION FACTORS** Regional conversion factors for services rendered on or after January 1, 2026. Section Region I Region II Region III Region IV Psychology $7.94 $7.94 $9.08 $9.86 Physicians and psychiatric nurse practitioners can bill codes from other sections of the Official New York State Workers' Compensation Medical Fee Schedule as appropriate (such as E/M, Medicine, etc.) and should determine their fees using the corresponding conversion factors listed in that manual's Introduction and General Guidelines section.	Copy of conversion factor chart applicable to this section. No changes in values from previous fee schedule.
	Page 8	NEW, CHANGED, OR DELETED CPT CODES	Moved to Appendix	

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	Page 8	**BEHAVIORAL HEALTH SERVICES PROVIDED BY PHYSICIANS, PSYCHIATRIC NURSE PRACTITIONERS, PSYCHOLOGISTS AND LICENSED CLINICAL SOCIAL WORKERS** Behavioral health services will be rendered by a New York State Workers' Compensation Board (NYS WCB) authorized psychiatrist or a NYS WCB authorized physician with a rating code of PN-ADP (Addiction Medicine) or PN-PM (Pain Management), an authorized psychiatric nurse practitioner, psychologist or licensed clinical social worker. A physician, psychiatric nurse practitioner, psychologist or licensed clinical social worker who is not Board authorized may not provide treatment. All reports and bills shall be submitted in the format prescribed by the Chair by the treating authorized provider. Fees shall be paid at the following rates: • Psychiatric nurse practitioners shall bill at 80 percent of the applicable medical treatment code and conversion factor available to physicians • Psychologists shall bill using the applicable behavioral health treatment code and conversion factor • Licensed clinical social workers shall bill at 80 percent of the applicable medical treatment code and conversion factor for psychologists	**BEHAVIORAL HEALTH SERVICES PROVIDED BY PHYSICIANS, PSYCHIATRIC NURSE PRACTITIONERS, PSYCHOLOGISTS AND LICENSED CLINICAL SOCIAL WORKER** Behavioral health services may be rendered by providers that are New York State Workers' Compensation Board (NYS WCB) authorized (unless an exception applies) and are: A. Licensed Psychiatrist B. Licensed Physician with a specialty classification code for Psychiatry & Neurology from American Board of Psychiatry & Neurology as published on the WCB webpage C. Board Certified psychiatric nurse practitioner D. Licensed psychologist E. Licensed clinical social worker F. Appropriately certified Physician Assistant with eligible Supervising Physician Physicians, physician assistants, and psychiatric nurse practitioners must use the full version of the Official New York State Workers' Compensation Medical Fee Schedule and the codes and conversion factors therein. All reports and bills shall be submitted in the format prescribed by the Chair by the treating authorized provider. Fees shall be paid at the following rates: • Psychiatric nurse practitioners and physician assistants shall bill at 80 percent of the applicable medical treatment code and conversion factor available to physicians • Psychologists shall bill using the applicable behavioral health treatment code and conversion factor • Licensed clinical social workers shall bill at 80 percent of the applicable medical treatment code and conversion factor for psychologists	updated information on provider ratings and billing

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Section	Ground Rule Number	2018-2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	1A	**NYS Medical Treatment Guidelines** Treatment of work-related injuries should be in accordance with any applicable medical treatment guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the fee schedule ground rules and the medical treatment guidelines, the guidelines will prevail. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.	**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.	updated reference to PAR requirements
	1B	**Biofeedback** Biofeedback is a form of behavioral medicine that helps patients learn self-awareness and self-regulation skills for the purpose of gaining greater control of their physiology. Electronic instrumentation is used to monitor the targeted physiology and then displayed or fed back to the patient through visual, auditory or tactile means, with coaching by a biofeedback specialist. Treatment is individualized to the patient's work-related diagnosis and needs. Home practice of skills is required for mastery and may be facilitated by the use of home training tapes. The ultimate goal of biofeedback treatment is the transfer of learned skills to the workplace and daily life. Candidates for biofeedback therapy or training must be motivated to learn and practice biofeedback and self-regulation techniques. Biofeedback is not appropriate for individuals suffering from acute pain or acute injury. It may be appropriate for non-acute pain when combined with a program including functional restoration. • Time to Produce Effect: 3 to 4 sessions. • Frequency: 1 to 2 times per week. • Optimum Duration: 5 to 6 sessions. • Maximum Duration: 10 to 12 sessions. When more than one treatment is performed on the same day, the maximum reimbursement will be limited to the highest single relative value.	**Biofeedback** When more than one treatment is performed on the same day, the maximum reimbursement will be limited to the highest single relative value.	abbreviated and deleted info available in MTG

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Section	Ground Rule Number	2018-2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	2	**Testing** Psychological tests should not be used routinely. When appropriate, documentation should include the specific indication for each test and overlapping and/or duplicate testing should be avoided. Tests, when administered, must be used in correlation with clinical interview data to monitor a patient's condition and progress. Repeat testing is not necessary or indicated when the clinical documentation supports improved outcomes. Reimbursement for testing is limited to 11 hours of testing in any 12-month period.	**Psychological, Behavioral, and Neuro-cognitive Testing** Reimbursement for Psychological, Behavioral, and Neurocognitive testing is limited to 11 hours in any 12-month period. Psychological, Behavioral, and Neuro-cognitive testing should not be used routinely. When appropriate, documentation should include the specific indication for each test and overlapping and/or duplicate testing should be avoided. Tests, when administered, must be used in correlation with clinical interview data to monitor a patient's condition and progress. Repeat testing is generally not necessary or indicated, particularly when the clinical documentation supports improved outcomes or stable condition. Ongoing documentation should include updates to treatment plans, efficacy of medications and/or treatments, and overall progress towards expected goals. Qualifications of the "technicians" and "qualified health care professionals" referenced in these procedure codes must satisfy the requirements as provided for in Article 153 of the State Education Law. All applicable Medical Treatment Guidelines must be followed. Reimbursement for CPT codes 97129 and 97130 for Cognitive Testing is limited to one unit of each code per day. All applicable Medical Treatment Guidelines should be followed. Code 97533 may be reported a maximum of 2 units per day and is limited to 1 unit per day when reported on the same date with code 97129. Both services must be performed face-to-face.	Testing Ground Rules Old 3,6,7 combined into new GR 2

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Section	Ground Rule Number	2018-2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	3	**Procedures Listed Without Specified Relative Value Units** By report (BR) items: "BR" in the Relative Value column represents services that are too variable in the nature of their performance to permit assignment of relative value units. Fees for such procedures need to be justified "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, skill, and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary, but sufficient information shall be submitted to permit a sound evaluation. It must be emphasized that reviews are based on records, hence the importance of documentation. The original official record, such as the chart notes will be given far greater weight than supplementary reports formulated and submitted at later dates. For any procedure where the relative value unit is listed in the schedule as "BR," the authorized medical provider shall establish a relative value unit consistent in relativity with other unit values shown in the schedule. The insurer shall review all submitted "BR" relative value units to ensure that the relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items.	**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.	Enhanced information for Misc and BR

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Section	Ground Rule Number	2018-2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	5	**Evaluation and Management** Evaluation and management services may be reported by physicians and psychiatric nurse practitioners with codes 90833, 90836, and 90838 when both services are performed and documented.	**Evaluation and Management** Evaluation and management services may be reported by physicians and psychiatric nurse practitioners with codes 90833, 90836, and 90838 when both services are performed and documented. If psychometric testing is indicated by findings in the initial encounter, time for such testing should not exceed an additional three hours of professional time.	additional testing information
	6	**Central Nervous System Assessments/Tests (e.g., Neuro-cognitive, Mental Status, Speech Testing) (96101–96127)** CPT codes 96101–96127 are used to report the services provided during testing of the cognitive function of the central nervous system. The testing of cognitive processes, visual motor responses, and abstractive abilities is accomplished by the combination of several types of testing procedures. It is expected that the administration of these tests will generate material that will be formulated into a report. Qualifications of the "technicians" and "qualified health care professionals" referenced in these procedure codes must satisfy the requirements as provided for in Article 153 of the State Education Law.	**Central Nervous System Assessments/Tests (e.g., Neuro-cognitive, Mental Status, Speech Testing) (96101–97130)** See Ground Rule #2 above for Psychological, Behavioral, and Neuro-cognitive Testing.	old GR 6 combined into new GR 2
	7	**Use of code 97127 and 97533** Reimbursement for code 97127 is limited to a maximum of 1 unit per day. Code 97533 may be reported a maximum of 2 units per day and is limited to 1 unit per day when reported on the same date with code 97127. Both services must be performed face-to-face. When billing code 97127, an initial report must be submitted containing: A) Outline of the claimant's current cognitive skill level B) Proposed treatment plan C) Expected goals Thereafter, a progress report should be filed at least every four weeks that updates: A) The claimant's current cognitive skill level B) The treatment plan C) Claimant's progress towards expected goals All reporting requirements are inclusive in the fee for the service.	**Use of codes 97129, 97130, and 97533** See Ground Rule #2 above for Psychological, Behavioral, and Neuro-cognitive Testing.	old GR 7 combined into new GR 2

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Section	Ground Rule Number	2018-2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	8	**Health and Behavior Assessment/Intervention** Assessment and intervention codes are reported for patients with physical health problems where the focus is not on mental health, but emotional and social factors contributing to the individual's well-being. When psychiatric services are performed during the same encounter, the dominating service should be reported, but not both services. Information obtained through the assessment testing is interpreted and a written report is generated. The interpretation and report are included in the service. Codes 96150–96155 describe services associated with an acute or chronic illness (not meeting criteria for psychiatric diagnosis), prevention of a physical illness or disability, and maintenance of health, not meeting criteria for a psychiatric diagnosis, or representing a preventive medicine service. For patients that require psychiatric services (90785–90899) as well as health and behavior assessment/intervention (96150–96155), report the predominant service performed. Do not report codes 96150–96155 in addition to codes 90785–90899 on the same date.	**Health and Behavior Assessment/Intervention** Assessment and intervention codes are reported for patients with physical health problems where the focus is not on mental health, but emotional and social factors contributing to the individual's well-being. When psychiatric services are performed during the same encounter, the dominating service should be reported, but not both services. Information obtained through the assessment testing is interpreted and a written report is generated. The interpretation and report are included in the service. Codes 96156-96170 describe services associated with an acute or chronic illness (not meeting criteria for psychiatric diagnosis), prevention of a physical illness or disability, and maintenance of health, not meeting criteria for a psychiatric diagnosis, or representing a preventive medicine service. For patients who require psychiatric services as well as health and behavior assessment/intervention, do not report both services on the same date of service, report only the predominant service. Evaluation and management services including counseling risk-factor reduction and behavior change services should not be reported on the same date of service when provided by the same provider.	updated information and codes
	9	**Modifiers** Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Modifiers commonly used in the Medicine section are:	**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:	updated reference to CPT book appendix in some modifier descriptions

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	9	1B∞ Behavioral Health Provider Enhanced Reimbursement Provides a 20 percent reimbursement increase for E/M and Medicine Behavioral Health services when rendered by Licensed Clinical Social Workers and the providers with the following WCB assigned provider rating codes:	1B∞ Behavioral Health Provider Enhanced Reimbursement • Provides a 20 percent reimbursement increase for certain E/M and psychotherapy services. • The following types of codes may not be appended with modifier 1B: diagnostic testing codes, procedural codes, and E/M visit codes 99202-99205, and 99211-99215. • Behavioral Health consultation codes may use modifier 1B. • ** Modifier 1B may be used by psychologists and LCSWs with the appropriate telehealth codes. • May only be used by the following WCB authorized Behavioral Health providers: a. Licensed psychiatrist b. Licensed physician with a specialty rating code from American Board of Psychiatry & Neurology as published on the WCB webpage c. Board certified psychiatric nurse practitioner (NP) d. Appropriately certified physician assistant (PA) with eligible supervising physician e. Licensed psychologist f. Licensed clinical social worker ** See current Telehealth Ground Rule and webpage: https://www.wcb.ny.gov/telehealth/ See Appendix for Behavioral Health Provider Enhanced Rating Codes.	Enhanced info for 1B modifier

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Section	Ground Rule Number	2018-2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	9	N/A	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.	new modifier for telehealth
	9	N/A	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.	new modifier for telehealth

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Section	Ground Rule Number	2018-2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	10	**Treatment by Out-of-State Providers** Claimant lives outside of New York State—A claimant who lives outside of New York State may treat with a qualified out-of-state medical provider. The medical treatment shall conform to the Medical Treatment Guidelines and the Ground Rules included herein. Payment for medical treatment shall be at the Fee Schedule for work related injuries and illnesses as available in the state where treatment is rendered, or if there is no such fee schedule, then such charges shall be as prevail in the community for similar treatment. All fees shall be subject to the jurisdiction of the Board. Claimant lives in New York State but treats outside of New York State—A claimant who lives in New York State may treat with a qualified or Board authorized out-of-state medical provider when such treatment conforms to the Workers' Compensation Law and regulations, the Medical Treatment Guidelines and the Medical Fee Schedule. Payment shall be made to the medical provider as set forth herein and using the regional conversion factor for the ZIP code where the claimant resides. Out-of-state medical treatment that does not "further the economic and humanitarian objectives" of Workers' Compensation Law may be denied by the Board. A medical provider who has had a NYSWCB authorization suspended, revoked or surrendered shall not be qualified to treat out-of-state. Permanency—The New York State guidelines on permanent impairment, pertaining to both the schedule loss of use and classification, apply regardless of whether claimant lives in or out of New York State.	**Treatment by Out-of-State Providers** Claimant lives outside of New York State—A claimant who lives outside of New York State may treat with a qualified out-of-state medical provider. The medical treatment shall conform to the Medical Treatment Guidelines and the Ground Rules included herein. This includes obtaining any required Prior Authorization (PAR). Payment for medical treatment shall be at the Fee Schedule for work-related injuries and illnesses as available in the state where treatment is rendered, or if there is no such fee schedule, then such charges shall be as prevail in the community for similar treatment. Out-of-state providers are required to use only those CPT codes listed in the current applicable New York State WCB fee schedules. Presence of a CPT code in this fee schedule does not imply medical necessity which is determined by the NYS Medical Treatment Guidelines. All fees shall be subject to the jurisdiction of the Board. Claimant lives in New York State but treats outside of New York State—A claimant who lives in New York State may treat with a qualified or Board authorized out-of-state medical provider when such treatment conforms to the Workers' Compensation Law and regulations, the Medical Treatment Guidelines and the Medical Fee Schedule. Payment shall be made to the medical provider as set forth herein and using the regional conversion factor for the ZIP code where the claimant resides. Out-of-state medical treatment that does not "further the economic and humanitarian objectives" of Workers' Compensation Law may be denied by the Board. A medical provider who has had a NYSWCB authorization suspended, revoked or surrendered shall not be qualified to treat out-of-state. Permanency—The New York State guidelines on permanent impairment, pertaining to both the schedule loss of use and classification, apply regardless of whether claimant lives in or out of New York State.	Updates including PAR information, use of NY fee schedule codes

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	12	**Behavioral Health Provider Enhanced Reimbursement** In an effort to increase the number of Board-authorized providers in behavioral health to render care and treatment to injured workers, the WCB has established WCB-specific modifier 1B which will provide a 20 percent reimbursement increase to providers with WCB assigned rating codes for designated services. Modifier 1B provides a 20 percent reimbursement increase for E/M and Medicine Behavioral Health services when rendered by licensed clinical social workers and the providers with the following WCB assigned provider rating codes	**Behavioral Health Provider Enhanced Reimbursement** In an effort to increase the number of Board-authorized providers in behavioral health to render care and treatment to injured workers, the WCB has established WCB specific modifier 1B. • Provides a 20 percent reimbursement increase for certain E/M and psychotherapy services. • The following types of codes may not be appended with modifier 1B: diagnostic testing codes, procedural codes, and E/M visit codes 99202-99205, and 9921199215. • Behavioral Health consultation codes may use modifier 1B. • ** Modifier 1B may be used by psychologists and LCSWs with the appropriate telehealth codes. • May only be used by the following WCB authorized Behavioral Health providers: a. Licensed psychiatrist b. Licensed physician with a specialty rating code from American Board of Psychiatry & Neurology as published on the WCB webpage c. Board certified psychiatric nurse practitioner (NP) d. Appropriately certified physician assistant (PA) with eligible supervising physician e. Licensed psychologist f. Licensed clinical social worker ** See current Telehealth Ground Rule and webpage: https://www.wcb.ny.gov/telehealth/ See Appendix for Behavioral Health Provider Enhanced Rating Codes.	updated and chart moved to appendix

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Section	Ground Rule Number	2018-2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	14	N/A	**Telehealth** Effective July 11, 2023, the NYS Workers' Compensation Board adopted permanent regulations for telehealth appointments in certain situations. Telemedicine is not available to all provider types. Treatment may be rendered by telehealth when medically appropriate and subject to the restrictions contained in the currently published regulations. 1. Behavioral Health Psychiatrists, Psych PAs, Psych NPs may bill: • E/M codes 99202-99204, 99212 • Psychotherapy/Combination/crisis codes: 9083290834, 90836-90840 • Group therapy: 90853 2. Psychologists and LCSWs may bill: • Psychotherapy/ crisis codes: 90832, 90834, 90837,90839, 90840 • Group therapy: 90853 3. All eligible provider types should use: • Modifier 95 for two-way Audio and Visual communication • Modifier 93 for Audio only • Place of service (POS) code 10 for patient located in their home • POS code 02 for patient located in a healthcare setting that is not their home 4. Modifier 1B may not be used with E/M codes but may be billed with applicable psychotherapy/group therapy telehealth codes. Updates or modifications to WCB Telemedicine regulations may supersede the content published in this edition of the WCB Fee Schedule. All current rules and restrictions for telehealth are found on the WCB webpage: https://www.wcb.ny.gov/telehealth/	new Telehealth Ground Rule

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	15	N/A	**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.	New GR with CMS1500 documentation guidelines
	16	N/A	**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.	New GR for electronic billing codes and cost offset
	17		**Multiple Case Numbers** If a claimant has more than one WCB claim/number, it is permissible to bill services for both claims on the same date of service. Separate bills should be submitted for each claim/visit. However, the total time billed for each claim number should not exceed the actual face to face time spent with the patient. The visits need to be scheduled and documented as two distinct and sequential office visits, with two distinct and separate office visit notes.	New GR 6A. Explaining practice for claimants with multiple WCB Case numbers

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	18		**Exempt From Modifier 51 Codes** As the description implies, modifier 51 exempt procedures are not subject to multiple procedure rules and, as such, modifier 51 does not apply. Fee schedule amounts for modifier 51 exempt codes are not subject to reduction and should be reimbursed at the lesser of 100 percent of the listed value or the billed amount. The CPT book identifies these services with the X 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. See Appendix.	included for consistency with other fee schedules
Appendix	Page 18 & 19		**Appendix**	New, deleted, changed codes. Zip codes by Region. Updated List of Psych provider rating codes.