NYS Official Workers' Compensation Chiropractic Fee Schedule Ground Rules

Section	Ground Rule Number	2018-2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
Introduction & General Guidelines	Page 6	The Official New York State Workers' Compensation Chiropractic Fee Schedule shows chiropractic services and their relative value units. The services are listed by Current Procedural Terminology (CPT®) codes. The relative value unit set for each CPT service is based on comparative magnitude among various services and procedures. The relative values within each section apply only to that section. CPT is a registered trademark of the American Medical Association. The accompanying instructions and ground rules explain the application of these procedure descriptors and relative value units in chiropractic practice. Because the Chiropractic Fee Schedule is applicable to all of New York State, a large and diverse geographical area, the relative value units contained herein do not necessarily reflect the charges of any individual chiropractor or the pattern of charges in any specific area of New York State. A primary purpose of the schedule is to provide a precise description and coding of the services provided by New York State chiropractors in the care of workers' compensation covered patients and ensures the proper payment for such services by assuring that they are specifically identifiable. This edition of the Official New York State Workers' Compensation Chiropractic Fee Schedule uses CPT procedure codes, modifiers, and descriptions. Please refer to the CPT book for an explanation of coding rules and regulations not listed in this schedule.	The Official New York State Workers' Compensation Chiropractic Fee Schedule shows chiropractic services and their relative value units. The services are listed by Current Procedural Terminology (CPT®) codes. The relative value unit set for each CPT service is based on comparative magnitude among various services and procedures. The relative values within each section apply only to that section. CPT is a registered trademark of the American Medical Association (AMA). The accompanying instructions and ground rules explain the application of these procedure descriptors and relative value units. Because the Chiropractic Fee Schedule is applicable to all of New York State, a large and diverse geographical area, the relative value units contained herein do not necessarily reflect the charges of any individual chiropractor or the pattern of charges in any specific area of New York State. A primary purpose of the schedule is to provide a precise description and coding of the services provided by New York State chiropractors in the care of workers' compensation covered patients and ensures the proper payment for such services by assuring that they are specifically identifiable. This edition of the Official New York State Workers' Compensation Chiropractic Fee Schedule uses CPT procedure codes, modifiers, and descriptions. Please refer to the CPT book for an explanation of coding rules and regulations not listed in this schedule. Inclusion of a code in this Fee Schedule does not guarantee reimbursement. All codes billed should be based on medical necessity and be in alignment with all applicable Medical Treatment Guidelines and Fee Schedule Ground Rules, as further discussed herein. Reimbursement may be dependent on multiple factors, including but not necessarily limited to, causal relationship, clinical necessity and appropriateness of the fees submitted. An attempt has been made to adhere as closely as possible to the terminology and coding of the American Medical Association's CPT 2024.	disclaimer paragraph added

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	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 99201, performed in Region I or Region II, would be calculated as follows: 5.83 (Relative Value) x $6.37 (Chiropractic E/M Section Conversion Factor for Region I or Region II) = $37.14 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."	**Relative Value** **T**he Relative Value column lists the relative value units used to calculate the fee amount for a service. Except as otherwise provided in this schedule, the maximum fee amount is calculated by multiplying the relative value units by the applicable conversion factor. Conversion factors are listed later in this chapter. Relative values are used to calculate fees using the following formula: Relative Value x Applicable Conversion Factor = Fee For example, the fee for code 99243, performed in Region I or Region II, would be calculated as follows: 16.49 x $6.37 (Relative Value) (Chiropractic E/M Section Conversion Factor for Region I or II) = $105.04 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."	example updated with current code
	Page 8	POSTAL ZIP CODES BY REGION, New, Changed, Deleted CPT codes	Moved to Appendix	
	Page 8	**CONVERSION FACTORS** Regional conversion factors for services rendered on or after April 1, 2019 except as noted below. Section Region I Region II Region III Region IV E/M $6.37 $6.37 $7.29 $7.92 Medicine $6.09 $6.09 $6.97 $7.57 Physical Medicine (eff. 04/01/2019-12/31/2019) $5.77 $5.77 $6.60 $7.17 (eff. 01/01/2020) $7.69 $7.69 $8.79 $9.55 Radiology $32.01 $32.01 $36.63 $39.82	**CONVERSION FACTORS** Regional conversion factors for services rendered on or after January 1, 2026. Section Region I Region II Region III Region IV E/M $6.37 $6.37 $7.29 $7.92 Medicine $6.09 $6.09 $6.97 $7.57 Physical Medicine $7.69 $7.69 $8.79 $9.55 Radiology $32.01 $32.01 $36.63 $39.82	deleted reference to 2019 conversion factors

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	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 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.	wording updated
	1B	**Unlisted Service or Procedure** When an unlisted service or procedure is provided the procedure should be identified and the value substantiated "by report" (see Ground Rule 2 below). All sections will have an unlisted service or procedure code number, usually ending in "99."	**Multiple Procedures** In extremely limited circumstances, if an acute problem arises during a routine visit, additional procedures may be reported on the same bill.	Old GR 1B & 2 content consolidated into new GR 2. New GR 1B is for Multiple Procedures. Added for consistency with other fee schedules.

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	2	**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, the 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 operative report and hospital chart, 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 chiropractor shall establish a relative value unit consistent in relativity with other relative value units shown in the schedule. The insurer shall review all submitted "BR" unit values 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	Old GR 1B & 2 content consolidated into new GR 2.

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			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.	

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	3	**Materials Supplied by Chiropractor** **Durable Medical Equipment Fee Schedule** Prior to the effective date of the 2020 Durable Medical Equipment Fee Schedule, for durable medical equipment 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. Following the effective date of the 2020 Durable Medical Equipment Fee Schedule, all durable medical equipment supplied shall be billed and paid using the 2020 Durable Medical Equipment Fee Schedule. The 2020 Durable Medical Equipment Fee Schedule is/will be available on the Board's website. Any item identified as requiring prior authorization in the 2020 Durable Medical Equipment Fee Schedule or not listed in the 2020 Durable Medical Equipment Fee Schedule may not be billed without such prior authorization. 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.	**Materials Supplied by Chiropractor** **Durable Medical Equipment Fee Schedule** All durable medical equipment (DME) supplied shall be billed and paid using the current published Durable Medical Equipment Fee Schedule. The WCB Durable Medical Equipment Fee Schedule is available on the Board's website. Any item identified as requiring prior authorization in the WCB DME Fee Schedule or not listed in the DME Fee Schedule may not be billed without such prior authorization. All DME prescriptions must follow any applicable Medical Treatment Guidelines. Medical necessity should be documented for all prescribed DME. Prescription or order form must be completed by the provider and accurately describe the item needed. Appropriate HCPCS codes should be billed for items. All miscellaneous/unspecified codes, or codes without a listed price- require prior authorization (PAR) and manufacture's invoice. Also see Surgery Ground Rules regarding post procedure casting/splinting DME. Do not bill for or report supplies that are customarily included in surgical packages, such as gauze, sponges, Steri-strips, and dressings; drug screening supplies; and hot and cold packs. These items are included in the fee for the medical services in which such supplies are used.	Emphasis on PARs, MTGs, and documentation
	4	**Miscellaneous** When reporting services in which the relativity is predicated on the basis of time, information concerning the amount of time spent should be indicated.	**Miscellaneous** When reporting services in which the relativity is predicated on the basis of time, information concerning the amount of time spent should be indicated. See also Narrative Reports Ground Rule.	reference to Narrative Report GR

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	9	**Treatment by Out-of-State Providers** Claimant lives outside of New York State—A claimant who lives outside of New York State may treat with a qualified out-of-state medical provider. The medical treatment shall conform to the Medical Treatment Guidelines and the Ground Rules included herein. 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. 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.	**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.	Updates including PAR information, use of NY fee schedule codes

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	11	**Moxibustion and Other Complementary Integrative Medicine Techniques** Moxibustion and other complementary integrative medicine techniques are often combined with acupuncture. No additional reimbursement will be provided for acupuncture combined with moxibustion or other similar adjunctive procedures.	**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.	Old GR 11 deleted - refers to different fee schedule. New GR 11 for Multiple Case numbers
	12	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
	13	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

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	14	N/A	**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.	added for consistency with other fee schedules
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 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.	changes as in Intro section

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	1B	**New and Established Patient Service** Several code subcategories in the Evaluation and Management section are based on the patient's status; new or established. Evaluation and Management codes for initial visits are 99201–99204. E/M established visit code 99212 may be used to bill for a periodic re-evaluation consisting of a thorough examination and report documenting diagnosis, thorough interim history, clinical findings, and future course of treatment. Chiropractors may also report CPT code 99243 for office consultations for a new or established patient. The maximum number of RVUs (including treatment) per patient per day per 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 99202 99203 99204 99212 99243 CPT 2018 guidelines define new and established patients. The patient definitions have been expanded from CPT 2018 for the New York State Fee Schedule (this text will be in italics). New Patient A new patient is one who has not received any professional services from the chiropractor, or another chiropractor who belongs to the same group practice, within the past three years. Established Patient An established patient shall also be considered one who has been treated for the same injury by any chiropractor who belongs to the same group practice. Because initial records such as history and physical are available within the group's facility, an initial new patient visit would not be indicated. The maximum number of RVUs (including treatment) per person per day per 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 a chiropractor is on call or covering for another chiropractor. In this instance, classify the patient encounter the same as if it were for the chiropractor who is unavailable.	**New and Established Patient Service** Several code subcategories in the Evaluation and Management section are based on the patient's status; new or established. Evaluation and Management codes for initial visits are 99202–99204. E/M established visit code 99212 may be used to bill for a periodic reevaluation consisting of a thorough examination and report documenting diagnosis, thorough interim history, clinical findings, and future course of treatment. Chiropractors may also report CPT code 99243 for office consultations for a new or established patient. The maximum number of RVUs (including treatment) per patient per day per WCB case number when billing for an initial evaluation shall be limited to 18.0. The following codes represent the treatments subject to this rule: 99202 99203 99204 99212 99243 CPT 2024 guidelines define new and established patients. The patient definitions have been expanded from CPT 2024 for the New York State Fee Schedule (this text will be in italics). **New Patien**t: A new patient is one who has not received any professional services from the chiropractor, or another chiropractor who belongs to the same group practice, within the past three years. **Established Patient:** An established patient shall also be considered one who has been treated for the same injury by any chiropractor who belongs to the same group practice. Because initial records such as history and physical are available within the group's facility, an initial new patient visit would not be indicated. The maximum number of RVUs (including treatment) per person per day per WCB case number when billing for a re-evaluation shall be limited to 15.0. The new versus established patient guidelines also clarify the situation in which a chiropractor is on call or covering for another chiropractor. In this instance, classify the patient encounter the same as if it were for the chiropractor who is unavailable.	codes updated

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	5	**Narrative Reports** A detailed narrative report must be submitted with the bill for the following procedure: 99204.	**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.	Enhanced GR with CMS1500 documentation guidelines
Radiology	Page 16		**CONVERSION FACTORS** chart	Copy of conversion factor chart applicable to this section. No changes in values from previous fee schedule.
	1C	N/A	**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 is reimbursable under this circumstance. The review of diagnostic tests is included in the evaluation and management codes.	New GR 1C- limiting billing for review of previously billed studies. Similar to existing GR in Lab/Path section
	5	**Miscellaneous** A) Emergency services rendered between 10:00 p.m. and 7:00 a.m. in response to requests received during those hours or on Sundays or legal holidays, provided such services are not otherwise reimbursed, may warrant an additional payment of one-third of the applicable fee. B) Relative value units for office visits are listed in the Evaluation and Management and Medicine sections. C) For diagnostic ultrasound procedures, use code 76999 and submit the required report.	**Miscellaneous** A. Emergency services rendered between 10:00 p.m. and 7:00 a.m. in response to requests received during those hours or on Sundays or legal holidays, provided such services are not otherwise reimbursed, may warrant an additional payment of one-third of the applicable fee. B. Relative value units for office visits are listed in the Evaluation and Management and Medicine sections.	deleted C, as non-applicable

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	7	N/A	**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.	Added for consistency with other fee schedules

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Medicine	Page 22		**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. 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** The recommendations of the NYS Medical Treatment Guidelines supersede the ground rule frequency limitation for services rendered to body parts covered by the NYS Medical Treatment Guidelines. The maximum reimbursement limitations per patient per day WCB case number for modalities is 12.0 RVUs, re-evaluation plus modalities is 15.0 RVUs, and initial evaluation plus modalities is 18.0 RVUs for all providers combined. Treatment of work-related injuries should be in accordance with any currently published, applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the Fee Schedule Ground Rules and the Medical Treatment Guidelines, the guidelines will prevail. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.	changes as in Intro section
	2	**Modifiers** Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Modifiers commonly used with medicine procedures are as follows:	**Modifiers** Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Appendixes referenced in the modifier descriptions are found in the CPT 2024 book. Modifiers commonly used with medicine procedures are as follows:	updated reference to CPT book appendix in some modifier descriptions

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	3	**EDX (Codes 95907–95913)** EDX is only recommended where there is failure of suspected radicular pain to resolve or plateau after waiting 4 to 6 weeks (to provide for sufficient time to develop EMG abnormalities as well as time for conservative treatment to resolve the problems), equivocal imaging findings, e.g., on CT or MRI studies, and suspicion by history and physical examination that a neurologic condition other than radiculopathy may be present instead of or in additionto radiculopathy. When such testing is recommended, the provider shall select from codes 95907–95913 using 1 unit of the 1 code that most closely represents the nerve(s) tested. Requests for repeat testing require approval from the carrier.	**EDX (Codes 95907–95913)** EDX testing must comply with all applicable Medical Treatment Guidelines (unless there is an approved prior authorization request), including provider qualifications. When such testing is recommended and/or approved, the provider shall bill 1 unit of the single code that most closely represents the nerve(s) tested.	updated information for billing
	4	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

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	5	N/A	**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.	added for consistency with other fee schedules

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Section	Ground Rule Number	2018-2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
Physical Medicine	Page 26		**CONVERSION FACTORS** chart	copy of conversion factor chart applicable to this section. No changes in values from previous fee schedule.
	1A change to 1	**NYS Medical Treatment Guidelines** The recommendations of the NYS Medical Treatment Guidelines supersede the ground rule frequency limitation for services rendered to body parts covered by the medical treatment guidelines. The maximum reimbursement limitations per patient per day per 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** The recommendations of the NYS Medical Treatment Guidelines supersede the ground rule frequency limitation for services rendered to body parts covered by the medical treatment guidelines. The maximum reimbursement limitations per patient per day per WCB case number for modalities is 12.0 RVUs, re-evaluation plus modalities is 15.0 RVUs, and initial evaluation plus modalities is 18.0 RVUs for all providers combined. Treatment of work-related injuries should be in accordance with any applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the fee schedule ground rules and the medical treatment guidelines, the guidelines will prevail. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.	changes as in Intro section

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Section	Ground Rule Number	2018-2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	2	**Initial Evaluation and Re-evaluation** Chiropractors may bill for an initial evaluation using CPT codes 99201–99204. Evaluations shall include the following elements: history, clinical testing, and interpretation of data and development of the plan of care with defined goals, appropriate interventions, and recommendations. The maximum number of relative value units (including treatment) per patient per day when billing for an initial evaluation shall be limited to 18.0 RVUs. The maximum number of relative value units (including treatment) per patient per day when billing for a re-evaluation shall be limited to 15.0 RVUs. The following codes represent the treatments subject to this rule: 97010 97012 97014 97024 97026 97028 97032 97033 97034 97035 97036 97039 97110 97112 97113 97116 97124 97139 97140 97530 97810 97811 97813 97814 98940 98941 98942 Re-evaluations may be billed using CPT code 99212 when any of the following applies: A) If following discharge (for whatever reason), the patient is referred again for treatment with the same or similar condition of the same body part. B) If there is a significant change in the patient's condition that warrants a revision of the treatment goals, intervention and/or the plan of care. C) If it is medically necessary to provide re-evaluation services over and above those normally included during therapeutic treatment. D) If the patient's status becomes stationary and it is not likely that significant improvement will occur with further treatment. E) If at the conclusion of the current episode of therapy care, re-evaluation is indicated for any of the following reasons: • Satisfactory goal achievement with present functional status defined including a home program and follow-up services, as necessary. • Patient declines to continue care • The patient is unable to continue to work toward goals due to medical or psychosocial complications	**Initial Evaluation and Re-evaluation** Chiropractors may bill for an initial evaluation using CPT codes 99202–99204. Evaluations shall include the following elements: history, clinical testing, and interpretation of data and development of the plan of care with defined goals, appropriate interventions, and recommendations. The maximum number of relative value units (including treatment) per patient per day per WCB case number when billing for an initial evaluation shall be limited to 18.0 RVUs. The maximum number of relative value units (including treatment) per patient per day when billing for a re-evaluation shall be limited to 15.0 RVUs. The following codes represent the treatments subject to this rule: 97010 97012 97014 97024 97026 97028 97032 97033 97034 97035 97036 97039 97110 97112 97113 97116 97124 97139 97140 97530 97810 97811 97813 97814 98940 98941 98942 Re-evaluations may be billed using CPT code 99212 when any of the following applies: A. If following discharge (for whatever reason), the patient is referred again for treatment with the same or similar condition of the same body part. B. If there is a significant change in the patient's condition that warrants a revision of the treatment goals, intervention and/or the plan of care. C. If it is medically necessary to provide re-evaluation services over and above those normally included during therapeutic treatment. D. If the patient's status becomes stationary and it is not likely that significant improvement will occur with further treatment. E. If at the conclusion of the current episode of therapy care, re-evaluation is indicated for any of the following reasons: • Satisfactory goal achievement with present functional status defined including a home program and follow-up services, as necessary. • Patient declines to continue care • The patient is unable to continue to work toward goals due to medical or psychosocial complications	codes updated

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Section	Ground Rule Number	2018-2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	3	**Multiple Physical Medicine Procedures and Modalities** When multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 12.0 RVUs per patient per day per accident or illness or the amount billed, whichever is less. Note: When a patient receives physical medicine procedures, acupuncture and/or chiropractic modalities from more than one provider, the patient may not receive more than 12.0 RVUs per day per accident or illness from all providers combined. The following codes represent the physical medicine procedures and modalities subject to this rule: 97010 97012 97014 97024 97026 97028 97032 97033 97034 97035 97036 97039 97110 97112 97113 97116 97124 97139 97140 97530 97810 97811 97813 97814 98940 98941 98942	**Multiple Physical Medicine Procedures and Modalities** When multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 12.0 RVUs per patient per WCB Case Number or the amount billed, whichever is less. Note: When a patient receives physical medicine procedures, acupuncture and/or chiropractic modalities from more than one provider, the patient may not receive more than 12.0 RVUs per day per case number from all providers combined. The following codes represent the physical medicine procedures and modalities subject to this rule: 97010 97012 97014 97024 97026 97028 97032 97033 97034 97035 97036 97039 97110 97112 97113 97116 97124 97139 97140 97530 97810 97811 97813 97814 98940 98941 98942	codes updated
	6	N/A	**Physical and Occupational Therapists Billing** All providers who can be authorized by the NYS Workers' Compensation Board, must be Board-authorized in order to treat injured workers. All Physical and Occupational Therapists, whether self-employed or part of another practice, must submit their own medical reports and bill independently in their own name, and must bill using the NYS WCB Physical and Occupational Therapy Fee Schedule and not through a supervising provider. Some exceptions may include: PT/OT performed in a hospital inpatient setting or ambulatory surgery setting may be billed by the facility. See WCB webpage for more information on Expanded Provider Law: www.wcb.ny.gov. Chiropractors may not bill for (incident to) physical/ occupational therapists that are performing the patient's therapy.	added for consistency with other fee schedules

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	7	N/A	**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.	added for consistency with other fee schedules

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Section	Ground Rule Number	2018-2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
Appendix	Page 30 & 31		**Appendix**	New, Changed, Deleted Code lists, Zip Codes by Region