NYS Official Workers' Compensation Medical Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
Intro & General	page 1	The Official New York State Workers' Compensation Medical Fee Schedule shows physician services and their relative value units. The services are listed by Current Procedural Terminology (CPT®) codes. The relative value 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 in medical practice. All sections of the book may be used by any or all physicians; appropriate surgery codes are not confined to use by surgeons, nor is the medicine section confined to use by internists, etc. Because the Medical 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 physician 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 physicians in the care of workers' compensation covered patients and to ensure the proper payment for such services by assuring that they are specifically identifiable. This edition of the Official New York State Workers' Compensation Medical Fee Schedule uses CPT procedure codes, modifiers, and descriptions and, where appropriate, the American Society of Anesthesiologists' Relative Value Guide®. 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 Medical Fee Schedule shows physician, nurse practitioner, and physician assistant services and their relative value units. The services are listed by Current Procedural Terminology (CPT®) codes. The relative value 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 in medical practice. All sections of the book may be used within the scope of practice as established by New York State Law by any or all appropriately trained physicians, nurse practitioners, and physician assistants. Appropriate surgery codes are not confined to use by surgeons, nor is the medicine section confined to use by internists, etc. Because the Medical 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 physician 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 physicians, nurse practitioners, physician assistants in the care of workers' compensation covered patients and to ensure the proper payment for such services by assuring that they are specifically identifiable. Inclusion of a code in this Fee Schedule does not guarantee reimbursement. All codes billed should be based on medical necessity and be in alignment with all applicable Medical Treatment Guidelines and Fee Schedule Ground Rules, as further discussed herein. Reimbursement may be dependent on multiple factors, including but not necessarily limited to, causal relationship, clinical necessity and appropriateness of the fees submitted. This edition of the Official New York State Workers' Compensation Medical Fee Schedule uses CPT procedure codes, modifiers, and descriptions and, where appropriate, the American Society of Anesthesiologists' Relative Value Guide®. Please refer to the CPT book for an explanation of coding rules and regulations not listed in this schedule.	disclaimer paragraph added

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	page 9	Postal Zip Codes By Region	moved to Appendix	
	page 9	Numerical List of Zip Codes	moved to Appendix	
	page 9	New, Changed, Deleted Codes, Changed Descriptions/Values Chart	moved to Appendix	
	page 9	N/A	E/M - Codes* 99202-99215 E/M - Codes 99221-99499	Conversion factor chart expanded for additional enhanced E/M codes
	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 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 for prior authorization

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	1B	**Multiple Procedures** It is appropriate to designate multiple procedures that are rendered on the same date by separate entries. For example, if a level three established patient office visit (99213) and an ECG (93000) are performed during the visit, it is appropriate to designate both the established patient office visit and the ECG. In this instance, both 99213 and 93000 would be reported.	**Multiple Procedures** In extremely limited circumstances, if an acute problem arises during a routine visit, additional procedures may be reported on the same bill. For example, if in the course of a level three established patient office visit (99213) an acute situation requires an ECG (93000), it is appropriate to designate both the established patient office visit and the ECG. In this instance, both 99213 and 93000 would be reported.	updated wording
	2	**Unlisted Service or Procedure** When an unlisted service or procedure is provided, the procedure should be identified and the value substantiated "by report" (see Rule 3 below). All sections will have an unlisted service or procedure code number, usually ending in "99."	**Enhanced Reimbursement for Office Visits** Specific Evaluation and Management (E/M) visit codes are now eligible for increased reimbursement only when billed by physicians (MD, DO), nurse practitioners (NP) and physician assistants (PA). Codes included are: 99202, 99203, 99204, 99205, and 99211, 99212, 99213, 99214, and 99215. See the adjusted Conversion Factors per region in the chart for these particular codes. The RVUs assigned to these codes have also increased. The codes' values can be found in the Evaluation and Management section. Modifier 1B cannot be added to these E/M codes.	Old GR 2 combined with New GR 3. New GR 2 explained enhanced reimbursement for certain E&M codes

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	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, 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 physician 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" 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	Old GR 3 combined with Old GR 2 and becomes New GR 3. Including clarifications for billing.

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			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.	

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	4	**Materials Supplied by Provider: Pharmaceuticals and Durable Medical Equipment** **A) Pharmacy** A prescriber cannot dispense more than a seventy-two-hour supply of drugs with the exceptions of: 1. Persons practicing in hospitals as defined in section 2801 of the public health law; 2. The dispensing of drugs at no charge to their patients; 3. Persons whose practices are situated ten miles or more from a registered pharmacy; 4. The dispensing of drugs in a clinic, infirmary, or health service that is operated by or affiliated with a post-secondary institution; 5. The dispensing of drugs in a medical emergency as defined in subdivision 6 of section 6810 of the State Education Law. For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070. B**) Durable Medical Equipmen**t 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	**Materials Supplied by Provider: Pharmaceuticals and Durable Medical Equipment** **A. Pharmacy** A prescriber cannot dispense more than a seventy-two hour supply of drugs with the exceptions of: i. Persons practicing in hospitals as defined in section 2801 of the public health law; ii. The dispensing of drugs at no charge to their patients; iii. Persons whose practices are situated ten miles or more from a registered pharmacy; iv. The dispensing of drugs in a clinic, infirmary, or health service that is operated by or affiliated with a post-secondary institution; v. The dispensing of drugs in a medical emergency as defined in subdivision 6 of section 6810 of the State Education Law. For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070. Identify the product being given with the NDC number and amount of product being used. Except in emergencies, any medications must follow all WCB Formulary and applicable Medical Treatment Guidelines. Any variations require or Prior Authorization (PAR). **B. Durable Medical Equipment** All durable medical equipment (DME) supplied shall be billed and paid using the current published WCB Durable Medical Equipment (DME) Fee Schedule. The WCB DME Fee Schedule is available on the Board's website. Any item identified as requiring prior authorization in the WCB Durable Medical Equipment Fee Schedule or not listed in the WCB Durable Medical Equipment Fee Schedule may not be billed without such prior authorization.	updated DME Fee Schedule information

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		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.	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.	

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

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	6	**Concurrent Care** When more than one physician treats a patient for the same condition during the same period of time, payment is made only to one physician, the one whose specialty is most relevant to the diagnosis. For example, if claims are received from both a cardiologist and a general practitioner for the treatment of a heart condition, or from both an orthopedist and a surgeon for the treatment of a back disorder, payment is due only to the cardiologist and orthopedist, respectively. Where the concurrent care involves overlapping or common services, the fees payable shall not be increased but prorated. Each physician shall submit separate bills but indicate if agreement has been reached on the proration. If no agreement between or among the physicians has been reached, the matter shall be referred to the Medical Arbitration Committee per Section 13-g of the Workers' Compensation Law. When the condition of the patient requires the disparate skills of two or more physicians to treat different conditions which do not fall within the scope of other physicians treating the patient at the same time (e.g., management of diabetes mellitus in a surgical case), payment is due each physician who plays an active role in the treatment program. The services rendered by each physician shall be distinct, in different disciplines, identifiable, and adequately documented in the records and reports. (For consultations, see 99241–99255.)	**Concurrent Care** When more than one physician treats a patient for the same condition during the same period of time, payment is made only to one physician, the one whose specialty is most relevant to the diagnosis. For example, if claims are received from both a cardiologist and a general practitioner for the treatment of a heart condition, or from both an orthopedist and a surgeon for the treatment of a back disorder, payment is due only to the cardiologist and orthopedist, respectively. Where the concurrent care involves overlapping or common services, the fees payable shall not be increased but prorated. Each physician shall submit separate bills but indicate if agreement has been reached on the proration. When the condition of the patient requires the disparate skills of two or more physicians to treat different conditions which do not fall within the scope of other physicians treating the patient at the same time (e.g., management of diabetes mellitus in a surgical case), payment is due each physician who plays an active role in the treatment program. The services rendered by each physician shall be distinct, in different disciplines, identifiable, and adequately documented in the records and reports.	deleted reference to arbitration committee

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	6A	N/A	**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. Each billing physician/provider must be WCB authorized, as applicable.	New GR 6A. Explaining practice for claimants with multiple WCB Case numbers
	7	**Alternating Physicians** When physicians of similar skills alternate in the care of a patient (e.g., partners, groups, or same facility covering for another physician on weekends or vacation periods), each physician shall bill individually for the services each personally rendered and in accordance with the Medical Fee Schedule	**Alternating Physicians** When physicians of similar skills alternate in the care of a patient (e.g., partners, groups, or same facility covering for another physician on weekends or vacation periods), each physician shall bill individually for the services each personally rendered and in accordance with the Medical Fee Schedule. Each billing physician/provider must be WCB authorized, as applicable. If a provider wishes to perform a procedure for which a Prior Authorization (PAR) was granted to a different provider, the subsequent provider should seek express written authorization from the payer, ideally as a new PAR, or as otherwise approved in writing by the payer.	added information on PAR when provider changes

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	8	**Proration of Scheduled Relative Value Unit Fee** When the schedule specifies a relative value unit fee for a definite treatment with an inclusive period of aftercare (follow-up days), and the patient is transferred from one physician to another physician, the employer (or carrier) is only responsible for the total amount listed in the schedule. Such amount is to be apportioned between the physicians. If the concerned physicians agree to the amounts to be prorated to each, they shall render separate bills accordingly. If no proration agreement is reached by them, the amounts payable to each party shall be settled by an arbitration committee appointed pursuant to Section 13-g of the Workers' Compensation Law, without cost to the contestants. When treatment is terminated by the departure of the patient from New York State before the expiration of the stated period of follow-up days, the fee shall be the portion of the appropriate fee having regard for the fact that usually the greater portion is earned at the time of the original operation or service. When treatment is terminated by the death of the patient before the expiration of follow-up days, the full fee is payable, subject to proration where applicable.	**Proration of Scheduled Relative Value Unit Fee** When the schedule specifies a relative value unit fee for a definite treatment with an inclusive period of aftercare (follow-up days), and the patient is transferred from one physician to another physician, the employer (or Payer) is only responsible for the total amount listed in the schedule. Such amount is to be apportioned between the physicians. If the concerned physicians agree to the amounts to be prorated to each, they shall render separate bills accordingly. When treatment is terminated by the departure of the patient from New York State before the expiration of the stated period of follow-up days, the fee shall be the portion of the appropriate fee having regard for the fact that usually the greater portion is earned at the time of the original operation or service. When treatment is terminated by the death of the patient before the expiration of follow-up days, the full fee is payable, subject to proration where applicable.	deleted reference to arbitration committee

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	11	**Ground Rules for Physician Assistants (PA) and Nurse Practitioners (NP)** Authorized Nurse Practitioners who render care and treatment in accordance with their scope of practice under State Education Law, and Physician Assistants who render treatment and care for ongoing temporary disability in accordance with the Workers' Compensation Law, shall report and bill using their individual authorization numbers and bills shall be payable at 80 percent of the fee available to physicians for such treatment code. Note: This Ground Rule is not applicable to Surgery Ground Rule 12 (F), whereby the surgeon must be directly and personally supervising the surgical assistants and such surgeon (or when the NP or PA is employed by the facility where the service is performed, the facility representative) must submit the bill for the surgical assistant's services in accordance with that Ground Rule. State-specific modifier 83 is used to identify assistant at surgery services provided by a physician assistant or nurse practitioner.	**Ground Rules for Physician Assistants (PA) and Nurse Practitioners (NP)** WCB Authorized Nurse Practitioners (NP) and Physician Assistants (PA) who render care within their scope of practice under NYS Education Law, and in accordance with their delineation of activities in Workers' Compensation Law, shall bill and be reimbursed for their services at 80 percent of the corresponding physician fee schedule rate. See currently published information on Expanded Provider Legislation available on the WCB webpage. This Ground Rule does not apply to bills for assistance during surgeries. Also see Surgery Ground Rule for Concurrent Services. See Ground Rule 12 F in Surgery section, and modifier 83 information. State-specific modifier 83 is used to identify assistant at surgery services provided by a physician assistant or nurse practitioner.	clarifying billing guidelines for NP/PA
	14	**Exempt From Modifier 51 Codes**	**Exempt From Modifier 51 Codes-** codes moved to appendix	

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	15	**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** 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 may be restricted by provider type. See any applicable Ground Rules listed in separate sections/ fee schedules. Appendixes referenced in the modifier descriptions are found in the CPT 2024 book.	reference to CPT Book appendix in some code's descriptions.

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	15	**1B∞ Behavioral Health Provider Enhanced Reimbursement** Provides a 20 percent reimbursement increase for E/M and Medicine services when rendered by 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 Appendix for Behavioral Health Provider Enhanced Rating Codes. ** See current Telehealth Ground Rule and webpage: https://www.wcb.ny.gov/telehealth/	Modifier 1B description updated. Provider rating code chart moved to appendix

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	15	N/A	**1R∞ Non-surgical services provided by residents and fellows** Billed and payable at the same applicable rate as the WCB authorized, supervising physician. 1R can be used for E/M codes, such as office visits, as well as for standalone procedures not performed during a surgery i.e., injections. This modifier is not used for assistance at surgery. See modifier 84.	New modifier for residents and fellows
	15	**83∞ Physician Assistant or Nurse Practitioner as Assistant Surgeon** When a physician assistant or nurse practitioner performs services for assistants at surgery, identify the services by adding modifier 83 to the usual procedure code. Services of a physician assistant or nurse practitioner are reimbursed at 10.7 percent of the listed value of the surgical code and payable to the supervising physician or facility where service was performed. This modifier is valid for surgery only. Note: General Ground Rule 11 is not applicable to Surgery Ground Rule 12 (F), whereby the surgeon must be directly and personally supervising the surgical assistants and such surgeon or facility where the service was performed must submit the bill for the surgical assistant's services in accordance with that Ground Rule.	**83∞ Services of Physician Assistants (PA) and Nurse Practitioners (NP) assisting during surgical procedures:** The operating physician must bill at 10.7 percent of the total physician fee schedule allowance for the surgical procedures performed by the NP/PA. Identify the services by adding modifier 83 to the specific procedure codes done by the NP/PA. Payment will be made to the supervising physician performing the surgery. This modifier is valid for surgery only. NPs and PAs cannot bill for surgery independently.	billing and reimbursement clarification

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	15	N/A	**84∞ Assistance at surgery provided by residents and fellows** This modifier should be appended to the individual codes representing work actually performed by the resident/fellow while assisting the WCB authorized, supervising physician. This modifier should not be used for E/M codes or for procedures not performed during a surgery i.e., injections. See modifier 1R.	new modifier for residents and fellows
	15	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 telemedicine modifiers

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	15	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 telemedicine modifiers
	15	**1D∞ Designated Provider Enhanced Reimbursement** Provides an additional 20 percent reimbursement increase for E/M services performed by providers with the following WCB assigned provider rating codes:	N/A	modifier 1D deleted

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	16	**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.	mentions of PARs and CPT codes

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	17	**Designated Provider Enhanced Reimbursement** In an effort to increase the number of Board authorized providers in the general medicine (Family Practice, General Practice and Internal Medicine) specialties available to render care and treatment to injured workers, the WCB has established WCB specific modifier 1D which will provide a 20 percent reimbursement increase to providers with WCB assigned rating codes for designated services. Modifier 1D provides an additional 20 percent reimbursement increase for E/M services performed by providers with the following WCB assigned provider rating codes:	**Narrative Reports** A detailed narrative report must be submitted with all services provided. Physicians & Nurse Practitioners narrative reports must include the following elements in a highly visible location: Work Status, Casual Relationship & Temporary Impairment Percentage. Physician Assistants must include Work Status & Temporary Impairment Percentages. 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.	Old GR 17 deleted as Modifier 1D is deleted. New GR 17 is information on documentation

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	18	Behavioral Health Provider Enhanced Reimbursement In an effort to increase the number of Board authorized providers in behavioral health available 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 services when rendered by 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 available 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 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	updated 1B information. Rating chart in appendix

NYS Official Workers' Compensation Medical Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	21	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. Non Behavioral Health Physicians, Nurse Practitioners, Physician Assistants, and Podiatrists may only bill: • E/M code 99212 2. Behavioral Health Psychiatrists, Psych PAs, Psych NPs may bill: • E/M codes 99202-99204, 99212 • Psychotherapy/Combination/crisis codes: 90832-90834, 90836-90840 • Group therapy: 90853 3. See the Behavioral Health Fee Schedule for Psychologist and LCSW telehealth billing guidelines. 4. 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 5. 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 GR for permanent Telemedicine

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Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	22	N/A	**Category III Codes** Category III codes are temporary codes identifying emerging technology and should be reported when available. The use of these codes supersedes reporting the service with an unlisted code. Because these codes are temporary, some of them may only be covered on a case-by-case review, and all require Prior Authorization. The temporary codes may be converted to permanent CPT codes or deleted during periodic updates of the code set. The Category III codes will utilize the Medicine conversion factor. Any currently published WCB Bulletins may supersede this Ground Rule if necessary. For a complete explanation of this process refer to the guidelines in CPT 2024.	New GR for Cat III billing
	22A	N/A	**Extracorporeal Shockwave Therapy** Please see all applicable Medical Treatment Guidelines (MTG). Extracorporeal Shockwave Therapy is only rarely, if ever, recommended in the MTGs. Therefore, use of extracorporeal shockwave therapy will generally require prior authorization. The Category III codes for shockwave treatments will utilize the Medicine Conversion factor. Any currently published WCB Bulletins may supersede this Ground Rule if necessary.	New GR for particular Cat III code billing

NYS Official Workers' Compensation Medical Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	23	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 CMS1500 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 WCB webpage.	new GR for electronic clearinghouse billing

NYS Official Workers' Compensation Medical Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	24	N/A	**Billing for Residents and Fellows** Treatment rendered by residents and fellows can only be billed by the Board authorized supervising physician. Non-surgical service codes should be appended with modifier 1R. Services with modifier 1R must be billed and reimbursed at the same amount payable to the authorized supervising physician. Assistant-at-surgery codes should be appended with modifier 84. Surgery codes with modifier 84 must be billed and reimbursed at 16 percent of the applicable physician code fee. A. All Fee Schedule Ground Rules for multiple procedures apply. B. Physicians cannot additionally bill for supervision of the resident. C. If the supervising surgeon bills for a resident/fellow assisting at surgery, only one additional assistant (NP/PA-modifier 83) may be billed, and only if documentation supports the necessity of the additional assistance. D. When applicable, modifier 84 should be appended to the individual codes of the surgery. All codes billed should accurately reflect work performed by the resident/fellow. Documentation in the operative/ procedure report should include all details. E. Payment may be decided based on review of documentation, as well as the usual and customary standards of CPT/CMS billing guidelines for allowance of assistants at surgery. F. Non-authorized out-of-state physicians may not bill for residents/fellows. G. Surgeons should not bill for services performed by a resident/fellow that would not normally be billed by another type of assistant at surgery. H. Payment shall not be made for observation, or for simple assistance such as closing basic surgical fields or work typically performed by nursing/technical staff. I. The name of the resident/fellow does not need to be documented on the CMS1500 form. J. All CMS1500 Narrative requirements do apply to any bills submitted. www.wcb.ny.gov/CMS-1500 K. See WCB webpage for further guidance: https://www.wcb.ny.gov/content/main/hcpp/residents-fellows.jsp	new GR for residents and fellows

NYS Official Workers' Compensation Medical Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
Evaluation & Management	Chart inserted-page 22	N/A	Conversion factor chart for this section	Conversion factor chart for this section
	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 applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the Fee Schedule Ground Rules and the Medical Treatment Guidelines, the guidelines will prevail. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.	updated as in previous sections

NYS Official Workers' Compensation Medical Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	1C	N/A	**1C. Enhanced Reimbursement for Office Visits** Specific Evaluation and Management (E/M) visit codes are now eligible for increased reimbursement only when billed by physicians (MD, DO), nurse practitioners (NP) and physician assistants (PA). Codes included are: 99202, 99203, 99204, 99205, and 99211, 99212, 99213, 99214, and 99215 See the adjusted Conversion Factors per region in the chart for these particular codes. The RVUs assigned to these codes have also increased. The codes' values can be found in the Evaluation and Management section. Modifier 1B cannot be added to these E/M codes.	New GR for certain enhanced visit codes
	3	**Clinical Examples** Examples for E/M services are provided to assist physicians in understanding the meaning of the descriptors and selecting the correct code for the services they have rendered. It is important to note that the same problem, when seen by different specialties, may involve different levels and amounts of work. Therefore, the appropriate level of encounter should be reported using the descriptions as outlined for explanation of E/M services in the CPT book and this fee schedule rather than the clinical examples. For more examples, please refer to CPT guidelines.	**Clinical Examples** It is important to note that the same problem, when seen by different specialties, may involve different levels and amounts of work. Therefore, the appropriate level of encounter should be reported using the descriptions as outlined for explanation of E/M services in the CPT book and this fee schedule rather than the clinical examples. For more examples, please refer to CPT guidelines	updated

NYS Official Workers' Compensation Medical Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	5	**E/M Service Components** The first three components of history, examination, and medical decision making are the keys to selecting the correct level of E/M codes, and all three components must be addressed in the documentation. However, in established, subsequent, and follow-up categories, only two of the three components must be met or exceeded for a given code. CPT 2018 guidelines define the following: A) The history component is categorized by four levels: Problem Focused: chief complaint; brief history of present illness or problem. Expanded Problem Focused: chief complaint; brief history of present illness; problem-pertinent system review. Detailed: chief complaint; extended history of present illness; problem-pertinent system review extended to include a review of limited number of additional systems; pertinent past, family medical and/or social history directly related to the patient's problems. Comprehensive: chief complaint; extended history of present illness; review of systems which is directly related to the problems identified in the history of the present illness plus a review of all additional body systems; complete past, family, and social history. B) The physical exam component is similarly divided into four levels of complexity: Problem Focused: an exam limited to the affected body area or organ system. Expanded Problem Focused: a limited examination of the affected body area or organ system and other symptomatic or related organ systems. Detailed: an extended examination of the affected body areas and other symptomatic or related organ systems. Comprehensive: a general multi-system	**E/M Service Components** Level of service should be chosen as defined in the CPT year/version used in the currently published fee schedule effective at the time of the encounter.	deleted outdated descriptions.

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
		examination or a complete examination of a single organ system. CPT 2018 guidelines identify the following body areas: • head, including face • neck • chest, including breasts and axilla • abdomen • genitalia, groin, buttocks • back • each extremity CPT 2018 guidelines identify the following organ systems: • eyes • ears, nose, mouth, and throat • cardiovascular • respiratory • gastrointestinal • genitourinary • musculoskeletal • skin • neurologic • psychiatric • hematologic/lymphatic/immunologic C) Medical decision making is the final portion of the E/M coding process. Medical decision making refers to the complexity of establishing a diagnosis or selecting a management option which can be measured by the following: 1) The number of diagnoses and/or the number of management options to be considered. 2) The amount and/or complexity of medical records, diagnostic tests, and other information that must be obtained, reviewed, and analyzed. 3) The risk of significant complications morbidity, and/or mortality, as well as co-morbidities associated with the patient's presenting problems, the diagnostic procedures, and/or the possible management options.		

NYS Official Workers' Compensation Medical Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	6	**Contributory Components** Counseling, coordination of care, and the nature of the presenting problem are not major considerations in most encounters, so they generally provide contributory information to the code selection process. The exception arises when counseling or coordination of care dominates the encounter (more than 50 percent of the time spent). In these cases, time determines the proper code. Document the exact amount of time spent to substantiate the selected code and clearly record what was discussed during the encounter. Counseling is defined in CPT 2018 guidelines as a discussion with a patient and/or family concerning one or more of the following areas: A) Diagnostic results, impressions, and/or recommended diagnostic studies; B) Prognosis; C) Risks and benefits of management (treatment) options; D) Instructions for management (treatment) and/or follow-up; E) Importance of compliance with chosen management (treatment) options; F) Risk factor reduction; and G) Patient and family education E/M codes are designed to report actual work performed, not time spent. But when counseling or coordination of care dominates the encounter, time overrides the other factors and determines the proper code. Per CPT 2018 guidelines for office encounters, count only the time spent face-to-face with the patient and/or family; for hospital or other inpatient encounters, count the time spent in the patient's unit or on the patient's floor. The time assigned to each code is an average and varies by provider. According to the CPT book, "a presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason" for the patient encounter. CPT 2018 defines five types of presenting problems. You should review these definitions	**Contributory Components** See Narrative Report section for details.	deleted outdated descriptions.

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
		frequently, but remember, this information merely contributes to code selection. The presenting problem is not a key factor.		

NYS Official Workers' Compensation Medical Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	7	**Narrative Reports** A detailed narrative report must be submitted with the bill for the following procedures: 92004 92014 99204 99205 99215 99223 99244 99245 99254 99255 99285 When submitting a medical report and bill using the CMS-1500, all E/M codes must be submitted with a detailed narrative report.	**Narrative Reports** A detailed narrative report must be submitted with all services provided. Physicians & Nurse Practitioners narrative reports must include the following elements in a highly visible location: Work Status, Casual Relationship & Temporary Impairment Percentage. Physician Assistants must include Work Status & Temporary Impairment Percentages. 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.	updated information form CMS1500 documentation

NYS Official Workers' Compensation Medical Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	8	**Guidelines Summary** This brief overview of the current guidelines should not be the provider's or payer's only experience with this section of the CPT book. Carefully read the complete guidelines in CPT 2018; much information is presented regarding aspects of a family history, the body areas, and organ systems associated with examinations, and so forth. The E/M code section is divided into subsections by type and place of service. Keep the following in mind when coding each service setting: • A patient is considered an outpatient at a health care facility until formal inpatient admission occurs. • All providers use codes 99281–99285 for reporting emergency department services, regardless of hospital-based or non-hospital-based status.	**Guidelines Summary** This brief overview of the current guidelines should not be the provider's or payer's only experience with this section of the CPT book. Carefully read the complete guidelines in CPT version in effect at the time of the encounter.	deleted several pages of outdated code descriptions
	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 with E/M 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 E/M procedures are as follows:	included reference to CPT appendix for some code descriptions

NYS Official Workers' Compensation Medical Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	9	**1B Behavioral Health Provider Enhanced Reimbursement** Provides a 20 percent reimbursement increase for E/M and Medicine services when rendered by providers with the following WCB assigned provider rating code	**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/	updated and chart moved to appendix
	9	N/A	**1R∞ Non-surgical services provided by residents and fellows** Billed and payable at the same applicable rate as the WCB authorized, supervising physician. 1R can be used for E/M codes, such as office visits, as well as for standalone procedures not performed during a surgery i.e., injections. This modifier is not used for assistance at surgery. See Modifier 84 in Surgery section.	new modifier for residents and fellows

NYS Official Workers' Compensation Medical Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	9	**1D Designated Provider Enhanced Reimbursement** Provides an additional 20 percent reimbursement increase for E/M services performed by providers with the following WCB assigned provider rating codes:	N/A	modifier 1D deleted
	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 telemedicine

NYS Official Workers' Compensation Medical Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	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 telemedicine

NYS Official Workers' Compensation Medical Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	10	**Designated Provider Enhanced Reimbursement** In an effort to increase the number of Board authorized providers in the general medicine (Family Practice, General Practice, and Internal Medicine) specialties available to render care and treatment to injured workers, the WCB has established WCB specific modifiers 1D which will provide a 20 percent reimbursement increase to providers with WCB assigned rating codes for designated services. Modifier 1D provides an additional 20 percent reimbursement increase for E/M services performed by 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 the 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 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.	Old GR 10 for modifier 1D deleted. New GR 10 updated information for Modifier 1B

NYS Official Workers' Compensation Medical Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	11	**Behavioral Health Provider Enhanced Reimbursement** In an effort to increase the number of Board authorized providers in the 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 services when rendered by providers with the following WCB assigned provider rating codes:	**Non-Schedule and Schedule Permanency Evaluations** Non-schedule: Code 99245 is used for examinations and reports of non-schedule permanency evaluations performed by an authorized physician. Schedule: Code 99243 is used for examinations and reports of schedule permanency evaluations performed by an authorized physician.	Old GR 11 replaced by updated GR 10. New GR 11 is old GR 12

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Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	12	**Non-Schedule and Schedule Permanency Evaluations** Non-schedule: Code 99245 is used for examinations and reports of non-schedule permanency evaluations performed by an authorized physician. Schedule: Code 99243 is used for examinations and reports of schedule permanency evaluations performed by an authorized physician	**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. Non Behavioral Health Physicians, Nurse Practitioners, Physician Assistants, and Podiatrists may only bill: • E/M code 99212 2. Behavioral Health Psychiatrists, Psych PAs, Psych NPs may bill: • E/M codes 99202-99204, 99212 • Psychotherapy/Combination/crisis codes: 90832-90834, 90836-90840 • Group therapy: 90853 3. See the Behavioral Health Fee Schedule for Psychologist and LCSW telehealth billing guidelines. 4. 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 5. 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/	Old GR 12 is now GR 11. New GR 12 is Telemedicine.

NYS Official Workers' Compensation Medical Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	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 CMS1500 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 our webpage.	New GR for electronic clearinghouse billing

NYS Official Workers' Compensation Medical Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	14	N/A	**Billing for Residents and Fellows: (Non-surgical)** Treatment rendered by residents and fellows can only be billed by the Board authorized supervising physician. Non-surgical service codes should be appended with modifier 1R. Services with modifier 1R must be billed and reimbursed at the same amount payable to the authorized supervising physician. A. Physicians cannot additionally bill for supervision of the resident. B. All codes billed should accurately reflect work performed by the resident/fellow. Documentation in the report/narrative should include all details. C. Non-authorized out-of-state physicians may not bill for residents/fellows. D. Payment shall not be made for observation, or for simple assistance such as closing basic surgical fields or work typically performed by nursing/technical staff. E. The name of the resident/fellow does not need to be documented on the CMS1500 form. F. All CMS1500 Narrative requirements do apply to any bills submitted. https://www.wcb.ny.gov/CMS-1500/ G. Also see modifier description 1R.	New GR for residents and fellows
Anesthesia	page 36	N/A	Chart with conversion factors for this section	

NYS Official Workers' Compensation Medical Fee Schedule Ground Rules

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 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.	

NYS Official Workers' Compensation Medical Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	1B	**General** Anesthesia services are listed for each procedure in the Anesthesia section and for certain procedures in other sections. The codes are to be used only when the anesthesia is personally administered by an anesthesiologist or a certified registered nurse anesthetist (CRNA) under the supervision of an anesthesiologist. The anesthesiologist or CRNA must remain in constant attendance during the procedure for the sole purpose of rendering such anesthesia service. Supervision of a CRNA requires that the supervising anesthesiologist be present in the office suite or operating room area at all times during the procedure The following services are included in the provision of anesthesia when performed on the same date and are not reported separately: • Pre- and postoperative visits • Administration of the anesthetic, fluids and/or blood • Usual monitoring services - Blood pressure - Capnography - ECG - Mass spectrometry - Oximetry - Temperature Intra-arterial, flow directed catheters (Swan-Ganz), and central venous are methods of monitoring that may be separately reported.	**General and CRNA Services** Anesthesia services are listed for each procedure in the Anesthesia section and for certain procedures in other sections. The codes are to be used only when the anesthesia is personally administered by an anesthesiologist or a certified registered nurse anesthetist (CRNA) under the supervision of an anesthesiologist. The anesthesiologist or CRNA must remain in constant attendance during the procedure for the sole purpose of rendering such anesthesia service. The bill for CRNA services must be submitted by the supervising anesthesiologist, using accurate and appropriate codes. The bill for CRNA services should be limited to anesthesia administration that is within their NYS scope of practice. Anesthesia Modifiers QY or QK should be used. Reimbursement will be at 80 percent of the Physician's Fee Schedule. Supervision of a CRNA requires that the supervising anesthesiologist be present in the office suite or operating room area at all times during the procedure. The following services are included in the provision of anesthesia when performed on the same date and are not reported separately: • Pre- and post-operative visits • Administration of the anesthetic, fluids and/or blood • Usual monitoring services – Blood pressure – Capnography – ECG – Mass spectrometry – Oximetry – Temperature Intra-arterial, flow directed catheters (Swan-Ganz), and central venous are methods of monitoring that may be separately reported.	additional billing information for CRNA

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Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	4	**Miscellaneous** A) For diagnostic or therapeutic nerve block see 62320–62327, 64400–64681. B) For cardiopulmonary resuscitation (separate procedure unrelated to the administration of anesthesia) see 92950 C) For obstetrical anesthesia refer to Ground Rule 6: Calculation of Total Anesthesia Values. D) Values for office, home, and hospital visits, consultations and other medical services, x-ray, surgery, and laboratory procedures are listed in the Evaluation and Management, Surgery, Radiology, Pathology and Laboratory, Medicine, and Physical Medicine sections. E) A consultation fee is not payable to an anesthesiologist examining the patient prior to administering anesthesia to that patient. No additional charge is to be made for routine follow-up care and observation. F) Materials and supplies used to administer anesthesia are included in the total anesthesia fee. Separate charges by the anesthesiologist or the hospital for supplies and materials are not allowed.	**Miscellaneous** A. For cardiopulmonary resuscitation (separate procedure unrelated to the administration of anesthesia) see 92950. B. For obstetrical anesthesia refer to Ground Rule 6: Calculation of Total Anesthesia Values. C. Values for office, home, and hospital visits, consultations and other medical services, x-ray, surgery, and laboratory procedures are listed in the Evaluation and Management, Surgery, Radiology, Pathology and Laboratory, Medicine, and Physical Medicine sections. D. A consultation fee is not payable to an anesthesiologist examining the patient prior to administering anesthesia to that patient. No additional charge is to be made for routine follow-up care and observation. E. Materials and supplies used to administer anesthesia are included in the total anesthesia fee. Separate charges by the anesthesiologist or the hospital for supplies and materials are not allowed.	updated references to codes

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	6	**Calculation of Total Anesthesia Value**s The total anesthesia value is calculated by adding the listed basic value and time units. A basic value is listed in the ASA Relative Value Guide® for most procedures. This includes the values of all anesthesia services except the value of the actual time spent administering the anesthesia or in the unusual detention with the patient. The time units are computed by allowing one unit for each 15 minutes, or fraction thereof, of anesthesia time. A fraction of time is defined as one minute. Therefore, 16 minutes constitutes two time units. Anesthesia time begins when the anesthesiologist starts physically to prepare the patient for the induction of anesthesia in the operating room area (or its equivalent) and ends not more than 15 minutes after service in the operating room is concluded and the patient is placed under postoperative supervision. If the anesthesia time extends beyond three hours, 1.0 unit for each 10 minutes, or fraction thereof, is allowed after the first three hours. This does not apply to obstetrical anesthesia for which 15-minute time increments are applicable for the entire duration of the service. Actual time of beginning and duration of anesthesia time may require documentation, such as a copy of the anesthesia record in the hospital file. Fees when applicable are identical for general, spinal, regional, or hypothermia anesthesia. When multiple surgical procedures are performed during the same period of anesthesia, only the greatest basic value of the various surgical procedures will be used. For example, when a bronchoscopy with a basic value of 4.0 units is followed by a thoracostomy with a basic value of 12.0 units during the same period of anesthesia, the basic value to be used is only 12.0 units. To this value are added time units applicable for the entire period of anesthesia time for the multiple procedures performed. The examples below illustrate two calculations: Example	**Calculation of Total Anesthesia Values** The total anesthesia value is calculated by adding the listed basic value and time units. A basic value is listed in the ASA Relative Value Guide® for most procedures. This includes the values of all anesthesia services except the value of the actual time spent administering the anesthesia or in the unusual detention with the patient. The time units are computed by allowing one unit for each 15 minutes, or fraction thereof, of anesthesia time. A fraction of time is defined as one minute. Therefore, 16 minutes constitutes two time units. Anesthesia time begins when the anesthesiologist starts physically to prepare the patient for the induction of anesthesia in the operating room area (or its equivalent) and ends not more than 15 minutes after service in the operating room is concluded and the patient is placed under postoperative supervision. If the anesthesia time extends beyond three hours, 1.0 unit for each 10 minutes, or fraction thereof, is allowed after the first three hours. This does not apply to obstetrical anesthesia for which 15-minute time increments are applicable for the entire duration of the service. Actual time of beginning and duration of anesthesia time may require documentation, such as a copy of the anesthesia record in the hospital file. Fees when applicable are identical for general, spinal, regional, or hypothermia anesthesia. When multiple surgical procedures are performed during the same period of anesthesia, only the greatest basic value of the various surgical procedures will be used. For example, when a bronchoscopy with a basic value of 6.0 units is followed by a thoracostomy with a basic value of 12.0 units during the same period of anesthesia, the basic value to be used is only 12.0 units. To this value are added time units applicable for the entire period of anesthesia time for the multiple procedures performed. The examples below illustrate two calculations: Example In a procedure with a basic value of 3.0 units requiring one hour and forty-five minutes of anesthesia time, the time units total 7.0 and are added to the basic value of 3.0,	consolidated wording

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		In a procedure with a basic value of 3.0 units requiring one hour and forty-five minutes of anesthesia time, the time units total 7.0 and are added to the basic value of 3.0, resulting in a value of 10.0 units for this anesthesia service. Multiply the 10.0 units by the anesthesia conversion factor for your region to calculate the fee expressed in dollars. Example In a procedure with a basic unit value of 25.0 units requiring four hours and twenty minutes of anesthesia time, the total value will be determined as follows: Basic unit value = 25.0 units First three hours (15 minute increments) = 12.0 units Subsequent 80 minutes (10 minute increments) = 8.0 units Total 45.0 units To calculate the fee expressed in dollars, multiply 45.0 units by the anesthesia conversion factor for your region. List basic unit values and time unit values separately; the sum of these values is the total anesthesia value, as per the following format: Step 1: Procedure Number Units + Anesthesia Modifier Units = Basic Value Units Step 2: Basic Value Units + Time Units (Anesthesia Time = Time Units) = Total Units Step 3: Basic Value Units + Time Units x Dollar Conversion Factor = Total Dollar Amount	resulting in a value of 10.0 units for this anesthesia service. Multiply the 10.0 units by the anesthesia conversion factor for your region to calculate the fee expressed in dollars. Example In a procedure with a basic unit value of 25.0 units requiring four hours and twenty minutes of anesthesia time, the total value will be determined as follows: Basic unit value = 25.0 units First three hours (15-minute increments) = 12.0 units Subsequent 80 minutes (10-minute increments) = 8.0 units Total = 45.0 units To calculate the fee expressed in dollars, multiply 45.0 units by the anesthesia conversion factor for your region. List basic unit values and time unit values separately; the sum of these values is the total anesthesia value, as per the following format: Step 1: Procedure Number Units + Anesthesia Modifier Units = Basic Value Units Step 2: Basic Value Units + Time Units (Anesthesia Time / 15 (or 10)) = Total Units Step 3: Total Units x Dollar Conversion Factor = Total Dollar Amount	

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	8	**Modifiers** Bill using the correct anesthesia codes 00100–01999. Add appropriate anesthesia modifiers to the procedure number to indicate that billing is for unusual or complicated circumstances. 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 anesthesia procedures are as follows:	**Modifiers** Bill using the correct anesthesia codes 00100–01999. Add appropriate anesthesia modifiers to the procedure number to indicate that billing is for unusual or complicated circumstances. 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 anesthesia procedures are as follows:	reference to CPT Book appendix in some code's descriptions.
	8	N/A	**Modifier QK** Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals. The supervising anesthesiologist must bill at 80 percent of the physician fee schedule for that code. **Modifier QY** Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist. The supervising anesthesiologist must bill at 80 percent of the physician fee schedule for that code	additional modifiers for billing CRNA services

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Surgery	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 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 Workers' Compensation Board has approved a variance. All other treatments require prior authorization.	updated as in previous sections
	page 50	N/A	Chart with conversion factors for this section	

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	7	**Separate or Independent Procedures** Certain procedures are an inherent portion of a procedure or service, and, as such, do not warrant a separate charge. When such a procedure is carried out as a separate entity not immediately related to other services, the indicated value for a separate procedure is applicable. Therefore, when a procedure that is ordinarily a component of a larger procedure is performed alone for a specific purpose, it may be considered a separate procedure.	**Separate or Independent Procedures** Certain procedures are an inherent portion of a procedure or service, and, as such, do not warrant a separate charge. When such a procedure is carried out as a separate entity not immediately related to other services, the indicated value for a separate procedure is applicable. Therefore, when a procedure that is ordinarily a component of a larger procedure is performed alone for a specific purpose, it may be considered a separate procedure. If a CPT code description includes the term “separate procedure,” the CPT code may not be used with a related procedure in an anatomically related region often through the same skin incision, or surgical approach. See also any currently published WCB policies and/or guidance.	additional code clarifications

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	9	**Operative Reports and Billing** Bills for operative procedures must include an operative report. A bill for an operative procedure shall not be deemed properly submitted unless and until an operative report is received by the payer. If the procedure is performed in a hospital, a copy of the hospital operative report is required. For other sites, the location should be identified and an informative description of the surgery submitted. An operative report shall include but not be limited to a brief but adequate summary of the history, physical findings, operative findings, and an accurate and complete description of the surgical procedures performed.	**Narrative Reports** A detailed narrative report must be submitted with all services provided. Physicians & Nurse Practitioners narrative reports must include the following elements in a highly visible location: Work Status, Casual Relationship & Temporary Impairment Percentage. Physician Assistants must include Work Status & Temporary Impairment Percentages. Providers are strongly encouraged to use the narrative template format found on the WCB webpage CMS-1500 Requirements. Additional narrative information should include the history of the injury/illness, any objective findings based on the clinical evaluation, plan of care and your diagnosis(es)/ assessment of the patient. Time must be documented whenever the CPT code definition is based on time spent with patient, or if necessary to justify a higher or additional code billed. Any ordered medications, durable medical equipment, tests, or procedures should be thoroughly explained. All entries in the medical record must be legible to another reader. The surgeon must submit all codes, including those for any NP/PA, Residents/Fellows, surgical assistants, on the same bill. If multiple pages are submitted for one procedure, the total charge should appear on the last page.	using enhanced language from CMS1500 documentation

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	10	**By Report (BR) Items** "BR" in the relative value column indicates that the value of this service is to be determined "by report" because the service is too unusual or variable to be assigned a relative value. Information concerning the nature, extent and need for the procedure or service, time, skill and equipment necessary, etc., is to be furnished using all of the following: A) Diagnosis (postoperative), pertinent history, and physical findings. B) Size, location, and number of lesions or procedures where appropriate. C) A complete description of the major surgical procedure and the supplementary procedures. D) When possible, list the closest similar procedure by code and relative value unit. The "BR" relative value unit shall be consistent in relativity with other relative value units in the schedule. E) Estimated follow-up period, if not listed. F) Operative time.	**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	old GR 10 and 11 combined into new GR 10

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			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.	

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	11	**Unlisted Services or Procedures** Some services performed are not described by any CPT code. These services should be reported using an unlisted code and substantiating it by report as discussed in Surgery Ground Rule 10. The unlisted procedures and accompanying codes for surgery will be found at the end of the relevant section or subsection.	**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 combined into new GR 10. New GR 11 clarifying billing
	12 B)	**B) Surgical Assistants**: Identify surgery performed by code number, appropriate modifier, and description of procedures. Assistants should bill at 16 percent of the code fee. The codes must coincide with those of the primary surgeon. Assistants' fees are not payable when the hospital provides intern or resident staff to assist at surgery.	**B. Surgical Assistants (Modifier 80):** Identify surgery performed by code number, appropriate modifier, and description of procedures. Assistants should bill at 16 percent of the code fee. The codes must coincide with those of the primary surgeon. Providers must document in their operative report why an assistant is required for the surgery. The operative report should document, with specificity, the activities the assistant surgeon performed. A separate operative note by the assistant surgeon or specific documentation of the assistant's activities within the primary surgeon's operative note is acceptable. Modifier 80 should not be used for Physician Assistant, Nurse Practitioner, Residents, or Fellows Nurse Practitioner services rendered during surgery (see Modifier 83 and 84).	additional billing guidelines

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	12 C)	C) **Two surgeons**: Under certain circumstances the skills of two surgeons (usually with different skills) may be required in the management of a specific surgical problem (e.g., urologist and a general surgeon in the creation of an ileal conduit). By prior agreement, the total value for the procedures may be apportioned by the providers in relation to the responsibility and work done. The total value may be increased by 25 percent in lieu of the assistant's charge. Under these circumstances, the services of each surgeon should be identified using the code number and appropriate modifier.	C. **Two surgeons** (Modifier 62): Under certain circumstances the skills of two surgeons (usually with different skills) may be required in the management of a specific surgical problem (e.g., urologist and a general surgeon in the creation of an ileal conduit). By prior agreement/contract, the total value for the procedures may be apportioned by the providers in relation to the responsibility and work done. The total value may be increased by 25 percent in lieu of the assistant's charge. Under these circumstances, the services of each surgeon should be identified using the code number and appropriate modifier.	additional billing guidelines
	12 D)	**D) Co-surgeons**: Under certain circumstances, two surgeons (usually with similar skills) may function simultaneously as primary surgeons performing distinct parts of a total surgical service (e.g., two surgeons simultaneously applying skin grafts to different parts of the body or two surgeons repairing different fractures in the same patient). By prior agreement, the total value may be apportioned by the providers in relation to the responsibility and work done. The total value for the procedures shall not, however, be increased but shall be prorated between the co-surgeons. Under these circumstances, the services of each surgeon should be identified using the code number and appropriate modifier. In the event of no agreement between co-surgeons, the proration shall be determined by a WCB Medical Arbitration Committee.	**Co-surgeons**: Under certain circumstances, two surgeons (usually with similar skills) may function simultaneously as primary surgeons performing distinct parts of a total surgical service (e.g., two surgeons simultaneously applying skin grafts to different parts of the body or two surgeons repairing different fractures in the same patient). By prior agreement, the total value may be apportioned by the providers in relation to the responsibility and work done. The total value for the procedures shall not, however, be increased but shall be prorated between the co-surgeons. Under these circumstances, the services of each surgeon should be identified using the code number and appropriate modifier.	clarifying billing guidelines-deleted reference to arbitration committee

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	12 E)	**Surgical Team**: Under some circumstances highly complex procedures (e.g., open heart or organ transplant surgery) requiring the concomitant services of several providers, often of different specialties, plus other highly skilled, specially trained personnel, and various types of complex equipment are carried out under the "surgical team" concept with a single fee charged for the total service. The services covered vary widely and a single value cannot be assigned. These situations should be identified by the code and appropriate modifier. The value should be supported by a report to include itemization of the provider services, paramedical personnel, and equipment involved.	E. **Surgical Team (Modifier 66)**: Under some circumstances highly complex procedures (e.g., open heart or organ transplant surgery) requiring the concomitant services of several providers, often of different specialties, plus other highly skilled, specially trained personnel, and various types of complex equipment are carried out under the "surgical team" concept with a single fee charged for the total service. The services covered vary widely and a single value cannot be assigned. These situations should be identified by the code and appropriate modifier. The value should be supported by a report to include itemization of the provider services, paramedical personnel, and equipment involved.	clarifying billing guidelines
	12 F	**F) Physician Assistants and Nurse Practitioners**: Services of physician assistants and nurse practitioners assisting during surgical procedures will be paid at two-thirds of the surgical assistant percentage (16.0 percent). Physician assistants will receive 10.7 percent of the total allowance for the surgical procedures. Payment will be made to the supervising physician performing the surgery. General Ground Rule 11 is not applicable to surgical assistants. The bill must be submitted by the supervising physician who performed the surgery where such assistance was rendered.	**Services of Physician Assistants (PA) and Nurse Practitioners (NP) assisting during surgical procedures (Modifier 83)**: The operating physician should bill at 10.7 percent of the total physician fee schedule allowance for the surgical procedures performed by the NP/PA. Identify the services by adding modifier 83 to the specific procedure codes done by the NP/PA. Payment will be made to the supervising physician performing the surgery. This modifier is valid for surgery only. NPs and PAs cannot bill for surgery independently. Modifier 83 is not used for NP/PA independently billing non-surgical services	clarifying billing guidelines for NP/PA
	12 G	N/A	Radiology codes billed during procedures/surgery: The same Radiology code should not be used by two providers during the same procedure. Codes billed with modifier 26 for the PC split, cannot be billed by two providers during the same procedure.	billing and reimbursement clarification

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	12 H	N/A	H. **Residents and Fellows assisting during surgical procedures:** Surgery codes with modifier 84 must only be billed by the Board authorized supervising physician and will be reimbursed at 16 percent of the applicable physician code fee. See Ground Rule for Residents and Fellows and Modifier descriptions for further details.	new section for residents and fellows

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	16	**Materials Supplied by Provider:** Pharmaceuticals and Durable Medical Equipment **A) Pharmacy** A prescriber cannot dispense more than a seventy-two-hour supply of drugs with the exceptions of 1. Persons practicing in hospitals as defined in section 2801 of the public health law; 2. The dispensing of drugs at no charge to their patients; 3. Persons whose practices are situated ten miles or more from a registered pharmacy; 4. The dispensing of drugs in a clinic, infirmary, or health service that is operated by or affiliated with a post-secondary institution; 5. The dispensing of drugs in a medical emergency as defined in subdivision 6 of section 6810 of the State Education Law. For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070. **B) Durable Medical Equipment** 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	**Materials Supplied by Provider: Pharmaceuticals and Durable Medical Equipment** **A) Pharmacy** A prescriber cannot dispense more than a seventy-two hour supply of drugs with the exceptions of: 1. Persons practicing in hospitals as defined in section 2801 of the public health law; 2. The dispensing of drugs at no charge to their patients; 3. Persons whose practices are situated ten miles or more from a registered pharmacy; 4. The dispensing of drugs in a clinic, infirmary, or health service that is operated by or affiliated with a post-secondary institution; 5. The dispensing of drugs in a medical emergency as defined in subdivision 6 of section 6810 of the State Education Law. For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070. Identify the product being given with the NDC number and amount of product being used Except in emergencies, any medications must follow all WCB Formulary and applicable Medical Treatment Guidelines. Any variations require Prior Authorization (PAR). **B) Durable Medical Equipment** All durable medical equipment (DME) supplies shall be billed and paid using the WCB Durable Medical Equipment Fee Schedule. The WCB DME Fee Schedule is available on the Board's website. Any item identified as requiring prior authorization in the DME Fee Schedule or not listed in the DME Fee Schedule may not be billed without such prior authorization. Medical necessity should be documented for all prescribed DME. Prescription or order form must be completed by	updated language for formulary reference and DME fee schedule

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		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.	the provider and accurately describe the item needed. Appropriate HCPCS codes should be billed for items. All miscellaneous/unlisted codes, or codes without a listed price require prior authorization (PAR) and manufacturer's invoice. Also see Surgery Ground Rule 19 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.	

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	20	**Modifiers** Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Modifiers commonly used with surgical 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 surgical procedures are as follows:	reference to CPT Book appendix in some code's descriptions.
	20	N/A	**1R∞ Non-surgical services provided by residents and fellows** Billed and payable at the same applicable rate as the WCB authorized, supervising physician. 1R can be used for E/M codes, such as office visits, as well as for standalone procedures not performed during a surgery i.e., injections. This modifier is not used for assistance at surgery. See modifier 84.	new modifier for residents and fellows
	20	**83 Physician Assistant or Nurse Practitioner as Assistant Surgeon** When a physician assistant or nurse practitioner performs services for assistants at surgery, identify the services by adding modifier 83 to the usual procedure code. Services of a physician assistant or nurse practitioner are reimbursed at 10.7 percent of the listed value of the surgical code and payable to the employing physician. This modifier is valid for surgery only. Please refer to Ground Rule 12 (F) and Surgery Ground Rule 12 for additional reimbursement guidelines.	**83∞ Services of Physician Assistants (PA) and Nurse Practitioners (NP) assisting during surgical procedures:** The operating physician must bill at 10.7 percent of the total physician fee schedule allowance for the surgical procedures performed by the NP/PA. Identify the services by adding modifier 83 to the specific procedure codes done by the NP/PA. Payment will be made to the supervising physician performing the surgery. This modifier is valid for surgery only. NPs and PAs cannot bill for surgery independently.	clarification of billing for NP/PA

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	20	N/A	**84∞ Assistance at surgery provided by residents and fellows** This modifier should be appended to the individual codes representing work actually performed by the resident/fellow while assisting the WCB authorized, supervising physician. This modifier should not be used for E/M codes or for procedures not performed during a surgery i.e., injections. See modifier 1R.	new modifier for residents and fellows
	20	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 telemedicine

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	20	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 telemedicine
	20	**63 Procedure Performed on Infants less than 4 kg** Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure number. Note: Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20005–69990 code series. Modifier 63 should not be appended to any CPT codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections.	N/A	deleted -infants not covered

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	21	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 CMS1500 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 our webpage.	electronic billing reimbursement

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	22	N/A	**22. Billing for Residents and Fellows** Treatment rendered by residents and fellows can only be billed by the Board authorized supervising physician. Non-surgical service codes should be appended with modifier 1R. Services with modifier 1R must be billed and reimbursed at the same amount payable to the authorized supervising physician. Assistant at surgery codes should be appended with modifier 84. Surgery codes with modifier 84 must be billed and reimbursed at 16 percent of the applicable physician code fee. All Fee Schedule Ground Rules for multiple procedures apply. Also see WCB webpage and any current bulletins for additional guidance. A. Physicians cannot additionally bill for supervision of the resident. B. If the supervising surgeon bills for a resident/fellow assisting at surgery, only one additional assistant (NP/PA-modifier 83) may be billed, and only if documentation supports the necessity of the additional assistance. C. When applicable, modifier 84 should be appended to the individual codes of the surgery. D. All codes billed should accurately reflect work performed by the resident/fellow. Documentation in the operative/procedure report shall include all details. Payment may be decided based on review of documentation, as well as the usual and customary standards of CPT/CMS billing guidelines for allowance of assistants at surgery. E. Non-authorized out-of-state physicians may not bill for residents/fellows. F. Surgeons should not bill for services performed by a resident/fellow that would not normally be billed by another type of assistant at surgery. Payment shall not be made for observation, or for simple assistance such as closing basic surgical fields or work typically performed by nursing/technical staff. G. The name of the resident/fellow does not need to be documented on the CMS1500 form. H. All CMS1500 Narrative requirements do apply to any bills submitted. https://www.wcb.ny.gov/CMS-1500/	new GR for residents and fellows

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Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
Radiology	page 292	N/A	Chart with conversion factors for this section	
	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 applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the Fee Schedule Ground Rules and the Medical Treatment Guidelines, the guidelines will prevail. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.	updated as in previous sections

NYS Official Workers' Compensation Medical Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	6	**Specific Billing Instructions** **A) Professional Component** The professional component represents the relative value unit of the professional radiological services of the provider. This includes examination of the patient, when indicated, interpretation and written report of the examination, and consultation with the referring provider. (Report using modifier 26.)	**Specific Billing Instructions** **A) Professional Component** The professional component represents the relative value unit of the professional radiological services of the provider. This includes examination of the patient, when indicated, interpretation and written report of the examination, and consultation with the referring provider. (Report using modifier 26.) The same radiology code should not be used by two providers during the same procedure. Codes billed with modifier 26 for the PC split, cannot be billed by two providers during the same procedure. **C) Review of Diagnostic Studies** When prior studies are reviewed in conjunction with a visit, consultation, record review, or other evaluation, no separate charge is warranted for the review by the medical practitioner or other medical personnel. Neither the professional component (modifier 26) nor technical component are reimbursable under this circumstance. The review of diagnostic tests is included in the evaluation and management codes.	additional billing guidelines

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Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	9	**9.Materials Supplied by Provider:** **Pharmacy:** A prescriber cannot dispense more than a seventy-two-hour supply of drugs with the exceptions of: 1. Persons practicing in hospitals as defined in section 2801 of the public health law; 2. The dispensing of drugs at no charge to their patients; 3. Persons whose practices are situated ten miles or more from a registered pharmacy; 4. The dispensing of drugs in a clinic, infirmary, or health service that is operated by or affiliated with a post-secondary institution; 5. The dispensing of drugs in a medical emergency as defined in subdivision 6 of section 6810 of the State Education Law. For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070. Identify the product being given with the NDC number and amount of product being used. Except in emergencies, any medications must follow all WCB Formulary and applicable Medical Treatment Guidelines. Any variations require or Prior Authorization (PAR).	**Materials Supplied by Provider:** **Pharmacy:** A prescriber cannot dispense more than a seventy-two hour supply of drugs with the exceptions of: 1. Persons practicing in hospitals as defined in section 2801 of the public health law; 2. The dispensing of drugs at no charge to their patients; 3. Persons whose practices are situated ten miles or more from a registered pharmacy; 4. The dispensing of drugs in a clinic, infirmary, or health service that is operated by or affiliated with a post-secondary institution; 5. The dispensing of drugs in a medical emergency as defined in subdivision 6 of section 6810 of the State Education Law. For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070. Identify the product being given with the NDC number and amount of product being used. Except in emergencies, any medications must follow all WCB Formulary and applicable Medical Treatment Guidelines. Any variations require or Prior Authorization (PAR).	

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	14	N/A	**14. 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	added here for consistency with other sections

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
			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.	

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Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
Pathology and Laboratory	page 324	N/A	Chart with conversion factors for this section	
	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 applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the Fee Schedule Ground Rules and the Medical Treatment Guidelines, the guidelines will prevail. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.	updated as in previous sections

NYS Official Workers' Compensation Medical Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	2	**Materials Supplied by Provider** **Pharmacy** A prescriber cannot dispense more than a seventy-two hour supply of drugs with the exceptions of: 1. Persons practicing in hospitals as defined in section 2801 of the public health law; 2. The dispensing of drugs at no charge to their patients; 3. Persons whose practices are situated ten miles or more from a registered pharmacy; 4. The dispensing of drugs in a clinic, infirmary, or health service that is operated by or affiliated with a post-secondary institution; 5. The dispensing of drugs in a medical emergency as defined in subdivision 6 of section 6810 of the State Education Law. For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070.	**Materials Supplied by Provider** **Pharmacy** A prescriber cannot dispense more than a seventy-two hour supply of drugs with the exceptions of: 1. Persons practicing in hospitals as defined in section 2801 of the public health law; 2. The dispensing of drugs at no charge to their patients; 3. Persons whose practices are situated ten miles or more from a registered pharmacy; 4. The dispensing of drugs in a clinic, infirmary, or health service that is operated by or affiliated with a post-secondary institution; 5. The dispensing of drugs in a medical emergency as defined in subdivision 6 of section 6810 of the State Education Law. For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070. Except in emergencies, any medications must follow all WCB Formulary and applicable Medical Treatment Guidelines. Any variations require or prior authorization (PAR)	updated reference to formulary

NYS Official Workers' Compensation Medical Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	4	**Reports** No bill for services or procedures included in this section shall be considered properly rendered unless it is accompanied by a report that includes the findings and the interpretation of such findings. Where the service or procedure results in producing an image or graph, such shall be submitted together with the bill.	**Narrative Reports** A detailed narrative report must be submitted with all services provided. Physicians & Nurse Practitioners narrative reports must include the following elements in a highly visible location: Work Status, Casual Relationship & Temporary Impairment Percentage. Physician Assistants must include Work Status & Temporary Impairment Percentages. 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.	updated information form CMS1500 documentation

NYS Official Workers' Compensation Medical Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	5	**By Report "BR"** "BR" in the Relative Value column indicates that the relative value unit of this service is to be determined "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. See the Ground Rules in the Introduction and General Guidelines section for a complete explanation of "by report" procedures.	**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	old GR 5 and 7 combined into new GR 5

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
			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.	

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	7	**Unlisted Service or Procedure** Specify the service by the last code number in the appropriate subdivision. Identify by name or description and submit report (see Pathology and Laboratory Ground Rule 5).	7. **Treatment by Out-of-State Providers** Labwork that is billed by out-of-state laboratories shall fall under WCB regulations for out-of-state treatment. A. Claimant lives outside of New York State and treats outside of NYS: A claimant who lives outside of New York State may treat with a qualified out-of-state medical provider/ laboratory. 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/labwork shall be at the Fee Schedule amount for work related injuries and illnesses as available in the state where treatment is rendered/labwork was drawn, 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. B. Claimant lives in New York State but treats outside of New York State: Labwork billed by out-of-state agency for claimant that lives in NY and/or for ordering provider office that is located in NY: A claimant who lives in New York State may treat with a qualified or Board authorized out-of-state medical provider when such treatment must conform to the Workers' Compensation Law and regulations, the Medical Treatment Guidelines and the Medical Fee Schedule. This includes obtaining any required Prior Authorization (PAR). Payment shall be made to the medical provider/ laboratory as set forth herein and using the regional conversion factor for the NY ZIP code where the claimant resides. Out-of-state medical treatment that does not "further	Old GR 5 and & combined into new GR 5. New GR 7 becomes Out of State instructions, added to this section for consistency with other sections

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
			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. Providers should only use codes listed in the Fee Schedule.	

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Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	8	**Organ or Disease-Oriented Panels** Organ or disease-oriented panels (80047–80076), are used to confirm specific diagnoses. These panels are problem-oriented in scope. Each panel contains a list of the tests that must be included in order to use that particular code number. This is not meant to limit the number of tests performed or ordered if medically appropriate. Other tests performed that are not part of the panel may be separately reported. It is also inappropriate to separately report the components of a panel test if the full set of identified tests was performed. Clinical information derived from results of laboratory data that are mathematically calculated is considered part of the test procedure and not separately coded. Please refer to CPT guidelines for a complete explanation of codes included in each panel.	**Organ or Disease-Oriented Panels** The AMA assigns CPT codes to organ or disease oriented panels consisting of groups of specified tests. If all tests of a CPT defined panel are performed, the provider/supplier shall bill the panel code. The panel codes shall be used when the tests are ordered as that panel. For example, if the individually ordered tests are cholesterol (82465), triglycerides (84478), and HDL cholesterol (83718), the service should be reported as a lipid panel (80061).	updated wording

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	12	**Drug Screening** Drug screening may be required as part of the non-acute pain management treatment protocol. Drug Testing—Urine Drug Testing (UDT) (or the testing of blood or any other body fluid) is a mandatory component of chronic opioid management, as part of the baseline assessment and ongoing re-assessment of opioid therapy. Baseline drug testing should be obtained on all transferring patients who are already using opioids or when a patient is being considered for ongoing opioid therapy. The table below offers guidance as to frequency of regular, random drug testing. Random drug screening (urine or other method) should be performed at the point of care using a quick or rapid screening test method utilizing a stick/dip stick, cup or similar device. Reimbursement will be limited to 1 unit of 80305, 80306, or 80307. In addition, the provider may bill the appropriate evaluation and management code commensurate with the services rendered. Drug Testing (urine or any other body fluid) by a laboratory—Drug testing performed by a laboratory (whether the lab is located at the point of care or not) should not be a regular part of the non-acute pain management treatment protocol, but rather shall be used as confirmatory testing upon receipt of unexpected or unexplained UDT results (Red Flags). Red Flags include: • Negative for opioid(s) prescribed • Positive for amphetamine or methamphetamine • Positive for cocaine or metabolites • Positive for drug not prescribed (benzodiazepines, opioids, etc.) • Positive for alcohol Upon documentation of the Red Flag, the provider shall direct confirmatory testing using GCL, GC/MS or LC/MS. Such tests shall be billed using 1 unit of 80375 for 1–3 drugs; 1 unit of 80376 for 4–6 drugs; or 1 unit of 80377 for 7 or more drugs.	**Drug Screening** Drug screening may be required for long term pain management. The clinical recommendations provided in the most recently adopted version of any applicable Medical Treatment Guideline shall take precedence over any guidance in any of the Fee Schedule Ground Rules. Drug Testing—Urine Drug Testing (UDT) (or the testing of blood or any other body fluid) is a mandatory component of chronic opioid management, as part of the baseline assessment and ongoing re-assessment of opioid therapy. Baseline drug testing should be obtained on all transferring patients who are already using opioids or when a patient is being considered for ongoing opioid therapy. The table below offers guidance as to frequency of regular, random drug testing. Individual CPT codes for substances should not be billed when 80305, 80306, 80307 can be used. If an individual drug test must be used, documentation should explain medical necessity of using a specific individual CPT code. See Ground Rule 8. Confidentiality and Reporting UDT Results (from Medical Treatment Guidelines): • UDT results are not to be released to the carrier, employer or the Board. However, the treating physician must certify the patient's adherence to or noncompliance with the Patient Understanding for Opioid Treatment Form in the medical record. • Noncompliance would include (but not necessarily be limited to) evidence that patient is taking any non-prescribed drug(s) or not taking those drugs prescribed as part of treatment. • Noncompliance can also be a refusal to undergo UDT, as noted above. • Please also see any applicable Medical Treatment Guidelines • Nothing in this paragraph shall preclude the Board from requesting, nor absolve a provider from the responsibility to provide the result of UDT when such request is part of a confidential request for information as part of an investigation of provider practices or related Board Quality Assurance activities—which are	updated wording and confidentiality guidelines

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
			not part of the patient's case file. Risk Category (Score) Random Drug Frequency Low Risk Periodic (At least once/year) Moderate Risk Regular (At least 2/year) High Risk Frequent (At least 3-4/year) Aberrant Behavior At time of visit Random drug screening (urine or other method) should be performed at the point of care using a quick or rapid screening test method utilizing a stick/dip stick, cup or similar device. Reimbursement will be limited to 1 unit of 80305, 80306, or 80307. In addition, the provider may bill the appropriate evaluation and management code commensurate with the services rendered. Drug Testing (urine or any other body fluid) by a laboratory—Drug testing performed by a laboratory (whether the lab is located at the point of care or not) should not be a regular part of the non-acute pain management treatment protocol, but rather shall be used as confirmatory testing upon receipt of unexpected or unexplained UDT results (Red Flags). Red Flags include: • Negative for opioid(s) prescribed • Positive for amphetamine or methamphetamine • Positive for cocaine or metabolites • Positive for drug not prescribed (benzodiazepines, opioids, etc.) • Positive for alcohol Upon documentation of the Red Flag, the provider shall direct confirmatory testing using GCL, GC/MS or LC/MS. Such tests shall be billed using 1 unit of 80375 for 1–3 drugs; 1 unit of 80376 for 4–6 drugs; or 1 unit of 80377 for 7 or more drugs.	
Medicine	page 394	chart inserted	Chart with conversion factors for this section	

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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 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.	

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Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	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, reimbursement is limited to the highest single relative value unit.	**Biofeedback** When more than one treatment is performed on the same day, reimbursement is limited to the highest single relative value unit.	extraneous information deleted

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	2	**Ophthalmology** Intermediate and comprehensive ophthalmological services: These are integrated services in which medical diagnostic evaluation cannot be separated from the examining techniques used. Itemization of service components (e.g., slit lamp examination, keratometry, ophthalmoscopy, retinoscopy, tonometry, and motor evaluation) is not applicable. Intermediate ophthalmological services: This term describes a level of service pertaining to the evaluation of a new diagnosis or a previous diagnosis with the addition of a new complicating diagnosis. Services include history, general medical observation, external ocular and adnexal examination, and other diagnostic procedures. Example A) Review of history, external examination, ophthalmoscopy, biomicroscopy for an acute complicated condition (e.g., iritis) not requiring comprehensive ophthalmological services B) Review of interval history, external examination, ophthalmoscopy, biomicroscopy, and tonometry in established patient with known cataract not requiring comprehensive ophthalmological services. Comprehensive ophthalmological services: This term describes a level of service in which the complete examination of the visual system is made. Services include history, general medical observation, external and ophthalmoscopic examination, gross visual field, and basic sensorimotor examination. Example A) The comprehensive services required for diagnosis and treatment of a patient with symptoms indicating possible disease of the visual system, such as glaucoma, cataract or retinal disease, or to rule out disease of the visual system, new or established patient. B) Ophthalmology services include the ordering and scheduling of treatment including medication,	**Ophthalmology** These are integrated services in which medical diagnostic evaluation cannot be separated from the examining techniques used. Itemization of service components (e.g., slit lamp examination, keratometry, ophthalmoscopy, retinoscopy, tonometry, and motor evaluation) is not applicable. Please see any applicable content in the WCB Medical Treatment Guideline for Eye Disorders.	deleted outdated information

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
		lenses, and other therapy or diagnostic procedures as may be indicated. Prescription of lenses may be deferred to a subsequent visit which is reported separately and billed as a separate item. Separate billing is based on medical necessity and documentation which will pertain to the final submitted attending ophthalmologist's report, and billable only once per injury. ("Prescription of lenses" does not include anatomical facial measurements or writing of laboratory specifications for spectacles. For Spectacle Services, see 92340 and subsequent codes.) Special ophthalmological services: This term describes services in which a special evaluation of a visual system, performed to a greater level than considered part of a general service, are given. Included in this service is the special report when indicated. Example A) Fluorescein angioscopy, quantitative visual field examination, or extended color vision examination (e.g., Nagel's anomaloscope) should be specifically reported as special ophthalmological services. B) Medical diagnostic evaluation by the provider is an integral part of all ophthalmological services. Technical procedures (which may or may not be performed by the provider personally) are often part of the service, but should not be mistaken to constitute the service itself.		

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Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	3	**Optometrists** Services provided by an optometrist should be billed in accordance with CPT codes and are subject to the Official New York State Workers' Compensation Medical Fee Schedule. Services must be billed utilizing the CMS-1500 form or 837p electronic format and supported by a narrative report. These services are only covered for compensable work-related injuries.	**Optometrists** Services provided by an optometrist should be billed in accordance with CPT codes and are subject to the Official New York State Workers' Compensation Medical Fee Schedule. Services must be billed utilizing the CMS1500 form and supported by a narrative report. These services are only covered for compensable work-related injuries. Please see any applicable content in the WCB Medical Treatment Guideline for Eye Disorders: see the most currently published information on the CMS1500 section on the NYS WCB webpage: https://www.wcb.ny.gov/CMS-1500/	updated CMS1500 reference

NYS Official Workers' Compensation Medical Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	6	**Osteopathic Manipulative Treatment** This form of manual treatment, performed by a provider with special training, is used to treat somatic dysfunction and related disorders. Usually provided by osteopathic providers, it may be performed by a provider with OMT training. Codes are selected according to the number of body regions treated and are reported per treatment day. Please refer to procedure codes 98925–98929. Other services may be reported in addition to osteopathic manipulation codes if, and only if, the service exceeds that associated with the osteopathic manipulative treatment. Body regions are referred to in CPT 2018 as: • Head region • Cervical region • Thoracic region • Lumbar region • Sacral region • Pelvic region • Lower extremities • Upper extremities • Rib cage region • Abdomen and viscera region	**Osteopathic Manipulative Treatment** This form of manual treatment, performed by a licensed osteopathic physician (DO), is used to treat somatic dysfunction and related disorders. Codes are selected according to the number of body regions treated and are reported per treatment day. Other services may be reported in addition to osteopathic manipulation codes if, and only if, the service exceeds that associated with the osteopathic manipulative treatment.	consolidated information
	8	**Use of Code 97127 and 97533** Please see Ground Rule 7 of the Behavioral Health Fee Schedule for guidelines related to the use of code 97127 and 97533.	**Cognitive Function Therapeutic Interventions** Reimbursement for CPT codes 97129 and 97130 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. Also see Ground Rule 16: Psychological, Behavioral, and Neuro-cognitive Testing.	code changes and content of GR added here so provider does not need to look in a different FS

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Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	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 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:	reference to CPT Book appendix in some code's descriptions.

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Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	9	**1B Behavioral Health Provider Enhanced Reimbursement** Provides a 20 percent reimbursement increase for E/M and Medicine services when rendered by 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 the Behavioral Health Provider Enhanced Rating Codes.	updated 1B information. Rating chart in appendix
	9	N/A	**1R∞ Non-surgical services provided by residents and fellows.** Billed and payable at the same applicable rate as the WCB authorized, supervising physician. 1R can be used for E/M codes, such as office visits, as well as for standalone procedures not performed during a surgery i.e., injections. This modifier is not used for assistance at surgery. See modifier 84.	new modifier for residents and fellows

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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 telemedicine modifiers
	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 telemedicine modifiers

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	10	**Behavioral Health Provider Enhanced Reimbursement** In an effort to increase the number of Board authorized providers in the 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 services when rendered by 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 the behavioral health to render care and treatment to injured workers, the WCB has established WCB specific modifier 1B. Reimbursement increase for E/M and Medicine services including psychotherapy visit codes but excluding diagnostic testing codes, procedural codes, and E/M visit codes 99202-99205, and 99211-99215 when 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. Appropriately certified Physician Assistant with eligible Supervising Physician • 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 the Behavioral Health Provider Enhanced Rating Codes.	updated GR for 1B Behavioral Health enhancement-chart moved to appendix

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Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	11	**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 addition to 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

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	12	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. Non Behavioral Health Physicians, Nurse Practitioners, Physician Assistants, and Podiatrists may only bill: • E/M code 99212 2. Behavioral Health Psychiatrists, Psych PAs, Psych NPs may bill: • E/M codes 99202-99204, 99212 • Psychotherapy/Combination/crisis codes: 90832-90834, 90836-90840 • Group therapy: 90853 3. See the Behavioral Health Fee Schedule for Psychologist and LCSW telehealth billing guidelines. 4. 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 5. 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 GR for telemedicine

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Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	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 CMS1500 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 clearinghouse billing

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Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	14	N/A	**Narrative Reports** A detailed narrative report must be submitted with all services provided. Physicians & Nurse Practitioners narrative reports must include the following elements in a highly visible location: Work Status, Casual Relationship & Temporary Impairment Percentage. Physician Assistants must include Work Status & Temporary Impairment Percentages. 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 information for CMS1500 documentation

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Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	15	N/A	**Category III Codes:** Category III codes are temporary codes identifying emerging technology and should be reported when available. The use of these codes supersedes reporting the service with an unlisted code. Because these codes are temporary, some of them may only be covered on a case-by-case review, and all require prior authorization. The temporary codes may be converted to permanent CPT codes or deleted during periodic updates of the code set. The Category III codes will utilize the Medicine conversion factor. Any currently published WCB Bulletins may supersede this Ground Rule if necessary. For a complete explanation of this process refer to the guidelines in CPT 2024.	New GR for Cat III billing
	15 A	N/A	**Extracorporeal Shockwave Therapy** Please see all applicable Medical Treatment Guidelines (MTG). Extracorporeal Shockwave Therapy is only rarely, if ever, recommended in the MTGs. Therefore, use of extracorporeal shockwave therapy will generally require prior authorization. The Category III codes for shockwave treatments will utilize the Medicine Conversion factor. Any currently published WCB Bulletins may supersede this Ground Rule if necessary.	New GR for shockwave tx

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Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	16	N/A	**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.	Consolidated GR for testing. Content of GR added here so provider does not need to look in a different FS

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Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	17	N/A	**Billing for Residents and Fellows:** Treatment rendered by residents and fellows can only be billed by the Board authorized supervising physician. Non-surgical service codes should be appended with modifier 1R. Services with modifier 1R must be billed and reimbursed at the same amount payable to the authorized supervising physician. A. Physicians cannot additionally bill for supervision of the resident. B. All codes billed should accurately reflect work performed by the resident/fellow. C. Documentation in the operative/procedure report should include all details. Payment may be decided based on review of documentation, as well as the usual and customary standards of CPT/CMS billing guidelines for allowance of assistants at surgery. D. Non-authorized out-of-state physicians may not bill for residents/fellows. E. Physicians should not bill for services performed by a resident/fellow that would not normally be billed by another type of assistant at surgery. Payment shall not be made for observation, or for simple assistance, work typically performed by nursing/technical staff. F. The name of the resident/fellow does not need to be documented on the CMS1500 form. G. All CMS1500 Narrative requirements do apply to any bills submitted. https://www.wcb.ny.gov/CMS-1500/	New GR for residents and fellows

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Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	18	N/A	**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.	GR from BH FS -Content added here so providers do not need to look in a different FS

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	19	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	GR added here for consistency from other sections

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
			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.	
Physical Medicine	page 452	N/A	Chart with conversion factors for this section	

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Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	page 452	The relative value units in this section were determined uniquely for physical medicine services. Use the physical medicine conversion factor when determining fee amounts. The physical medicine conversion factor is not applicable to any other section.	The relative value units in this section were determined uniquely for physical medicine services. Use the physical medicine conversion factor when determining fee amounts. The physical medicine conversion factor is not applicable to any other section. Physical and Occupational Therapists may not bill from this section of the fee schedule. Please see the separate fee schedule for Physical and Occupational Therapy.	billing reminder
	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** Treatment of work-related injuries should be in accordance with any applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the Fee Schedule Ground Rules and the Medical Treatment Guidelines, the guidelines will prevail. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.	updated as in previous sections

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Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	3	**Physical Medicine and Rehabilitation Program** If the provider deems that the patient's condition warrants a physical medicine and rehabilitation program and the referral is made during the follow-up period, no preauthorization from the insurance carrier is required for the referral.	**Physical Medicine and Rehabilitation Program** If the provider deems that the patient's condition warrants a physical medicine and rehabilitation program and the referral is made during the post operative follow-up period, such treatment must be consistent with the Medical Treatment Guidelines or be subject to prior authorization.	reference to MTGs
	6	**Report Requirements** Authorized physical and occupational therapists shall submit reports of treatment in the electronic format prescribed by the Chair.	**Narrative Reports** A detailed narrative report must be submitted with all services provided. Physicians & Nurse Practitioners narrative reports must include the following elements in a highly visible location: Work Status, Casual Relationship & Temporary Impairment Percentage. Physician Assistants must include Work Status & Temporary Impairment Percentages. 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.	updated guidelines for documentation

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Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	7	**Postoperative Procedures by a Physical Therapist or Occupational Therapist** Physical or occupational therapists that render therapy during the follow-up period for fractures, dislocations, or other postoperative procedures shall be reimbursed for therapy during and after the follow-up period in accordance with the Acupuncture and Physical and Occupational Therapy Fee Schedules.	**Post-operative Procedures by a Physical Therapist or Occupational Therapist** Physical or occupational therapists that render therapy during the follow-up period for fractures, dislocations, or other post-operative procedures shall be reimbursed for therapy during and after the follow-up period in accordance with any applicable Medical Treatment Guidelines and the Physical and Occupational Therapy Fee Schedules.	reference to MTGs
	9	**Employed Physical Therapists and Occupational Therapists** Physical therapists and occupational therapists employed by physicians must bill separately from the physician-employer using the Acupuncture and Physical and Occupational Therapy Fee Schedules.	**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, with limited exceptions for out-of-state providers. All Physical and Occupational Therapists, whether self-employed or part of a physician practice, must bill using the NYS WCB Physical and Occupational Therapy Fee Schedule and submit their own medical reports and bill independently in their own name, not through a supervising physician. 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 • Physicians may not bill for (incident to) physical/ occupational therapists that are performing the patient's therapy.	updated information per Expanded provider Law

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Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	10	**Hospital-based EMG** When electro-diagnostic testing is performed in a hospital setting using hospital-owned equipment and hospital-employed technicians, the hospital may bill for the technical portion of the service.	**Hospital-based EMG** When electro-diagnostic testing is performed in a hospital setting using hospital-owned equipment and hospital employed technicians, the hospital may bill for the technical portion of the service, provided that the studies are conducted according to the requirements set forth in the Medical Treatment Guidelines.	reference to MTGs
	11	**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 accident or illness or the amount billed, whichever is less. Note: When a patient receives physical medicine procedures and/or 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 97016 97018 97022 97024 97026 97028 97032 97033 97034 97035 97036 97039 97110 97112 97113 97116 97124 97139 97140 97150 97530 97535 97537 97542 97760 97761 97763	**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 and/or modalities from more than one provider, the patient may not receive more than 12.0 RVUs per day per WCB case number from all providers combined. The following codes represent the physical medicine procedures and modalities subject to this rule: 97010 97012 97014 97016 97018 97022 97024 97026 97028 97032 97033 97034 97035 97036 97039 97110 97112 97113 97116 97124 97139 97140 97150 97530 97535 97537 97542 97760 97761 97763	clarifying per patient per WCB case number

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Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	15	**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 physical 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 physical medicine procedures are as follows:	reference to CPT Book appendix in some code's descriptions.

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Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	16	**Supplies and Materials: Durable Medical Equipment** 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.	**Supplies and Materials: Durable Medical Equipment** All durable medical equipment (DME) supplied s shall be billed and paid using the current published WCB Durable Medical Equipment Fee Schedule. The WCB Durable Medical Equipment Fee Schedule is/will be available on the Board's website. Any item identified as requiring prior authorization in the WCB Durable Medical Equipment Fee Schedule or not listed in the WCB Durable Medical Equipment Fee Schedule, may not be billed without such prior authorization. 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.	updated mention of MTGs and PARs

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	17	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 Repor**t (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	as in other sections

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
			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.	

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
Category III Codes	page 464	**Category III codes** are temporary codes identifying emerging technology and should be reported when available. The use of these codes supersedes reporting the service with an unlisted code. Category III codes are released semiannually by the AMA. Because these codes are temporary, some of them may only be covered on a case-by-case review. The temporary codes may be converted to permanent CPT codes or deleted during a semiannual update of the code set. For a complete explanation of this process refer to the guidelines in CPT 2018. Because Category III codes represent new and emerging technology, a limited number of these codes have been assigned relative value units. Codes without an assigned relative value are by report (BR) procedures. See Ground Rule 10 in the Surgery section for the complete rule related to BR procedures. CONVERSION FACTORS The following codes are subject to the conversion factor from the section listed. Surgery 0054T 0055T 0075T 0076T 0100T 0101T 0102T 0163T 0164T 0165T 0184T 0190T 0191T 0200T 0201T 0202T 0205T 0213T 0214T 0215T 0216T 0217T 0218T 0228T 0229T 0230T 0231T 0232T 0234T 0235T 0236T 0237T 0238T 0249T 0253T 0254T 0263T 0264T 0265T 0308T 0338T 0339T 0345T 0377T 0387T 0388T 0406T 0407T 0474T 0479T 0480T 0483T 0484T 0487T 0491T 0492T 0499T Radiology 0042T 0159T 0174T 0175T 0346T 0355T 0394T 0395T 0470T 0471T 0475T 0476T 0477T 0478T 0482T Medicine 0198T 0206T 0207T 0208T 0209T 0210T 0212T 0295T 0296T 0297T 0298T 0379T 0389T 0390T 0391T 0472T 0473T 0497T 0498T	**Category III codes** are temporary codes identifying emerging technology and should be reported when available. The use of these codes supersede reporting the service with an unlisted code. Because these codes are temporary, some of them may only be covered on a case-by-case review and all require prior authorization. The temporary codes may be converted to permanent CPT codes or deleted during a semiannual update of the code set. For a complete explanation of this process refer to the guidelines in CPT 2024. Because Category III codes represent new and emerging technology, a limited number of these codes have been assigned relative value units. Codes without an assigned relative value are by report (BR) procedures. See Ground Rule 10 in the Surgery section for the complete rule related to BR procedures	Updated GR. All Cat III require PAR and will use Medicine conversion factor

NYS Official Workers' Compensation Medical Fee Schedule Ground Rules

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 applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the Fee Schedule Ground Rules and the Medical Treatment Guidelines, the guidelines will prevail. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.	
	2	N/A	**Conversion Factor** The Category III codes will utilize the Medicine conversion factor. Any currently published WCB Bulletins may supersede this Ground Rule if necessary.	further explanation for billing
	3	N/A	**Authorization** Since Cat III codes may only be covered on a case-by-case review ALL codes require prior authorization.	PAR requirements