NYS Official Workers' Compensation Physical & Occupational Therapy Fee Schedule Ground Rules

Section	Ground Rule Number	2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
Introduction & General Guidelines	Page 15		Inclusion of a code in this Fee Schedule does not guarantee reimbursement. All codes billed should be based on medical necessity and be in alignment with all applicable Medical Treatment Guidelines and Fee Schedule Ground Rules, as further discussed herein. Reimbursement may be dependent on multiple factors, including but not necessarily limited to, causal relationship, clinical necessity and appropriateness of the fees submitted.	disclaimer paragraph added. Also, newer cover page to distinguish PT/OT fee schedule section from Acupuncture FS section
	Page 16	POSTAL ZIP CODES BY REGION	Moved to Appendix B	
	Page 17	NEW, CHANGED, AND DELETED CPT CODES	Moved to Appendix B	
	1A	**NYS Medical Treatment Guidelines** The recommendations of the NYS Medical Treatment Guidelines supersede the ground rule frequency limitation for services rendered to body parts covered by the NYS Medical Treatment Guidelines. Treatment of work-related injuries should be in accordance with any applicable medical treatment guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the fee schedule ground rules and the medical treatment guidelines, the guidelines will prevail. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.	**NYS Medical Treatment Guidelines** The recommendations of the NYS Medical Treatment Guidelines supersede the ground rule frequency limitation for services rendered to body parts covered by the NYS Medical Treatment Guidelines. Treatment of work-related injuries should be in accordance with any applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the fee schedule ground rules and the Medical Treatment Guidelines, the guidelines will prevail. 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 and included reference to PARs

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	3	**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. Narrative report must include the following element in a highly visible location: Work Status. Providers are strongly encouraged to use the narrative template format found on the WCB webpage CMS 1500 Requirements. Additional narrative information should include the history of the injury/illness, any objective findings based on the clinical evaluation, plan of care and your diagnosis(es)/ assessment of the patient. Time must be documented whenever the CPT code definition is based on time spent with patient, or if necessary to justify a higher or additional code billed. 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 GR with CMS1500 documentation guidelines

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	4	**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.	**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.	Updates including PAR information, use of NY fee schedule codes

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	6	**Employed Physical Therapists and Occupational Therapists** Physical therapists and occupational therapists employed by physicians must bill separately from the physician-employer.	**Employed Physical Therapists and Occupational Therapists** All NYS Physical and Occupational Therapists, whether self-employed or part of a physician practice, must submit their own medical reports and bill independently under their own authorization number, and not through a supervising physician. See WCB webpage for more information on Expanded Provider Law: www.wcb.ny.gov A hospital/ambulatory surgery center facility may bill for PT/OT services only when services are rendered during an inpatient admission or for an immediate post operative evaluation needed for safe discharge.	updated info for billing and Expanded Provider Law requirements
	8		**Multiple Case Numbers** If a claimant has more than one WCB claim/number, it is permissible to bill services for both claims on the same date of service. Separate bills should be submitted for each claim/visit. However, the total time billed for each claim number should not exceed the actual face to face time spent with the patient. The visits need to be scheduled and documented as two distinct and sequential office visits, with two distinct and separate office visit notes.	New GR 6A. Explaining practice for claimants with multiple WCB Case numbers

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	9		**Physical Therapy Assistants (PTAs) and Occupational Therapy Assistants (OTAs):** PTA and OTAs must be directly supervised by an authorized Physical Therapist (PT) or authorized Occupational Therapist (OT) respectively. PTAs and OTAs may not become authorized, provide treatment, or bill for services independently. Only the supervising PT/OT provider may bill for these services. Modifier CQ indicates the codes performed by the PTA. Modifier CO indicates the codes performed by the OTA Also see Physical Medicine Modifiers. Services billed using the modifiers CQ or CO should be billed and reimbursed at 85 percent of the amount payable to authorized PTs/OTs for such services. Clinical notes by PTAs/OTAs must be cosigned by the supervising PT/OT. The maximum numbers of billable RVUs for physical therapy and occupational therapy on any given date of service, as outlined elsewhere in the fee schedule remain the same and are not increased or otherwise changed based on whether the services are provided by PTs, OTs, PTAs or OTAs. If a PT/OT and PTA/OTA provide services on the same day/session, the services provided by the PT/OT will be prioritized towards the daily RVU limits. All care should be within the appropriate NYS Scope of Practice parameters. PTAs and OTAs may not perform Functional Capacity Evaluations (FCEs) for NYS WCB claimants. Please see any current guidelines published on the WCB webpage.	New GR for Physical/ Occupational Assistants.
	10		**Electronic Billing:** Providers may offset the cost of using an electronic submission partner by using code 99080 as a "By Report" (BR) code, up to a maximum value of one dollar. The code should be placed on the same CMS 1500 form for which the billable services payment and the electronic submission costs are being requested. The price listed by the provider for code 99080 should accurately reflect the actual cost incurred by the provider for the electronic submission of the individual bill, up to a maximum of one dollar. Please see any current guidance on the WCB webpage.	New GR for electronic billing codes and cost offset

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	11		**Miscellaneous and By Report Codes** 1. Providers should only use codes listed in the Fee Schedule. When billing a service or procedure, select the CPT code from the WCB Fee schedule that accurately identifies the service or procedure performed. If no such code is available, report the service or procedure using the closest appropriate Miscellaneous code in the Fee Schedule (often ending in -99). These codes may also be titled "Unlisted," "Unspecified," or "Not Otherwise Specified". 2. By Report (BR) in the Relative Value (RVU) column represents services that too variable to permit assignment of RVUs. Fees for such procedures need to be justified with additional information. • The inclusion of a miscellaneous or by report code in this Fee Schedule does not guarantee reimbursement. All codes billed should be based on medical necessity and be in alignment with all applicable Medical Treatment Guidelines and Fee Schedule Ground Rules. Reimbursement may be dependent on multiple factors, including but not necessarily limited to, causal relationship, clinical necessity and appropriateness of the fees submitted. • It is the responsibility of the provider to ensure all information required to process a miscellaneous or by report procedure is included with the bill. If required information is missing, or if there is a valid code that describes the procedure, then the code may not be reimbursed. • Nearly all miscellaneous and by report codes, require prior authorization (PAR). If a procedure or item is not recommended or not addressed in an applicable WCB Medical Treatment Guideline (MTG), then prior authorization is always required. If the procedure or item involves a body part or condition for which there is no MTG, and costs over $1,000 then prior authorization must be obtained. • While emergency procedures/items do not require prior authorization, the circumstances must be identified and explained in the procedure record. The codes billed may be subject to review and non-payment. • When a miscellaneous or by report code is used, the actual service/item should be identified on the bill, narrative note, and in an additional attached report. • The price billed must be substantiated by indicating the closest comparable code found in the current fee schedule and/or with a manufacturer's invoice. • Documentation should include: any decision making, medical necessity and explanation why an existing fee schedule code could not be used. • Any PARs including identification numbers should also be submitted with bills. • Miscellaneous and by report codes should not be billed merely to describe a proprietary product or procedure, when an existing fee schedule code adequately describes the procedure or item. • Surgical miscellaneous or by report codes may require additional documentation including: time, skill, equipment necessary, diagnosis, pertinent history, and physical findings, size/ location/number of lesions or procedures	added for consistency with other fee schedules

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	12		**Exempt From Modifier 51 Codes** As the description implies, modifier 51 exempt procedures are not subject to multiple procedure rules and, as such, modifier 51 does not apply. Fee schedule amounts for modifier 51 exempt codes are not subject to reduction and should be reimbursed at the lesser of 100 percent of the listed value or the billed amount. The CPT book identifies these services with the X symbol. Modifier 51 exempt services and procedures can be found in current CPT books. In addition to the codes noted in CPT book, Optum has identified codes that are modifier 51 exempt according to CPT guidelines. The additional Optum modifier 51 exempt codes are identified in the data with the icon. See Appendix.	added for consistency with other fee schedules

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Section	Ground Rule Number	2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
Physical Medicine	2	**Initial Evaluation and Re-evaluation by a Physical or Occupational Therapist** Authorized physical therapists (PT) and occupational therapists (OT) may bill for an initial evaluation using CPT codes 97161–97163 and 97165–97167, respectively. Evaluations shall include the following elements: history, examination, clinical testing, interpretation of data, clinical presentation, clinical decision making, and development of the plan of care with defined goals, appropriate interventions, and recommendations. The maximum number of relative value units (including treatment) when billing for an initial evaluation shall be limited to 18.0. The following codes represent the treatments subject to this rule: 97010 97024 97035 97116 97535 97012 97026 97036 97124 97537 97014 97028 97039 97139 97542 97016 97032 97110 97140 97760 97018 97033 97112 97150 97761 Re-evaluations using CPT codes 97164 (PT) and 97168 (OT) may be billed in addition to the modalities rendered when any of the following applies: A) If following discharge (for whatever reason), the patient is referred again for treatment with the same or similar condition of the same body part. B) If there is a significant change in the patient's condition that warrants a revision of the treatment goals, intervention and/or the plan of care. C) If it is medically necessary to provide re-evaluation services over and above those normally included during therapeutic treatment. D) If the patient's status becomes stationary and it is not likely that significant improvement will occur with further treatment. E) If at the conclusion of the current episode of therapy care, re-evaluation is indicated for any of the following reasons: • Satisfactory goal achievement with present functional status defined including a home program and follow-up services, as necessary. • Patient declines to continue care. • The patient is unable to continue to work toward goals due to medical or psychosocial complications. Please note, however, that re-evaluations may be billed only in instances where such evaluation is therapeutically necessary, and in any event, not more than once in a 30-day period. 97022 97034 97113 97530 97763 The maximum number of relative value units (including treatment) when billing for a re-evaluation shall be limited to 15.0.	**Initial Evaluation and Re-evaluation by a Physical or Occupational Therapist** Authorized physical therapists (PT) and occupational therapists (OT) may bill for an initial evaluation using CPT codes 97161–97163 and 97165–97167, respectively. The maximum number of relative value units (including treatment) when billing for an initial evaluation shall be limited to 18.0. The following codes represent the treatments 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 Re-evaluations using CPT codes 97164 (PT) and 97168 (OT) may be billed in addition to the modalities rendered when any of the following applies: A. If following discharge (for whatever reason), the patient is referred again for treatment with the same or similar condition of the same body part. B. If there is a significant change in the patient's condition that warrants a revision of the treatment goals, intervention and/or the plan of care. C. If it is medically necessary to provide re-evaluation services over and above those normally included during therapeutic treatment. D. If the patient's status becomes stationary and it is not likely that significant improvement will occur with further treatment. E. If at the conclusion of the current episode of therapy care, re-evaluation is indicated for any of the following reasons: • Satisfactory goal achievement with present functional status defined including a home program and follow-up services, as necessary. • Patient declines to continue care. • The patient is unable to continue to work toward goals due to medical or psychosocial complications. Please note, however, that re-evaluations may be billed only in instances where such evaluation is therapeutically necessary, and in any event, not more than once in a 30-day period. The maximum number of relative value units (including treatment) when billing for a re-evaluation shall be limited to 15.0.	deleted outdated documentation information. Updated codes.

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	3	**Multiple Physical Medicine Procedures and Modalities** When multiple physical therapy or occupational therapy 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 acupuncture, chiropractic, physical or occupational therapy procedures 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. 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 therapy or occupational therapy 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 acupuncture, chiropractic, physical or occupational therapy procedures 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. 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	clarified wording "per patient per day per accident or illness " to "per patient per day per WCB case number". Updated codes.
	7	**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 or occupational therapy services 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 or occupational therapy services are as follows:	updated reference to CPT book appendix in some modifier descriptions
	7	N/A	**CO** Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant. **CQ** Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant.	New modifiers for PTA and OTA

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	8	**Durable Medical Equipment (DME) Fee Schedule** Prior to the effective date of the 2020 Durable 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 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.	**Durable Medical Equipment (DME) Fee Schedule** All durable equipment supplies shall be billed and paid using the WCB DME Fee Schedule available on the Board's webpage. Any item identified as requiring prior authorization in the WCB DME Fee Schedule or not listed in the WCB 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 the provider and accurately describe the item needed. Appropriate HCPCS codes should be billed for items. All miscellaneous/unspecified codes, or codes without a listed price require Prior Authorization (PAR) and manufacture's invoice. Also see Surgery Ground Rules regarding post procedure casting/splinting DME. Do not bill for or report supplies that are customarily included in surgical packages, such as gauze, sponges, Steri-strips, and dressings; drug screening supplies; and hot and cold packs. These items are included in the fee for the medical services in which such supplies are used	Emphasis on PARs, MTGs, and documentation
	9	N/A	**Narrative Reports** A detailed narrative report must be submitted with all services provided. Narrative report must include the following element in a highly visible location: Work Status. Providers are strongly encouraged to use the narrative template format found on the WCB webpage CMS 1500 Requirements. Additional narrative information should include the history of the injury/illness, any objective findings based on the clinical evaluation, plan of care and your diagnosis(es)/ assessment of the patient. Time must be documented whenever the CPT code definition is based on time spent with patient, or if necessary to justify a higher or additional code billed. Any ordered medications, durable medical equipment, tests, or procedures should be thoroughly explained. All entries in the medical record must be legible to another reader.	New GR with CMS1500 documentation guidelines

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Appendix B	Page 32	N/A	**Appendix**	New, Changed, Deleted Code lists, Zip Codes by Region