NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
Introduction	page 1	The Official New York State Workers' Compensation Podiatry Fee Schedule shows podiatry services and their relative value units. The services are listed by Current Procedural Terminology (CPT®) codes. The relative value unit set for each CPT service is based on comparative magnitude among various services and procedures. The relative value units within each section apply only to that section. CPT is a registered trademark of the American Medical Association (AMA). The accompanying instructions and ground rules explain the application of these procedure descriptors and relative value units. Because the Podiatry 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 podiatrist 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 podiatrists in the care of workers' compensation covered patients and ensure the proper payment for such services by assuring that they are specifically identifiable. An attempt has been made to adhere as closely as possible to the terminology and coding of the American Medical Association's CPT 2018.	The Official New York State Workers' Compensation Podiatry Fee Schedule shows podiatry services and their relative value units. The services are listed by Current Procedural Terminology (CPT®) codes. The relative value unit set for each CPT service is based on comparative magnitude among various services and procedures. The relative value units within each section apply only to that section. CPT is a registered trademark of the American Medical Association (AMA). The accompanying instructions and ground rules explain the application of these procedure descriptors and relative value units. Because the Podiatry 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 podiatrist 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 podiatrists in the care of workers' compensation covered patients and 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. An attempt has been made to adhere as closely as possible to the terminology and coding of the American Medical Association's CPT 2024.	disclaimer paragraph added

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	page 3	Postal Zip Codes By Region	Moved to Appendix	
	page 3	Numerical List of Zip Codes	Deleted as duplicative	
	page 3	New, Changed, Deleted Codes, Changed Descriptions/Values Chart	Moved to Appendix	
	1A	**NYS Medical Treatment Guidelines** Treatment of work-related injuries should be in accordance with any applicable medical treatment guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the fee schedule ground rules and the medical treatment guidelines, the guidelines will prevail. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.	**NYS Medical Treatment Guidelines** Treatment of work-related injuries should be in accordance with any currently published, applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the Fee Schedule Ground Rules and the Medical Treatment Guidelines, the guidelines will prevail. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.	wording updated for prior authorization
	1B.	**Multiple Procedures** It is appropriate to designate multiple procedures that are rendered on the same date by separate entries.	**Multiple Procedures** In extremely limited circumstances, if an acute problem arises during a routine visit, additional procedures may be reported on the same bill.	wording updated

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	2	**Unlisted Service or Procedure** 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 Rule 3 below. All sections will have an unlisted service or procedure code number, usually ending in "99."	**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	Old GR 2 & 3 content consolidated into new GR 2.

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	3	**Procedures Listed Without Specified Unit Values: By Report (BR) Items** "BR" in the unit 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 podiatrist 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.	**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 Podiatry 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, and also Modifier 83 information. State-specific modifier 83 is used to identify assistant at surgery services provided by a physician assistant or nurse practitioner.	Old GR 2 & 3 consolidated into new GR 2. GR 3 for PA/NPs. Ground rule is not new but was not previously included in this fee schedule.

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	4	**Materials Supplied by Podiatrist: 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 six 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 medical equipment supplied shall be billed and paid using the 2020 Durable Medical Equipment Fee Schedule. The 2020 Durable Medical Equipment Fee Schedule is/will be available on the Board's website. Any item identified as requiring prior authorization in the 2020 Durable Medical Equipment Fee Schedule or not listed in the 2020 Durable Medical Equipment Fee Schedule may not be billed without such prior authorization. Do not bill for or report supplies that are customarily included in surgical packages, such as gauze, sponges, Steri-strips, and dressings; drug screening supplies; and hot and cold packs. These items are included in the fee for the medical services in which such supplies are used.	**Materials Supplied by Podiatrist: 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 six 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). B. Durable Medical Equipment All durable medical equipment (DME) supplied shall be billed and paid using the currently published 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 or not listed in the WCB DME Fee Schedule may not be billed without such prior authorization. All DME must be prescribed according to any applicable Medical Treatment Guidelines. Medical necessity should be documented for all prescribed DME. Prescription or order form must be completed by the provider and accurately describe the item needed. Appropriate HCPCS codes should be billed for items. All miscellaneous/unspecified codes, or codes without a listed price- require Prior Authorization (PAR)and manufacture's invoice. Also see Surgery Ground Rules regarding post procedure casting/splinting DME. Do not bill for or report supplies that are customarily included in surgical packages, such as gauze, sponges, Steri-strips, and dressings; drug screening supplies; and hot and cold packs. These items are included in the fee for the medical services in which such supplies are used.	Emphasis on PARs, MTGs, and documentation

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	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. 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.	Additional information in new paragraph
	6	**Concurrent Care** When more than one provider treats a patient for the same condition during the same period of time, payment is made only to one provider. Where the concurrent care involves overlapping or common services, the fees payable shall not be increased but prorated. Each provider shall submit separate bills but indicate if agreement has been reached on the proration. If no agreement has been reached, the matter shall be referred to a Medical Arbitration Committee.	**Concurrent Care** When more than one provider treats a patient for the same condition during the same period of time, payment is made only to one provider. Where the concurrent care involves overlapping or common services, the fees payable shall not be increased but prorated. Each provider shall submit separate bills but indicate if agreement has been reached on the proration. 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. Emphasizing documentation.
	6A	None	**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 spent with the patient should be prorated such that the time billed on each visit does not exceed the total 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

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	7	**Alternating Providers** When providers of similar skills alternate in the care of a patient (e.g., partners, groups, or same facility covering for another provider on weekends or vacation periods), each provider shall bill individually for the services they personally rendered and in accordance with the fee schedule.	**Alternating Providers** When providers of similar skills alternate in the care of a patient (e.g., partners, groups, or same facility covering for another provider on weekends or vacation periods), each provider shall bill individually for the services they personally rendered and in accordance with the 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.	Information for billing and PARs if physician changes
	14 Modifiers	**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. If more than one modifier is needed, place modifier 99 after the procedure code to indicate that two or more modifiers will follow.	**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. If more than one modifier is needed, place modifier 99 after the procedure code to indicate that two or more modifiers will follow. Appendixes referenced in the modifier descriptions are found in the CPT 2024 book.	Some AMA CPT definitions reference the appendix in the CPT Book (not this fee schedule appendix)
	14 Modifiers	N/A	**1R∞** Non-surgical services provided by residents and fellows. Billed and payable at the same applicable rate as the WCB authorized, supervising podiatrist. 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 a surgery assistant. See Modifier 84.	New modifier for Residents and Fellows

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	14 Modifiers	**Modifier 26 Professional Component** Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.	**modifier 26 Professional Component** Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number. For intra-operative imaging, this modifier should not be used on the same code by two providers during the same procedure.	additional information for billing
	14 Modifiers	**modifier 63 Procedure Performed on Infants less than 4kg** 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 since only references infants
	14 Modifiers	N/A	**83∞ Services of Physician Assistants (PA) and Nurse Practitioners (NP) assisting during surgical procedures** The operating podiatrist must bill at 10.7 percent of the total podiatry fee schedule allowance for the surgical procedures performed by the PA/NP. Identify the services by adding Modifier 83 to the specific procedure codes done by the NP/PA. Payment will be made to the supervising podiatrist performing the surgery. This modifier is valid for surgery only. NPs and PAs cannot bill for surgery independently.	New modifier in this fee schedule

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	14 Modifiers	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 podiatrist. 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 surgery assist by residents and fellows
	14 Modifiers	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-audio only
	14 Modifiers	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 Audio and visual

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

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

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	17	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. Podiatrists may only bill: • E/M code 99212 2. 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 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 - with billing information for Podiatrists
	18	N/A	**Electronic Billing** Providers may offset the cost of using an electronic submission partner by using code 99080 as a "By Report" (BR) code, up to a maximum value of one dollar. The code should be placed on the same CMS 1500 form for which the billable services payment and the electronic submission costs are being requested. The price listed by the provider for code 99080 should accurately reflect the actual cost incurred by the provider for the electronic submission of the individual bill, up to a maximum of one dollar. Please see any current guidance on the WCB webpage.	New GR for electronic billing codes and cost offset

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	19	N/A	**Narrative Reports** A detailed narrative report must be submitted with all services provided. Narrative report must include the following elements in a highly visible location: Work Status, Casual Relationship & Temporary Impairment Percentage. Providers are strongly encouraged to use the narrative template format found on the WCB webpage CMS 1500 Requirements. Additional narrative information should include the history of the injury/illness, any objective findings based on the clinical evaluation, plan of care and your diagnosis(es)/ assessment of the patient. Time must be documented whenever the CPT code definition is based on time spent with patient, or if necessary to justify a higher or additional code billed. Any ordered medications, durable medical equipment, tests, or procedures should be thoroughly explained. All entries in the medical record must be legible to another reader.	New GR with CMS1500 documentation guidelines

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	20	N/A	**Billing for Residents and Fellows** Treatment rendered by residents and fellows can only be billed by the Board authorized supervising podiatrist. 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 podiatrist. 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 podiatrist code fee. All Fee Schedule Ground Rules for multiple procedures apply. Also see WCB webpage and any current bulletins for additional guidance. A. Podiatrists cannot additionally bill for supervision of the resident. B. If the supervising podiatrist bills for a resident/fellow assisting at surgery, only one additional assistant (PA/NP-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 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. E. Non-Authorized Out-of-State Podiatrists may not bill for residents/fellows. F. Podiatrists should not bill for services performed by a resident/fellow that would not normally be billed by another type of assistant at surgery. G. 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. H. The name of the resident/fellow does not need to be documented on the CMS 1500 form. I. All CMS 1500 Narrative requirements do apply to any bills submitted. https://www.wcb.ny.gov/CMS-1500/	New GR for billing of treatment provided by residents and fellows

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	21	N/A	**Exempt From Modifier 51 Codes** As the description implies, modifier 51 exempt procedures are not subject to multiple procedure rules and, as such, modifier 51 does not apply. Fee schedule amounts for modifier 51 exempt codes are not subject to reduction and should be reimbursed at the lesser of 100 percent of the listed value or the billed amount. The CPT book identifies these services with the X symbol. Modifier 51 exempt services and procedures can be found in current CPT books. In addition to the codes noted in CPT book, Optum has identified codes that are modifier 51 exempt according to CPT guidelines. The additional Optum modifier 51 exempt codes are identified in the data with the icon. See Appendix.	GR previously omitted but now included in this fee schedule. Not new information and found in the other fee schedule as applicable
Evaluation & Management	chart inserted	N/A	copy of Conversion factor chart applicable to this section	copy of conversion factor chart applicable to this section. No changes in values from previous fee schedule.
	1A	**NYS Medical Treatment Guidelines** Treatment of work-related injuries should be in accordance with any applicable medical treatment guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the fee schedule ground rules and the medical treatment guidelines, the guidelines will prevail. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.	**NYS Medical Treatment Guidelines** Treatment of work-related injuries should be in accordance with any currently published, applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the Fee Schedule Ground Rules and the Medical Treatment Guidelines, the guidelines will prevail. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.	changes as in Intro section

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	3	**Modifiers** Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Modifiers commonly used in the Evaluation and Management section of this fee schedule are:	Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Appendixes referenced in the modifier descriptions are found in the CPT 2024 book. Modifiers commonly used in the Evaluation and Management section of this fee schedule are:	reference to CPT book appendix in some modifier descriptions
	3	N/A	**1R∞ Non-surgical services provided by residents and fellows** Billed and payable at the same applicable rate as the WCB authorized, supervising podiatrist. 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 a surgery assistant. See Modifier 84.	New modifier for residents and fellows
	3	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.	telemedicine modifiers

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	3	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.	telemedicine modifiers
	4	**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. Narrative report must include the following elements in a highly visible location: Work Status, Casual Relationship & Temporary Impairment Percentage. Providers are strongly encouraged to use the narrative template format found on the WCB webpage CMS 1500 Requirements. Additional narrative information should include the history of the injury/illness, any objective findings based on the clinical evaluation, plan of care and your diagnosis(es)/ assessment of the patient. Time must be documented whenever the CPT code definition is based on time spent with patient, or if necessary to justify a higher or additional code billed. Any ordered medications, durable medical equipment, tests, or procedures should be thoroughly explained. All entries in the medical record must be legible to another reader.	Clarified documentation for CMS1500

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	5	N/A	**Billing for Residents and Fellows** Treatment rendered by residents and fellows can only be billed by the Board authorized supervising podiatrist. 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 podiatrist. Also see WCB webpage and any current bulletins for additional guidance. A. Podiatrists cannot additionally bill for supervision of the resident. B. All codes billed should accurately reflect work performed by the resident/fellow. 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. C. Non-Authorized out-of-state podiatrists may not bill for residents/fellows. D. Podiatrists should not bill for services performed by a resident/fellow that would not normally be billed by another type of assistant. Payment shall not be made for observation, or for simple assistance or work typically performed by nursing/technical staff. E. The name of the resident/fellow does not need to be documented on the CMS 1500 form. F. All CMS 1500 Narrative requirements do apply to any bills submitted. https://www.wcb.ny.gov/CMS-1500/	New regulations for residents and fellows

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	6	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. Podiatrists may only bill: • E/M code 99212 2. 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 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/	Permanent telehealth regulations
	7	N/A	**Schedule Permanency Evaluations** Code 99243 is used for examinations and reports of schedule permanency evaluations performed by an authorized podiatrist.	Instructions for billing Permanency evaluations
Surgery	**chart inserted**	N/A	copy of Conversion factor chart applicable to this section	copy of conversion factor chart applicable to this section. No changes in values from previous fee schedule.

NYS Official Workers' Compensation Podiatry 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 currently published, applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the Fee Schedule Ground Rules and the Medical Treatment Guidelines, the guidelines will prevail. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.	**NYS Medical Treatment Guidelines** Treatment of work-related injuries should be in accordance with any currently published, applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the Fee Schedule Ground Rules and the Medical Treatment Guidelines, the guidelines will prevail. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.	changes as in Intro section
	6	**Follow-up or Aftercare** A) Follow-up care for therapeutic surgical procedures includes all normal postoperative care. Uncommon or unusual complications, recurrence or the presence of other diseases or injuries requiring significant additional services concurrent with the procedure(s) or during the listed period of follow-up care may warrant additional charges. If such charges are made, explain by report with adequate description. B) When an additional surgical procedure is performed during the follow-up period and it is related to the previously performed procedure, but is not an intrinsic part of the latter, the additional procedure will be paid at one-half the allowed fee. In these instances, the follow-up periods will continue concurrently. C) When multiple procedures and/or services are performed concurrently or sequentially within the same operative or treatment setting, the longest follow-up period will apply to all as one item.	**Follow-up or Aftercare** A. Normal postoperative care is included with all services assigned follow-up days of 0, 10, or 90. Uncommon or unusual complications, recurrence, or the presence of other diseases or injuries requiring significant additional services concurrent with the procedures or during the listed period of follow-up care, may warrant additional charges. Additional charges must be substantiated by report. B. When an additional surgical procedure is performed during the follow-up period and it is related to the previously performed procedure but is not an intrinsic part of the latter, the additional procedure will be paid at one-half the allowed fee. In these instances, the follow-up periods will continue concurrently. C. When multiple procedures and/or services are performed concurrently or sequentially within the same operative or treatment setting, the longest follow-up period will apply to all as one item.	updates to wording

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	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 "separate procedure" is applicable. Therefore, when a procedure is ordinarily a component of a larger procedure and 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 "separate procedure" is applicable. Therefore, when a procedure is ordinarily a component of a larger procedure and 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. Also refer to any currently published WCB policies and/or guidance.	additional guidance for use of codes
	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 should be submitted. An operative report shall include but not be limited to a brief but adequate summary of the history, physical findings, and operative findings, and an accurate and complete description of the surgical procedure performed.	**Narrative Reports** A detailed narrative report must be submitted with all services provided. Narrative report must include the following elements in a highly visible location: Work Status, Casual Relationship & Temporary Impairment Percentage. Providers are strongly encouraged to use the narrative template format found on the WCB webpage CMS 1500 Requirements. Additional narrative information should include the history of the injury/illness, any objective findings based on the clinical evaluation, plan of care and your diagnosis(es)/ assessment of the patient. Time must be documented whenever the CPT code definition is based on time spent with patient, or if necessary to justify a higher or additional code billed. Any ordered medications, durable medical equipment, tests, or procedures should be thoroughly explained. All entries in the medical record must be legible to another reader. The podiatrist 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.	updated to consistent requirements for CMS1500 documentation

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	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 unit. 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, using any of the following as indicated: A) Diagnosis (postoperative), pertinent history and physical findings. B) Size, location, and number of lesion(s) or procedure(s) where appropriate. C) Major surgical procedure with supplementary procedure(s). D) Whenever possible, list the closest similar procedure by number and relative value unit. The "BR" relative value units 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 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.	combined old GR 10 and 11 into updated version of guidance

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	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 substantiated by report as discussed in Surgery Ground Rule 10 above. The unlisted procedures and accompanying codes for surgery will be found at the end of the relevant section or subsection.	**Billing for Residents and Fellows** Treatment rendered by residents and fellows can only be billed by the Board authorized supervising podiatrist. 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 podiatrist code fee. All Fee Schedule Ground Rules for multiple procedures apply. Also see WCB webpage and any current bulletins for additional guidance. A. Podiatrists cannot additionally bill for supervision of the resident. B. If the supervising podiatrist 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 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. E. Non-Authorized out-of-state podiatrists may not bill for residents/fellows. F. Podiatrists 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 CMS 1500 form. H. All CMS 1500 Narrative requirements do apply to any bills submitted. https://www.wcb.ny.gov/CMS-1500/	old GR 11 combined into New GR 10. New GR 11 instructions for billing residents and fellows

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	12	**Concurrent Services by More Than One Podiatrist** Charges for concurrent services of two or more podiatrists may be warranted under the following circumstances: **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. By prior agreement, the total value may be apportioned in relation to the responsibility and work done. The total value for the procedure shall not, however, be increased but shall be prorated between the co-surgeons. Identify surgery performed by code number, appropriate modifier, and description of procedures. In the event of no agreement between co-surgeons, the proration shall be determined by an Arbitration Committee	**Concurrent Services by More Than One Podiatrist** Charges for concurrent services of two or more podiatrists may be warranted under the following circumstances: **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. By prior agreement, the total value may be apportioned in relation to the responsibility and work done. The total value for the procedure shall not, however, be increased but shall be prorated between the co-surgeons. Identify surgery performed by code number, appropriate modifier, and description of procedures. **F) Services of Physician Assistants (PA) and Nurse Practitioners (NP) assisting during surgical procedures (Modifier 83):** The operating podiatrist should bill at 10.7 percent of the total podiatrist 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 podiatrist 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. **G. Assistance at surgery provided by residents and fellows.** Surgery codes with modifier 84 must only be billed by the Board authorized supervising podiatrist and will be reimbursed at 16 percent of the applicable podiatrist code fee. See Ground Rule and Modifier descriptions for further details.	Added subsection F- for guidance billing NP/PA surgical assistants. Also added new subsection G for residents and fellows. Deleted language to Arbitration Committee.

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	16	**Materials Supplied by Podiatrist: 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 six 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 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	**Materials Supplied by Podiatrist: 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 six 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). **B) Durable Medical Equipment** All durable medical equipment (DME) supplied shall be billed and paid using the current published WCB Durable Medical Equipment Fee Schedule. The WCB Durable Medical Equipment Fee Schedule is available on the Board's website. Any item identified as requiring prior authorization in the WCB Durable Medical Equipment Fee Schedule or not listed in the WCB Durable Medical Equipment Fee Schedule may not be billed without such prior authorization. All DME must be prescribed according to any applicable Medical Treatment Guidelines. Medical necessity should be documented for all prescribed DME. Prescription or order form must be completed by the provider and accurately describe the item needed. Appropriate HCPCS codes should be billed for items. All miscellaneous/unlisted codes, or codes without a listed price require prior authorization (PAR) and manufacturer's invoice. Also see Surgery Ground Rules regarding post procedure casting/splinting DME. Do not bill for or report supplies that are customarily	updated wording and guidance

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

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

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	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 in surgery 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 in surgery are as follows:	updated reference to CPT book appendix in some modifier 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 stand-alone procedures not performed during a surgery i.e., injections. This modifier is not used for assistance at surgery. See modifier 84.	added new modifier for residents and fellows
	20	N/A	**83∞ Services of Physician Assistants (PA) and Nurse Practitioners (NP) assisting during surgical procedures** The operating podiatrist 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 podiatrist performing the surgery. This modifier is valid for surgery only. NPs and PAs cannot bill for surgery independently.	instructions for billing NP/PA assistants at surgery
	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 podiatrist. This modifier should not be used for E/M codes or for procedures not performed during a surgery i.e., injections. See Modifier 1R.	added new modifier for residents and fellows
Radiology	**chart**	N/A	conversion factors for this section	conversion factors for this section

NYS Official Workers' Compensation Podiatry 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 currently published, applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the Fee Schedule Ground Rules and the Medical Treatment Guidelines, the guidelines will prevail. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.	updated as per previous sections
	2	**Multiple Diagnostic Procedures**	**Multiple Diagnostic Procedures** **G. 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 the technical component are reimbursable under this circumstance. The review of diagnostic tests is included in the evaluation and management codes.	added subsection G: limiting billing for review of previously billed studies. Similar to existing GR in Lab/Path section
	5	**Specific Billing Instructions:** **A) Professional Component** The professional component represents the value of the professional radiological services of the podiatrist. This includes examination of the patient, when indicated, interpretation and written report of the examination, and consultation with the referring podiatrist. (Report using modifier 26.)	**Specific Billing Instructions:** **A. Professional Component** The professional component represents the value of the professional radiological services of the podiatrist. This includes examination of the patient, when indicated, interpretation and written report of the examination, and consultation with the referring podiatrist. (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.	added additional billing rule for modifier 26 use

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	7	**Materials Supplied by Podiatrist:** **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 six 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. Radiopharmaceutical or other radionuclide material cost: listed relative value units in this section do not include these costs. List the name and dosage of radiopharmaceutical material and cost. Bill with code 99070. Appliances and prostheses as listed within this fee schedule can be billed separately and do not apply to the supply rules as listed here.	**Materials Supplied by Podiatrist:** Radiopharmaceutical or other radionuclide material cost: listed relative value units in this section do not include these costs. List the name and dosage of radiopharmaceutical material and cost. Bill with code 99070. Except in emergencies, any medications must follow all WCB Formulary and applicable Medical Treatment Guidelines. Any variations require or Prior Authorization (PAR). Appliances and prostheses as listed within this fee schedule can be billed separately and do not apply to the supply rules as listed here	deleted paragraph not applicable to radiology section- and is mentioned in other sections.

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	10	**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. If more than one modifier is needed, place modifier 99 after the procedure code to indicate that two or more modifiers will follow. Modifiers commonly used with radiology 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. If more than one modifier is needed, place modifier 99 after the procedure code to indicate that two or more modifiers will follow. Appendixes referenced in the modifier descriptions are found in the CPT 2024 book. Modifiers commonly used with radiology procedures are as follows:	updated reference to CPT book appendix in some modifier descriptions

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	11	N/A	**Miscellaneous and By Report Codes** 1. Providers should only use codes listed in the Fee Schedule. When billing a service or procedure, select the CPT code from the WCB Fee schedule that accurately identifies the service or procedure performed. If no such code is available, report the service or procedure using the closest appropriate Miscellaneous code in the Fee Schedule (often ending in -99). These codes may also be titled "Unlisted," "Unspecified," or "Not Otherwise Specified". 2. By Report (BR) in the Relative Value (RVU) column represents services that too variable to permit assignment of RVUs. Fees for such procedures need to be justified with additional information. • The inclusion of a miscellaneous or by report code in this Fee Schedule does not guarantee reimbursement. All codes billed should be based on medical necessity and be in alignment with all applicable Medical Treatment Guidelines and Fee Schedule Ground Rules. Reimbursement may be dependent on multiple factors, including but not necessarily limited to, causal relationship, clinical necessity and appropriateness of the fees submitted. • It is the responsibility of the provider to ensure all information required to process a miscellaneous or by report procedure is included with the bill. If required information is missing, or if there is a valid code that describes the procedure, then the code may not be reimbursed. • Nearly all miscellaneous and by report codes, require prior authorization (PAR). If a procedure or item is not recommended or not addressed in an applicable WCB Medical Treatment Guideline (MTG), then prior authorization is always required. If the procedure or item involves a body part or condition for which there is no MTG and costs over $1,000 then prior authorization must be obtained. While emergency procedures/items do not require prior authorization, the circumstances must be identified and explained in the procedure record. The codes billed may be subject to review and non-payment. • When a miscellaneous or by report code is used, the actual service/item should be identified on the bill, narrative note, and in an additional attached report.	section added- as in other sections for billing instructions BR and Misc codes

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
			• 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.	
Pathology and Laboratory	**Chart inserted**	N/A	conversion factors for this section	conversion factors for this section

NYS Official Workers' Compensation Podiatry 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 currently published, applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the Fee Schedule Ground Rules and the Medical Treatment Guidelines, the guidelines will prevail. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.	updated as per previous sections
	1B.	Attending Podiatrist The attending podiatrist will not make a charge for obtaining and handling of specimens.	N/A	GR moved to #7

NYS Official Workers' Compensation Podiatry 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 six 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 six 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 WCB drug formulary

NYS Official Workers' Compensation Podiatry 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. Narrative report must include the following elements in a highly visible location: Work Status, Casual Relationship & Temporary Impairment Percentage. Providers are strongly encouraged to use the narrative template format found on the WCB webpage CMS 1500 Requirements. Additional narrative information should include the history of the injury/illness, any objective findings based on the clinical evaluation, plan of care and your diagnosis(es)/ assessment of the patient. Time must be documented whenever the CPT code definition is based on time spent with patient, or if necessary to justify a higher or additional code billed. Any ordered medications, durable medical equipment, tests, or procedures should be thoroughly explained. All entries in the medical record must be legible to another reader.	updated information for documentation

NYS Official Workers' Compensation Podiatry 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, skill, and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary. See the General Ground Rules for an explanation of "BR" 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 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	expanded guidelines for use of By Report and Misc codes

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

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

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

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 above).	**Attending Podiatrist** The attending podiatrist will not make a charge for obtaining and handling of specimens.	Old GR 7 consolidated into New GR 5. Old GR 1B moved to #7 slot to maintain previous numbering
	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. Please refer to CPT guidelines for a complete explanation of codes included in each panel	**Organ or Disease-Oriented Panels** The CPT Professional 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 (code 82465), triglycerides (84478), and HDL cholesterol (83718), the service should be reported as a lipid panel (80061).	updated examples
	12	**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. Appendixes referenced in the modifier descriptions are found in the CPT 2024 book.	updated reference to CPT book appendix in some modifier descriptions

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	13	**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. 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 GLC, 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. 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 GLC, 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. Confidentiality and Reporting UDT Results (from Medical Treatment Guidelines)	updated wording and including information on confidentiality of reporting results - as outlined in MTGs

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
			• UDT results are not to be released to the carrier, employer or the Board. However, the treating podiatrist 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.	
Medicine	chart inserted	N/A	conversion factors for this section	conversion factors for this section

NYS Official Workers' Compensation Podiatry 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 currently published, applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the Fee Schedule Ground Rules and the Medical Treatment Guidelines, the guidelines will prevail. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.	updates as in previous sections

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	2	**Modifiers** Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Modifiers commonly used in the Medicine section are:	**2. Billing for Residents and Fellows** Treatment rendered by residents and fellows can only be billed by the Board authorized supervising podiatrist. 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 podiatrist. A. Podiatrists cannot additionally bill for supervision of the resident. B. All codes billed should accurately reflect work performed by the resident/fellow. 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. C. Non-Authorized out-of-state podiatrists may not bill for residents/fellows. D. Podiatrists should not bill for services performed by a resident/fellow that would not normally be billed by another type of assistant. Payment shall not be made for observation, simple assistance or work typically performed by nursing/technical staff. E. The name of the resident/fellow does not need to be documented on the CMS 1500 form. F. All CMS 1500 narrative requirements do apply to any bills submitted. https://www.wcb.ny.gov/CMS-1500/	New GR 2 for residents and fellows inserted. Modifiers becoming GR 3.
	3	N/A	**Modifiers** Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Appendixes referenced in the modifier descriptions are found in the CPT 2024 book. Modifiers commonly used in the Medicine section are:	updated reference to CPT book appendix in some modifier descriptions.

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	3	N/A	**1R∞ Non-surgical services provided by residents or fellows** Billed and payable at the same applicable rate as the WCB authorized, supervising podiatrist. 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 non-surgical services by resident and fellows
	4	N/A	**Narrative Reports** A detailed narrative report must be submitted with all services provided. Narrative report must include the following elements in a highly visible location: Work Status, Casual Relationship & Temporary Impairment Percentage. Providers are strongly encouraged to use the narrative template format found on the WCB webpage CMS 1500 Requirements. Additional narrative information should include the history of the injury/illness, any objective findings based on the clinical evaluation, plan of care and your diagnosis(es)/ assessment of the patient. Time must be documented whenever the CPT code definition is based on time spent with patient, or if necessary to justify a higher or additional code billed. Any ordered medications, durable medical equipment, tests, or procedures should be thoroughly explained. All entries in the medical record must be legible to another reader.	added GR used in other sections emphasizing CMS1500 documentation requirements

NYS Official Workers' Compensation Podiatry Fee Schedule Ground Rules

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
	5	N/A	**Miscellaneous and By Report Codes** 1. Providers should only use codes listed in the Fee Schedule. When billing a service or procedure, select the CPT code from the WCB Fee schedule that accurately identifies the service or procedure performed. If no such code is available, report the service or procedure using the closest appropriate Miscellaneous code in the Fee Schedule (often ending in -99). These codes may also be titled "Unlisted," "Unspecified," or "Not Otherwise Specified". 2. By Report (BR) in the Relative Value (RVU) column represents services that too variable to permit assignment of RVUs. Fees for such procedures need to be justified with additional information. • The inclusion of a miscellaneous or by report code in this Fee Schedule does not guarantee reimbursement. All codes billed should be based on medical necessity and be in alignment with all applicable Medical Treatment Guidelines and Fee Schedule Ground Rules. Reimbursement may be dependent on multiple factors, including but not necessarily limited to, causal relationship, clinical necessity and appropriateness of the fees submitted. • It is the responsibility of the provider to ensure all information required to process a miscellaneous or by report procedure is included with the bill. If required information is missing, or if there is a valid code that describes the procedure, then the code may not be reimbursed. • Nearly all miscellaneous and by report codes, require prior authorization (PAR). If a procedure or item is not recommended or not addressed in an applicable WCB Medical Treatment Guideline (MTG), then prior authorization is always required. If the procedure or item involves a body part or condition for which there is no MTG and costs over $1,000 then prior authorization must be obtained. • While emergency procedures/items do not require prior authorization, the circumstances must be identified and explained in the procedure record. The codes billed may be subject to review and non-payment. • When a miscellaneous or by report code is used, the actual service/item should be identified on the bill, narrative note, and in an additional	mentioned in other sections but applicable to medicine visits

Section	Ground Rule Number	2018 -2020 Ground Rule Description	2025 Proposed Ground Rule Description	Comments
			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.	
Appliances and Prostheses	chart inserted	N/A	chart with conversion factors for this section	chart with conversion factors for this section.

NYS Official Workers' Compensation Podiatry 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 currently published, applicable Medical Treatment Guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the Fee Schedule Ground Rules and the Medical Treatment Guidelines, the guidelines will prevail. Treatment that correctly applies the recommendations of the Medical Treatment Guidelines does not require prior authorization, unless prior authorization is otherwise required by statute, regulation, or the fee schedules. Treatment that is not a correct application of or is outside or in excess of the Medical Treatment Guidelines is not authorized, unless the payer or Workers' Compensation Board has approved a variance. All other treatments require prior authorization.	updated as per previous sections
Appendix		N/A	**Appendix**	New, Changed, Deleted Code lists, Zip Codes by Region