

OFFICIAL  
NEW YORK STATE WORKERS' COMPENSATION

---

# ACUPUNCTURE AND PHYSICAL AND OCCUPATIONAL THERAPY FEE SCHEDULE

**Effective 1/1/2020**

DRAFT



**Workers'  
Compensation  
Board**

**COPYRIGHT**

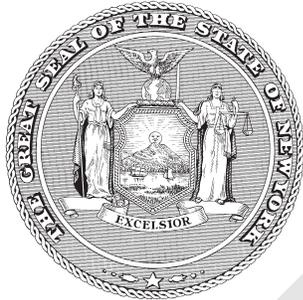
© 2019 State of New York

Fee data © 2019 Optum360, LLC.

CPT codes, descriptions, and two-digit numeric modifiers only, © 2017 American Medical Association

All rights reserved. Printed in the United States of America. No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, recording, or storage in a database retrieval system, without the prior written permission of the publisher.

Made in the USA



**OPTUM360<sup>o</sup>®**

1.800.464.3649

DRAFT

## **OPTUM360 NOTICE**

The *Official New York State Workers' Compensation Acupuncture and Physical and Occupational Therapy Fee Schedule* is designed to be an accurate and authoritative source of information about medical coding and reimbursement. Every reasonable effort has been made to verify its accuracy, and all information is believed reliable at the time of publication. Absolute accuracy, however, cannot be guaranteed.

Optum360 worked closely with the New York Workers' Compensation Board in the development, formatting, and production of this fee schedule. However, all decisions resulting in the final content of this schedule were made solely by the New York State Workers' Compensation Board.

This publication is made available with the understanding that the publisher is not engaged in rendering legal and other services that require a professional license.

For additional copies of this publication or other fee schedules, please call 1.800.464.3649.

## **AMERICAN MEDICAL ASSOCIATION NOTICE**

CPT © 2017 American Medical Association. All rights reserved.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

CPT is a registered trademark of the American Medical Association.

## **NEW YORK WORKERS' COMPENSATION BOARD FILING NOTICE**

The Acupuncture and Physical Therapy and Occupational Therapy Fee Schedule was duly filed in the Office of the Department of State, and constitutes Sections 329.1 and 329.3, and Appendix C-3 of Title 12 of the Official Compilation of Codes, Rules, and Regulations of the State of New York.

## **OUR COMMITMENT TO ACCURACY**

Optum360 is committed to producing accurate and reliable materials. To report corrections, please visit [www.optum360coding.com/accuracy](http://www.optum360coding.com/accuracy) or email [accuracy@optum.com](mailto:accuracy@optum.com). You can also reach customer service by calling 1.800.464.3649, option 1.

## **FOREWORD**

The Workers' Compensation Board is pleased to present the *Official New York State Workers' Compensation Acupuncture and Physical and Occupational Therapy Fee Schedule*.

The fee schedule is an essential tool for health care providers and those paying the cost of health care services under the New York State Workers' Compensation system. This schedule provides comprehensive billing guides, which will allow health care providers to appropriately describe their services and minimize disputes over reimbursement.

This fee schedule could not have been produced without the assistance of many individuals. The spirit of cooperation between the provider and payer communities is very much appreciated. The excellence of this schedule is due, in large part, to the commitment of many people in the workers' compensation community. We are grateful for their efforts.

This fee schedule is effective for services rendered on or after January 1, 2020, regardless of the date of accident. The fees established herein are payable to health care providers authorized or permitted to render care under the Workers' Compensation Law, Volunteer Firefighters' Benefit Law, and Volunteer Ambulance Workers' Benefit Law.

New York State Workers' Compensation Board

DRAFT

---

# Contents

---

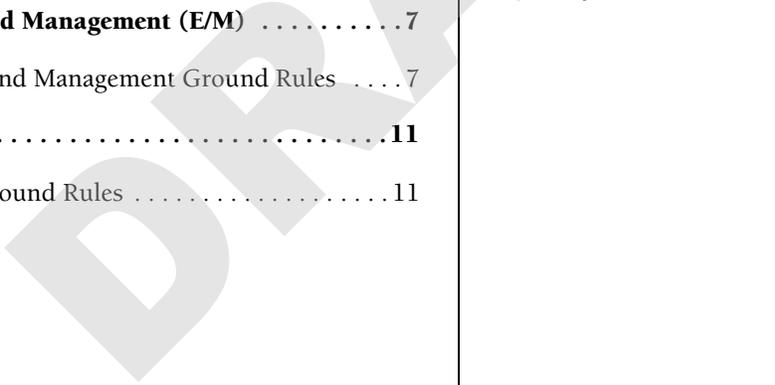
*The Official New York State Workers' Compensation  
Acupuncture and Physical and Occupational Therapy Fee  
Schedule*

**Section 1: Acupuncture**

- 1 Introduction and General Guidelines . . . . . 3**
  - Format . . . . . 3
  - How to Interpret the Fee Schedule Data . . . . . 3
  - Postal Zip Codes By Region . . . . . 4
  - Acupuncture Conversion Factors . . . . . 5
  - Calculating Fees Using Relative Values  
and Conversion Factors . . . . . 5
  - General Ground Rules . . . . . 5
- 2 Evaluation and Management (E/M) . . . . . 7**
  - Evaluation and Management Ground Rules . . . . . 7
- 3 Medicine . . . . . 11**
  - Medicine Ground Rules . . . . . 11

**Section 2: Physical and Occupational Therapy**

- 1 Introduction and General Guidelines . . . . . 15**
  - Format . . . . . 15
  - How To Interpret Fee Schedule Data . . . . . 15
  - Postal Zip Codes By Region . . . . . 16
  - Physical and Occupational Therapy Conversion  
Factors . . . . . 17
  - Calculating Fees Using Relative Values  
and Conversion Factors . . . . . 17
  - General Ground Rules . . . . . 17
- 2 Physical Medicine . . . . . 19**
  - Physical Medicine Ground Rules . . . . . 19





---

Section 1:

# **Acupuncture**

---

DRAFT



# 1 Introduction and General Guidelines

The Acupuncture section of the *Official New York Workers' Compensation Acupuncture and Physical and Occupational Therapy Fee Schedule* shows acupuncture services and their relative value units. The services are listed by Current Procedural Terminology (CPT®) codes. The relative value unit set for each CPT service is based on comparative magnitude among various services and procedures. The relative values within each section apply only to that section. CPT is a registered trademark of the American Medical Association (AMA).

The accompanying instructions and ground rules explain the application of these procedure descriptors and relative value units in the acupuncture practice.

Because the Acupuncture 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 acupuncturist or the pattern of charges in any specific area of New York.

A primary purpose of the schedule is to provide a precise description and coding of the services provided by New York acupuncturists in the care of workers' compensation covered patients and ensures the proper payment for such services by assuring that they are specifically identifiable.

This edition of the *Official New York Workers' Compensation Acupuncture and Physical and Occupational Therapy Fee Schedule* uses CPT procedure codes, modifiers, and descriptions. Please refer to the CPT book for an explanation of coding rules and regulations not listed in this schedule.

To ensure uniformity of billing, when multiple services are rendered, each relative value unit is to be multiplied by the conversion factor separately.

## FORMAT

The Acupuncture section of the *Official New York Workers' Compensation Acupuncture and Physical and Occupational Therapy Fee Schedule* consists of two sections, Evaluation and Management and Medicine. Each section has instructions which precede the codes, descriptions, and values.

The sections are organized according to type of service and the variations of overhead expense ratios for providing the services. Therefore, each section uses a single conversion factor.

## Introductory Information

The introductory ground rules that precede the data in each section include definitions, references, prohibitions, and directions for proper use. It cannot be emphasized too strongly that the introductory ground rules be read and understood before using the data in this schedule.

## Regions

The Board has established four regions within New York State based on the difference in the cost of maintaining a practice in different localities of the state. The Board has defined each such region by use of the U.S. Postal Service ZIP codes for the state of New York, based upon the relative cost factors which are compatible to that region.

The fees payable for Acupuncture services shall be determined by the region in which the services were rendered.

## HOW TO INTERPRET THE FEE SCHEDULE DATA

There are six columns used throughout the Acupuncture Fee Schedule. The columns vary by section throughout the schedule.

## Icons

The following icons are included in the Acupuncture Fee Schedule:

- + Add-on service—Add-on codes have been designated in the CPT book as being additional or supplemental procedures that are carried out in addition to the primary procedure.

## Code

The Code column lists the American Medical Association's (AMA) CPT code. *CPT 2018* is used by arrangement with the AMA. Any altered CPT codes are identified with the

registered trademark symbol (®). State-specific codes are identified with the infinity symbol (∞).

**Description**

This manual lists full CPT 2018 descriptions.

**Relative Value**

The Relative Value column lists the relative value units used to calculate the fee amount for a service. Except as otherwise provided in this schedule, the maximum fee amount is calculated by multiplying the relative value units by the applicable conversion factor. Conversion factors are listed later in this chapter.

Relative values are used to calculate fees using the following formula:

Relative Value x applicable conversion factor = fee.

For example, the fee for code 99201, performed in Region I or Region II, would be calculated as follows:

	5.83	(Relative Value)
x	\$6.37	(Acupuncture E/M Section Conversion Factor for Region I or II)
=	\$37.14	(Subject to PC/TC Split)

**POSTAL ZIP CODES BY REGION**

Postal ZIP codes included in each region:

**Region I**

From	Thru	From	Thru
12007	12099	13601	13699
12106	12177	13730	13797
12184	12199	13801	13865
12401	12498	14001	14098
12701	12792	14101	14174
12801	12887	14301	14305
12901	12998	14410	14489
13020	13094	14501	14592
13101	13176	14701	14788
13301	13368	14801	14898
13401	13439	14901	14925
13450	13495		

**Region II**

From	Thru	From	Thru
12179	12183	13440	13449
12201	12288	13501	13599
12301	12345	13901	13905
12501	12594	14201	14280
12601	12614	14601	14694
13201	13290		

**Region III**

From	Thru	From	Thru
06390	06390	10801	10805
10501	10598	10901	10998
10601	10650	11901	11980
10701	10710		

**Region IV**

From	Thru	From	Thru
00501	00501	11101	11120
00544	00544	11201	11256
10001	10099	11301	11390
10100	10199	11401	11499
10200	10299	11501	11599
10301	10314	11601	11697
10401	10499	11701	11798
11001	11096	11801	11854

**Numerical List of Postal Zip Codes**

From	Thru	Region	From	Thru	Region
00501	00501	IV	12401	12498	I
00544	00544	IV	12501	12594	II
06390	06390	III	12601	12614	II
10001	10099	IV	12701	12792	I
10100	10199	IV	12801	12887	I
10200	10299	IV	12901	12998	I
10301	10314	IV	13020	13094	I
10401	10499	IV	13101	13176	I
10501	10598	III	13201	13290	II
10601	10650	III	13301	13368	I
10701	10710	III	13401	13439	I
10801	10805	III	13440	13449	II
10901	10998	III	13450	13495	I
11001	11096	IV	13501	13599	II
11101	11120	IV	13601	13699	I
11201	11256	IV	13730	13797	I
11301	11390	IV	13801	13865	I
11401	11499	IV	13901	13905	II
11501	11599	IV	14001	14098	I
11601	11697	IV	14101	14174	I
11701	11798	IV	14201	14280	II
11801	11854	IV	14301	14305	I
11901	11980	III	14410	14489	I
12007	12099	I	14501	14592	I
12106	12177	I	14601	14694	II
12179	12183	II	14701	14788	I
12184	12199	I	14801	14898	I
12201	12288	II	14901	14925	I
12301	12345	II			

## ACUPUNCTURE CONVERSION FACTORS

Regional conversion factors for services rendered on or after January 1, 2020.

Section	Region I	Region II	Region III	Region IV
E/M	\$6.37	\$6.37	\$7.29	\$7.92
Medicine	\$6.09	\$6.09	\$6.97	\$7.57

## CALCULATING FEES USING RELATIVE VALUES AND CONVERSION FACTORS

Except as otherwise provided in this schedule, the maximum fee amount is calculated by multiplying the relative value by the applicable conversion factor. For example, the total fee for code 99201, performed in Region I or Region II, would be calculated as follows:

Relative values are used to calculate fees using the following formula:

$$\begin{array}{rcl}
 & \text{Relative Value} & \\
 \times & \text{Applicable Conversion Factor} & \\
 = & \text{Fee.} & \\
 \\
 & 5.83 \quad (\text{Relative Value}) & \\
 \times & \$6.37 \quad (\text{Acupuncture E/M Section Conversion} & \\
 & \quad \text{Factor for Region I or Region II}) & \\
 = & \$37.14 & 
 \end{array}$$

## GENERAL GROUND RULES

### 1A. NYS Medical Treatment Guidelines

The recommendations of the New York State (NYS) Medical Treatment Guidelines supersede the ground rule frequency limitation for services rendered to body parts covered by the NYS Medical Treatment Guidelines. Treatment of work-related injuries should be in accordance with any applicable medical treatment guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the fee schedule ground rules and the medical treatment guidelines, the guidelines will prevail. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

### 1B. Referral and Prescription by Physician, Nurse Practitioner, Physician Assistant or Podiatrist

Services may be rendered by an authorized acupuncturist upon the referral or prescription of an authorized physician, nurse practitioner, physician assistant or, if applicable, podiatrist. Such referring provider should also oversee the written instructions for treatment for a given diagnosis. Written instructions should include precautions, goals, frequency, and modalities to be used.

### 2. Acupuncture Utilization

Acupuncture services in excess of 12 treatments or after 45 days from the first treatment, require documentation that includes provider certification of medical necessity for continued treatment, progress notes, and treatment plans. This documentation should be submitted to the insurance carrier as part of the claim.

### 3. Report Requirements

Authorized acupuncturists shall provide reports of treatment in the electronic format prescribed by the Chair of the Workers' Compensation Board.

### 4. Treatment by Out of State Providers

*Claimant lives outside of New York State*—A claimant who lives outside of New York State may treat with a qualified out-of-state medical provider. The medical treatment shall conform to the Medical Treatment Guidelines and the Ground Rules included herein. Payment for medical treatment shall be at the Fee Schedule amount for work related injuries and illnesses as available in the state where treatment is rendered, or if there is no such fee schedule, then such charges shall be as prevail in the community for similar treatment. All fees shall be subject to the jurisdiction of the Board.

*Claimant lives in New York State but treats outside of New York State*—A claimant who lives in New York State may treat with a qualified or Board authorized out-of-state medical provider when such treatment conforms to the Workers' Compensation Law and regulations, the Medical Treatment Guidelines and the Medical Fee Schedule. Payment shall be made to the medical provider as set forth herein and using the regional conversion factor for the zip code where the claimant resides.

Out-of-state medical treatment that does not "further the economic and humanitarian objective" of Workers' Compensation Law may be denied by the Board.

A medical provider who has had a NYS WCB authorization suspended, revoked, or surrendered shall not be qualified to treat out-of-state.

**5. Billing for Acupuncture Needles**

The cost of needles is included in the Acupuncture service and will be denied if submitted in addition to the Acupuncture service.

**6. Moxibustion and Other Complementary Integrative Medicine Techniques**

Moxibustion and other complementary integrative medicine techniques are often combined with acupuncture. No additional reimbursement will be provided for acupuncture combined with moxibustion or other similar adjunctive procedures. Acupuncture must be performed by a professional who is authorized under the Workers' Compensation Laws and duly certified in New York State to provide acupuncture services.

**7. Codes in the Acupuncture Fee Schedule**

A licensed acupuncturist may only use CPT® codes contained in the Acupuncture Fee Schedule for billing of treatment. A licensed acupuncturist may not use codes that do not appear in the Acupuncture Fee Schedule. Chiropractors who are licensed acupuncturists should use the Chiropractic Fee Schedule when performing acupuncture services. Physicians should use the Medical Fee Schedule when performing acupuncture services.

**8. Modifiers**

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Modifiers commonly used with surgical procedures are as follows:

**25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service**

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57.

# 2 Evaluation and Management (E/M)

The relative value units listed in this section have been determined on an entirely different basis than those in other sections. A conversion factor applicable to this section is not applicable to any other section.

The relative value units listed in this section reflect the relativity of charges for procedures within this section only.

The fee for a particular procedure or service in this section is determined by multiplying the listed “relative value unit” by the current dollar “conversion factor” applicable to this section, subject to the ground rules, instructions, and definitions of the schedule.

To ensure uniformity of billing, when multiple services are rendered, each relative value unit is to be multiplied by the conversion factor separately, and then products are to be added.

## EVALUATION AND MANAGEMENT GROUND RULES

Visits, examinations, consultations, and similar services as listed in this section reflect the wide variations in time and skills required in the diagnosis and treatment of illness or injury. The listed relativities apply only when these services are performed by an authorized licensed acupuncturist unless otherwise stated. Please refer to the CPT® guidelines for a full explanation of the proper use of the Evaluation and Management codes.

When exact text of the AMA CPT® guidelines is used, the text is either in quotations or is preceded by the phrase “CPT guidelines state.”

Rules used by all acupuncturists in reporting their services are presented in the Introduction and General Guidelines section. Definitions and rules pertaining to Evaluation and Management services are as follows:

### 1A. NYS Medical Treatment Guidelines

The recommendations of the NYS Medical Treatment Guidelines supersede the ground rule frequency limitation for services rendered to body parts covered by the NYS Medical Treatment Guidelines. Treatment of work-related injuries should be in accordance with

any applicable medical treatment guidelines adopted by the Chair of the Workers’ Compensation Board. If there is a conflict between the fee schedule ground rules and the medical treatment guidelines, the guidelines will prevail. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers’ Compensation Board has approved a variance.

### 1B. New and Established Patient Service

Several code subcategories in the Evaluation and Management section are based on the patient’s status; new or established. The Evaluation and Management code for initial visits is 99201. E/M established visit code 99212 may be used to bill for a periodic re-evaluation consisting of a thorough examination and report documenting diagnosis, thorough interim history, clinical findings, and future course of treatment. The maximum number of RVUs (including treatment) per patient per day per accident or illness when billing for an initial evaluation shall be limited to 18. The following codes represent the treatments subject to this rule:

99201, 99212

*CPT 2018* guidelines define new and established patients. The patient definitions have been expanded from *CPT 2018* for the New York Fee Schedule (this text will be in italics).

#### New Patient

A new patient is one who has not received any professional services from the *acupuncturist, or another acupuncturist* who belongs to the same group practice, within the past three years.

#### Established Patient

An established patient *shall also be considered one who has been treated for the same injury by any acupuncturist* who belongs to the same group practice. *Because*

*initial records such as history and physical are available within the group's facility, an initial new patient visit would not be indicated.* The maximum number of RVUs (including treatment) per person per day per accident or illness when billing for a re-evaluation shall be limited to 15.

The procedure codes that exclusively represent established patient visits are identified in the fee schedule with the tilde (~) symbol.

The new versus established patient guidelines also clarify the situation in which an acupuncturist is on call or covering for another acupuncturist. In this instance, classify the patient encounter the same as if it were for the acupuncturist who is unavailable.

### 3. Periodic Re-evaluation

Code 99212 may be used to bill for a periodic re-evaluation consisting of documentation of: (1) an

interim history describing the patient's response to the current treatment regimen (i.e., efficacy of the treatment/modality), (2) objective findings on physical examination, and (3) the future treatment plan and goals. If there is a positive patient response, functional gains must be objectively measured (including but not limited to improvement in positional tolerances, range of motion, strength, endurance) and documented. If the patient has not demonstrated a positive response, the treatment regimen should be modified or discontinued. The provider should re-evaluate the efficacy of the treatment or modality 2–3 weeks after the initial visit and every 3–4 weeks thereafter.

### 4. Narrative Reports

A detailed narrative report must be submitted with the bill for the following procedures: 99201 and 99212.

**99201, 99212****EVALUATION AND MANAGEMENT**

Effective January 1, 2020

**Acupuncture Fee Schedule**

	<b>Code</b>	<b>Description</b>	<b>Relative Value</b>	<b>FUD</b>
	<b>99201</b>	Initial E/M	5.83	XXX
~	<b>99212</b>	Re-Evaluation	4.57	XXX

DRAFT



# 3 Medicine

The relative values listed in this section have been determined on an entirely different basis than those in other sections. A conversion factor applicable to this section is not applicable to any other section. The relative value units listed in this section reflect the relativity of charges for procedures within this section only. The fee for a particular procedure or service in this section is determined by multiplying the listed “relative value unit” by the current dollar “conversion factor” applicable to this section, subject to the ground rules, instructions, and definitions of the schedule. To ensure uniformity of billing, when multiple services are rendered, each relative value unit is to be multiplied by the conversion factor separately, and then the products are to be added.

## MEDICINE GROUND RULES

Rules used by all acupuncturists in reporting their services are presented in the Introduction and General Guidelines section preceding the Medicine section. Definitions and rules pertaining to Medicine services are as follows:

### 1A. NYS Medical Treatment Guidelines

The recommendations of the NYS Medical Treatment Guidelines supersede the ground rule frequency limitation for services rendered to body parts covered by the NYS Medical Treatment Guidelines. The maximum reimbursement limitations per patient per day per accident or illness for modalities is 12.0 RVUs, re-evaluation plus modalities is 15.0 RVUs, and

initial evaluation plus modalities is 18 RVUs. 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.

### 1B. Multiple Acupuncture Procedures

When multiple acupuncture procedures are performed on the same day, reimbursement is limited to 12.0 RVUs per patient per accident or illness or the amount billed, whichever is less. **Note:** When a patient receives acupuncture, chiropractic, physical or occupational therapy procedures or modalities from more than one provider, the patient may not receive more than 12 RVUs per day per accident or illness from all providers. The following codes represent the acupuncture procedures subject to this rule:

97810, 97811, 97813, 97814

**MEDICINE****97810-97814****Acupuncture Fee Schedule****Effective January 1, 2020**

	<b>Code</b>	<b>Description</b>	<b>Relative Value</b>	<b>FUD</b>
	<b>97810</b>	Acupuncture	3.55	XXX
<b>+</b>	<b>97811</b>	Acupuncture	3.04	XXX
	<b>97813</b>	Acupuncture	3.89	XXX
<b>+</b>	<b>97814</b>	Acupuncture	3.38	XXX

DRAFT

---

Section 2:

**Physical and  
Occupational  
Therapy**

---

DRAFT



# 1 Introduction and General Guidelines

The Physical and Occupational Therapy section of the *Official New York Workers' Compensation Acupuncture and Physical and Occupational Therapy Fee Schedules* shows physical and occupational therapy services and their relative value units. The services are listed by Current Procedural Terminology (CPT®) codes. The relative value unit set for each CPT service is based on comparative magnitude among various services and procedures. The relative values within each section apply only to that section. CPT is a registered trademark of the American Medical Association.

The accompanying instructions and ground rules explain the application of these procedure descriptors and relative value units in the physical and occupational therapy practice.

Because the Physical and Occupational Therapy Fee Schedule is applicable to all of New York State (NYS), a large and diverse geographical area, the relative value units contained herein do not necessarily reflect the charges of any individual therapist or the pattern of charges in any specific area of New York State.

A primary purpose of the fee schedule is to provide a precise description and coding of the services provided by New York physical and occupational therapists in the care of workers' compensation covered patients and ensures the proper payment for such services by assuring that they are specifically identifiable.

This edition of the *Official New York Workers' Compensation Acupuncture and Physical and Occupational Therapy Fee Schedule* uses CPT procedure codes, modifiers, and descriptions. Please refer to the CPT book for an explanation of coding rules and regulations not listed in this schedule.

## FORMAT

The Physical and Occupational Therapy section of the *Official New York Workers' Compensation Acupuncture and Physical and Occupational Therapy Fee Schedule* consists of one section, Physical Medicine. This section has instructions which precede the codes, descriptions, and values.

The section is organized according to type of service and the variations of overhead expense ratios for providing the services. The Physical and Occupational Therapy Fee Schedule uses a single physical/occupational therapy conversion factor with the amount varying by region.

## Introductory Information

The introductory ground rules that precede the data include definitions, references, prohibitions, and directions for proper use. It cannot be emphasized too strongly that the introductory ground rules be read and understood before using the data in this schedule.

## Regions

The Board has established four regions within New York State based on the difference in the cost of maintaining a practice in different localities of the state. The Board has defined each such region by use of the U.S. Postal Service ZIP codes for the state of New York, based upon the relative cost factors which are compatible to that region.

The fees payable for Physical and Occupational therapy services shall be determined by the region in which the services were rendered.

## HOW TO INTERPRET FEE SCHEDULE DATA

There are six columns used throughout the Physical and Occupational Therapy Fee Schedule. The columns vary by section throughout the schedule.

## Icons

The following icons are included in the Physical and Occupational Therapy Fee Schedule:

- + Add-on service—Add-on codes have been designated in the CPT book as being additional or supplemental procedures that are carried out in addition to the primary procedure.
- ⊖ Modifier 51 exempt service—Modifier 51 exempt codes have not been identified as add-on services but are exempt from modifier 51 when performed in conjunction with other services.

- ⑤ Optum360 identified modifier 51 exempt service—Additional modifier 51 exempt codes identified by Optum360 based upon CPT language are exempt from modifier 51 when performed in conjunction with other services.
- ® Altered CPT codes—Services listed have been altered from the official CPT code description.
- ∞ State-specific codes or modifiers—Where a CPT code or modifier does not currently exist to describe a service there may be a state-specific code number assigned to describe the service. Relative value units (RVUs) are state assigned or gap filled.

**Code**

The Code column lists the American Medical Association's (AMA) CPT® 2018 is used by arrangement with the AMA. Any altered CPT codes are identified with the registered trademark symbol (®). State-specific codes are identified with the infinity symbol (∞).

**Description**

This manual lists full CPT 2018 descriptions.

**Relative Value**

The Relative Value column lists the relative value units used to calculate the fee amount for a service. Except as otherwise provided in this schedule, the maximum fee amount is calculated by multiplying the relative value units by the applicable conversion factor. Conversion factors are listed later in this chapter.

Relative values are used to calculate fees using the following formula:

$$\text{Relative value} \times \text{applicable conversion factor} = \text{fee}$$

For example, the total fee for code 97161, performed in Region I or Region II, would be calculated as follows:

$$\begin{array}{r}
 9.47 \quad (\text{Relative Value}) \\
 \times \quad \$7.69 \quad (\text{Physical Medicine Section Conversion} \\
 \quad \quad \quad \text{Factor for Region I or II}) \\
 \hline
 = \quad \$72.82
 \end{array}$$

**POSTAL ZIP CODES BY REGION**

Postal ZIP codes included in each region:

**Region I**

<i>From</i>	<i>Thru</i>	<i>From</i>	<i>Thru</i>
12007	12099	13601	13699
12106	12177	13730	13797
12184	12199	13801	13865
12401	12498	14001	14098
12701	12792	14101	14174
12801	12887	14301	14305
12901	12998	14410	14489
13020	13094	14501	14592
13101	13176	14701	14788
13301	13368	14801	14898
13401	13439	14901	14925
13450	13495		

**Region II**

<i>From</i>	<i>Thru</i>	<i>From</i>	<i>Thru</i>
12179	12183	13440	13449
12201	12288	13501	13599
12301	12345	13901	13905
12501	12594	14201	14280
12601	12614	14601	14694
13201	13290		

**Region III**

<i>From</i>	<i>Thru</i>	<i>From</i>	<i>Thru</i>
06390	06390	10801	10805
10501	10598	10901	10998
10601	10650	11901	11980
10701	10710		

**Region IV**

<i>From</i>	<i>Thru</i>	<i>From</i>	<i>Thru</i>
00501	00501	11101	11120
00544	00544	11201	11256
10001	10099	11301	11390
10100	10199	11401	11499
10200	10299	11501	11599
10301	10314	11601	11697
10401	10499	11701	11798
11001	11096	11801	11854

**Numerical List of Postal Zip Codes**

From	Thru	Region	From	Thru	Region
00501	00501	IV	12401	12498	I
00544	00544	IV	12501	12594	II
06390	06390	III	12601	12614	II
10001	10099	IV	12701	12792	I
10100	10199	IV	12801	12887	I
10200	10299	IV	12901	12998	I
10301	10314	IV	13020	13094	I
10401	10499	IV	13101	13176	I
10501	10598	III	13201	13290	II
10601	10650	III	13301	13368	I
10701	10710	III	13401	13439	I
10801	10805	III	13440	13449	I
10901	10998	III	13450	13495	I
11001	11096	IV	13501	13599	II
11101	11120	IV	13601	13699	I
11201	11256	IV	13730	13797	I
11301	11390	IV	13801	13865	I
11401	11499	IV	13901	13905	II
11501	11599	IV	14001	14098	I
11601	11697	IV	14101	14174	I
11701	11798	IV	14201	14280	II
11801	11854	IV	14301	14305	I
11901	11980	III	14410	14489	I
12007	12099	I	14501	14592	I
12106	12177	I	14601	14694	II
12179	12183	II	14701	14788	I
12184	12199	I	14801	14898	I
12201	12288	II	14901	14925	I
12301	12345	II			

**PHYSICAL AND OCCUPATIONAL THERAPY CONVERSION FACTORS**

Regional conversion factors for services rendered on or after January 1, 2020.

Section	Region I	Region II	Region III	Region IV
<b>Physical Medicine</b>	\$7.69	\$7.69	\$8.79	\$9.55

**CALCULATING FEES USING RELATIVE VALUES AND CONVERSION FACTORS**

Except as otherwise provided in this schedule, the maximum fee amount is calculated by multiplying the relative value by the applicable conversion factor. For example, the total fee for code 97161, performed in Region I or Region II, would be calculated as follows:

$$9.47 \text{ (Relative Value)}$$

$$\times \$7.69 \text{ (Physical Medicine Section Conversion Factor for Region I or II)}$$

$$= \$72.82$$

**GENERAL GROUND RULES**

**1A. NYS Medical Treatment Guidelines**

The recommendations of the NYS Medical Treatment Guidelines supersede the ground rule frequency limitation for services rendered to body parts covered by the NYS Medical Treatment Guidelines. Treatment of work-related injuries should be in accordance with any applicable medical treatment guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the fee schedule ground rules and the medical treatment guidelines, the guidelines will prevail. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

**1B. Referral and Prescription by Physician, Nurse Practitioner, Physician Assistant or Podiatrist**

Occupational and physical therapy services must be rendered only upon the prescription or referral of an authorized physician, nurse practitioner, physician assistant or podiatrist. The referring or prescribing provider should also oversee the written instructions for treatment for a given diagnosis. Written instructions should include precautions, goals, frequency, and modalities to be used.

**2. Utilization**

Physical or occupational therapy services may not exceed 12 sessions/visits per patient per accident or illness or be rendered more than 45 days from the first session/visit.

**3. Report Requirements**

Authorized physical and occupational therapists shall submit reports of treatment in the electronic format prescribed by the Chair.

**4. Treatment by Out of State Providers**

*Claimant lives outside of New York State*—A claimant who lives outside of New York State may treat with a qualified out-of-state medical provider. The medical treatment shall conform to the Medical Treatment Guidelines and the Ground Rules included herein.

Payment for medical treatment shall be at the Fee Schedule amount for work related injuries and illnesses as available in the state where treatment is rendered, or if there is no such fee schedule, then such charges shall be as prevail in the community for similar treatment. All fees shall be subject to the jurisdiction of the Board.

*Claimant lives in New York State but treats outside of New York State*—A claimant who lives in New York State may treat with a qualified or Board authorized out-of-state medical provider when such treatment conforms to the Workers' Compensation Law and regulations, the Medical Treatment Guidelines and the Medical Fee Schedule. Payment shall be made to the medical provider as set forth herein and using the regional conversion factor for the zip code where the claimant resides.

Out-of-state medical treatment that does not “further the economic and humanitarian objective” of Workers' Compensation Law may be denied by the Board.

A medical provider who has had a NYS WCB authorization suspended, revoked or surrendered shall not be qualified to treat out-of-state.

## **5. Codes in the Physical and Occupational Therapy Fee Schedule**

A PT/OT may only use CPT codes contained in the Physical and Occupational Therapy Fee Schedule for billing of treatment. A PT/OT may not use codes that do not appear in the Physical and Occupational Therapy Fee Schedule.

DRAFT

# 2 Physical Medicine

## PHYSICAL MEDICINE GROUND RULES

### 1. Home Treatment

When treatment is rendered in a patient's home by an authorized occupational or physical therapist, add 50 percent to the listed value. Documentation explaining the necessity of home treatment instead of an office or outpatient treatment setting is required with the bill to the insurance carrier.

### 2. Initial Evaluation and Re-evaluation by a Physical or Occupational Therapist

Authorized physical therapists (PT) and occupational therapists (OT) may bill for an initial evaluation using CPT codes 97161–97163 and 97165–97167, respectively.

Evaluations shall include the following elements: history, examination, clinical testing, interpretation of data, clinical presentation, clinical decision making, and development of the plan of care with defined goals, appropriate interventions, and recommendations.

The maximum number of relative value units (including treatment) when billing for an initial evaluation shall be limited to 18. The following codes represent the treatments subject to this rule:

97010	97012	97014	97016	97018	97022
97024	97026	97028	97032	97033	97034
97035	97036	97039	97110	97112	97113
97116	97124	97139	97140	97150	97530
97535	97537	97542	97760	97761	97762
97763					

Re-evaluations using CPT codes 97164 (PT) and 97168 (OT) may be billed in addition to the modalities rendered when any of the following applies:

- A) If following discharge (for whatever reason), the patient is referred again for treatment with the same or similar condition of the same body part.

- B) If there is a significant change in the patient's condition that warrants a revision of the treatment goals, intervention and/or the plan of care.
- C) If it is medically necessary to provide re-evaluation services over and above those normally included during therapeutic treatment.
- D) If the patient's status becomes stationary and it is not likely that significant improvement will occur with further treatment.
- E) If at the conclusion of the current episode of therapy care, re-evaluation is indicated for any of the following reasons:
- Satisfactory goal achievement with present functional status defined including a home program and follow-up services, as necessary.
  - Patient declines to continue care.
  - The patient is unable to continue to work toward goals due to medical or psychosocial complications.

Please note, however, that re-evaluations may be billed only in instances where such evaluation is therapeutically necessary, and in any event, not more than once in a 30-day period.

The maximum number of relative value units (including treatment) when billing for a re-evaluation shall be limited to 15.

### 3. Multiple Physical Medicine Procedures and Modalities

When multiple physical therapy or occupational therapy procedures and/or modalities are performed on the same day, reimbursement is limited to 12.0 RVUs per patient per accident or illness or the amount billed, whichever is less. **Note:** When a patient receives occupational or physical therapy procedures and/or modalities from more than one provider, the patient may not receive more than 12.0 RVUs per day per accident or illness from all providers. The following codes represent the physical medicine procedures and modalities subject to this rule:

97010	97012	97014	97016	97018	97022
97024	97026	97028	97032	97033	97034
97035	97036	97039	97110	97112	97113
97116	97124	97139	97140	97150	97530
97535	97537	97542	97760	97761	97762
97763					

#### 4. Tests and Measurements

Codes 97760–97763 training and management for orthotic/prosthetic use, shall not be billed on the same day as an office visit.

#### 5. Work Hardening Rules

Work hardening programs are interdisciplinary, goal-specific, vocationally-driven treatment programs designed to maximize the likelihood of return to work through functional, behavioral, and vocational management.

Not all claimants require these programs to reach a level of function that will allow successful return to work.

Only those programs that meet all of the specific guidelines will be defined as work hardening programs.

Programs will be reimbursed per the fee schedule after meeting all other requirements.

##### Pre-Admission Criteria

All claimants must complete a preprogram assessment including a Functional Capacity Evaluation (FCE) and Vocational Evaluation.

The goal of the program is return to work, therefore, for all anticipated returns to previous employment or placement with a new employer, the following must be provided:

- A) Specific written critical job demands and/or job site analysis
- B) Verified written employment opportunities

##### Evaluation Process

Initial screening evaluation is performed by the treatment team consisting of:

- A) Physical Therapy and/or Occupational Therapy PLUS
- B) Psychology/Psychiatry and/or Vocational Rehabilitation, Chiropractor, or other providers suitable by scope of practice as determined in the State Education Law

The outcome of this evaluation will be:

- A) Recommendation of release to return to work
- B) Acceptance into the program with an Individual Written Rehabilitation Plan stating specific goals and recommended services
- C) Rejection from program for specific reasons
- D) Referral back to provider for medical evaluation
- E) Recommendation of vocational rehabilitation, either by referral to and acceptance by Adult Career and Continuing Education Services—Vocational Rehabilitation (ACCES-VR), or by other providers if approved by the carrier

Claimants must be referred by a physician, nurse practitioner, physician assistant or podiatrist authorized by the NYSWCB to provide care to injured claimants, who will provide a written referral for evaluation and treatment.

##### Programs and Providers

Claimants will be provided with the availability of the following providers as determined by the needs of the claimant:

- A) A minimum of two (2) of the following: Physical Therapist, Occupational Therapist, Vocational Rehabilitation Counselor, Psychologist/Psychiatrist/Psychiatric Nurse Practitioner/Licensed Clinical Social Worker, Chiropractor, or other provider suitable by scope of practice as determined in the State Education Law; in addition to a Case Manager, either internal or external to the program.
- B) Providers who can provide initial medical evaluation, participation in the development of the treatment plan, and coordination of work restrictions and discharge planning with the recommendation of specialists in Physical Medicine and Rehabilitation.

##### Discharge Criteria

Discharge criteria must be provided to all claimants in writing prior to initiation of treatment at the time program goals are determined.

Voluntary discharge is achieved by:

- A) Meeting program goals
- B) Early return to work
- C) Acute or worsening medical conditions
- D) The claimant declining further treatment

Non-voluntary discharge may be necessary in cases of:

- A) Failure to comply with program policies
- B) Absenteeism
- C) Lack of demonstrable benefit from treatment

Non-voluntary discharge requires written documentation of prior and repeated counseling of the claimant, and immediate notification of the employer, insurer, case manager, and referring and attending (if different) provider.

Under all circumstances of voluntary and non-voluntary discharge, the claimant will return to the referring attending provider for release from the program.

The attending provider must sign a release to return to work when the program goals are achieved.

#### **Program Evaluation**

Programs are subject to disclosure and evaluation as permitted by local and state health care agencies and other appropriate individuals or groups in the State of New York, including issues of:

- A) Written policies and procedures
- B) Program implementation
- C) Maintenance of medical records
- D) Outcomes achieved
- E) Site design and equipment
- F) Affiliations with non-site-based providers
- G) Admission and discharge criteria

Programs must provide insurers and referring providers with:

- A) Initial interdisciplinary team evaluation report
- B) Proposed treatment plan
- C) Progress reports at weekly intervals
- D) Opportunity to attend team meetings
- E) Final discharge summary report
- F) Any information described in sections above

#### **Integration of Vocation Rehabilitation Services**

Work hardening programs are vocationally directed and driven rehabilitation services. The vocational rehabilitation counselor serves to:

- A) Coordinate efforts between the claimant, program, and employer

- B) Obtain job descriptions and critical job demands from the employer
- C) Gather and provide information to the treatment team
- D) Educate employers toward work tasks and work-site design
- E) Assist claimants toward appropriate employment opportunities within their safe maximal capabilities

Programs that do not retain the services of vocational rehabilitation counselors on a full time basis may utilize private rehabilitation agencies, specialists provided by insurance carriers, or ACCES-VR. These individuals are required to make continuous on-site contact with claimants and program providers, including participation in team meetings.

The qualifications for serving as a vocational rehabilitation counselor with respect to work hardening programs shall be determined by the Director of Rehabilitation and Social Services of the State of New York Workers' Compensation Board. Vocational rehabilitation counselors should be reimbursed at the usual and customary rate currently paid by insurers in each region.

#### **Program Duration**

Work hardening programs will be provided on the following time schedule:

- A) Daily treatment, full or partial days, with fee differential
- B) Minimum of ten (10) treatment days and maximum of thirty (30) treatment days subject to carrier prior approval
- C) Treatment to be completed within six (6) consecutive weeks
- D) Any additional treatment days beyond thirty (30) upon approval by the carrier

#### **Fee Schedule**

Fees for work hardening programs will be paid in accordance with the medical fee schedule, with written prior approval by the carrier, utilizing the following guidelines:

- A) In all cases, for both voluntary and non-voluntary discharge, payment is for the actual duration of treatment provided.
- B) Payment differential for partial and full day program.

- C) CPT codes 97545 and 97546 will be reimbursed for work hardening programs only as described above.
- D) Non-multidisciplinary "work conditioning" programs will be reimbursed utilizing existing PT, OT, and physical medicine codes.
- E) Behavioral health services as requested in the Individual Written Rehabilitation Plan and approved by the carrier will be billed separately from codes 97545 and 97546, in accordance with the appropriate fee schedules.
- F) Payment for external case managers and vocational rehabilitation counselors will be the responsibility of the carrier, exclusive of program codes 97545 and 97546.
- G) Billing will not exceed eight (8) hours for any given treatment day.

## 6. Functional Capacity Evaluations (FCE)

### Indications

The FCE is utilized for the following purposes:

- A) To determine the level of safe maximal function at the time of maximal medical improvement.
- B) To provide a prevocational baseline of functional capabilities to assist in the vocational rehabilitation process.
- C) To objectively set restrictions and guidelines for return to work.
- D) To determine whether specific job tasks can be safely performed by modification of technique, equipment, or by further training.
- E) To determine whether additional treatment or referral to a work hardening program is indicated.
- F) To assess outcome at the conclusion of a work hardening program.

### General Requirements

- A) The FCE may be prescribed only by an authorized physician, nurse practitioner, physician assistant or podiatrist, or may be requested by the carrier when indicated.
- B) The FCE does not require prior authorization by the carrier.
- C) The prescribing provider must justify the indication for each at the request of the carrier (see Eligibility Criteria).
- D) The FCE shall be performed by a physical or occupational therapist currently holding a valid

license in New York State, or other licensed provider qualified by scope of practice. Constant supervision by the licensed provider is required.

### Specific Requirements

- A) The FCE, when medically necessary and indicated, may be performed only at the point of maximum medical improvement in the opinion of the attending provider.
- B) The FCE should not be prescribed prior to three (3) months post-injury unless there is a significant documented change in the claimant's status which justifies earlier utilization.
- C) At least one of the following eligibility criteria is required for all claimants:
  - 1) Claimant is preparing to return to previous job.
  - 2) Claimant has been offered a new job (verified).
  - 3) Claimant is working with a rehabilitation provider and a vocational objective is established.
  - 4) Claimant is expected to be classified with a non-schedule permanent partial disability.
- D) Reports will include the following information:
  - 1) Patient demographics including work history.
  - 2) Indication for evaluation.
  - 3) Type of evaluation performed.
  - 4) Raw and tabulated data.
  - 5) Normative data values.
  - 6) Narrative cover sheet with recommendations.
- E) The bill for services provided must be attached to the report to be processed by the carrier.
- F) All evaluation tools must be standardized, and normative data and interpretive guidelines must be attached to the report.

### NYS Allowable for FCE

∞97800 Functional Capacity Evaluation:

<b>Region I</b>	<b>\$496.00</b>	<b>Region II</b>	<b>\$496.00</b>
<b>Region III</b>	<b>\$564.00</b>	<b>Region IV</b>	<b>\$614.00</b>

## 7. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Modifiers commonly used with physical or occupational therapy services are as follows:

### 22 **Increased Procedure**

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

### 51 **Multiple Procedures**

When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D).

### 96 **Habilitative Services**

When a service or procedure that may be either habilitative or rehabilitative in nature is provided for habilitative purposes, the occupational or physical therapist may add modifier 96 to the service or procedure code to indicate that the service or procedure provided was a habilitative service. Habilitative services help an individual learn skills and functioning for daily living that the individual has not yet developed, and then keep and/or improve those learned skills. Habilitative services also help an individual keep, learn, or improve skills and functioning for daily living.

### 97 **Rehabilitative Services**

When a service or procedure that may be either habilitative or rehabilitative in nature is provided for rehabilitative purposes, the occupational or physical therapist may add modifier 97 to the service or procedure code to indicate that the service or procedure provided was a rehabilitative service. Rehabilitative services help an individual keep, get back, or

improve skills and functioning for daily living that have been lost or impaired because the individual was sick, hurt, or disabled.

### 99 **Multiple Modifiers**

Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

### GO **Services Delivered Under an Outpatient Occupational Therapy Plan of Care**

When occupational therapy services are provided under the plan of care for occupational therapy this modifier is re-reported with the list of applicable therapy codes.

### GP **Services Delivered Under an Outpatient Physical Therapy Plan of Care**

When physical therapy services are provided under the plan of care for physical therapy this modifier is reported with the list of applicable therapy codes.

## 8. Durable Medical Equipment (DME) Fee Schedule

All durable medical equipment supplied shall be billed and paid using the Durable Medical Equipment Fee Schedule dated [TO BE DETERMINED]. The Durable Medical Equipment Fee Schedule may be obtained [TO BE DETERMINED].

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.

Prior Authorization for any item not included in the Durable Medical Fee Schedule is required prior to providing it to the patient.

**PHYSICAL MEDICINE 95831-95852, 97010-97124, 97139-97150, 97161-97168, 97530, 97535-97546, 97750-97763, ∞97800****Physical and Occupational Therapy Fee Schedule****Effective January 1, 2020**

	<b>Code</b>	<b>Description</b>	<b>Relative Value</b>	<b>FUD</b>	
	95831	PT/OT codes	0.00	XXX	
	95832	PT/OT codes	0.00	XXX	
	95833	PT/OT codes	0.00	XXX	
	95834	PT/OT codes	0.00	XXX	
	95851	PT/OT codes	0.00	XXX	
	95852	PT/OT codes	0.00	XXX	
Ⓜ	97010	PT/OT codes	0.55	XXX	
Ⓜ	97012	PT/OT codes	2.71	XXX	
Ⓜ	97014	PT/OT codes	2.66	XXX	
Ⓜ	97016	PT/OT codes	3.30	XXX	
Ⓜ	97018	PT/OT codes	2.71	XXX	
Ⓜ	97022	PT/OT codes	2.62	XXX	
Ⓜ	97024	PT/OT codes	2.71	XXX	
Ⓜ	97026	PT/OT codes	2.54	XXX	
Ⓜ	97028	PT/OT codes	2.54	XXX	
Ⓜ	97032	PT/OT codes	2.45	XXX	
Ⓜ	97033	PT/OT codes	3.55	XXX	
Ⓜ	97034	PT/OT codes	2.37	XXX	
Ⓜ	97035	PT/OT codes	2.41	XXX	
Ⓜ	97036	PT/OT codes	3.89	XXX	
	97039	PT/OT codes	BR	XXX	
Ⓜ	97110	PT/OT codes	3.97	XXX	
Ⓜ	97112	PT/OT codes	3.89	XXX	
Ⓜ	97113	PT/OT codes	4.40	XXX	
Ⓜ	97116	PT/OT codes	3.51	XXX	
Ⓜ	97124	PT/OT codes	2.62	XXX	
	97139	PT/OT codes	2.89	XXX	
Ⓜ	97140	PT/OT codes	4.23	XXX	
Ⓜ	97150	PT/OT codes	3.63	XXX	
	97161	PT/OT codes	9.47	XXX	
	97162	PT/OT codes	9.47	XXX	
	97163	PT/OT codes	9.47	XXX	
	97164	PT/OT codes	4.00	XXX	
	97165	PT/OT codes	9.47	XXX	
	97166	PT/OT codes	9.47	XXX	
	97167	PT/OT codes	9.47	XXX	
	97168	PT/OT codes	4.00	XXX	
Ⓜ	97530	PT/OT codes	2.87	XXX	
Ⓜ	97535	PT/OT codes	3.38	XXX	
Ⓜ	97537	PT/OT codes	3.38	XXX	
Ⓜ	97542	PT/OT codes	2.37	XXX	
Ⓜ	Ⓜ 97545	PT/OT codes	28.00	XXX	
+	Ⓜ	Ⓜ 97546	PT/OT codes	3.30	ZZZ
	Ⓜ 97750	PT/OT codes	0.00	XXX	
	Ⓜ 97755	PT/OT codes	NC	XXX	

95831-95852, 97010-97124, 97139-97150, 97161-97168, 97530, 97535-97546, 97750-97763, ∞97800 **PHYSICAL MEDICINE**

Effective January 1, 2020

Physical and Occupational Therapy Fee Schedule

	<b>Code</b>	<b>Description</b>	<b>Relative Value</b>	<b>FUD</b>
	Ⓢ <b>97760</b>	PT/OT codes	4.23	XXX
	Ⓢ <b>97761</b>	PT/OT codes	4.23	XXX
	Ⓢ <b>97763</b>	PT/OT codes	3.55	XXX
	∞ <b>97800</b>	PT/OT codes	Refer to Rules	

DRAFT

