

Introduction and General Guidelines

The *Official New York State Workers' Compensation Behavioral Health Fee Schedule* shows behavioral health 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 Behavioral Health 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 medical provider 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 authorized psychologists, psychiatric nurse practitioners, licensed clinical social workers, and physicians in the care of workers' compensation covered patients and ensure the proper payment for such services by assuring that they are specifically identifiable. The Behavioral Health Fee Schedule is for use by these medical providers delivering behavioral health services and treatment to injured workers covered under Workers' Compensation Law. Physicians and psychiatric nurse practitioners can use the full version of the *Official New York State Workers' Compensation Medical Fee Schedule* and the codes and conversion factors therein. Psychologists and licensed clinical social workers are to bill for services listed in this section of the fee schedule as appropriate.

An attempt has been made to adhere as closely as possible to the terminology and coding of the American Medical Association's *CPT 2018*.

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.

FORMAT

The *Official New York State Workers' Compensation Behavioral Health Fee Schedule* consists of one section, which uses the psychology conversion factor.

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 Workers' Compensation 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 behavioral health services shall be determined by the region in which the services were rendered.

HOW TO INTERPRET THE FEE SCHEDULE DATA

The columns used in the Behavioral Health Fee Schedule vary by section throughout the schedule.

Icons

The following icons are included in the Behavioral Health Fee Schedule:

- New and changed codes—Codes that are new, changed description, or changed value from June 1, 2012.
- + 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.

From	Thru	Region	From	Thru	Region
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			

CONVERSION FACTORS

Regional conversion factors for services rendered on or after April 1, 2019.

Section	Region I	Region II	Region III	Region IV
Psychology	\$7.94	\$7.94	\$9.08	\$9.86

Physicians and psychiatric nurse practitioners can bill codes from other sections of the *Official New York State Workers' Compensation Medical Fee Schedule* as appropriate (such as E/M, Medicine, etc.) and should determine their fees using the corresponding conversion factors listed in that manual's Introduction and General Guidelines section. Nurse practitioners and licensed clinical social workers should use appropriate modifiers and bill in accordance with General Ground Rules 9 and 12 herein.

NEW CPT CODES

The table below is a complete list of CPT codes that have been added to the Behavioral Health Fee Schedule since the June 1, 2012 fee schedule.

These codes are identified in the fee schedule with "■".

90785	90791	90792	90832	90833	90834
90836	90837	90838	90839	90840	97127

CHANGED CODES

Changed Values

The following table is a list of CPT and state-specific codes applicable to the Behavioral Health Fee Schedule that have a relative value change, an FUD change, or a PC/TC split change since the June 1, 2012 fee schedule. Codes that have had a description change are listed in a separate table below.

Columns that are blank for any code, either do not apply to the code or the code was not assigned a value on the current or previous (June 1, 2012) fee schedule.

For each code listed, the following information is included:

NY 2018 RVU. This is the current RVU for services rendered on or after April 1, 2019.

NY 2012 RVU. This is the RVU effective June 1, 2012.

NY 2018 FUD. This is the FUD for services rendered on or after April 1, 2019.

NY 2012 FUD. This is the FUD listed in the June 1, 2012 fee schedule.

NY 2018 PC/TC Split. This is the PC/TC split for services rendered on or after April 1, 2019. Only codes with distinct professional and technical components are assigned a PC/TC split; therefore, many codes will not have a value in this column.

NY 2012 PC/TC Split. This is the PC/TC split effective June 1, 2012.

These codes are identified in the fee schedule with "■".

CODE	NY 2018 RVU	NY 2012 RVU	NY 2018 FUD	NY 2012 FUD	NY 2018 PC/TC Split	NY 2012 PC/TC Split
99075	\$350.00	\$400.00				

Changed Descriptions

The table below is a list of CPT codes applicable to the Behavioral Health Fee Schedule that have had a description change since the June 1, 2012 fee schedule.

90846	90847	90875	90876	90889	96110
97533					

DELETED CPT CODES

The table below is a list of CPT codes that have been deleted from the Behavioral Health Fee Schedule since the June 1, 2012 fee schedule.

90801	90802	90804	90806	90808	90810
90812	90814	90816	90818	90821	90823
90826	90828	90857	97532		

BEHAVIORAL HEALTH SERVICES PROVIDED BY PHYSICIANS, PSYCHIATRIC NURSE PRACTITIONERS, PSYCHOLOGISTS AND LICENSED CLINICAL SOCIAL WORKERS

Behavioral health services will be rendered by a New York State Workers' Compensation Board (NYS WCB) authorized psychiatrist or a NYS WCB authorized physician with a rating code of PN-ADP (Addiction Medicine) or PN-PM (Pain Management), an authorized psychiatric nurse practitioner, psychologist or licensed clinical social worker. A physician, psychiatric nurse practitioner, psychologist or licensed clinical social worker who is not Board authorized may not provide treatment.

All reports and bills shall be submitted in the format prescribed by the Chair by the treating authorized provider using the appropriate modifier. Fees shall be paid at the following rates:

- Psychiatric nurse practitioners shall bill at 80 percent of the applicable medical treatment code and conversion factor available to physicians using modifier NP
- Psychologists shall bill using the applicable behavioral health treatment code and conversion factor
- Licensed clinical social workers shall bill at 80 percent of the applicable medical treatment code and conversion factor for psychologists using modifier AJ

BEHAVIORAL HEALTH GROUND RULES

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.

1B. Biofeedback

Biofeedback is a form of behavioral medicine that helps patients learn self-awareness and self-regulation skills for the purpose of gaining greater control of their physiology. Electronic instrumentation is used to monitor the targeted physiology and then displayed or fed back to the patient through visual, auditory or tactile means, with coaching by a biofeedback specialist. Treatment is individualized to the patient's work-related diagnosis and needs. Home practice of skills is required for mastery and may be facilitated by the use of home training tapes. The ultimate goal of biofeedback treatment is the transfer of learned skills to the workplace and daily life. Candidates for biofeedback therapy or training must be motivated to learn and practice biofeedback and self-regulation techniques.

Biofeedback is not appropriate for individuals suffering from acute pain or acute injury. It may be appropriate for non-acute pain when combined with a program including functional restoration.

- Time to Produce Effect: 3 to 4 sessions.
- Frequency: 1 to 2 times per week.
- Optimum Duration: 5 to 6 sessions.
- Maximum Duration: 10 to 12 sessions.

When more than one treatment is performed on the same day, the maximum reimbursement will be limited to the highest single relative value.

2. Testing

Psychological tests should not be used routinely. When appropriate, documentation should include the specific indication for each test and overlapping and/or duplicate testing should be avoided. Tests, when administered, must be used in correlation with clinical interview data to monitor a patient's condition and progress. Repeat testing is not necessary or indicated when the clinical documentation supports improved outcomes.

Reimbursement for testing is limited to 11 hours of testing in any 12-month period.

3. Procedures Listed Without Specified Relative Value Units

By report (BR) items: "BR" in the Relative Value column represents services that are too variable in the nature of their performance to permit assignment of relative value units. Fees for such procedures need to be justified "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, 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 the chart notes 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 authorized medical provider shall establish a relative value unit consistent in relativity with other unit values 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.

4. Medical Testimony

As provided in Part 301 of the Workers' Compensation regulations and following direction by the Board, whenever the attendance of the injured employee's treating or consultant authorized physician or psychiatric nurse practitioner is required at a hearing or deposition, such physician or nurse practitioner shall be entitled to an attendance fee of \$450. Fees for testimony shall be billed following a direction by the Board as to the fee amount using code 99075.

As provided in Part 301 of the Workers' Compensation regulations and following direction by the Board, whenever the attendance of the injured employee's treating or consultant authorized psychologist or licensed clinical social worker is required at a hearing or deposition, such psychologist or social worker shall be entitled to an attendance fee of \$350. Fees for testimony shall be billed following a direction by the Board as to the fee amount using code 99075.

5. Evaluation and Management

Evaluation and management services may be reported by physicians and psychiatric nurse practitioners with codes 90833, 90836, and 90838 when both services are performed and documented.

6. Central Nervous System Assessments/Tests (e.g., Neuro-cognitive, Mental Status, Speech Testing) (96101–96127)

CPT codes 96101—96127 are used to report the services provided during testing of the cognitive function of the central nervous system. The testing of cognitive processes, visual motor responses, and abstractive abilities is accomplished by the combination of several types of testing procedures. It is expected that the administration of these tests will generate material that will be formulated into a report. Qualifications of the "technicians" and "qualified health care professionals" referenced in these procedure codes must satisfy the requirements as provided for in Article 153 of the Education Law.

7. Use of code 97127 and 97533

Reimbursement for code 97127 is limited to a maximum of 1 unit per day. Code 97533 may be reported a maximum of 2 units per day and is limited to 1 unit per day when reported on the same date with code 97127. Both services must be performed face-to-face.

When billing code 97127, an initial report must be submitted containing:

- A) Outline of the claimant's current cognitive skill level
- B) Proposed treatment plan
- C) Expected goals

Thereafter, a progress report should be filed at least every four weeks that updates:

- A) The claimant's current cognitive skill level
- B) The treatment plan
- C) Claimant's progress towards expected goals

All reporting requirements are inclusive in the fee for the service.

8. Health and Behavior Assessment/Intervention

Assessment and intervention codes are reported for patients with physical health problems where the focus is not on mental health, but emotional and social factors contributing to the individual's well-being. When psychiatric services are performed during the same encounter, the dominating service should be reported, but not both services.

Information obtained through the assessment testing is interpreted and a written report is generated. The interpretation and report are included in the service.

Codes 96150–96155 describe services associated with an acute or chronic illness (not meeting criteria for psychiatric diagnosis), prevention of a physical illness or disability, and maintenance of health, not meeting criteria for a psychiatric diagnosis, or representing a preventive medicine service.

For patients that require psychiatric services (90785–90899) as well as health and behavior assessment/intervention (96150–96155), report the predominant service performed. Do not report codes 96150–96155 in addition to codes 90785–90899 on the same date.

9. Modifiers

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

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. For significant, separately identifiable non-E/M services, see modifier 59.

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 provider, 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).

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.

1B∞ **Behavioral Health Provider Enhanced Reimbursement**

Provides a 20 percent reimbursement increase for E/M and Medicine Behavioral Health services when rendered by Licensed Clinical Social Workers and the providers with the following WCB assigned provider rating codes: PN-P (Psychiatry), PN-ADP (Addiction Psychiatry), PN-PM (Pain Management), and PSY (Psychology).

AJ **Services Performed by a Licensed Clinical Social Worker**

When services of a licensed clinical social worker are performed, identify the services by adding modifier AJ to the usual procedure code. Refer to Ground Rule 12 for further clarification.

NP **Services Performed by a Nurse Practitioner**

When pre- or postsurgery services of a nurse practitioner are performed, identify the services by adding modifier NP to the usual procedure code. Refer to General Ground Rule 12 for further clarification.

PA **Services Performed by a Physician Assistant**

When pre- or postsurgery services of a physician assistant are performed, identify the services by adding modifier PA to the usual

procedure code. Refer to General Ground Rule 12 for further clarification.

10. 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 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 objectives" of Workers' Compensation Law may be denied by the Board.

A medical provider who has had a NYSWCB 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.

11. Non-Schedule Permanency Evaluations

Code 99243 is used to report a non-scheduled permanency evaluation. Codes 99455–99456 may not be used for this purpose.

12. Behavioral Health Provider Enhanced Reimbursement

In an effort to increase the number of Board-authorized providers in behavioral health to render care and treatment to injured workers, the WCB has established WCB-specific modifier 1B which will provide a 20 percent reimbursement increase to providers with WCB assigned rating codes for designated services. Modifier 1B provides a 20 percent reimbursement increase for E/M and Medicine Behavioral Health services when rendered by licensed clinical social workers and the providers with the following WCB assigned provider rating codes:

PN-P (Psychiatry), PN-ADP (Addiction Psychiatry), PN-PM (Pain Management), and PSY (Psychology).

13. Codes in the Behavioral Health Fee Schedule

An authorized psychologist and licensed clinical social worker may only use CPT codes contained in the Behavioral Health Fee Schedule for billing of treatment. A psychologist and social worker may not use codes that do not appear in the Behavioral Health Fee Schedule.