

90827	90828	90829	90857	90862	92140
92506	92543	92980	92981	92982	92984
92995	92996	93651	93652	93965	93982
94620	95010	95015	95075	95900	95903
95904	95920	95934	95936	95973	97001
97002	97003	97004	97005	97006	97532
97762	99143	99144	99145	99148	99149
99150	99363	99364	99420		

GENERAL 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. Multiple Procedures

It is appropriate to designate multiple procedures that are rendered on the same date by separate entries. For example, if a level three established patient office visit (99213) and an ECG (93000) are performed during the visit, it is appropriate to designate both the established patient office visit and the ECG. In this instance, both 99213 and 93000 would be reported.

2. Unlisted Service or Procedure

When an unlisted service or procedure is provided, the procedure should be identified and the value substantiated "by report" (see Rule 3 below). All sections will have an unlisted service or procedure code number, usually ending in "99."

3. Procedures Listed Without Specified Relative Value Units

By report (BR) items: "BR" in the Relative Value column represents services that are too variable in the nature of their performance to permit assignment of relative value units. Fees for such procedures need to be justified "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary, but sufficient information shall be submitted to permit a sound evaluation. It must be emphasized that reviews are

based on records, hence the importance of documentation. The original official record, such as operative report and hospital chart, will be given far greater weight than supplementary reports formulated and submitted at later dates. For any procedure where the relative value unit is listed in the schedule as "BR," the physician shall establish a relative value unit consistent in relativity with other relative value units shown in the schedule. The insurer shall review all submitted "BR" relative value units to ensure that the relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items.

4. Materials Supplied by Provider

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.

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 this article.

Durable Medical Equipment Fee Schedule

All durable 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 Equipment Fee Schedule is required prior to providing it to the patient.

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.

6. **Concurrent Care**

When more than one physician treats a patient for the same condition during the same period of time, payment is made only to one physician, the one whose specialty is most relevant to the diagnosis. For example, if claims are received from both a cardiologist and a general practitioner for the treatment of a heart condition, or from both an orthopedist and a surgeon for the treatment of a back disorder, payment is due only to the cardiologist and orthopedist, respectively. Where the concurrent care involves overlapping or common services, the fees payable shall not be increased but prorated. Each physician shall submit separate bills but indicate if agreement has been reached on the proration. If no agreement between or among the physicians has been reached, the matter shall be referred to the Medical Arbitration Committee per Section 13-g of the Workers' Compensation Law.

When the condition of the patient requires the disparate skills of two or more physicians to treat different conditions which do not fall within the scope of other physicians treating the patient at the same time (e.g., management of diabetes mellitus in a surgical case), payment is due each physician who plays an active role in the treatment program. The services rendered by each physician shall be distinct, in different disciplines, identifiable, and adequately documented in the records and reports. (For consultations, see 99241-99255.)

7. **Alternating Physicians**

When physicians of similar skills alternate in the care of a patient (e.g., partners, groups, or same facility covering for another physician on weekends or vacation periods), each physician shall bill individually for the services each personally rendered and in accordance with the Medical Fee Schedule.

8. **Proration of Scheduled Relative Value Unit Fee**

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

9. **Home Visits**

The necessity for such visits is infrequent in cases covered by the Workers' Compensation Law. When necessary, a statement setting forth the medical indications justifying such visits shall be submitted. Please refer to the Evaluation and Management section for coding of these services.

10. **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 physician or podiatrist is required at a hearing or deposition, such physician or podiatrist 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 chiropractor or psychologist is required at a hearing or deposition, such chiropractor or psychologist 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.

11. Ground Rules for Physician Assistants (PA) and Nurse Practitioners (NP)

Authorized Nurse Practitioners who render care and treatment in accordance with their scope of practice under NYS Education Law, and Physician Assistants who render treatment and care for ongoing temporary disability in accordance with the Workers' Compensation Law, shall report and bill using their individual authorization numbers and bills shall be payable at 80 percent of the fee available to physicians for such treatment code.

Note: This Ground Rule is not applicable to Surgery Ground Rule 12 (F), whereby the surgeon must be directly and personally supervising the surgical assistants and such surgeon (or when the NP or PA is employed by the facility where the service is performed, the facility representative) must submit the bill for the surgical assistant's services in accordance with that Ground Rule.

When a physician assistant (PA) or nurse practitioner (NP) or licensed clinical social worker (AJ) bills for services (other than assistant at surgery), state-specific modifiers PA, NP, or HCPCS modifier AJ are used. State-specific modifier 83 is used to identify assistant at surgery services provided by a physician assistant or nurse practitioner.

12. Moderate (Conscious) Sedation

Sedation with or without analgesia is used to achieve a state of depressed consciousness while maintaining the patient's ability to control their own breathing as well as respond to stimulation. The use of these codes requires the presence of an independent trained observer to assist the physician in monitoring the patient's level of consciousness and physiological status.

Conscious sedation includes pre- and post-sedation evaluations, administration of the sedation, and monitoring of cardiorespiratory function.

Procedures that are integral to the moderate (conscious) sedation service and that should not be reported separately include:

- Assessment of the patient
- Establishment of IV access and provision of fluids to maintain patency
- Administration of sedation agents
- Maintenance of sedation
- Monitoring of oxygen saturation, heart rate, and blood pressure
- Recovery

Do not report minimal sedation (anxiolysis), deep sedation, or monitored anesthesia care with moderate (conscious) sedation codes.

Codes 99151–99153 identify moderate (conscious) sedation services provided by the same physician performing the diagnostic or therapeutic service that the sedation supports. CPT codes 99155–99157 identify moderate (conscious) sedation services provided by a second physician other than the health care professional performing the diagnostic or therapeutic service. When moderate (conscious) sedation services are provided by a second physician in a facility or nonfacility setting, the conscious sedation service may be billed separately.

13. Add-on Procedures

CPT identifies procedures that are always performed in addition to the primary procedure and designates them with a + in the CPT book. Add-on codes are never reported for stand-alone services but are reported secondarily in addition to the primary procedure. CPT uses specific language to identify add-on procedures such as "each additional" or "(List separately in addition to primary procedure)."

The same physician that performed the primary procedures/services must perform the add-on procedures. Add-on codes describe additional intra-service work associated with the primary procedure/service (e.g., additional digits, lesion, neurorrhaphy, vertebral segment, tendon, joint).

Add-on procedures are not subject to multiple procedure rules and, as such, modifier 51 does not apply. Fee schedule amounts for add-on codes are not subject to reduction and should be reimbursed at the lesser of 100 percent of the listed value or the billed amount. Do not append modifier 51 to a code identified as an add-on procedure.

The CPT codes currently designated as add-on codes are listed in Appendix D of *CPT 2018*.

14. 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 (Ⓞ) symbol.

Modifier 51 exempt services and procedures can be found in Appendix E of *CPT 2018*.

In addition to the codes noted in Appendix E, Optum360 has identified codes that are modifier 51 exempt according to CPT guidelines. The following additional modifier 51 exempt codes are identified in the data with the icon Ⓞ:

90281	90283	90284	90287	90288	90291
90296	90371	90375	90376	90378	90384
90385	90386	90389	90393	90396	90399
90476	90477	90581	90585	90586	90587
90620	90621	90625	90630	90632	90633
90634	90636	90644	90647	90648	90649
90650	90651	90653	90654	90655	90656
90657	90658	90660	90661	90662	90664
90666	90667	90668	90670	90672	90673
90674	90675	90676	90680	90681	90682
90685	90686	90687	90688	90690	90691
90696	90697	90698	90700	90702	90707
90710	90713	90714	90715	90716	90717
90723	90732	90733	90734	90736	90738
90739	90740	90743	90744	90746	90747
90748	90749	90750	90756	97010	97012
97014	97016	97018	97022	97024	97026
97028	97032	97033	97034	97035	97036
97110	97112	97113	97116	97124	97140
97150	97530	97533	97535	97537	97542
97545	97546	97597	97598	97602	97605
97606	97607	97608	97610	97750	97755
97760	97761	97763	99050	99051	99053
99056	99058	99060			

15. Modifiers

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

22 Increased Procedural Services

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.

23 Unusual Anesthesia

Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.

24 Unrelated Evaluation and Management Services by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period

The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

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

applicable to surgical assistants. The bill must be submitted by the supervising physician who performed the surgery where such assistance was rendered.

13. Surgery and Follow-up Care Provided by Different Providers

When one provider performs the surgical procedure itself and another provides the follow-up care, the value may be apportioned between them by agreement and in accordance with medical ethics. Use the appropriate modifier to identify and indicate whether the value is for the procedure or the follow-up care, rather than the whole. The "global fee" is not increased, but is prorated between the providers. If no agreement is reached by the providers involved, the apportionment shall be determined by the WCB Medical Arbitration Committee.

14. Repeat Procedure by Another Provider

A basic procedure performed by another provider may have to be repeated. Identify the repeated procedure using the appropriate modifier and submit an explanatory note.

15. Proration of Scheduled Relative Value Unit Fee

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

16. Materials Supplied by Provider

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.

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 this article.

Durable Medical Equipment Fee Schedule

All durable 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.

17. Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting provider, such procedures are to be billed directly to the insurance carrier by the laboratory.

18. Surgical Destruction

Destruction or ablation of tissue is considered an inherent portion of surgical procedures and may be performed by any of the following methods used alone or in combination: electrosurgery, cryosurgery, laser, and chemical treatment. Unless specified by the CPT code description, destruction by any method does not change the selection of code to report the surgical service.

more than 12.0 RVUs per day per accident or illness from all providers. The following codes represent the physical medicine procedures and modalities subject to this rule:

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

12. 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.

13. 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, 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.

14. 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 attending physician 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:

Region I	\$496.00	Region II	\$496.00
Region III	\$564.00	Region IV	\$614.00

15. Modifiers

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

22 Increased Procedure Services

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 physician or other qualified health care professional 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 physician or other qualified health care professional 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.

16. Hospital Affiliated Therapy Services

Billing for hospital affiliated physical and occupational therapy services, whether performed on site or at off site facilities, will be paid at the level of physician-supervised therapy services, when billed under the hospital tax ID number.

17. Supplies and Materials

Do not 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. Surgical services do not include the supply of medications, sterile trays, and other materials which may be reported separately with code 99070. The specific items provided must be identified. Payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping and handling 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.