Introduction and General Guidelines

The *Official New York Workers' Compensation Chiropractic Fee Schedule* shows chiropractic 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 chiropractic practice.

Because the Chiropractic 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 chiropractor 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 chiropractors 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 Chiropractic 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 *Official New York Workers' Compensation Chiropractic Fee Schedule* consists of four sections. Each section has instructions which precede the codes, descriptions, and values. The sections in this schedule are: Evaluation and Management, Radiology, Medicine, and Physical Medicine.

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 Chiropractic 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 Chiropractic Fee Schedule. The columns vary by section throughout the schedule.

\Icons

The following icons are included in the Chiropractic 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.

* 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.

B 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—Where a CPT code does not currently exist to describe a service there may be a state-specific code number assigned to describe the service. RVU's are state assigned or gap filled.

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. FOR COMPLETE LIST OF APPLICABLE CHIROPRACTIC CPT CODES, SEE CPT CODES WCB WEB POSTING

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 II, would be calculated as follows:

5.83 (Relative Value)
x $6.37 (Chiropractic E/M Section Conversion Factor for Region II)
= $37.14

BR
Some services do not have a relative value unit assigned because they are too variable or new. These by report services are identified with a "BR."

FUD

The FUD column lists the follow-up days included in a surgical procedure's global charge. In counting follow-up days, day one is the day of surgery, not the discharge day. The State of New York has determined the follow-up days in this schedule and these follow-up days are consistent with those found in the Medicare Physician Fee Schedule. Follow-up days will be designated as 000 (0 follow-up days), 010 (10 follow-up days), or 090 (90 follow-up days). Medicare also uses letter designations to identify four circumstances where the usual follow-up days concept does not apply. These four circumstances are as follows:

MMM Describes services in uncomplicated maternity care. This includes antepartum, delivery, and postpartum care. The usual global surgery concept does not apply

XXX Indicates that the global surgery concept does not apply.

YYY Indicates that the global period is to be established by report.

ZZZ Indicates that the service is an add-on service and therefore is treated in the global period of the primary procedure that is billed in conjunction with the ZZZ service. Do not bill these codes with modifier 51.

PC/TC Split

The Relative Value column lists the relative value units used to calculate the fee amount for a service. Except, as otherwise provided in this fee schedule, the maximum fee amount is calculated by multiplying the relative value unit by the applicable conversion factor. Conversion factors are listed in this fee schedule. The PC/TC column shows the percentage of the procedure that is professional or technical. A procedure with a relative value of 3.0 RVUs and a 40/60 in the PC/TC column would be calculated as follows: 40 percent of the value (3.0 x conversion factor x .40 = PC) is for the professional component and 60 percent of the value (3.0 x conversion factor x .60 = TC) represents the technical component. The total component reimbursed should never be more than the professional component plus the technical component combined.

POSTAL ZIP CODES BY REGION

Postal ZIP codes included in each region:

Region I

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

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		11001	11120
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		IV	12401	12498	I

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			

CONVERSION FACTORS

Regional conversion factors effective XXXX 1, 2018.

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
Physical Medicine	$5.77	$5.77	$6.60	$7.17
Radiology	$32.01	$32.01	$36.63	$39.82

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 99213, performed in Region II, would be calculated as follows:

5.83 (Relative Value)
x $6.37 (Chiropractic E/M Section Conversion Factor for Region II)
= $37.14

New CPT Codes

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

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

TO BE INCLUDED IN FINAL DRAFT.

NOTE: FOR PUBLIC COMMENT PURPOSES COMPLETE LIST OF 2018 CHIROPRACTIC CPT CODES, SEE CHIROPRACTIC CPT CODES ON WCB WEB POSTING

Changed Codes

Changed Values

The following table is a list of CPT and state-specific codes applicable to the Chiropractic 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 effective XXXX 1, 2018.

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

NY 2018 FUD. This is the FUD effective XXXX 1, 2018.

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 effective XXXX 1, 2018. 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 "■."

PLACEHOLDER FOR FINAL PUBLICATION

NOTE: FOR PUBLIC COMMENT PURPOSES COMPLETE LIST OF 2018 CHIROPRACTIC CPT CODES, SEE CHIROPRACTIC CPT CODES ON WCB WEB POSTING

CODE	NY 2018 RVU	NY 2012 RVU	NY 2018 FUD	NY 2012 FUD	NY 2018 PC/TC Split	NY 2012 PC/TC Split

Changed Descriptions

The table below is a complete list of CPT codes that have had a description change in the Chiropractic Fee Schedule since the June 1, 2012 fee schedule.

PLACEHOLDER FOR FINAL PUBLICATION

NOTE: FOR PUBLIC COMMENT PURPOSES COMPLETE LIST OF 2018 CHIROPRACTIC CPT CODES, SEE CHIROPRACTIC CPT CODES ON WCB WEB POSTING. TO REVIEW DESCRIPTIONS, CONTACT REGULATIONS@WCB.NY.GOV

DELETED CPT CODES

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

PLACEHOLDER FOR FINAL PUBLICATION

NOTE: FOR PUBLIC COMMENT PURPOSES COMPLETE LIST OF 2018 CHIROPRACTIC CPT CODES, SEE CHIROPRACTIC CPT CODES ON WCB WEB POSTING

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. Unlisted Service or Procedure

When an unlisted service or procedure is provided the procedure should be identified and the value substantiated "by report" (see Ground Rule 2 below). All sections will have an unlisted service or procedure code number, usually ending in "99."

2. 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 chiropractor 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" unit values to ensure that the relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items.

3. Materials Supplied by a Chiropractor

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(s), applicable taxes, and

any shipping and handling costs associated with delivery from the supplier of the item to the chiropractor's office. No additional "handling" costs will be added to the total cost of the item. To bill, use procedure code 99070.

The Durable Medical Equipment Fee Schedule does not apply to medical providers supplying durable medical equipment to injured workers as part of medical treatment described in the *Official New York Workers' Compensation Medical Fee Schedule.* Billing and reimbursement follows the ground rules as described in this fee schedule.

4. Miscellaneous

When reporting services in which the relativity is predicated on the basis of time, information concerning the amount of time spent should be indicated.

5. 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 chiropractor is required at a hearing or deposition, such chiropractor 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.

6. Chiropractic Manipulative Treatment (CMT)

Chiropractic manipulative treatment (CMT) is a form of manual spinal treatment performed by a chiropractor. Please see procedure codes 98940–98943.

The CMT codes include charges for standard premanipulation assessment. Evaluation and management services can be reported separately by adding modifier 25, if the condition of a patient requires a significantly separate E/M service, beyond the usual pre- and postservice associated with the procedure.

Per *CPT* 2018 the five spinal regions for CMT are:

- Cervical region includes atlanto-occipital joint
- Thoracic region—includes the costovertebral and costotransverse joints
- Lumbar region
- Sacral region
- Pelvic region—includes sacro-iliac joint

7. 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. 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.

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.

25 *Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of a 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 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 the decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

26 *Professional Component*
Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC *Technical Component*
Certain procedures are a combination of a professional component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

50 *Bilateral Procedure*
Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5 digit code.

59 *Distinct Procedural Service*
Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

76 *Repeat Procedure or Service by the Same Physician or Other Qualified Health Care Professional*
It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

77 *Repeat Procedure by Another Physician or Other Qualified Health Care Professional*
It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

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.

9. Treatment by Out of State Providers

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

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

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

Permanency—The New York State guidelines on permanent impairment, pertaining to both the schedule loss of use and classification, apply regardless of whether claimant lives in or out of New York.

10. Codes in the Chiropractic Fee Schedule

A chiropractor may only use CPT codes contained in the Chiropractic Fee Schedule for billing of treatment. A chiropractor may not use codes that do not appear in the Chiropractic Fee Schedule.

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 chiropractor 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 chiropractors 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. Evaluation and Management codes for initial visits are 99201–99204. 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. Chiropractors may also report CPT code 99243 for office consultations for a new or established patient. 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:

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 chiropractor, or another chiropractor 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 chiropractor* 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 a chiropractor is on call or covering for another chiropractor. In this instance, classify the patient encounter the same as if it were for the chiropractor who is unavailable.

2. Referral

A referral is the transfer of the total or specific care of a patient from one chiropractor to another and does not constitute a consultation. (Initial evaluations and subsequent services are designated as listed in E/M services.)

3. Clinical Examples

The codes for E/M services are provided to assist chiropractors in understanding the meaning of the descriptors and selecting the correct code for the services they have rendered. It is important to note that the same problem, when seen by different specialists, may involve different amounts of work. Therefore, the appropriate level of encounter should be reported using the descriptions as outlined for explanation of E/M services in the CPT book and this fee schedule rather than the examples. For more examples please refer to CPT guidelines.

4. 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.

5. Narrative Reports

A detailed narrative report must be submitted with the bill for the following procedure: 99204.

6. 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.

25 *Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of a 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 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 the decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

7. Non-Schedule Permanency Evaluations

Code 99243 is used for examination and reports of a non-schedule permanency evaluation.

Radiology

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 products are to be added.

RADIOLOGY GROUND RULES

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

X-rays of any portion of the skeletal system are permitted if the x-rays are necessary to diagnose problems arising in the vertebral column.

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. Duplication of X-Rays

Every attempt should be made to minimize the number of x-rays taken. The attending doctor or any other person or institution having possession of x-rays which pertain to the patient that are deemed to be needed for diagnostic or treatment purposes should make these x-rays available upon request. No payments shall be made for additional x-rays when recent x-rays are available except when supported by adequate information. The use of digital or photographic media and/or imaging is not reported separately but is considered to be a component of the basic procedure, and shall not merit any additional payment.

When a diagnostic procedure in conjunction with clinical information provides sufficient information to establish an accurate diagnosis, the second procedure will be redundant if performed only for diagnostic purposes. At the same time, a subsequent diagnostic procedure can be a complementary diagnostic procedure if the first or preceding procedures in conjunction with clinical information cannot provide an accurate diagnosis.

2. Multiple Diagnostic Procedures

The following adjustments apply to all diagnostic radiology procedures including MRI:

A) For two contiguous parts, the charge shall be the greater fee plus 50 percent of the lesser fee.

B) For two remote parts, the charge shall be the greater fee plus 75 percent of the lesser fee. Bilateral procedures are considered remote parts.

C) For three or more parts, whether contiguous or remote, the charge shall be the greatest fee plus 75 percent of the total of the lesser fees.

D) Where more than one part is included in a single line item, it shall be charged for as a single line item. Any additional item examined shall be considered under rules 2A–2C above, whichever pertains.

E) No charge shall be made for comparative x-rays except when such x-rays are specifically authorized by the carrier or the Chairman. Comparative x-rays specifically authorized shall be subject to fees for contiguous and remote parts as provided in this formula as provided in rules 2A–2D above.

F) X-rays/imaging stidies of different areas taken within 7 days of the first x-rays/imaging stidies and related to the injury or problem necessitating the first x-ray/imaging studies, and which could have reasonably been performed at one time, shall be subject to rules 2A–2E above.

3. Specific Billing Instructions

The total relative value includes professional services plus expenses for personnel, materials (including usual contrast media), space, equipment, and other facilities. Supplies and materials provided by the chiropractor over and above those usually included with or necessitated by the services rendered may be charged for separately; in these instances, list items individually on the bill. Payment shall not exceed the cost of the item(s) to the chiropractor.

The listed values are for technical and professional components. Total reimbursement for the professional and technical components shall not exceed the listed value for the total procedure, regardless of the site where services are rendered. Use of codes 70010–79999 without modifier 26 or TC implies that the charge is inclusive of both the professional and technical components. To report either the professional or technical component separately, use modifier 26 or TC, respectively. When either the professional or technical component is billed separately, the listed percent of the total value is apportioned as indicated in the PC/TC column of the fee schedule.

4. Reports and Custody of X-rays and Other Recorded Images

A written report of the findings must be submitted as prescribed by the Chair.

Films or other recorded images shall be preserved in accordance with New York State Department of Health retention requirements .. They (or satisfactory reproductions) shall be made available to the attending chiropractor, insurance carrier, or self-insured employer. When requested, carriers and self-insured employers shall return original films to the chiropractor within 20 days of their receipt.

When a carrier or self-insured employer requests x-rays, MRI's, or other recorded images and satisfactory reproductions including electronic media are furnished in lieu of the original films, a fee of $5.00 may be charged for the first sheet of duplicating film or for reproduction on an electronic media (e.g., digital images copied to a CD) regardless of the number of images contained on the media, and $3.00 for each additional sheet of film or electronic media. When recorded images are capable of electronic transmission, without creation of a physical copy of the film, CD or other physical reproduction, no fee may be charged for such electronic transmission.

These reproductions are not returnable to the chiropractor. Copies of images produced by copiers (e.g., Xerox) shall not merit any additional payment and shall not be returnable to the chiropractor; such copies should accompany the bill submitted for the particular imaging procedure. (The use of digital or photographic media and/or imaging is not reported separately but is considered to be a component of the basic procedure.) In cases where the patient transfers from one chiropractor to another, the original chiropractor will promptly forward all images or copies of images to the new attending chiropractor.

5. Miscellaneous

A) Emergency services rendered between 10:00 p.m. and 7:00 a.m. in response to requests received during those hours or on Sundays or legal holidays, provided such services are not otherwise reimbursed, may warrant an additional payment of one-third of the applicable fee.

B) Relative value units for office visits are listed in the Evaluation and Management and Medicine sections.

C) For diagnostic ultrasound procedures, use code 76999 and submit the required report.

6. 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.

26 *Professional Component*
Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC∞ *Technical Component*
Certain procedures are a combination of a professional component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

50 *Bilateral Procedure*
Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5 digit code.

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 chiropractors 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. Special Services and Reports

Charges for services generally provided as an adjunct to common medical services should be made only when circumstances clearly warrant an additional charge over and above the scheduled charges for basic services.

2. Modifiers

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

26 Professional Component

Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

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).

TC∞ *Technical Component*
Certain procedures are a combination of a professional component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number

3. EDX (Codes 95907–95913)

EDX is only recommended where there is failure of suspected radicular pain to resolve or plateau after waiting 4 to 6 weeks (to provide for sufficient time to develop EMG abnormalities as well as time for conservative treatment to resolve the problems), equivocal imaging findings, e.g., on CT or MRI studies, and suspicion by history and physical examination that a neurologic condition other than radiculopathy may be present instead of or in addition to radiculopathy. When such testing is recommended, the provider shall select from codes 95907–95913 using 1 unit of the 1 code that most closely represents the nerve(s) tested. Requests for repeat testing require approval from the carrier.

Physical Medicine

The relative values in this section were determined uniquely for physical medicine services. Use the physical medicine conversion factor when determining fee amounts. The physical medicine conversion factor is not applicable to any other section. The fee for a procedure or service in this section is determined by multiplying the relative value by the physical medicine conversion factor, subject to the ground rules, instructions, and definitions of the schedule. Conversion factors are located in the Introduction and General Guidelines section. To ensure uniformity of billing when multiple services are rendered, each relative value unit is to be multiplied by the conversion factor separately. After which, charges for products may be added.

PHYSICAL MEDICINE GROUND RULES

The fees for physical medicine services are payable when services are rendered by a chiropractor. When physical medicine treatment is rendered in the follow-up period of surgical or fracture care procedures, the treatment is not considered part of the global surgical fee. Physical medicine services are separately covered procedures when rendered during the follow-up period of any surgical service. When a patient is seen by a chiropractor prior to and during the implementation of a physical medicine program, and a history and physical examination is performed, a fee for an office visit is permitted. Definitions and rules pertaining to physical medicine services are as follows:

Note: Rules used by a chiropractor in reporting services are presented in the General Ground Rules in the Introduction and General Guidelines section.

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 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.

2. Initial Evaluation and Re-evaluation

Chiropractors may bill for an initial evaluation using CPT codes 99201–99204. Evaluations shall include the following elements: history, clinical testing, and interpretation of data and development of the plan of care with defined goals, appropriate interventions, and recommendations.

The maximum number of relative value units (including treatment) per patient per day when billing for an initial evaluation shall be limited to 18.0 RVUs. The maximum number of relative value units (including treatment) per patient per day when billing for a re-evaluation shall be limited to 15.0 RVUs.

The following codes represent the treatments subject to this rule:

97010	97012	97014	97024	97026
97028	97032	97033	97034	
97035	97036	97039	97110	
97112	97113	97116	97124	
97139	97140	97530	98940	
98941	98942			

Re-evaluations may be billed using CPT code 99212 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

3. Multiple Physical Medicine Procedures and Modalities

When multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 12.0 RVUs per patient per day per accident or illness or the amount billed, whichever is less. Note: When a patient receives physical medicine 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 and such procedure or modalities must be performed within 180 days of the accident or illness date. The following codes represent the physical medicine procedures and modalities subject to this rule:

97010	97012	97014	97024	97026
97028	97032	97033	97034	
97035	97036	97039	97110	
97112	97113	97116	97124	
97139	97140	97530	98940	
98941	98942			

4. Tests and Measurements

Code 97762 Checkout for orthotic/prosthetic use, shall not be billed on the same day as an office visit.

5. 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).

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.