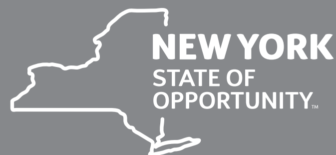
OFFICIAL

NEW YORK STATE WORKERS' COMPENSATION

PODIATRY FEE SCHEDULE

Effective 4/1/2019
Revisions Effective 1/1/2020



Workers' Compensation Board

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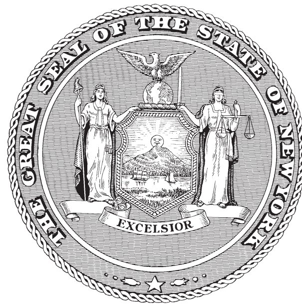

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Optum360 worked closely with the New York Workers' Compensation Board in the development, formatting, and production of this fee schedule. However, all decisions resulting in the final content of this schedule were made solely by the New York Workers'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

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New York Workers' Compensation Board Filing Notice

The Podiatry Fee Schedule was duly filed in the Office of the Department of State, and constitutes Sections 343.1 and 343.2 of Title 12 of the Official Compilation of Codes, Rules, and Regulations of the State of New York.

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Revised Printing

This revised printing contains revisions effective January 1, 2020.

Foreword

The Workers' Compensation Board is pleased to present the updated version of the *New York State Workers' Compensation Podiatry Fee Schedule*.

The revised fee schedule is an essential tool for health care providers and those paying the cost of health care services under the New York State Workers' Compensation system. This schedule provides comprehensive billing guides, which will allow health care providers to appropriately describe their services and minimize disputes over reimbursement. Also, this schedule includes many new procedures and coding changes that have taken place since the previously published fee schedule.

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

Except where noted, this fee schedule is effective for medical services rendered on or after April 1, 2019, regardless of the date of accident. The fees established herein are payable to health care providers authorized or permitted to render care under the Workers' Compensation Law, Volunteer Firefighters' Benefit Law, and Volunteer Ambulance Workers' Benefit Law.

New York State Workers' Compensation Board

From	Thru	From	Thru
13301	13368	14801	14898
13401	13439	14901	14925
13450	13495		

Region II

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

Region III

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

Region IV

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

Numerical List of Postal ZIP Codes

From	Thru	Region	From	Thru	Region
00501	00501	IV	12401	12498	I
00544	00544	IV	12501	12594	II
06390	06390	III	12601	12614	II
10001	10099	IV	12701	12792	I
10100	10199	IV	12801	12887	I
10200	10299	IV	12901	12998	I
10301	10314	IV	13020	13094	I
10401	10499	IV	13101	13176	I
10501	10598	III	13201	13290	II
10601	10650	III	13301	13368	I
10701	10710	III	13401	13439	I
10801	10805	III	13440	13449	II
10901	10998	III	13450	13495	I
11001	11096	IV	13501	13599	II
11101	11120	IV	13601	13699	I
11201	11256	IV	13730	13797	I
11301	11390	IV	13801	13865	I
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 are for services rendered on or after April 1, 2019.

Section	Region I	Region II	Region III	Region IV
E/M	$12.11	$12.11	$13.85	$15.06
Medicine	$8.91	$8.91	$10.19	$11.07
Surgery	$202.53	$202.53	$231.78	$251.94
Radiology	$46.77	$46.77	$53.53	$58.19
Pathology and Laboratory	$1.06	$1.06	$1.21	$1.31
Appliances and Prostheses	$17.18	$17.18	$17.18	$17.18

New CPT Codes

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

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

28291

Changed Codes

Changed Values

The following table is a list of CPT and state-specific codes applicable to the Podiatry 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:

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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
77002	2.81	2.81	ZZZ	XXX	34/66	34/66
99075	$450.00	$400.00				

Changed Descriptions

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

11623	15777	17250	20600	20605	20610
20665	27615	27616	28046	28047	28292
28296	28297	28298	28299	28890	76881
76882	77002	95004	95024	99205	99211
99213	99214	99215	99217	99218	99219
99220	99221	99222	99223	99224	99225
99226	99231	99232	99233	99234	99235
99236	99241	99242	99243	99244	99245
99251	99252	99253	99254	99255	99281
99282	99283	99284	99285	99304	99305
99306	99307	99308	99309	99310	99318
99324	99325	99326	99327	99328	99334
99335	99336	99337	99341	99342	99343
99344	99345	99347	99348	99349	99350
99354	99355	99375			

Deleted CPT Codes

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

11752	28290	28293	28294	29582	29590
95015					

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.

2. Unlisted Service or Procedure

Some services performed are not described by any CPT code. These services should be reported using an unlisted code and substantiating it by report as discussed in Rule 3 below. All sections will have an unlisted service or procedure code number, usually ending in "99."

3. Procedures Listed Without Specified Unit Values: By Report (BR) Items

"BR" in the unit value column represents services that are too variable in the nature of their performance to permit assignment of relative value units. Fees for such procedures need to be justified "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary, but sufficient information shall be submitted to permit a sound evaluation. It must be emphasized that reviews are based on records; hence the importance of documentation. The original official record, such as operative report and hospital chart, will be given far greater weight than supplementary reports formulated and submitted at later dates. For any procedure where the relative value unit is listed in the Schedule as "BR," the podiatrist shall establish a relative value unit consistent in relativity with other relative value units shown in the Schedule. The insurer shall review all submitted "BR" relative value units to ensure that the relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items.

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4. Materials Supplied by Podiatrist: Pharmaceuticals and Durable Medical Equipment

A) **Pharmacy**

A prescriber cannot dispense more than a seventy-two hour supply of drugs with the exceptions of:

1. Persons practicing in hospitals as defined in section 2801 of the public health law;
2. The dispensing of drugs at no charge to their patients;
3. Persons whose practices are situated ten miles or more from a registered pharmacy;
4. The dispensing of drugs in a clinic, infirmary, or health service that is operated by or affiliated with a post-secondary institution;
5. The dispensing of drugs in a medical emergency as defined in subdivision six of section 6810 of the State Education Law.

For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070.

B) **Durable Medical Equipment**

Prior to the effective date of the 2020 Durable Medical Equipment Fee Schedule, for durable medical equipment administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070.

Following the effective date of the 2020 Durable Medical Equipment Fee Schedule, all durable medical equipment supplied shall be billed and paid using the 2020 Durable Medical Equipment Fee Schedule. The 2020 Durable Medical Equipment Fee Schedule is/will be available on the Board's website. Any item identified as requiring prior authorization in the 2020 Durable Medical Equipment Fee Schedule or not listed in the 2020 Durable Medical Equipment Fee Schedule may not be billed without such prior authorization.

Do not bill for or report supplies that are customarily included in surgical packages, such as gauze, sponges, Steri-strips, and dressings; drug screening supplies; and hot and cold packs. These items are included in the fee for the medical services in which such supplies are used.

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 provider treats a patient for the same condition during the same period of time, payment is made only to one provider. Where the concurrent care involves overlapping or common services, the fees payable shall not be increased but prorated. Each provider shall submit separate bills but indicate if agreement has been reached on the proration. If no agreement has been reached, the matter shall be referred to a Medical Arbitration Committee.

7. Alternating Providers

When providers of similar skills alternate in the care of a patient (e.g., partners, groups, or same facility covering for another provider on weekends or vacation periods), each provider shall bill individually for the services they personally rendered and in accordance with the fee schedule.

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 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 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, 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 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

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original operation or service. When treatment is terminated by the death of the patient before the expiration of the 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. Referrals/Direct Care

A fee is payable for the examination of a patient who seeks the care of a podiatrist either directly or by a referral from another provider or another podiatrist, in instances when it is incumbent upon the podiatrist to examine the patient in order to make a proper diagnosis, prognosis, and to decide on the necessity and type of treatment to be rendered. This fee is in addition to the unit fee prescribed for the operation or treatment subsequently rendered by the podiatrist except that where the therapeutic procedure or treatment is of a minor character and the fee for the procedure or treatment is in excess of the fee for the office visit, the greater fee (not both fees) is payable. Similarly, if the fee for the minor procedure or treatment is less than the fee for the office visit, the fee for the office visit alone is payable.

11. Multiple Services

Where a fee for an office therapeutic procedure or treatment is in excess of the fee for an ordinary office visit (e.g., a fee for a minor operation), the greater fee, not both, shall be payable.

12. Miscellaneous

A) Listings and relativities for other diagnostic, therapeutic, surgical, anesthetic, x-ray, and laboratory procedures may be found within the Surgery, Radiology and Nuclear Medicine, Pathology, and Appliances and Prostheses sections.

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

C) 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.

13. 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 podiatrist is required at a hearing or deposition, such podiatrist shall be entitled to an attendance fee of $450.00. Fees for testimony shall be billed following a direction by the Board as to the fee amount using code 99075.

14. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. If more than one modifier is needed, place modifier 99 after the procedure code to indicate that two or more modifiers will follow.

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.

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

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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.

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 physician 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.

27 Multiple Outpatient Hospital E/M Encounters on the Same Date
(This CPT modifier is for use by Ambulatory Surgery Center (ASC) and Hospital Outpatient Settings Only.) For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (eg, hospital emergency department, clinic). **Note:** This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient evaluation and management services provided by the same physician on the same date and performed in multiple outpatient setting(s) (eg, hospital emergency department, clinic), see **Evaluation and Management, Emergency Department,** or **Preventive Medicine Services** codes.

32 Mandated Services
Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

47 Anesthesia by Surgeon
Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) **Note:** Modifier 47 would not be used as a modifier for the anesthesia procedures.

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.

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).

52 Reduced Services
Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73

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and 74 (see modifiers approved for ASC hospital outpatient use).

54 Surgical Care Only
When 1 physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

55 Postoperative Management Only
When 1 physician or other qualified health care professional performs the postoperative management and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

56 Preoperative Management Only
When 1 physician or other qualified health care professional performed the preoperative care and evaluation and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

57 Decision for Surgery
An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

58 Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** For treatment of a problem that requires a return to the operating/procedure room (eg, unanticipated clinical condition), see modifier 78.

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.

62 Two Surgeons
When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure[s]) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. **Note:** If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

63 Procedure Performed on Infants less than 4 kg
Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure number. **Note:** Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20005–69990 code series. Modifier 63 should not be appended to any CPT codes listed in the **Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory,** or **Medicine** sections.

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10. By Report (BR) Items

"BR" in the Relative Value column indicates that the value of this service is to be determined "by report" because the service is too unusual or variable to be assigned a relative value unit. Pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary, etc., is to be furnished, using any of the following as indicated:

A) Diagnosis (postoperative), pertinent history and physical findings.

B) Size, location, and number of lesion(s) or procedure(s) where appropriate.

C) Major surgical procedure with supplementary procedure(s).

D) Whenever possible, list the closest similar procedure by number and relative value unit. The "BR" relative value units shall be consistent in relativity with other relative value units in the schedule.

E) Estimated follow-up period, if not listed.

F) Operative time.

11. Unlisted Services or Procedures

Some services performed are not described by any CPT code. These services should be reported using an unlisted code and substantiated by report as discussed in Surgery Ground Rule 10 above. The unlisted procedures and accompanying codes for surgery will be found at the end of the relevant section or subsection.

12. Concurrent Services by More Than One Podiatrist

Charges for concurrent services of two or more podiatrists may be warranted under the following circumstances:

A) **Identifiable medical services** provided prior to or during the surgical procedure or in the postoperative period are to be charged for by the podiatrist rendering the service identified by the appropriate code and relative value units. Such payable fees are unrelated to the surgeon's fee.

B) **Surgical assistants:** Identify surgery performed by code number, appropriate modifier, description of procedures, and bill at 16 percent of the code fee. The code must coincide with those of the primary surgeon. Assistants' fees are not payable when the hospital provides intern or resident staff to assist at surgery.

C) **Two surgeons:** Under certain circumstances the skills of two surgeons (usually with different skills) may be required in the management of a specific surgical problem. By prior agreement, the total value for the procedures may be apportioned in relation to the responsibility and work done. The total value may be increased by 25 percent in lieu of the assistant's charge. Under these circumstances, the services of each surgeon should be identified. Identify surgery performed by code number, appropriate modifier, and description of procedures.

D) **Co-surgeons:** Under certain circumstances, two surgeons (usually with similar skills) may function simultaneously as primary surgeons performing distinct parts of a total surgical service. By prior agreement, the total value may be apportioned in relation to the responsibility and work done. The total value for the procedure shall not, however, be increased but shall be prorated between the co-surgeons. Identify surgery performed by code number, appropriate modifier, and description of procedures.

In the event of no agreement between co-surgeons, the proration shall be determined by an Arbitration Committee.

E) **Surgical team:** Under some circumstances highly complex procedures requiring the concomitant services of several providers, often of different specialties, plus other highly skilled, specially trained personnel, and various types of complex equipment are carried out under the "surgical team" concept with a single fee charged for the total service. The services covered vary widely and a single value cannot be assigned. These situations should be identified. The value should be supported by a report to include itemization of the provider services, paramedical personnel, and equipment involved.

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. 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 prorated between the providers. If no agreement is reached by the providers involved, the apportionment shall be determined by arbitration.

14. Repeat Procedure by Another Provider

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

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15. Proration of a 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 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, 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 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 the follow-up days, the full fee is payable, subject to proration where applicable.

16. Materials Supplied by Podiatrist: Pharmaceuticals and Durable Medical Equipment

A) **Pharmacy**

A prescriber cannot dispense more than a seventy-two hour supply of drugs with the exceptions of:

1) Persons practicing in hospitals as defined in section 2801 of the public health law;
2) The dispensing of drugs at no charge to their patients;
3) Persons whose practices are situated ten miles or more from a registered pharmacy;
4) The dispensing of drugs in a clinic, infirmary, or health service that is operated by or affiliated with a post-secondary institution;
5) The dispensing of drugs in a medical emergency as defined in subdivision six of section 6810 of the State Education Law.

For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070..

B) **Durable Medical Equipment**

Prior to the effective date of the 2020 Durable Medical Equipment Fee Schedule, for durable medical equipment administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070.

Following the effective date of the 2020 Durable Medical Equipment Fee Schedule, all durable medical equipment supplied shall be billed and paid using the 2020 Durable Medical Equipment Fee Schedule. The 2020 Durable Medical Equipment Fee Schedule is/will be available on the Board's website. Any item identified as requiring prior authorization in the 2020 Durable Medical Equipment Fee Schedule or not listed in the 2020 Durable Medical Equipment Fee Schedule may not be billed without such prior authorization.

Do not bill for or report supplies that are 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.

17. Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting podiatrist, 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 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.

19. Fractures and Dislocations

The terms "closed" and "open" are used with reference to the type of procedure (e.g., fracture or dislocation) and to the type of reduction.

A) **Casting and Strapping Guidelines**
Application of casts and strapping codes are used to report replacement procedures during or after the period of follow-up care. These codes can also be used when the cast application or strapping is an initial service performed to stabilize or protect a fracture, injury, or dislocation without a restorative treatment or procedure. Restorative treatment or procedure rendered by another provider following the application of the initial cast, splint, or strap may

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be reported with a treatment of fracture or dislocation codes.

Codes found in the application of casts and strapping section (29000–29799) should be reported separately when:

- The cast application or strapping is a replacement procedure used during or after the period of follow-up care.
- The cast application or strapping is an initial service performed without restorative treatment or procedures to stabilize or protect a fracture, injury, or dislocation, and to afford comfort to a patient.
- An initial casting or strapping when no other treatment or procedure is performed or will be performed by the same provider.
- A provider performs the initial application of a cast or strapping subsequent to another provider having performed a restorative treatment or procedure.

A provider who applies the initial cast, strap, or splint and also assumes all of the subsequent fracture, dislocation, or injury care cannot use the application of casts and strapping codes as an initial service. The first cast, splint, or strap application is included as a part of the service of the treatment of the fracture and dislocation codes. If no fracture care code is reported, for instance for a sprain, then it is appropriate to report the cast application.

B) **Re-reduction**
Re-reduction of a fracture and/or dislocation, performed by the primary podiatrist may warrant an additional payment when performed during the inclusive follow-up period; see Surgery Ground Rule 6, Follow-up or Aftercare.

C) **Bone, Cartilage, and Fascial Grafts**
Listed values for most graft procedures include obtaining the graft. When a second surgeon obtains the graft, the value of the total procedure will not be increased but in accordance with Surgery Ground Rule 12-D, the value may be apportioned between the surgeons. Procedure 20900 is NOT to be used with procedures that include the graft as part of the descriptor. Procedure 20900 can be used in those unusual circumstances when a graft is used that is not included in the descriptor.

Unless separately listed, when an alloplastic implant or non-autogenous graft is used in a procedure which "includes obtaining graft," the value is to be the same as for using a local bone graft. The phrase "iliac or other autogenous bone graft" refers only to grafts obtained from an anatomical site distinct from the primary operative area and obtained through a separate incision. Plastic and/or metallic implant or non-autogenous graft materials are to be valued at the cost to the podiatrist.

D) **Dislocations Complicated by a Fracture**
Increase the unit value of the fracture/dislocation by 50 percent. The additional charge is not applicable to ankle fractures/dislocations.

E) **Multiple Injuries**
For concurrent care of multiple injuries, not contiguous and not in the same foot, and not otherwise specified, see Surgery Ground Rule 5, Multiple or Bilateral Procedures. Superficial injuries not requiring extensive care do not carry cumulative or additional allowances.

20. Modifiers

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

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.

32 ***Mandated Services***
Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

47 ***Anesthesia by Surgeon***
Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) **Note:** Modifier 47 would not be used as a modifier for the anesthesia procedures.

50 ***Bilateral Procedure***
Unless otherwise identified in the listings, bilateral procedures that are performed at the

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same session should be identified by adding modifier 50 to the appropriate 5 digit code.

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).

52 Reduced Services
Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

54 Surgical Care Only
When 1 physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

57 Decision for Surgery
An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

58 Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** For treatment of a problem that requires a return to the operating/procedure room (eg, unanticipated clinical condition), see modifier 78.

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.

62 Two Surgeons
When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure[s]) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. **Note:** If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

66 Surgical Team
Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians or other qualified health care professionals, often of different specialties,

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plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating individual with the addition of modifier 66 to the basic procedure number used for reporting services.

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.

78 ***Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period***
It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)

79 ***Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period***
The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

80 ***Assistant Surgeon***
Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

81 ***Minimum Assistant Surgeon***
Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.

82 ***Assistant Surgeon (when qualified resident surgeon not available)***
The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).

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.

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SURGERY 10060–64911

Podiatry Fee Schedule Effective April 1, 2019

	Code	Description	Relative Value	FUD	PC/TC Split
	10060	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single	0.29	010	
	10061	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple	0.90	010	
	10120	Incision and removal of foreign body, subcutaneous tissues; simple	0.36	010	
	10121	Incision and removal of foreign body, subcutaneous tissues; complicated	1.08	010	
	10140	Incision and drainage of hematoma, seroma or fluid collection	0.54	010	
	10160	Puncture aspiration of abscess, hematoma, bulla, or cyst	0.29	010	
	10180	Incision and drainage, complex, postoperative wound infection	1.62	010	
	11010	Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin and subcutaneous tissues	1.10	010	
	11011	Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, and muscle	1.98	000	
	11012	Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle, and bone	2.42	000	
	11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less	1.10	000	
	11043	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less	1.98	000	
	11044	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less	2.42	000	
+	**11045**	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	0.18	ZZZ	
+	**11046**	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	0.45	ZZZ	
+	**11047**	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	0.90	ZZZ	
	11055	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion	0.18	000	
	11056	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions	0.22	000	
	11057	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than 4 lesions	0.36	000	
	11100	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion	0.34	000	
+	**11101**	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; each separate/additional lesion (List separately in addition to code for primary procedure)	0.25	ZZZ	
	11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions	0.31	010	
+	**11201**	Removal of skin tags, multiple fibrocutaneous tags, any area; each additional 10 lesions, or part thereof (List separately in addition to code for primary procedure)	0.25	ZZZ	
	11420	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less	0.47	010	
	11421	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm	0.61	010	
	11422	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm	0.76	010	
	11423	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm	1.12	010	

+ Add-on Procedure ∞ State Specific Code ® Altered CPT Code ⊘ Modifier 51 Exempt ⑤ Optum360 Mod 51 Exempt
■ New code, changed description, or changed value from June 1, 2012
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7. Materials Supplied by Podiatrist

Pharmacy

A prescriber cannot dispense more than a seventy-two hour supply of drugs with the exceptions of:

1. Persons practicing in hospitals as defined in section 2801 of the public health law;
2. The dispensing of drugs at no charge to their patients;
3. Persons whose practices are situated ten miles or more from a registered pharmacy;
4. The dispensing of drugs in a clinic, infirmary, or health service that is operated by or affiliated with a post-secondary institution;
5. The dispensing of drugs in a medical emergency as defined in subdivision six of section 6810 of the State Education Law.

For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070.

Radiopharmaceutical or other radionuclide material cost: listed relative value units in this section do not include these costs. List the name and dosage of radiopharmaceutical material and cost. Bill with code 99070.

Appliances and prostheses as listed within this fee schedule can be billed separately and do not apply to the supply rules as listed here.

8. Injection Procedures

Relative value units for injection procedures include all usual pre- and postinjection care specifically related to the injection procedure, necessary local anesthesia, placement of needle or catheter, and injection of contrast media.

9. Miscellaneous

A) Emergency services rendered between 10 p.m. and 7 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. Submit report (see Medicine Ground Rule 1B).

B) Relative value units for office, home and hospital visits, consultation, and other medical services, surgical and laboratory procedures are listed in the Evaluation and Management, Medicine, Surgery, and Pathology and Laboratory sections.

10. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. If more than one modifier is needed, place modifier 99 after the procedure code to indicate that two or more modifiers will follow. Modifiers commonly used with radiology procedures are as follows:

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.

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 physician 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.

32 Mandated Services
Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

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

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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).

52 Reduced Services
Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

62 Two Surgeons
When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure[s]) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. **Note:** If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

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.

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5 Pathology and Laboratory

The relative value units in this section were determined uniquely for pathology and laboratory services. Use the pathology and laboratory conversion factor when determining fee amounts. The pathology and laboratory 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 pathology and laboratory conversion factor, 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. After which, charges for products may be added.

Fees for pathology items are for podiatrists who perform their own laboratory work. All serological procedures are to be performed by registered pathologists or laboratories.

Items used by all podiatrists in reporting their services are presented in the Introduction and General Guidelines section under General Ground Rules.

Pathology and Laboratory 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. Attending Podiatrist

The attending podiatrist will not make a charge for obtaining and handling of specimens.

2. Materials Supplied by Provider

Pharmacy

A prescriber cannot dispense more than a seventy-two hour supply of drugs with the exceptions of:

1. Persons practicing in hospitals as defined in section 2801 of the public health law;
2. The dispensing of drugs at no charge to their patients;
3. Persons whose practices are situated ten miles or more from a registered pharmacy;
4. The dispensing of drugs in a clinic, infirmary, or health service that is operated by or affiliated with a post-secondary institution;
5. The dispensing of drugs in a medical emergency as defined in subdivision six of section 6810 of the State Education Law.

For pharmaceuticals administered by the medical provider in a medical office setting, payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping costs associated with delivery from the supplier of the item to the provider's office. There should be no additional "handling" costs added to the total cost of the item. Bill using procedure code 99070.

3. Referral Laboratory

When the service or procedure is performed by other than the attending podiatrist, be it hospital, commercial, or other laboratory, only the laboratory rendering the service may bill and such shall be submitted directly to the responsible payer.

4. Reports

No bill for services or procedures included in this section shall be considered properly rendered unless it is accompanied by a report that includes the findings and the interpretation of such findings. Where the service or procedure results in producing an image or graph, such shall be submitted together with the bill.

5. By Report "(BR)"

"BR" in the Relative Value column indicates that the relative value unit of this service is to be determined "by report." Pertinent information concerning the

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nature, extent, and need for the procedure or service, the time, skill, and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary. See the General Ground Rules for an explanation of "BR" procedures.

6. Indices or Ratios

Tests which produce an index or ratio based on mathematical calculations from two or more other results may not be billed as a separate independent test (e.g., A/G ratio, free thyroxine index).

7. Unlisted Service or Procedure

Specify the service by the last code number in the appropriate subdivision. Identify by name or description, and submit report (see Pathology and Laboratory Ground Rule 5 above).

8. Organ or Disease-Oriented Panels

Organ or disease-oriented panels (80047–80076), are used to confirm specific diagnoses. These panels are problem-oriented in scope. Each panel contains a list of the tests that must be included in order to use that particular code number. This is not meant to limit the number of tests performed or ordered if medically appropriate. Other tests performed that are not part of the panel may be separately reported. It is also inappropriate to separately report the components of a panel test if the full set of identified tests was performed. Please refer to CPT guidelines for a complete explanation of codes included in each panel.

9. Specific Billing Instructions

The relative value units listed in this section include recording the specimen, performance of the test, and reporting of the result. They do not include specimen collection, transfer, or individual patient administrative services. (For reporting collection and handling, see the 99000 series)

The listed relative value units are total values that include both the professional and technical components. Utilization of the listed code without modifier 26 or TC implies that there will only be one charge, inclusive of the professional and technical components. The listed relative value units apply to podiatrists, podiatrist-owned laboratories, commercial laboratories, and hospital laboratories.

The column designated PC/TC Split indicates the percent of the global fee (relative value) for the technical and professional components of the procedure.

A) **Professional Component**
The professional component represents the value of the professional pathology services of the podiatrist. This includes examination of the patient, when indicated, interpretation and written report of the laboratory procedure, and consultation with the referring podiatrist. (Report using modifier 26.)

B) **Technical Component**
The technical component includes the charges for performance and/or supervision of the procedure, personnel, materials, space, equipment, and other facilities. (Report using modifier TC.)

10. Collection and Handling

Relative value units assigned to each test represent only the cost of performing the individual test, be it manual or automated. The collection, handling, and patient administrative services have been assigned relative value units and separate code numbers.

11. Review of Diagnostic Studies

When prior studies are reviewed in conjunction with a visit, consultation, record review, or other evaluation, no separate charge is warranted for the review by the medical practitioner or other medical personnel. Neither the professional component modifier 26 nor the pathology consultation codes (80500 and 80502) are reimbursable under this circumstance. The review of diagnostic tests is included in the evaluation and management codes.

12. Modifiers

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

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.

26 Professional Component
Certain procedures are a combination of a physician or other qualified health care

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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 physician 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.

32 Mandated Services
Services related to *mandated* consultation and/or related services (eg, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

52 Reduced Services
Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

90 Reference (Outside) Laboratory
When laboratory procedures are performed by a party other than the treating or reporting physician or other qualified health care professional, the procedure may be identified by adding modifier 90 to the usual procedure number.

91 Repeat Clinical Diagnostic Laboratory Test
In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number with the addition of modifier 91. **Note:** This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

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.

13. Drug Screening

Drug screening may be required as part of the non-acute pain management treatment protocol.

Drug Testing—Urine Drug Testing (UDT) (or the testing of blood or any other body fluid) is a mandatory component of chronic opioid management, as part of the baseline assessment and ongoing re-assessment of opioid therapy. Baseline drug testing should be obtained on all transferring patients who are already using opioids or when a patient is being considered for ongoing opioid therapy. The table below offers guidance as to frequency of regular, random drug testing.

Risk Category (Score)	Random Drug Frequency
Low Risk	Periodic (At least once/year)
Moderate Risk	Regular (At least 2/year)
High Risk	Frequent (At least 3–4/year)
Aberrant Behavior	At time of visit

Random drug screening (urine or other method) should be performed at the point of care using a quick or rapid screening test method utilizing a stick/dip stick, cup or similar device. Reimbursement will be limited to 1 unit of 80305, 80306, or 80307. In addition, the provider may bill the appropriate evaluation and management code commensurate with the services rendered.

Drug Testing (urine or any other body fluid) by a laboratory—Drug testing performed by a laboratory (whether the lab is located at the point of care or not) should not be a regular part of the non-acute pain management treatment protocol, but rather shall be used as confirmatory testing upon receipt of unexpected or unexplained UDT results (Red Flags).

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Red Flags include:

- Negative for opioid(s) prescribed
- Positive for amphetamine or methamphetamine
- Positive for cocaine or metabolites
- Positive for drug not prescribed (benzodiazepines, opioids, etc.)
- Positive for alcohol

Upon documentation of the Red Flag, the provider shall direct confirmatory testing using GLC, GC/MS or LC/MS. Such tests shall be billed using 1 unit of 80375 for 1–3 drugs; 1 unit of 80376 for 4–6 drugs; or 1 unit of 80377 for 7 or more drugs.

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