

OFFICIAL

NEW YORK STATE WORKERS' COMPENSATION

CHIROPRACTIC FEE SCHEDULE

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



Workers'
Compensation
Board

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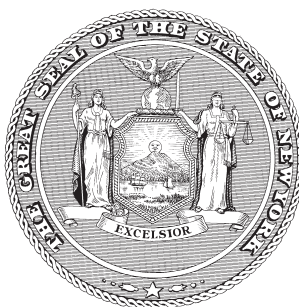
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NEW YORK WORKERS' COMPENSATION BOARD FILING NOTICE

The Chiropractic Fee Schedule was duly filed in the Office of the Department of State, and constitutes Sections 348.1 and 348.2 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 Chiropractic 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

Region II

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

Region III

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

Region IV

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

Numerical List of Postal ZIP Codes

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

From	Thru	Region	From	Thru	Region
12007	12099	I	14501	14592	I
12106	12177	I	14601	14694	II
12179	12183	II	14701	14788	I
12184	12199	I	14801	14898	I
12201	12288	II	14901	14925	I
12301	12345	II			

CONVERSION FACTORS

Regional conversion factors for services rendered on or after April 1, 2019 except as noted below.

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				
(eff. 04/01/2019-12/31/2019)	\$5.77	\$5.77	\$6.60	\$7.17
(eff. 01/01/2020)	\$7.69	\$7.69	\$8.79	\$9.55
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 99201, performed in Region I or Region II, would be calculated as follows:

$$\begin{aligned}
 & 5.83 \text{ (Relative Value)} \\
 & \times \$6.37 \text{ (Chiropractic E/M Section Conversion Factor} \\
 & \text{for Region I or Region II)} \\
 & = \$37.14
 \end{aligned}$$

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 "■".

72081	72082	72083	72084	73501	73502
73503	73521	73522	73523	73551	73552
95885	95886	95887	95907	95908	95909
95910	95911	95912	95913	97763	

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 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
97010	0.55	2.37	XXX	XXX		
97750	0.00	5.41	XXX	XXX		
99075	\$350.00	\$400.00				

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.

72040	72050	72052	72080	95930	97530
99070	99201	99202	99203	99204	99212

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.

72010	72069	72090	73500	73510	73520
73550	95900	95903	95904	95934	95936
97762					

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 Chiropractor**Durable Medical Equipment Fee Schedule**

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.

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 15.0.

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

Claimant lives in New York State but treats outside of New York State—A claimant who lives in New York State may treat with a qualified or Board authorized out-of-state medical provider when such treatment conforms to the Workers' Compensation Law and regulations, the Medical Treatment Guidelines and the Medical Fee Schedule. Payment shall be made to the

medical provider as set forth herein and using the regional conversion factor for the ZIP code where the claimant resides.

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

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

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

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.

11. Moxibustion and Other Complementary Integrative Medicine Techniques

Moxibustion and other complementary integrative medicine techniques are often combined with acupuncture. No additional reimbursement will be provided for acupuncture combined with moxibustion or other similar adjunctive procedures.

4 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 18.0 RVUs for all providers combined. 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.

5 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 18.0 RVUs for all providers combined. 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	97810	97811	97813	97814
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, acupuncture and/or chiropractic 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 combined. 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	97810	97811	97813	97814
98940	98941	98942			

4. Tests and Measurements

Code 97763 training and management 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.