



DAVID A. PATERSON
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STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
OFFICE OF GENERAL COUNSEL
20 PARK STREET
ALBANY, NY 12207

(518) 486-9564



ROBERT E. BELOTEN
CHAIR

August 27, 2010

Jason Tenenbaum, Esq.
The Law Offices of Jason Tenenbaum, P.C.
595 Stewart Avenue
Suite 550
Garden City, New York 11530

**RE: Kenneth J. Munnelly Correspondence
FOIL No. 10-220**

Dear Mr. Tenenbaum:

Please accept the following in response to your August 25, 2010, Freedom of Information Law (FOIL) request addressed to the Workers' Compensation Board's (Board's) Office of General Counsel, which was received on the same date by electronic mail. You seek a copy of the August 14, 2009, correspondence of General Counsel Kenneth J. Munnelly regarding the proper fee schedule of chiropractors who perform manipulation under anesthesia.

I have identified a two-page document that is responsive to your FOIL request, namely the August 14, 2009, correspondence from Kenneth J. Munnelly, Esq. to James K. Hogan, Esq. A copy of this correspondence is enclosed for your consideration. The copying fee authorized by Public Officers Law Article 6 is hereby waived as a courtesy to you.

In all future correspondence relating to this request, please refer to the above FOIL Number.
Thank you.

Sincerely,

Patrick J. Cremonese
Senior Attorney & Records Access Officer

Enclosure



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ROBERT E. BELOTEN
CHAIR

August 14, 2009

James K. Hogan, Esq.
Bruno, Gerbino & Soriano, LLP
445 Broad Hollow Road, Suite 220
Melville, New York 11747

Dear Mr. Hogan:

This letter serves as a reply to your July 27, 2009, correspondence directed to the Office of General Counsel, in which you ask our office to provide guidance and or a legal opinion as to: 1) the proper Group Code for reimbursement to surgical centers providing Manipulation Under Anesthesia that are currently billing at the same rate as an orthopedic surgeon; and 2) the correct terminology and calculation for 8 units of physical therapy. Please be advised that the Office of General Counsel does not render legal opinions but will provide the requested guidance on the two issues posed.

It appears that your first question relates to medical providers other than orthopedic surgeons who are performing manipulation under anesthesia (MUA). Generally, ambulatory surgical centers (ASC) and outpatient hospital facilities bill per PAS (Products of Ambulatory Surgery) methodology, which is predicated on the ICD-9 Code (International Classification of Diseases). The ICD-9 codes match the diagnosis to the procedure. The type of medical provider who performed the service is irrelevant. The appropriate designated grouping for MUA is PAS Group 34 (Bone Therapeutic).

For example, if an appropriately trained chiropractor performs MUA, then that chiropractor can bill under the pertinent codes. The CPT codes most commonly billed under are 22505 and 27275. The relative value unit (RVU) is established for such CPT codes by the Official Medical Fee Schedule and remains constant whether a medical doctor, osteopathic doctor or chiropractor bills for services using that code. The reimbursement rate, however, differs based on the conversion factor assigned to the type of provider. A comparison of conversion factors that a medical or osteopathic doctor would bill versus the factor under which the chiropractor would bill indicates that the chiropractor should be billing and get paid at 68.4% of the allowable conversion factor for medical and osteopathic doctors performing the same procedure. Additionally of note in billing is that when a medical provider bills from the surgery portion of the fee schedule, reimbursement is subject to all relevant Ground Rules in that subsection of the fee schedule, such as Ground Rule 5 for multiple procedures. Also, it is common for MUAs to be billed by "co-surgeons." When two trained chiropractors bill for MAU, e.g., traction/counter-traction, a pro-ration agreement assigning a percentage of the total allowable charges to each provider, which are subject to 68.4% of the RVU.

James K. Hogan, Esq.

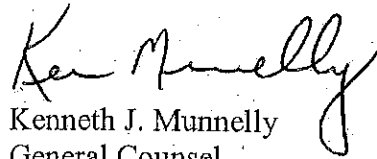
August 14, 2009

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The second issue you raised concerns the wording of Physical Medicine Ground Rule 11 of the Official Medical fee Schedule. The Workers' Compensation Board construes the use of the term "reimbursement is limited to 8.0 units or the amount billed, whichever is less" to mean the RVUs assigned to the CPT codes in that subsection. The C series forms or an OT/PT-4 form can be used when billing, on which the provider can enter the number of units up to eight. For example, when billing for multiple treatments/modalities under the same code, units are entered on the form. Ground Rule 11 specifically lists which codes are subject to this Ground Rule and should be construed to mean RVUs.

I trust this information gives you a better understanding of the practical application of and calculations regarding MUAs and RVUs. If you have specific concerns, please direct them to the Office of Health Provider Administration at (518) 486-3313.

Sincerely,



Kenneth J. Munnelly
General Counsel

c: Joseph Salamone, Director, Bureau of Health Management
Lynne Cuva, Program Manager, Office of Health Provider Administration