

# PHYSICAL MEDICINE

## GENERAL INFORMATION

Physical and occupational therapy services must be ordered by the worker's:

- Attending doctor
- Nurse practitioner or
- By the physician assistant for the attending doctor.

## Who May Bill For Physical Medicine Services

### **Board Certified Physical Medicine and Rehabilitation (Physiatry) Physicians**

Medical or osteopathic physicians who are board qualified or board certified in physical medicine and rehabilitation may provide physical medicine services.

- They use CPT<sup>®</sup> codes 97001 through 97799 and 95831 through 95852 to bill for their services.
- CPT<sup>®</sup> code 64550 may also be used but is payable only once per claim (see WAC 296-21-290).

### **Licensed Physical Therapists**

Physical therapy services must be provided by a licensed physical therapist or a physical therapist assistant serving under the supervision of a licensed physical therapist (see WAC 296-23-220).

### **Licensed Occupational Therapists**

Occupational therapy services must be provided by a licensed occupational therapist or occupational therapy assistant serving under the direction of a licensed occupational therapist (see WAC 296-23-230).

### **Nonboard Certified/Qualified Physical Medicine Providers**

Special payment policies apply for attending doctors who are not board qualified or certified in physical medicine and rehabilitation:

- They **will not be paid** for CPT<sup>®</sup> codes 97001-97799.
- They may perform physical medicine modalities and procedures described in CPT<sup>®</sup> codes 97001-97750 if their scopes of practice and training permit it, but must bill local code 1044M for these services.
- Local code 1044M is limited to 6 units per claim, except when the attending doctor practices in a remote location where no licensed physical therapist is available.
- After 6 units, the patient must be referred to a licensed, physical or occupational therapist or physiatrist for such treatment except when the attending doctor practices in a remote location. Refer to WAC 296-21-290 for more information.

1044M Physical medicine modality (ies) and/or procedure(s) by attending doctor who is not board qualified or certified in physical medicine and rehabilitation. Limited to 6 units except when doctor practices in a remote area..... \$ 43.06

## Who Will Not Be Paid For Physical Medicine Services

- Physical or occupational therapist students
- Physical or occupational therapist assistant students
- Physical or occupational therapist aides
- Athletic trainers

## PHYSICAL AND OCCUPATIONAL THERAPY

### **Billing Codes**

Physical and occupational therapists must use the appropriate CPT<sup>®</sup> and HCPCS codes 64550, 95831-95852, 95992, 97001-97799 and G0283, with the exceptions noted later in the Noncovered and Bundled Codes section. They must bill the appropriate **covered** HCPCS codes for miscellaneous materials and supplies. For information on surgical dressings dispensed for home use, refer to the [Supplies, Materials and Bundled Services](#) section, page **120**. If more than 1 patient is treated at the same time use CPT<sup>®</sup> code 97150. Refer to the Physical Medicine [CPT<sup>®</sup> Codes Billing Guidance](#) section, page **64** for additional information.

### **Noncovered and Bundled Codes**

**The following physical medicine codes are not covered:**

CPT <sup>®</sup> Code
97005
97006
97033

**The following are examples of bundled items or services:**

- Application of hot or cold packs.
- Ice packs, ice caps and collars.
- Electrodes and gel.
- Activity supplies used in work hardening, such as leather and wood.
- Exercise balls.
- Therataping.
- Wound dressing materials used during an office visit and/or physical therapy treatment.

Refer to the appendices for complete lists of noncovered and bundled codes.

### **Untimed Services**

Supervised modalities and therapeutic procedures that do not list a specific time increment in their description are limited to 1 unit per day:

CPT <sup>®</sup> Code	CPT <sup>®</sup> Code
97001	97018
97002	97022
97003	97024
97004	97026
97012	97028
97014	97150
97016	

## **Daily Maximum for Services**

The daily maximum allowable fee for physical and occupational therapy services  
(see WAC 296-23-220 and WAC 296-23-230 ..... \$ 118.07

The daily maximum applies to CPT® codes 64550, 95831-95852 and 97001-97799 and HCPCS code G0283 when performed for the same claim for the same date of service. If physical and occupational therapy services are provided on the same day, the daily maximum applies once for each provider type.

If the worker is treated for 2 separate claims with different allowed conditions on the same date, the daily maximum will apply for each claim.

If part of the visit is for a condition unrelated to an accepted claim and part is for the accepted condition, therapists must apportion their usual and customary charges equally between the insurer and the other payer based on the level of service provided during the visit. In this case, separate chart notes for the accepted condition should be sent to the insurer since the employer does not have the right to see information about an unrelated condition.

The daily maximum allowable fee does not apply to:

- Performance based physical capacities examinations (PCEs),
- Work hardening services,
- Work evaluations or
- Job modification/prejob accommodation consultation services.

## **PHYSICAL AND OCCUPATIONAL THERAPY EVALUATIONS**

Use CPT® codes 97001 through 97004 to bill for physical and occupational therapy evaluations and reevaluations. Use CPT® codes 97001 and 97003 to report the evaluation by the physician or therapist to establish a plan of care. Use CPT® codes 97002 and 97004 to report the evaluation of a patient who has been under a plan of care established by the physician or therapist in order to revise the plan of care. CPT® codes 97002 and 97004 have no limit on how frequently they can be billed.

## **PHYSICAL CAPACITIES EVALUATION**

The following local code is payable only to physicians who are board qualified or certified in physical medicine and rehabilitation, and physical and occupational therapists. The evaluation must be provided as a 1-on-1 service.

1045M Performance-based physical capacities evaluation with report and  
summary of capacities ..... \$ 705.78  
(Limit of 1 per 30 days)

## **POWERED TRACTION THERAPY**

Powered traction devices **are covered** as a physical medicine modality.

The insurer **will not pay** any additional cost when powered devices are used. Published literature has not substantially shown that powered devices are more effective than other forms of traction, other conservative treatments or surgery. This policy applies to all FDA approved powered traction devices. For more information go to

<http://www.Lni.wa.gov/ClaimsIns/Providers/Treatment/CovMedDev/SpecCovDec/PTD.asp>

## WOUND CARE

### Debridement

Therapists **cannot bill** the surgical CPT® codes for wound debridement. Therapists must bill CPT® 97597, 97598 or 97602 when performing wound debridement that exceeds what is incidental to a therapy (for example, whirlpool).

Wound dressings and supplies used in the office are bundled and are not separately payable.

Wound dressings and supplies sent home with the patient for self-care can be billed with HCPCS codes appended with local modifier –1S. See the [Supplies, Materials and Bundled Services](#) section, page 120 for more information.

### Electrical Stimulation for Chronic Wounds

Electrical stimulation passes electric currents through a wound to accelerate wound healing.

Electrical stimulation is **covered** for the following chronic wound indications:

- Stage III and IV pressure ulcers
- Arterial ulcers
- Diabetic ulcers
- Venous stasis ulcers

**Prior authorization** is required if electrical stimulation for chronic wounds is requested for use on an outpatient basis using the following criteria:

- Electrical stimulation will be authorized if the wound has not improved following 30 days of standard wound therapy.
- In addition to electrical stimulation, standard wound care must continue.
- In order to pay for electrical stimulation beyond 30 days, licensed medical personnel must document improved wound measurements within the past 30 days.

Use HCPCS code G0281 to bill for electrical stimulation for chronic wounds. For more information go to

<http://www.Lni.wa.gov/ClaimsIns/Providers/Treatment/CovMedDev/SpecCovDec/ElecStimulation.asp>

## MASSAGE THERAPY

Massage is a **covered** physical medicine service when performed by a licensed massage therapist (WAC 296-23-250) or other provider whose scope of practice includes massage techniques.

Massage therapists must bill CPT® code 97124 for all forms of massage therapy, regardless of the technique used. The insurer **will not pay** massage therapists for additional codes.

Massage therapists must bill their usual and customary fee and designate the duration of the massage therapy treatment.

Massage therapy is paid at 75% of the maximum daily rate for physical and occupational therapy services and the daily maximum allowable amount is ..... \$ 88.55

The following are bundled into the massage therapy service and are not separately payable:

- Application of hot or cold packs,
- Anti-friction devices and
- Lubricants (For example, oils, lotions, emollients).

Refer to WAC 296-23-250 for additional information.



Document the amount of time spent performing the treatment. Your documentation must support the units of service billed.

## PHYSICAL MEDICINE CPT® CODES BILLING GUIDANCE

### Timed Codes

The following provides guidance regarding the use of CPT® codes 97032-97036, 97110-97124, 97140, 97530-97542 and 97750-97762.

Several CPT® codes used for therapy modalities, procedures and tests and measurements specify that the direct (1-on-1) time spent in patient contact is 15 minutes.

Providers bill procedure codes for services delivered on any calendar day using CPT® codes. The number of units billed is based on the number of minutes outlined in the chart below.

Providers **must document** in the treatment note the amount of time spent for each **time based code** billed.

For any single CPT® code, providers bill a single unit for treatment greater than or equal to 8 minutes and less than 23 minutes.

If the duration of a single modality or procedure is greater than or equal to 23 minutes and less than 38 minutes, then 2 units must be billed. Time intervals for the number of units are as follows:

Units Reported on the Claim	Number Minutes
1 unit	≥ 8 minutes to < 23 minutes
2 units	≥ 23 minutes to < 38 minutes
3 units	≥ 38 minutes to < 53 minutes
4 units	≥ 53 minutes to < 68 minutes
5 units	≥ 68 minutes to < 83 minutes
6 units	≥ 83 minutes to < 98 minutes
7 units	≥ 98 minutes to < 113 minutes
8 units	≥ 113 minutes to < 128 minutes

**NOTE:** The above schedule of times does not imply that any minute until the 8th should be excluded from the total count. The timing of active treatment counted includes all direct treatment time.

### **Billing Tip**

Report the duration of treatment for each timed code billed in the daily treatment note. You must submit all documents that support your billing (e.g. flow sheets and chart notes.)

If more than 1 CPT® code is billed during a calendar day, then the total number of units that can be billed is constrained by the total treatment time.

### **Example 1**

On the same day you provide:

- 24 minutes of neuromuscular reeducation (CPT® code 97112) and
- 23 minutes of therapeutic exercise (CPT® code 97110).

Total treatment time is 47 minutes. A maximum of 3 units can be billed.

The correct coding is 2 units of CPT® code 97112 and 1 unit of CPT® code 97110, assigning more units to the service that took the most time.

### **Example 2**

On the same day you provide:

- 5 minutes of ultrasound (CPT® code 97035) and
- 6 minutes of manual therapy (CPT® code 97140) and
- 10 minutes of therapeutic exercise (CPT® code 97110)

The total treatment time is 21 minutes. A maximum of 1 unit can be billed.

The correct coding is 1 unit of CPT® code 97110 (the service provided for the longest time).

The clinical record will serve as documentation that the other 2 services were also performed.

## Prohibited Pairs

A therapist cannot bill any of the following pairs of CPT<sup>®</sup> codes for outpatient therapy services provided simultaneously to 1 or more patients for the same time period.

- Any 2 CPT<sup>®</sup> codes for “therapeutic procedures” requiring direct, 1-on-1 patient contact.
- Any 2 CPT<sup>®</sup> codes for modalities requiring “constant attendance” and direct, 1-on-1 patient contact.
- Any 2 CPT<sup>®</sup> codes requiring either constant attendance or direct, 1-on-1 patient contact—as described above—. For example: any CPT<sup>®</sup> codes for a therapeutic procedure with any attended modality CPT<sup>®</sup> code.
- Any CPT<sup>®</sup> code for therapeutic procedures requiring direct, 1-on-1 patient contact with the group therapy CPT<sup>®</sup> code. For example: CPT<sup>®</sup> code 97150 with CPT<sup>®</sup> code 97112.
- Any CPT<sup>®</sup> code for modalities requiring constant attendance with the group therapy code. For example: (CPT<sup>®</sup> code 97150 with CPT<sup>®</sup> code 97035)
- Any untimed evaluation or reevaluation code with any other timed or untimed CPT<sup>®</sup> codes, including constant attendance modalities, therapeutic procedures and group therapy.

## DETERMINING WHAT TIME COUNTS TOWARDS TIMED CODES

Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. In other words, the time counted as “intraservice care” begins when the therapist or physician (or a physical therapy or occupational therapy assistant under the supervision of a physician or therapist) is directly working with the patient to deliver treatment services. The patient should already be in the treatment area (For example, on the treatment table or mat or in the gym) and prepared to begin treatment. The time counted is the time the patient is treated. The time the patient spends not being treated because of the need for toileting or resting should not be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin is not considered treatment time.

Regardless of the number of units billed, the daily maximum fee for services will not be exceeded.

More information about L&I’s Physical, Occupational and Massage Therapy policies is also available on L&I’s web site at

<http://www.Lni.wa.gov/ClaimsIns/Providers/Manage/RTW/Therapy/default.asp>

## WORK HARDENING AND WORK CONDITIONING

### Work Hardening

Work hardening is an interdisciplinary, individualized, job specific program of activity with the goal of return to work. Work hardening programs use real or simulated work tasks and progressively graded conditioning exercises that are based on the individual’s measured tolerances. Work hardening provides a transition between acute care and successful return to work and is designed to improve the biomechanical, neuromuscular, cardiovascular and psychosocial functioning of the worker. Work hardening programs require prior approval by the worker’s attending physician and **prior authorization** by the claim manager.

Only L&I approved work hardening providers will be paid for work hardening services.

More information about L&I’s work hardening program, including a list of approved work hardening providers, criteria for admission into a work hardening program and other work hardening program standards is available on L&I’s web site at

<http://www.Lni.wa.gov/ClaimsIns/Providers/Manage/RTW/WorkHard/default.asp>

This information is also available by calling the Provider Hotline at 1-800-848-0811 or the work hardening program reviewer at (360) 902-4480.

The work hardening evaluation is billed using local code 1001M. Treatment is billed using CPT® codes 97545 and 97546. These codes are subject to the following limits:

Work hardening programs are authorized for up to 4 weeks.

Code	Description	Unit limit (four week program)	Unit price
1001M	Work hardening evaluation	6 units (1 unit = 1 hour)	\$ 117.02
97545	Initial 2 hours per day	20 units per program; max.1 unit per day per worker (1 unit = 2 hours)	\$ 128.60
97546	Each additional hour	70 units per program; add-on, will not be paid as a stand-alone procedure per worker per day. (1 unit = 1 hour)	\$ 60.30

### Program extensions

Program extensions must be authorized in advance by the claim manager and are based on documentation of progress and the worker's ability to benefit from the program extension up to 2 additional weeks. Additional units available for extended programs

Code	Description	6 week program limit
1001M	Work hardening evaluation	no additional units
97545	Initial 2 hours per day	10 units (20 hours)
97546	Each additional hour	50 units (50 hours)

Providers may only bill for the time that services are provided in the presence of the client. The payment value of procedure codes 97545 and 97546 takes into consideration that some work occurs outside of the time the client is present (team conference, plan development, etc.).

Time spent in treatment conferences is **not covered** as a separate procedure regardless of the presence of the patient at the conference. Job coaching and education are provided as part of the work hardening program. These services must be billed using procedure codes 97545 and 97546.

### Billing for additional services

The provision of additional services during a work hardening program is atypical and must be authorized in advance by the claim manager. Documentation must support the billing of additional services.

### Billing for less than 2 hours of service in 1 day (97545)

Services provided for less than 2 hours on any day do not meet the work hardening program standards. Therefore, the services must be billed outside of the work hardening program codes. For example, the worker arrives for work hardening but is unable to fully participate that day. Services should be billed using CPT® codes that appropriately reflect the services provided. This should be considered as an absence in determining worker compliance with the program. The standard for participation continues to be a minimum of 4 hours per day, increasing each week to 7-8 hours per day by week 4.

### Billing less than 1 hour of 97546

After the first 2 hours of service on any day, if less than 38 minutes of service are provided the -52 modifier must be billed. For that increment of time, procedure code 97546 must be billed as a separate line item with a -52 modifier and the charged amount prorated to reflect the reduced level of service. For example: Worker completes 4 hours and 20 minutes of treatment. Billing for that date of service would include 3 lines:

Code	Modifier	Charged Amt	Units
97545		Usual and customary	1
97546		Usual and customary	2
97546	-52	33% of usual and customary (completed 20 of 60 minutes)	1

## Billing for services in multidisciplinary programs

Each provider must bill for the services that they are responsible for each day. Both occupational and physical therapists may bill for the same date of service.

Only 1 unit of 97545 (first 2 hours) will be paid per day per worker and the total number of hours billed should not exceed the number of hours of direct services provided.

Example: The occupational therapist (OT) is responsible for the work simulation portion of the worker's program, which lasted 4 hours. On the same day, the worker performed 2 hours of conditioning/aerobic activity that the physical therapist (PT) is responsible for. The 6 hours of services could be billed in 1 of 2 ways.

Option 1		
PT	1 unit 97545	2 hours
OT	4 units 97546	4 hours
	Total hours billed	6 hours

Option 2		
OT	1 unit 97545 +	2 hours
	2 units 97546	2 additional hours
PT	2 units 97546	2 hours
	Total hours billed	6 hours

## Billing for evaluation and treatment on the same day – multiple disciplines

If both the OT and the PT need to bill for 1 hour of evaluation and 1 hour of treatment on the same date of service, the services must be billed as follows:

Provider	Service	Bill As:
OT	1 hour evaluation	1 unit 1001M
PT	1 hour evaluation	1 unit 1001M
OT (or PT)	1 hour treatment	1 unit 97545 with modifier -52 (billed amount proportionate to 1 hour)
PT (or OT)	1 hour treatment	1 unit 97546

## Work Conditioning

L&I does not recognize work conditioning as a special program. Work conditioning is paid according to the rules for outpatient physical and occupational therapy. See WAC 296-23-220 and WAC 296-23-230.

## OSTEOPATHIC MANIPULATIVE TREATMENT

Only osteopathic physicians may bill osteopathic manipulative treatment (OMT). CPT® code 97140 is **not covered** for osteopathic physicians.

For OMT services body regions are defined as:

- Head
- Cervical
- Thoracic
- Lumbar
- Sacral
- Pelvic
- Rib cage
- Abdomen and viscera regions
- Lower and upper extremities

These codes ascend in value to accommodate the additional body regions involved. Therefore, only 1 code is payable per treatment. For example, if 3 body regions were manipulated, 1 unit of the correct CPT® code would be payable.

OMT includes pre- and post-service work (For example, cursory history and palpatory examination). E/M office visit service may be billed in conjunction with OMT **only when all of the following conditions are met:**

- When the E/M service constitutes a significant separately identifiable service that exceeds the usual pre- and post-service work included with OMT, and
- There is documentation in the patient's record supporting the level of E/M billed, and
- The E/M service is billed using the –25 modifier.

The insurer **will not pay** for E/M codes billed on the same day as OMT without the –25 modifier.

The E/M service may be caused or prompted by the same diagnosis as the OMT service. A separate diagnosis is not required for payment of E/M in addition to OMT services on the same day.

The insurer may reduce payments or process recoupments when E/M services are not documented sufficiently to support the level of service billed. The CPT® book describes the key components that must be present for each level of service.

## ELECTRICAL STIMULATORS

### Electrical Stimulators Used in the Office Setting

Providers may bill professional services for application of stimulators with the CPT® physical medicine codes when it is within the provider's scope of practice. Attending doctors who are not board qualified or certified in physical medicine and rehabilitation must bill local code 1044M.

### Devices and Supplies for Home Use or Surgical Implantation

See the Transcutaneous Electrical Nerve Stimulators (TENS) section for policies pertaining to TENS units and supplies. Coverage policies for other electrical stimulators and supplies are described as follows.

### **Electrical Stimulator Devices for Home Use or Surgical Implantation**

HCPCS Code	Brief Description	Coverage Status
E0744	Neuromuscular stim for scoli	Not covered
E0745	Neuromuscular stim for shock	Covered for muscle denervation only. Prior authorization is required.
E0747	Elec Osteo stim not spine	Prior authorization is required.
E0748	Elec Osteogen stim spinal	Prior authorization is required
E0749	Elec Osteogen stim, implanted	Authorization subject to utilization review.
L8680	Implantable neurostimulator electrode	UW study only
E0755	Electronic salivary reflex s	Not covered
E0760	Osteogen ultrasound, stimltor	Covered for appendicular skeleton only (not the spine). Prior authorization is required.
E0761	Nontherm electromgntc device	Covered
E0762	Trans elec jt stim dev sys	Not covered
E0764	Functional neuromuscular stimulator	Prior authorization is required
E0765	Nerve stimulator for tx n&v	Not covered
E0769	Electric wound treatment dev	Not covered

## Electrical Stimulator Supplies for Home Use

HCPCS Code	Brief Description	Coverage Status
A4365	Adhesive remover wipes	Payable for home use only Bundled for office use
A4455	Adhesive remover per ounce	
A4556	Electrodes, pair	
A4557	Lead wires, pair	
A4558	Conductive paste or gel	
A5120	Skin barrier wipes box per 50	
A6250	Skin seal protect moisturizer	
E0731	Conductive garment for TENS	Not covered
E0740	Incontinence treatment system	Not covered

## TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS (TENS)

The Medical Treatment Guidelines Subcommittee of the Washington State Medical Association reviewed literature on the effectiveness of TENS units in treating pain. There is evidence the units can be effective in treating acute or postoperative pain. However, there is less evidence the devices are effective in treating chronic pain. In particular, it is unusual for a patient to benefit from a TENS unit for more than 3 months.

Electrotherapy standards are set by the U.S. Food and Drug Administration, FDA 510(k), and classified into 3 categories:

- TENS units
- Interferential current stimulators
- Neuromuscular stimulators

L&I's definition of TENS therapy includes TENS units and interferential current stimulators. Neuromuscular stimulators do not fall under the TENS definition.

### Prescribing TENS

TENS units may be prescribed by licensed

- Medical physicians
- Osteopathic physicians
- Naturopathic physicians
- Podiatric physicians
- ARNPs
- Dental surgeons
- Physician assistants

These providers can also sign L&I's *TENS Purchase Recommendation* form for the State Fund TENS contract.

Chiropractors (DCs) licensed in Washington are not allowed to prescribe TENS units according to WAC 246-808-640. Out-of-state chiropractors can usually prescribe TENS units for workers who do not live in Washington. A chiropractor's ability to prescribe TENS units is based on his or her state's scope of practice.

**NOTE:** Physical and occupational therapists may only fit workers with TENS units upon referral by the provider types listed above.

## **TENS Instruction**

L&I allows the initial TENS application and training by a physical therapist or other qualified provider only once per claim. This service must be billed with CPT® code 64550.

## **Rental and Purchase of TENS**

TENS rental and purchase require authorization by the insurer, per WAC 296-20-03001(9), WAC 296-20-1102 and WAC 296-23-165(3). Vendors who attempt to bill the insurer for TENS units without authorization will not be paid.

The insurer will purchase only 1 TENS unit per claim unless:

- The worker's TENS unit is worn out, obsolete, or not repairable;
- A replacement TENS unit with improved and/or more advanced technology will substantially benefit the worker; or
- The worker's medical condition has changed sufficiently to warrant another attempt at TENS therapy after an initial failed attempt.

Self-insurers must negotiate:

- Their own rates for rental and purchase of TENS units, supplies and repairs.
- All warranty-covered TENS replacement or repair.

The State Fund contracts with Empi, Inc. for all TENS units, supplies and repairs. Conditions of the contract are provided later in this section.

## **TENS Supplies and Batteries**

The insurer **will pay** for medically necessary supplies and batteries if it has authorized the worker's use of the TENS unit for an accepted condition(s).

## **TENS Unit Repair and Replacement**

In cases where damage to the TENS unit is due to worker abuse, neglect or misuse, TENS unit repair or replacement is the responsibility of the worker. Replacement of a lost or stolen TENS unit is also the responsibility of the worker.

The TENS vendor is responsible for warranty-covered TENS repair and replacement. TENS warranty covers defects in workmanship and materials, including parts and labor. TENS units obtained through the State Fund's contracted vendor have 5-year warranties.

The insurer is responsible for nonwarranty-covered TENS unit repair and replacement. Nonwarranty covered repair includes repair needed because of normal wear or a work related incident damaged the unit. For State Fund claims, all nonwarranty repair and replacement must be arranged through Empi, Inc.

L&I and Empi, at their discretion, will decide when or if to repair a TENS unit or if the unit should be replaced with the same TENS unit or a TENS unit comparable to the damaged unit.

## **TENS Billing Codes**

L&I's contracted vendor and providers treating self-insured workers must use the appropriate HCPCS codes to bill for TENS units, supplies and services. Sales tax and delivery charges are not separately payable and must be included in the total charge for the TENS unit, supplies and services.

<b>HCPCS Code</b>	<b>Brief Description</b>	<b>Coverage Status</b>
A4595	TENS Supp 2 lead per month	For State Fund claims: Payable to L&I's contracted TENS vendor. For self-insured claims: Payable to DME suppliers.
A4630	Repl batt TENS own by pt	
E0730	TENS, 4 lead	

Additional supply codes that may be billed by L&I's contracted vendor and DME suppliers for self-insured claims.

HCPSC Code	Brief Description	Coverage Status
A4365	Adhesive Remover Wipes, any type, per 50	Payable for home use
A4450	Tape, nonwaterproof, per 18 square inches	
A4452	Tape, waterproof, per 18 square inches	
A4455	Adhesive remover or solvent (for tape, cement or other adhesive), per ounce	
A4556	Electrodes, (For example, apnea monitor), per pair	
A4557	Lead wires, (For example, apnea monitor), per pair	
A4558	Conductive paste or gel, for use with electrical device (For example, TENS, NMES), per oz.	
A5120	Skin barrier, wipes or swabs, each	
A5126	Adhesive or non adhesive; disk or foam pad	
A6250	Skin sealants, protectorants, moisturizers, ointments, any type, any size	
K0739	Repair or nonroutine service for durable medical equipment other than oxygen requiring the skills of a technician, labor component, per 15 minutes.	
E1399	DME equipment, miscellaneous	

### STATE FUND CONTRACT

Providers, both in and out-of-state, who prescribe or dispense TENS units for State Fund workers, per WAC 296-23-165(1) (b), must use L&I's contracted vendor. L&I's contracted vendor is:

Empi, Inc.

599 Cardigan Road

St. Paul, MN 55126

Phone: (800) 999-TENS, (800) 999-8367

Fax: (800) 400-5022

### Services Provided by Empi

Empi has technical specialists who provide assistance regarding the TENS units available through L&I's TENS contract. In addition, Empi provides customer service that supports both workers and providers.

Some services provided by Empi's technical, customer service, and quality programs include:

- Technical instructions to individual clinics and providers on an as-needed basis;
- Training to individual or groups of Washington TENS providers. During the training sessions, Empi will, at a minimum, present information about the contracted TENS units, supplies, and services provided under L&I's TENS contract. Hands-on training for all the TENS units in the contract will also be provided;
- Visits to clinics with inventories of TENS units and supplies at least every 6 weeks;
- Toll-free numbers for providers' and workers' use;
- Follow-up calls to new TENS users to ensure they understand how to properly use the TENS unit and accessories, order supplies, and obtain assistance;
- Assistance to workers whose primary language is not English; and
- In exceptional circumstances, in-home instruction and assistance.

## **Dispensing TENS**

Providers may have on-site inventories of the TENS units included in L&I's TENS contract with Empi, or they may order a TENS unit from Empi by calling 1-800-999-TENS (1-800-999-8367).

- In special cases L&I may approve requests for TENS units that are not included in the TENS contract. For further information, contact L&I's TENS contract manager at (360) 902-6821.
- Additional TENS units and updated TENS unit models may be added to the contract with L&I's approval.

Providers who maintain inventories of TENS units must notify Empi when they dispense a unit so Empi can replenish their inventories. Providers who do not have inventories of TENS units must contact Empi if a unit is needed, Empi will express mail or hand deliver a unit to you usually within 1 day of your request.

### **Providers may prescribe and dispense the following TENS units:**

<b>MANUFACTURER</b>	<b>UNIT NAME</b>	<b>TYPE OF UNIT</b>
Electromedical Products	Alpha-Stim 100	Micro-current
Empi	Epix VT	Conventional
Empi	IF 3Wave <sup>(1)</sup>	Interferential
Empi	Max II Elite (also known as Maxima)	Conventional
Empi	ProMax	Conventional
Empi	Select	Conventional
Intelect	TENS Basic	Conventional

- (1) This unit is classified by the FDA as a true interferential current stimulator. Only the interferential unit listed in the Empi contract with L&I is eligible for rental and purchase on an at-home basis. Interferential units must be obtained from Empi.

## **Trial Evaluation Period**

A provider may dispense a TENS unit to a worker for a free trial evaluation period. Prior authorization is not required for the trial evaluation.

The trial evaluation period begins when the TENS unit is dispensed to the worker and may last up to 30 days. During the trial evaluation period, the provider and the worker must assess whether the TENS treatment is working and if rental of the unit is medically necessary.

## **Rental Period**

If the TENS unit is beneficial during the trial evaluation period, Empi will contact L&I and request authorization for a 4-month rental period. If authorized, the 4-month authorization is dated from the day the TENS unit was initially dispensed to the worker for the trial evaluation.

Providers may request authorization for rental of a TENS unit by contacting Empi at 1-800-999-TENS (1-800-999-8367).

## **Purchase**

L&I requires a 4-month rental period before TENS purchase will be considered.

After a TENS unit has been rented for 3 months, Empi will send a *TENS Purchase Recommendation* form to the prescribing provider for his or her completion.

The prescribing provider must decide if he or she wants to pursue purchasing the TENS unit for the worker. If the worker continues to exhibit substantial, measurable improvement as a direct result of TENS therapy, the prescribing provider may request purchase of the unit by completing the *TENS Purchase Recommendation* form (see Requesting Purchase of a TENS Unit below for details).

If the prescribing provider does not believe purchase of the TENS unit will be of benefit to the worker, the prescribing provider must check box 12 on the *TENS Purchase Recommendation* form and return the signed and dated form to Empi.

If a worker's claim is ready for closure prior to the completion of 4 months of TENS rental, the claim manager may authorize early purchase of the TENS unit if TENS therapy is determined to be beneficial.

### **Requesting Purchase of a TENS Unit**

If the prescribing provider decides that purchase of the TENS unit will benefit the worker, the prescribing provider may request TENS purchase by completing the *TENS Purchase Recommendation* form and sending the form back to Empi.

Empi will forward the request to L&I. After L&I has received the request:

1. An L&I medical consultant or his or her designee will review the TENS purchase request and provide a medical perspective as to whether the request is substantiated by the objective medical evidence included on the form.
2. After the medical consultant or his or her designee has completed the TENS purchase review, Empi will contact the L&I Provider Hotline to request authorization for TENS unit purchase.
3. L&I's purchase decision will be communicated to Empi. If L&I denies TENS purchase, Empi will contact the worker.

**NOTE:** Prescribing providers are not permitted to bill L&I for completion of the *TENS Purchase Recommendation* form.

### **Denial and Second Purchase Review**

If the TENS unit purchase request is denied and the prescribing provider and worker disagree with L&I's decision, the provider may submit a written request for a second purchase review.

The second purchase review request must be submitted to Empi and must include additional objective information supporting both the worker's functional improvement and the effectiveness of TENS therapy. Empi will submit the second purchase review request to L&I for consideration and will notify the provider and the worker of L&I's authorization decision.

### **When a TENS Unit is No Longer Authorized**

Per RCW 51.28.020 and WAC 296-20-020, a worker with an accepted claim with L&I is entitled to benefits and may not be charged for any costs of treatment deemed appropriate for that claim. This includes postage for any items returned by mail.

When a TENS unit is no longer authorized by L&I, Empi will contact the worker by letter, notifying the worker that his or her TENS unit must be returned. All TENS units come with a postage paid, self-addressed package for easy return. If a worker should lose the return packaging, Empi will send replacement packaging at no charge.

Until L&I authorizes TENS purchase, a worker's TENS unit is owned by Empi. If an unauthorized TENS unit is not returned to Empi, Empi can bill the worker for all charges related to TENS rental, purchase, supplies and repair that accrue after TENS authorization is denied by L&I.

### **TENS Supplies and Batteries**

L&I **will pay** for medically necessary supplies and batteries if it has authorized the worker's use of the TENS unit for an accepted condition(s). All supplies and batteries must be obtained from Empi.