Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 6: Biofeedback, Electrocardiograms (EKG), Electrodiagnostic Services, and Extracorporeal Shockwave Therapy (ESWT)

Effective July 1, 2023

Link: Look for possible **updates and corrections** to these payment policies on L&I's website.

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Payment policy: Biofeedback

Prior authorization

Biofeedback treatment requires an attending provider's order and prior authorization.

When the condition is accepted under the industrial insurance claim, the insurer will authorize biofeedback treatment for:

- Idiopathic Raynaud's disease,
- Temporomandibular joint dysfunction,
- Myofascial pain dysfunction syndrome (MPD),
- Tension headaches,
- Migraine headaches,
- Tinnitus,
- Torticollis,
- Neuromuscular reeducation as result of neurological damage in a stroke (also known as "CVA") or spinal cord injury,
- Inflammatory and/or musculoskeletal disorders causally related to the accepted condition.

Link: For more information, see WAC 296-21-280.

Twelve biofeedback treatments in a 90 day period will be authorized for the conditions listed above when an evaluation report is submitted documenting all the following:

- The basis for the worker's condition, *and*
- The condition's relationship to the industrial injury, *and*
- An evaluation of the worker's current functional measurable modalities (for example, range of motion, up time, walking tolerance, medication intake), *and*
- An outline of the proposed treatment program, *and*
- An outline of the expected restoration goals.

No further biofeedback treatments will be authorized or paid for without substantiation of evidence of improvement in measurable, functional modalities (for example, range of motion, up time, walking tolerance, medication intake). Also:

- Only 1 additional treatment block of **12 treatments per 90 days** will be authorized, *and*
- Requests for biofeedback treatment beyond **24 treatments or 180 days** will be granted only after file review by and on the advice of the department's medical consultant.

In addition to treatment, pretreatment and periodic evaluation will be authorized. Follow-up evaluation can be authorized at 1, 3, 6, and 12 months post treatment.

Home biofeedback device rentals are time limited and require prior authorization.

Link: Refer to WAC 296-20-1102 for the insurers' policy on rental equipment.

Who must perform these services to qualify for payment

Practitioners must submit a copy of their biofeedback certification or supply evidence of their qualifications to the department or self-insurer to administer biofeedback treatment to workers. Administration of biofeedback treatment is limited to practitioners who:

- Are certified by the Biofeedback Certification Institute of America (BCIA), *or*
- Meet the minimum education, experience, and training qualifications to be certified.

Link: For more information, see WAC 296-21-280.

Paraprofessionals who aren't independently licensed must practice under the direct supervision of a qualified, licensed practitioner:

- Whose scope of practice includes biofeedback, *and*
- Who is BCIA certified or meets the certification qualifications.

A qualified or certified biofeedback provider who isn't licensed as a practitioner may not receive direct payment for biofeedback services.

Link: For legal definition of licensed practitioner, see WAC 296-20-01002.

Services that can be billed

CPT® codes **90875** and **90876** are payable to L&I approved biofeedback providers who are clinical psychologists or psychiatrists (MD or DO).

CPT® codes **90901**, **90912**, and **90913** are payable to any L&I approved biofeedback provider.

HCPCS code **E0746** is payable to DME or pharmacy providers (for rental or purchase).

Requirements for billing

The supervising licensed practitioner must bill the biofeedback services for paraprofessionals.

When biofeedback is performed along with individual psychotherapy, bill using either CPT® code **90875** or **90876**.

Don't bill CPT® codes **90901**, **90912**, or **90913** with the individual psychotherapy codes.

Use evaluation and management codes for diagnostic evaluation services.

Payment limits

CPT® code **90901** is limited to **1 unit of service per day**, **90912** is limited to **1 unit per day** and **90913** is limited to **3 units per day** regardless of the number of modalities.

For HCPCS code **E0746**, use of the device in the office isn't separately payable.

Payment policy: Electrocardiograms (EKG)

Service that can be billed

Separate payment is allowed for electrocardiograms (CPT® codes **93000**, **93010**, **93040**, and **93042**) when an interpretation and report is included. These services may be paid along with office services.

Services that aren't covered

EKG tracings without interpretation and report (CPT® codes **93005** and **93041**) aren't payable with office services.

Payment limits

Transportation of portable EKG equipment to a facility or other patient location (HCPCS code **R0076**) is bundled into the EKG procedure and doesn't pay separately.

Payment policy: Electrodiagnostic services

Who must perform these services to qualify for payment

Prior to performing and billing for these services, physical therapists (PTs) performing electrodiagnostic testing must provide documentation of proper Department of Health (DOH) licensure to L&I's Provider Credentialing.

PTs who meet the requirements of DOH rules may provide electroneuromyographic tests.

Links: For information on where to send proper license documentation, contact L&I's Provider Credentialing at PACMail@Lni.Wa.Gov.

To see the DOH rules, refer to WAC 246-915-370.

Services that can be billed

The insurer covers the use of electrodiagnostic testing, including nerve conduction studies and needle electromyography only when:

- Proper and necessary, *and*
- Testing meets the requirements described in L&I's Electrodiagnostic Testing policy.

Performance and billing of NCS (including SSEP and H-reflex testing) and EMG that consistently falls outside of the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommended number of tests may be reviewed for quality and whether it is "proper and necessary."

Qualified PT providers may bill for the technical and professional portion of the nerve conduction and electromyography tests performed.

Services that aren't covered

Electrodiagnostic testing isn't covered when:

- It isn't proper and necessary (see Note and Link, below this list), *or*
- Performed in a mobile diagnostic lab in which the specialist physician isn't present to examine and test the patient, *or*
- Performed with noncovered devices, including:
    - Portable, *and*
    - Automated, *and*
    - "Virtual" devices not demonstrated equivalent to traditional lab based equipment (for example, NC-stat®, Brevio), *or*
- Determined to be outside of AANEM recommended guidelines without proper documentation supporting that the testing is proper and necessary.

In general, repetitive testing isn't considered proper and necessary except if:

- Documenting ongoing nerve injury (for example, following surgery), *or*
- Required to provide an impairment rating, *or*
- Documenting significant changes in clinical condition.

Link: The legal definition of "proper and necessary" is available in WAC 296-20-01002.

Requirements for billing

Billing of electrodiagnostic medicine codes must be in accordance with CPT® code definitions and supervision levels.

Link: The complete requirements for appropriate electrodiagnostic testing are available online.

Billing of the technical and professional portions of the codes may be separated. However, the physician billing for interpretation and diagnosis (professional component) must have direct contact with the patient at the time of testing.

Note: The insurer may recoup payments made to a provider, plus interest, for NCS and EMG tests paid inappropriately.

Example: Reasonable limits on units required to determine a diagnosis

The table below was developed by the AANEM and summarizes reasonable limits on units required, per diagnostic category, to determine a diagnosis 90% of the time.

Note: Review of the quality and appropriateness (whether the test is "proper and necessary") may occur when testing repeatedly exceeds AANEM recommendations.

Recommended maximum number of studies by indication (from "AANEM Table 1"; recreated and adapted with written permission from AANEM):

Indication	Needle EMG CPT® 95860-95864, 95867-95870	NCS CPT® 95907-95913	Other EMG studies CPT® 95907-95913		
	# of tests	**Motor NCS with and without Fwave**	**Sensory NCS**	**H-Reflex**	**Neuromuscular Junction Testing** (repetitive stimulation)
Carpal tunnel (unilateral)	1	3	4	—	—
Carpal tunnel (bilateral)	2	4	6	—	—
Radiculopathy	2	3	2	2	—
Mononeuropathy	1	3	3	2	—
Poly/ mononeuropathy multiplex	3	4	4	2	—
Myopathy	2	2	2	—	2
Motor neuronopathy (for example, ALS)	4	4	2	—	2
Plexopathy	2	4	6	2	—

Indication	Needle EMG CPT® 95860-95864, 95867-95870	NCS CPT® 95907-95913	Other EMG studies CPT® 95907-95913		
	# of tests	Motor NCS with and without Fwave	Sensory NCS	H-Reflex	Neuromuscular Junction Testing (repetitive stimulation)
Neuromuscular Junction	2	2	2	—	3
Tarsal tunnel (unilateral)	1	4	4	—	—
Tarsal tunnel (bilateral)	2	5	6	—	—
Weakness, fatigue, cramps, or twitching (focal)	2	3	4	—	2
Weakness, fatigue, cramps, or twitching (general)	4	4	4	—	2
Pain, numbness, or tingling (unilateral)	1	3	4	2	—
Pain, numbness or tingling (bilateral)	2	4	6	2	—

Payment policy: Extracorporeal shockwave therapy (ESWT)

Services that aren't covered

The insurer doesn't cover extracorporeal shockwave therapy because there is insufficient evidence of effectiveness of ESWT in the medical literature.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for biofeedback	Washington Administrative Code (WAC) 296-21-280
Administrative rules for the definitions of "licensed practitioner" and "proper and necessary"	WAC 296-20-01002
Administrative rules for the policy on rental equipment	WAC 296-20-1102
Administrative rules for the requirements on who may provide electroneuromyographic tests	WAC 246-915-370
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Coverage decision for extracorporeal shockwave therapy	Extracorporeal shockwave therapy coverage decision
Fee schedules for all healthcare professional services (including chiropractic)	Fee schedules on L&I's website
Policy for **electrodiagnostic testing**	Electrodiagnostic testing policy
Sending proper license documentation to perform electrodiagnostic services	PACMail@Lni.Wa.Gov

Need more help?

Call L&I's Provider Hotline at **1-800-848-0811** or email **PHL@lni.wa.gov**