

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 25: Physical Medicine Services

Effective July 1, 2023



Link: Look for possible [updates and corrections](#) to these payment policies on L&I's website.



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Definitions

The following terms are utilized in this chapter and are defined as follows:

Body regions: For osteopathic manipulation treatment (OMT) services, body regions are defined as:

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

Bundled codes: Procedure codes that are not separately payable because they are accounted for and included in the payment of other procedure codes and services.

Distant site: The location of the provider who performs telehealth services. This provider is not at the originating site with the worker.

Originating site: The place where the worker is located when receiving telehealth. For the purposes of this policy, the worker may be at home when receiving telehealth.

Student: As part of their clinical training, a student is a person who is enrolled and participating in an accredited educational program to become a physical therapist, physical therapist assistant, occupational therapist, occupational therapy assistant, or speech language pathologist. Interim permitted students who have already completed their training but aren't yet licensed can also act as students for the purposes of this chapter.

Supervising therapist: a licensed physical or occupational therapist with an active L&I provider account number who has entered into a private agreement with a student and their educational institution to provide hands on training, instruction and supervision during the clinical phase of the student's course work. A supervising therapist can only supervise a student within their discipline. They are responsible for all services provided to injured workers by their students. Physical therapist assistants and occupational therapy assistants must not act as supervising therapists.

Student supervision: The supervising therapist can only supervise one student at a time and won't treat another patient while supervising the student. The supervising therapist must maintain line-of-sight and be physically present for the entire session during treatment to provide direct instruction to the student, oversee the work, and adjust the treatment or change other patient-centered tasks while the service is being provided. Services may be single patient (student therapist to patient) or group services (student therapist to a group of patients).

Telehealth: Face-to-face services delivered by a qualified medical provider through a real-time, two-way, audio video connection. These services aren't appropriate without a video connection.



Modifiers

The following CPT®, HCPCS, and/or local code modifiers apply to this chapter:

-1S (Surgical dressings for home use)

Bill the appropriate HCPCS code for each dressing item using this modifier -1S for each item. Use this modifier to bill for surgical dressing supplies dispensed for home use.

-25 (Significant, separately identifiable evaluation and management (E/M) service by the same physician or other qualified health care professional on the day of a procedure or other procedure)

Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

-52 (Reduced services)

Under certain circumstances, a service or procedure is partially reduced or eliminated at the discretion of the provider. Under these circumstances the service 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.

A 50% payment reduction will be applied for discontinued radiology procedures and any other procedures that do not require anesthesia.

-GT (Via interactive audio and video telecommunication systems)

Used to indicate a telehealth procedure was performed. Documentation to support the service must be submitted. Payment is made at 100% of the fee schedule level or billed charge, whichever is less.



Payment policy: Electrical stimulators (including TENS)

Prior authorization

These HCPCS codes for **electrical stimulator devices for home use or surgical implantation** require prior authorization:

HCPCS code	Brief description	Additional coverage information
E0745	Neuromuscular stimulator for shock	This code is covered for muscle denervation only .
E0747	Electrical osteogenesis stimulator, not spine	—
E0748	Electrical osteogenesis stimulator, spinal	—
E0749	Electrical osteogenesis stimulator, implanted	Authorization for this code is subject to utilization review .
E0760	Osteogenesis ultrasound, stimulator	This code is covered for appendicular skeleton only (not the spine).
E0764	Functional neuromuscular stimulator	—

Services that can be billed

For electrical stimulator devices **used in the office setting**:

- When it is within the provider's scope of practice, a provider may bill professional services for application of stimulators with the CPT® physical medicine codes.
- Attending providers who aren't board qualified or certified in physical medicine and rehabilitation must bill local code **1044M**, which is limited to 6 units per claim. See [Payment Limits in the Physical Therapy and Occupational Therapy payment policy](#) for more information.

For electrical stimulator devices and supplies for **home use or surgical implantation**, HCPCS code **E0761** (Nonthermal electromagnetic device) is covered.

Services that aren't covered

For **use outside of medically supervised facility settings** (including home use and purchase or rental of durable medical equipment and supplies), the insurer doesn't cover:

- Transcutaneous Electrical Nerve Stimulators (TENS) units and supplies, or
- Interferential current therapy (IFC) devices, or
- Percutaneous neuromodulation therapy (PNT) devices.

Use of these therapies will continue to be covered during hospitalization and in supervised facility settings.

For **home use or surgical implantation devices and supplies**, these HCPCS codes aren't covered:

- **E0731** (Conductive garment for TENS),
- **E0740** (Incontinence treatment system),
- **E0744** (Neuromuscular stimulator for scoliosis),
- **E0755** (Electronic salivary reflex stimulator),
- **E0762** (Transcutaneous electrical joint stimulation device system),
- **E0765** (Nerve stimulator for treatment of nausea and vomiting),
- **E0769** (Electric wound treatment device, not otherwise classified),
- **L8680** (Implantable neurostimulator electrode),
- **S8130** (Interferential current stimulator, 2 channel),
- **S8131** (Interferential current stimulator, 4 channel).

For home use or in medically supervised facility settings, CPT® code **64555** (Peripheral nerve neurostimulator) isn't covered.

Treatment of chronic migraine or chronic tension-type headache with trigger point injections or massage therapy isn't a covered benefit. See [L&I's coverage decision](#) for more details.

Payment limits

These supplies are **bundled and not payable separately for office use**:

- **A4365** (Adhesive remover wipes),
- **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).

Additional information: Why the insurer doesn't cover TENS

Based on extensive review of the evidence for use of Electrical Nerve Stimulation (ENS), including TENS, interferential current therapy (IFC), and percutaneous neuromodulation therapy (PNT) as treatment for acute and chronic pain, the State Health Technology Clinical Committee (HTCC) determined that ENS is not covered for use outside of medically-supervised facilities. Purchase or rental of TENS, IFC, or PNT equipment is also not covered. For more details, see the [HTCC decision paper](#).



Payment policy: Functional capacity evaluation

Prior authorization

Requires prior authorization by the claim manager.

Who must perform these services to qualify for payment

To qualify for payment, a functional capacity evaluation must be performed by:

- Physicians who are board qualified or certified in physical medicine and rehabilitation, *or*
- Physical and occupational therapists.

Services that can be billed

Standard Functional Capacity Evaluation

1045M is used to bill the Standard Functional Capacity Evaluation. When billing for this service:

- Units of service must be billed. 1 hour of direct time = 1 unit of service. If the service is 31 minutes or greater, this meets requirement for 1 unit of service.
- The fee for 3-6 units of service is **\$845.64**.
- A maximum of 6 units may be billed.
- Each provider must bill independently for their time.
- Time accumulates regardless of the number of days. Evaluations will involve at least 3 hours of face-to-face time. The fee for 1 unit of service is **\$281.88** and the fee for 2 units of service is **\$563.76**.

Supplemental Functional Capacity Evaluation

1098M is used to bill the Supplemental Functional Capacity Evaluation. Use this code when billing more than 6 hours of time beyond a Standard Functional Capacity Evaluation or for follow up testing. When billing for this service:

- Units of service must be billed. 1 hour of direct time = 1 unit of service. If the service is 31 minutes or greater, this meets requirement for 1 unit of service.
- The fee for each 1 unit of service is **\$141.46**.
- A maximum of 6 units may be billed.
- Each provider must bill independently for their time.
- Time accumulates regardless of the number of days.

Requirements for billing

Eligible providers must bill their usual and customary fee for Standard Functional Capacity Evaluations and Supplemental Functional Capacity Evaluations.

When the service is performed by multiple providers, each provider must bill for the amount of direct one-on-one time spent performing the evaluation using their individual provider account number.

These services include testing, a summary of findings, and full evaluation report. All summary reports must be submitted **within 10 days of when the service was performed and full evaluation reports within 30 days.**



Note: Ensure all documentation is submitted before billing or the bill may be denied.

Examples of billing options for multiple provider evaluations

Scenario: The Occupational Therapist (OT) performed 3.2 hours of direct time and the Physical Therapist (PT) performed 0.8 hours of direct time for a Standard FCE.

OT:	Bill 3 units of 1045M
PT:	Bill 1 unit of 1045M
Total units billed: 4	
Maximum fee of \$845.64	

Documentation must include:

- 1) A summary of findings- State fund, in-state claims complete the Summary Report Form [F245-434-000](#). Out of state claims complete a summary of findings equivalent to [F245-434-000](#); and
- 2) Full evaluation report demonstrating:
 - L&I's [minimum evaluation elements](#) were met; *and*
 - Duration of the evaluation. Each provider must separately document the amount of direct one-on-one time spent performing the service; *and*
 - Signature and date of all evaluators.

For follow up testing, include:

- Date of service, worker name, claim number and a summary of test findings, and
- List of all tests that were performed, *and*
- Results of all testing performed, *and*
- Duration of the service. Each provider must separately document the amount of direct one-on-one time spent performing the service, *and*
- Signature and date of all evaluators.



Note: Documentation must clearly note who performed each service and how much time each individual provider spent providing the direct one-on-one evaluation. Include this information on both the summary of findings and full evaluation report.

Supplemental Functional Capacity Evaluation

1) For use when standard evaluation length is more than 6 hours.

Examples:

- Evaluating multiple jobs with opposite physical demands
- Performing a whole body and upper extremity focused evaluation
- Symptomatic neurological disease impacting testing tolerance

AND/OR

2) For use when follow up testing is indicated after completion of a Standard FCE.

- The Attending Provider and/or Vocational Provider determined additional testing is needed to facilitate return to work decisions.

Not Covered:

- Additional time to perform missed or forgotten testing
- Updates to an incomplete/conflicting report

Payment limits

Standard and Supplemental Functional Capacity Evaluations may only be billed once per worker every 30 days.

If the FCE is performed by multiple providers, the maximum fee applies once per worker regardless of how many providers and/or provider types performed the evaluation.

If the worker has multiple claims, the maximum fee for the FCE applies once per worker regardless of the number of claims a worker may have.

Standard and Supplemental Functional Capacity Evaluations may be provided over multiple days. If this occurs, the bill must span the dates of service to reflect the actual dates in which the evaluation was performed. For example, if the evaluation began on January 1st and was completed on January 3rd, the bill will reflect the “From Date of Service” as January 1st and the “To Date of Service” as January 3rd.

Multiple Claims: Split Billing: Refer to the General Provider Billing Manual [F245-432-000](#).



Payment policy: Massage therapy

Who must perform these services to qualify for payment

To qualify for payment, massage therapy services must be performed by:

- A licensed massage therapist, *or*
- Other covered provider whose scope of practice includes massage techniques.

Prior authorization

Services provided by massage therapists require prior authorization after the 6th visit.



Link: For more information, see [WAC 296-23-250](#).

Services that can be billed

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

Requirements for billing

Massage therapists must bill CPT® code **97124** for all forms of massage therapy, regardless of the technique used. Massage therapists must also use CPT® code **97124** for evaluations and reevaluations.

Massage therapists must bill their usual and customary fee and document the duration of the massage therapy treatment. Bill the appropriate units based on the length of time the service is rendered, per CPT® code description.

Documentation must support the units of service billed. Document the amount of time spent performing evaluations and reevaluations as well as the treatment.

Progress Reports

Massage therapists are required to submit progress reports following every 6 treatment visits or after each month, whichever comes first. Documentation must include:

- an outline of the proposed treatment program, *and*
- the expected restoration goals, *and*
- the expected length of treatment, *and*
- substantiation of improvement during the most recent treatment period, such as:
 - signs of treatment progress (e.g. range of motion, sitting and standing tolerance, reduction in medication), *and/or*
 - [self-reported functional outcome measures from L&I's recommended scales](#) (such as the patient-specific functional scale).

Failure to submit a progress report after each set of 6 visits or 1 month of treatment, whichever comes first, may result in denial of bills and/or revocation of authorization for treatment.



Link: See pages 16-20 in [Options for Documenting Functional Improvement in Conservative Care](#) for more examples of appropriate functional scales.

Payment limits

Massage therapy is paid at **75%** of the maximum daily rate for PT and OT services.

The daily maximum allowable amount is **\$107.75**.



Link: For more information, see [WAC 296-23-250](#).

Services that aren't covered

These items are bundled into the massage therapy service and aren't separately payable:

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

Massage therapy isn't a covered benefit for the treatment of chronic migraine or chronic tension-type headaches. See [L&I's coverage decision](#) for more details.



Payment policy: Osteopathic manipulative treatment (OMT)

Who must perform these services to qualify for payment

Only osteopathic physicians may bill for OMT services.

Requirements for billing

OMT includes pre and post service work (for example, cursory history and palpatory examination). The E/M service may be caused or prompted by the same diagnosis as the OMT service. A separate diagnosis isn't required for payment of an E/M service in addition to OMT services on the same day.

An 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*
- The worker's record contains documentation supporting the level of E/M service billed, *and*
- The E/M service is billed using modifier **-25**. Without modifier **-25**, the insurer won't pay for E/M codes billed on the same day as OMT.

Payment limits

The insurer may reduce payments or process recoupments when E/M services aren't documented sufficiently to support the level, type and extent of service billed. The MARFS and CPT® book describes the requirements that must be present for each level of service.

For OMT services, only 1 CPT® code is payable per treatment. This is because CPT® codes for body regions ascend in value to accommodate the additional body regions involved.

Example: If 3 body regions were manipulated, 1 unit of the correct CPT® code would be payable.

(See definition of **Body regions** in Definitions at the beginning of this chapter.)

Services that aren't covered

CPT® code **97140** isn't covered for osteopathic physicians.



Payment policy: Physical medicine CPT® codes billing guidance

Timed codes

Some physical medicine services (such as ultrasound and therapeutic exercises) are billed based on the number of minutes spent performing the service. These services are referred to as “timed services” and are billed using “timed codes”.

Timed codes can be identified in CPT® by the code description. The definition will include words such as “each 15 minutes.”

Providers must document in the daily medical record (chart note and flow sheet, if used):

- The amount of time spent for each time based service performed, *and*
- The specific interventions or techniques performed, including:
 - Frequency and intensity (if appropriate), *and*
 - Intended purpose of each intervention or technique.

Simply documenting the procedure code and the amount of time the service is performed is insufficient and may result in denial of the bill or recoupment of payment. All documentation must be submitted to support your billing (for example, flow sheets, chart notes, and reports).



Note: Documenting a range of time (for example, 8-22 minutes) for a timed service isn't acceptable. Providers must document the actual amount of minutes spent performing the service.

The number of units you can bill is:

- Determined by the time spent performing each “timed service,” and
- Constrained by the total minutes spent performing these services on a given day.

To obtain the number of units of timed services that can be billed, add together the minutes spent performing each individual timed service and reference the table below.

If the combined duration of all time based services is at least...	and less than...	Then, when billing, report:
8 minutes	23 minutes	1 unit
23 minutes	38 minutes	2 units
38 minutes	53 minutes	3 units
53 minutes	68 minutes	4 units
68 minutes	83 minutes	5 units
83 minutes	98 minutes	6 units
98 minutes	113 minutes	7 units
113 minutes	128 minutes	8 units

How to use this table

The above schedule of times doesn't imply that any of the first 8 minutes should be excluded from the total count. The total time of active treatment counted includes all direct treatment time. Use the table above to determine the maximum number of units that can be billed for the date of service. Begin with applying the maximum number of units to the service performed for the longest amount of time and continue assigning units to each timed service, based on length of service performed, until the maximum number of billable units has been reached. Pre and post delivery services (for example, warmup and cool down) aren't counted in determining the treatment time. See [Determining what time counts towards timed codes](#). Detailed examples can be found below.

Examples of how to document and bill timed codes

The following examples show how the required elements of interventions can be documented and billed. These examples aren't reflective of a complete medical record for the patient's visit. The other elements of reporting (SOAPER) **also must be documented**.

Example 1

Procedural intervention	Specific intervention	Purpose	Treatment time
Attended E-Stim and Ultrasound performed simultaneously	5mA right forearm 1.5 W/cm ² ; 100% right forearm	Increase joint mobility	8 minutes
Whirlpool	Heat bath to right forearm and hand	Facilitate movement; reduce inflammation	8 minutes
Therapeutic exercise	Active assisted ROM to right wrist; flexion/extension; 15 reps x 2 sets	Increase motion and strength for gripping	10 minutes
Total treatment time = 26 minutes			
Total timed intervention (treatment time spent performing timed services) = 18 minutes			

At 18 total minutes of timed services, a maximum of **1 unit** of timed services can be billed. Correct billing for the services documented is:

- **97110** (Therapeutic exercise) x 1 unit, and
- **97022** (Whirlpool) x 1 unit.



Note: Untimed services are billed separately. In addition, please see the [Prohibited Pairs section](#) of the policy for more information as to which outpatient therapy CPT® codes cannot be billed if provided to 1 or more patients **during the same time period**.

Example 2

Procedural intervention	Specific intervention	Purpose	Treatment time
Therapeutic exercise	Left leg straight leg raises x 4 directions; 3 lbs. each direction. 10 reps x 2 sets	Strength and endurance training for lifting	20 minutes
Neuromuscular reeducation	1 leg stance, 45 seconds left; 110 seconds on right using balance board x 2 sets each	Normalize balance for reaching overhead	15 minutes
Cold pack	Applied to left knee	Decrease edema	10 minutes
Total treatment time = 45 minutes			
Total timed intervention (treatment time spent performing timed services) = 35 minutes			

At 35 total minutes of timed services, a maximum of **2 units** of timed services can be billed. Correct billing for the services documented is:

- **97110** (Therapeutic exercise) x 1 unit, and
- **97112** (Neuromuscular reeducation) x 1 unit.



Note: Cold packs are considered bundled.

Example 3

Procedural intervention	Specific intervention	Purpose	Treatment time
Manual therapy	Soft tissue mobilization to medial knee - right	Mobilization	12 minutes
Therapeutic exercises	Prone hip extension 10 reps x 2 sets; hamstring stretch 3 reps x 2 sets; right single leg stance 3 sets of 5 for 15 second hold	Increase strength and range of motion	25 minutes
Cold pack	Applied to right knee	Decrease edema	10 minutes
Total treatment time = 47 minutes			
Total timed intervention (treatment time spent performing timed services) = 37 minutes			

At 37 total minutes of timed services, a maximum of **2 units** of timed services can be billed. Begin with applying the maximum number of units to the service performed for the longest time. Therapeutic exercise was performed for 25 minutes, which equates to 2 units of timed service. Because no additional units of timed services are allowed, manual therapy is not billable. Correct billing for the services documented is:

- **97110** (Therapeutic exercise) x 2 units



Note: Cold packs are considered bundled.

Example 4

Procedural intervention	Specific intervention	Purpose	Treatment time
Neuromuscular re-education	Squats on Airex Balance pad 10 reps x 2 sets; tandem balance on Bosu Ball 2 sets 30 seconds each; single stance on Airex Balance pad 2 sets x 5	Normalize balance for reaching overhead	8 minutes
Manual therapy	Soft tissue mobilization to medial knee - right	Mobilization	12 minutes
Therapeutic exercises	Hamstring curls 10 reps x 2 sets; short arc quads 3 sets of 5 for 5 second hold; straight leg raise 3 sets of 5 for 15 second hold	Increase strength and range of motion	25 minutes
Cold pack	Applied to right knee	Decrease edema	10 minutes
Total treatment time = 55 minutes			
Total timed intervention (treatment time spent performing timed services) = 45 minutes			

At 45 minutes of timed services, a maximum of **3 units** of timed services can be billed. Begin with applying the maximum number of units to the service performed for the longest time. Therapeutic exercises was performed for 25 minutes, which equates to 2 units of timed service. The balance of billable units is 1 unit. Since more time was spent performing manual therapy, assign the last unit of service to manual therapy. Because no additional units of timed services are allowed, neuromuscular re-education is not billable. Correct billing for the services documented is:

- **97110** (Therapeutic exercise) x 2 units
- **97140** (Manual therapy) x 1 unit



Note: Cold packs are considered bundled.

Prohibited pairs: Which CPT® codes can't be billed together

A therapist can't bill any of the following pairs of CPT® codes for outpatient therapy services provided simultaneously to 1 or more patients **for the same time period**:

- Any 2 codes for “therapeutic procedures” requiring direct, one-on-one patient contact, *or*
- Any 2 codes for modalities requiring “constant attendance” and direct, one-on-one patient contact, *or*
- Any 2 codes requiring either constant attendance or direct, one-on-one patient contact, as described above (for example, any CPT® codes for a therapeutic procedure with any attended modality CPT® code), *or*
- Any code for therapeutic procedures requiring direct, one-on-one patient contact with the group therapy code (for example, CPT® code **97150** with CPT® code **97112**), *or*
- Any code for modalities requiring constant attendance with the group therapy code (for example, CPT® code **97150** with CPT® code **97035**), *or*
- An untimed evaluation or reevaluation code with any other timed or untimed 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 (for example, warmup and cool down services) aren't counted in determining the treatment service time. In other words, the time counted as “intra-service care” begins when the therapist is working directly 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 can't be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin isn't considered treatment time.

Regardless of the number of units billed, the daily maximum fee for services won't be exceeded.



Link: More information about [L&I's PT, OT, and massage therapy policies](#) is available online.



Payment policy: Physical therapy (PT) and occupational therapy (OT)

Prior Authorization

No authorization is needed for less than 12 visits as long as the claim is open and allowed, treatment is for accepted conditions on the claim, and referral is from the attending provider per [WAC 296-20-030](#).

Prior authorization is required for additional visits beyond the initial 12. To request authorization for visits 13-24, fax the [Physical/Occupational/Massage Therapy Provider Hotline Service Authorization Request](#) form to the department for consideration. For beyond 24 visits, request Utilization Review from [Comagine Health](#) directly.

Physical and Occupational therapy visits accumulate separately. Visit counts are the total number of visits per claim. New referrals, restart of therapy following surgery, or treatment of new conditions on the same claim don't start again at visit 1.

Learn more about these services on [the L&I PT/OT webpage](#).

Who must perform these services to qualify for payment

PT services

PT services must be ordered by the worker's attending provider. The services must be provided by a:

- Licensed physical therapist, or
- Physical therapist assistant serving under a licensed physical therapist's direction, or
- Athletic trainer serving under a licensed physical therapist's direction.

For details about students performing PT services, see the [Therapy student and therapy assistant payment policy](#).



Link: For more information, see [WAC 296-23-220](#).

OT services

OT services must be ordered by the worker's attending provider. The services must be provided by a:

- Licensed occupational therapist, *or*
- Occupational therapy assistant serving under a licensed occupational therapist's direction.

For details about students performing OT services, see the [Therapy student and therapy assistant payment policy](#).



Link: For more information, see [WAC 296-23-230](#).

Physical medicine services

Physical medicine services may be provided by:

- Medical or osteopathic physicians who are board qualified or board certified in physical medicine and rehabilitation (physiatry), *or*
- Attending doctors who aren't board qualified or certified in physical medicine and rehabilitation. For non-board certified/qualified providers, special payment policies apply. (See [Requirements for billing and Payment limits](#), below.)



Link: For more information, see [WAC 296-21-290](#).

Who won't be paid for physical medicine services

- Exercise physiologists, *or*
- Kinesiologists, *or*
- Physical or occupational therapist aides, *or*
- Gym supervisors.

Services that can be billed

Physical and occupational therapists must use the appropriate covered CPT® and HCPCS codes **97161-97168** and **97010-97799**. These therapists must bill the appropriate covered HCPCS codes for miscellaneous materials and supplies. Some of these CPT® and HCPCS codes aren't covered or are bundled.

Only physiatrists and doctors of physical therapy may bill **95992**.

If more than 1 patient is treated at the same time, use CPT® code **97150**. For PT and OT evaluations and reevaluations, bill using CPT® codes **97161** through **97168**.

To report the evaluation by the physician or therapist to establish a plan of care, use CPT® codes **97161** through **97163** or **97165** through **97167**.

To revise the plan of care by reporting the evaluation of a patient who has been under a plan of care established by the physician or therapist, use CPT® codes **97164** and **97168**. CPT® codes **97164** and **97168** have no limit on how often they can be billed.

For information on billing telephone calls or team conferences, see [Chapter 10: Evaluation and Management Services](#).



Link: For information on Surgical dressings dispensed for home use, see [Chapter 28: Supplies, Materials, and Bundled Services](#).

For billing requirements for prosthetic and orthotic devices, see [Chapter 9: Durable Medical Equipment \(DME\)](#).

Other Physical medicine services

Board qualified and board certified physiatrists bill for services using:

- CPT® codes **97010** through **97799**.

Non-board certified/qualified physical medicine attending providers may perform physical medicine modalities and procedures described in CPT® codes **97010-97750** if their scopes of practice and training permit it, but for these services they must bill local code **1044M**. The description for local code **1044M** is “Physical medicine modality(ies) and/or procedure(s) by an attending doctor who isn't board qualified or certified in physical medicine and rehabilitation.”

See [Payment limits for local code 1044M](#).

Services that aren't covered

Physical medicine CPT® codes **97033** and **97169-97172** aren't covered.

Low level laser therapy **S8948** isn't a covered benefit. For more information, please review [L&I's coverage decision for low level laser therapy](#).

Cryotherapy devices with or without compression for home use aren't covered benefits. These devices used in a clinical setting are considered bundled into existing physical medicine services. For more information, please review [L&I's coverage decision for Cryotherapy Devices With or Without Compression](#).

Non-vasopneumatic compression devices without a cryotherapy component are not a covered benefit. For more information, please review [L&I's coverage decision for Non-vasopneumatic Devices without a Cryotherapy Component](#).

Requirements for billing

Progress reports are due following 12 treatment visits or every 1 month, whichever comes first. PT and OTs treating workers covered by state-fund must use the Physical Medicine Progress Report form [F245-453-000](#) and submit this to the insurer and the attending provider. Progress reports must include functional outcome measures.

Providers can use the [Documenting Functional Improvement resource](#) to help prepare these progress reports.



Link: For more information, see [WAC 296-23-220](#) and [WAC 296-23-230](#)

Payment limits

Physical medicine services

Non-board certified/qualified physical medicine providers won't be paid for CPT® codes **97010-97799**.

Local code **1044M** is limited to 6 units per claim. After 6 units, the patient must be referred to a licensed physical or occupational therapist or physiatrist except when the attending doctor practices in a remote location where no licensed physical or occupational therapist or physiatrists is available.

Bundled items or services

Bundled items or services include, but are not limited to:

- Activity supplies used in work hardening, such as leather and wood,
- Application of hot or cold packs (this includes all forms of cryotherapy with or without compression. **97016** may not be used to bill for these services),
- Electrodes and gel,
- Exercise balls,
- Ice packs, ice caps, and ice collars,
- Thera-tape,
- Wound dressing materials used during an office visit and/or PT treatment.



Link: For complete lists of bundled codes, see [Chapter 28: Supplies, Materials and Bundled Services](#).

Daily maximum for services

The daily maximum allowable fee for PT and OT services is **\$143.66**.

If PT, OT, and massage therapy services are provided on the same day, the daily maximum applies once for each provider type. See [Massage Therapy Payment Limits](#) above for the daily maximum fee that applies to massage therapists.

When performed for the same claim for the same date of service, the daily maximum applies to CPT® codes **97161-97168**, **95992**, and **97010-97799**.

If the worker receives PT or OT services for 2 separate claims with different allowed conditions on the same date, the daily maximum will apply for each claim.

The daily maximum allowable fee doesn't apply to:

- Speech language pathologists, *or*
- Physicians board certified in Physical Medicine, *or*
- Functional capacity evaluations (FCEs), *or*
- Work hardening services, *or*
- Work evaluations, *or*
- Job modification/prejob accommodation consultation services.



Links: For more information, see [WAC 296-23-220](#) and [WAC 296-23-230](#).

Split Billing – Unrelated Conditions

If part of the visit is for a condition unrelated to an accepted claim and part is for the accepted condition:

- Therapists must appropriately bill L&I only for the portion of the visit related to the accepted claim.
- Treatment rendered for a condition unrelated to an accepted L&I claim may be billed to a secondary insurer, if appropriate.

Only send chart notes related to the accepted L&I claim to the insurer, since the employer doesn't have the right to see information about an unrelated condition.



Links: [Chapter 2: Information for All Providers](#)

Untimed Services

Supervised modalities and therapeutic procedures that don't list a specific time increment in their description are limited to 1 unit per day. Refer to CPT® and HCPCS to determine whether a service is timed or untimed.

Providers must document the actual service provided including frequency and intensity (if appropriate), and the intended purpose for each service. Simply documenting the procedure code is insufficient and may result in denial of the bill or recoupment of payment. All documentation **must be submitted** to support your billing (for example, flow sheets, chart notes, and reports).

Work conditioning: Guidelines

- **Frequency:** At least 3 times per week and no more than 5 times per week.
- **Duration:** No more than 8 weeks for 1 set. 1 set equals up to 20 visits.
 - An additional 10 visits may be approved after review of progress.
- **Plan of Care:** Goals are related to:
 - Increasing physical capacities, *and*
 - Return to work function, *and*
 - Establishing a home program allowing the worker to progress and/or maintain function after discharge.
- **Documentation:** Besides standard documentation, the plan of care and progress report must include return to work capacities, which may include lifting, carrying, pushing, pulling, sitting, standing, and walking tolerances.
- **Treatment:** May be provided by a single therapy discipline (PT or OT) or combination of both (PT and OT).
 - PT and OT visits accumulate separately and both are allowed on the same date of service.
 - Billing reflects active treatment. Examples include CPT® **97110**, **97112**, **97530**, **97535**, and **97537**.
- **Billing:** Work conditioning programs are reimbursed as outpatient PT and OT under the daily fee cap.



Payment policy: Powered traction therapy

Services that can be billed

Powered traction devices are covered as a physical medicine modality.

Payment limits

The insurer won't pay any additional cost when powered devices are used.

Additional information: Why the insurer won't pay additional cost when powered devices are used

Published literature hasn't 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. See [L&I's coverage decision](#) for more details.



Payment policy: Telehealth for physical medicine services

General information

The insurer reimburses **telehealth** at parity with in-person appointments.

The insurer prefers that PT and OT services be provided in person. Telehealth may be used only when hands-on services aren't required.

The provider is expected to make arrangements for in-person evaluation and intervention for certain circumstances.

Telehealth services must occur either from a medical or vocational **origination site** or the worker's home. The selection of a provider is the worker's choice by law. Services may not be delivered from either the employer's worksite or any location owned or controlled by the employer that isn't operated by a Medical Provider Network practitioner.

The provider performing **telehealth** services may have to be licensed in the state where the worker is receiving **telehealth** services.

Services that must be performed in person

In-person evaluation is required when:

- The provider has determined the worker is not a candidate for **telehealth** either generally or for a specific service, *or*
- The worker does not want to participate via **telehealth**, *or*
- The worker has an emergent issue such as re-injury, new injury, or worsening status.

System requirements

Telehealth services and teleconsultations require an interactive telecommunication system, consisting of special two-way audio and video equipment that permits real time consultation between the patient and provider. Providers are responsible for ensuring complete confidentiality and privacy of the worker is protected at all times. No payment shall be made to the worker or provider for obtaining or maintaining equipment for a **telehealth** appointment.

Prior authorization

The prior authorization requirements listed in this chapter apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

Services that are covered

Services that don't require a hands-on component are covered when performed via **telehealth**. Students, speech, physical and occupational therapists may conduct services via **telehealth**. The same prior authorization requirements in this chapter apply regardless of how the service is performed.

Originating Site Fee (Q3014)

The insurer will pay an **originating site** fee to a provider when they allow the worker to use their telecommunications equipment for a **telehealth** service with a provider at another location. To bill for the **originating site** fee, use HCPCS code **Q3014**.

Q3014 is payable to the **originating site** provider when no other billable service, provided to the same patient, is rendered concurrently.



Note: If the **distant site** and the **originating site** are owned or rented by the same entity, **Q3014** is payable the as long as billing and documentation requirements are met.

Q3014 billing example

A worker, attends an in-person Evaluation and Management (E/M) appointment at their attending provider's office. The attending provider documents all necessary information as part of this visit and bills for the E/M service. The originating site (attending provider's office) also arranges a secure and private space for the worker to participate in a consultation with their cardiologist at another location (distant site provider). The originating site provider may bill the insurer **Q3014** for allowing the worker to use their space for their telehealth visit with the distant site provider. The originating site provider is required to separately document the use of their space as part of their bill for **Q3014**. The distant site provider bills for the services they provide; they can't bill **Q3014**.

How to bill for this scenario

For this telehealth visit:

- The distant site provider would bill the appropriate CPT® E/M code, with modifier **-GT**.
- The originating site provider would bill **Q3014**.

Store and Forward

G2250 is covered for patient-to-provider store and forward of images or video recordings, including interpretation and follow up when it isn't part of a visit. Follow up must occur within 24 business hours of receiving the images or video recordings, and follow up may occur by phone,

telehealth, or in-person, and isn't separately payable. **G2250** isn't covered if the patient provides the image or video recording as follow-up from a visit in the prior 7 days, nor if the provider's evaluation of the image or video recording leads to a visit within the next 24 hours or soonest available appointment. Providers are required to document their interpretation of the image or video recording. Chart notes that don't state the interpretation by the provider are insufficient.

Services that aren't covered

Telephonic visits don't replace video two-way communication and can't be billed using non-telephonic E/M services codes. Case management services may be delivered telephonically (audio only) and are detailed in [Chapter 10: Evaluation and Management \(E/M\) Services](#).

Telehealth procedures

Telehealth procedures and services that aren't covered include:

- Work hardening,
- Functional Capacity Evaluations
- The services listed under "Services that must be performed in-person",
- Services that require hands-on and/or attended treatment of a patient,
- Purchase, rental, installation, or maintenance of telecommunication equipment or systems,
- Home health monitoring, *and*
- Telehealth transmission, per minute (HCPCS code **T1014**).

Telehealth locations

Q3014 isn't covered when:

- The **originating site** provider performs another service during a **telehealth** visit, *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, *or*
- The provider uses audio only.

The worker won't be reimbursed for using home as an **originating site**, or for any other **telehealth** related services.

Requirements for billing

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person.

Distant site providers must use place of service **-02** to denote the **telehealth** visit when the worker isn't located in their home and will be reimbursed at the facility rate. **Distant site** providers must use place of service **-10** to denote the **telehealth** visit when the worker is located in their home and will be reimbursed at the non-facility rate.

Bill using the **-GT** modifier to indicate **telehealth**.

Documentation requirements

For the purposes of this policy, the following must be included in addition to the documentation and coding requirements for services billed, as noted in MARFS:

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in **telehealth** services. This must be noted for each **telehealth** visit.

If treatment is to continue via **telehealth**, the evaluation report must include a detailed plan for implementing **telehealth** as agreed upon in a collaborative manner between the provider and worker.

Chart notes must contain documentation that justifies the level, type and extent of services billed.

When **Q3014** is the only code billed, documentation is still required to support the service. When a provider bills **Q3014** on the same day they render in-person care to a worker, separate documentation is required for both the in-person visit and the **Q3014** service. The **originating site** provider billing **Q3014** must submit separate documentation indicating who the **distant site** provider is and that the service is separate from the in-person visit that occurred on the same day.

Payment limits

The same general limits as those already noted in this chapter apply, regardless how the service is provided to the worker.

Services conducted by **telehealth** are limited to 2 hours per day per worker, regardless of the service provided.



Payment policy: Therapy student and therapy assistant student supervision

General information

L&I has adopted a modified version of Medicare Part B's policy on physical and occupational therapy students. L&I considers supervised students an extension of their supervising therapist.

Please refer to the [Definitions](#) section at the beginning of this chapter to see the definitions of **student**, **supervising therapist**, and **student supervision**.

Services that can be billed

Supervising therapists will direct all care provided by their **students** to injured workers and must bill for these services under the **supervising therapist's** provider number.

All billed services must meet the billing and documentation requirements applicable to the **supervising therapist**.

Services that aren't covered

Any service provided by a **student** that is unsupervised (including skilled nursing facilities) aren't payable.

Students can't independently:

- Make clinical judgements;
- Provide evaluations, re-evaluations or assessments;
- Develop, manage or deliver services.

Any service that deviates from the requirements outlined in Medical Aid Rules and Fee Schedules isn't covered.

Two-way audio/visual direct supervision isn't covered (modifier **-FR**).

Requirements for billing

All documentation must identify both the **supervising therapist** and the **student** and must be signed by both parties.

All services must be billed by the **supervising therapist** under their provider number and must comply with supervision and documentation requirements for physical medicine services.

Supervising therapist responsibilities

Supervising therapists are responsible for:

- All services provided to injured workers by their **students**.
- Ensuring that the work **students** perform does not exceed their education, skills, and abilities, nor the **supervising therapist's** scope of practice.
- Providing **supervision** to the student regardless of what setting care is being rendered in (clinic, hospital or skilled nursing facility).
- Ensuring that all documentation requirements are met.
- Co-signing all documentation for services rendered to injured workers.
- Keep a copy of the private agreement between them and the **student** in accordance with [WAC 296-20-02005](#).

Payment limits

Students won't be directly reimbursed for their time or services.



Links: For more information, see [WAC 296-20-015](#).



Payment policy: Work hardening

L&I is in the process of revising the work hardening program, with an anticipated start date in early 2024. [Sign up for GovDelivery](#) to stay informed of changes (select “Physical Medicine Updates”).

Prior authorization

Work hardening programs require:

- Prior approval by the worker’s attending physician, *and*
- Prior authorization by the claim manager.

Providing **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.

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.

Who must perform these services to qualify for payment

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



Link: 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 website.

Services that can be billed

Work hardening

- For the evaluation, bill using local code **1001M**.
- For treatment, bill using CPT® codes **97545** and **97546**.

Services that aren't covered

Billing for less than 2 hours of service in 1 day

Services provided for less than 2 hours of total program time on any day don't meet the work hardening program standards and cannot be billed under CPT® **97545**. The services must be billed outside of the work hardening program codes. This should be considered as an absence in determining worker compliance with the program.

Example: The worker arrives for work hardening, but isn't able to participate fully that day.

Requirements for billing

Work hardening

CPT® codes should be billed that appropriately reflect the services provided.

A worker typically starts at 4 hours per day and gradually increases to 7-8 hours per day by week 4.

Billing less than 1 hour of CPT® code 97546

After the first 2 hours of service on any day, if less than 38 minutes of service are provided modifier **-52** must be billed. For that increment of time:

- CPT® code **97546** must be billed as a separate line item with modifier **-52**, and
- The charged amount must be prorated to reflect the reduced level of service.

Example: Worker completes 4 hours and 20 minutes of treatment. Billing for that date of service would include 3 lines:

Code	Modifier	Charged amount	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.

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:

If the provider type is...	and the service provided is...	Then bill as:
OT	1 hour of evaluation	1 unit of 1001M
PT	1 hour of evaluation	1 unit of 1001M
OT (or PT)	1 hour of treatment	1 unit of 97545 with modifier -52 (billed amount proportionate to 1 hour)
PT (or OT)	1 hour of treatment	1 unit of 97546

Examples of billing options for services in multidisciplinary programs

Scenario: The 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 for which the PT is responsible.

The providers could bill for the 6 hours of services in either 1 of 2 ways:

Billing option 1	
PT:	1 unit 97545 2 hours
OT:	4 units 97546 4 hours
Total hours billed:	6 hours

Billing 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

Payment limits

Work hardening

Work hardening programs are authorized for up to 4 weeks. Only 1 unit of **97545** (first 2 hours) will be paid per day per worker and the total number of hours billed shouldn't exceed the number of hours of direct services provided.

These codes are subject to the following limits:

Code	Description	Unit limit (4 week program)	Unit price
1001M	Work hardening evaluation	6 units (1 unit = 1 hour)	\$140.21
97545	Initial 2 hours per day	20 units per program; Maximum of 1 unit per day per worker (1 unit = 2 hours)	\$165.69
97546	Each additional hour	70 units per program Add-on, won't be paid as a stand-alone procedure. (1 unit = 1 hour)	\$84.55

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

Time spent in treatment conferences isn't 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 CPT® **97545** and **97546**.

Program extensions

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)

Additional information: L&I's work hardening program

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 the [Helping Workers Get Back to Work](#) page,
- By calling the Therapy Services Program at **360-902-4480**, or
- By sending an email to Therapy@Lni.wa.gov



Payment policy: Wound care

Prior authorization

Electrical stimulation for chronic wounds

If electrical stimulation for chronic wounds is requested for use on an outpatient basis, prior authorization is required using the following criteria:

- Electrical stimulation will be authorized if the wound hasn't improved following 30 days of standard wound therapy, *and*
- In addition to electrical stimulation, standard wound care must continue.



Note: In order to pay for electrical stimulation beyond 30 days, licensed medical personnel must document improved wound measurements within the past 30 days.

Services that can be billed

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 sent home with the patient for self-care may be billed with HCPCS codes appended with local modifier **-1S**.



Link: For more information on billing with local modifier **-1S**, see the Surgical dressings for home use section (Requirements for billing and Payment limits) of [Chapter 28: Supplies, Materials, and Bundled Services](#).

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.

To bill for electrical stimulation for chronic wounds, use HCPCS code **G0281**.



Link: For more information, see the [Electrical Stimulation for Chronic Wounds](#) coverage decision.

Requirements for billing

Debridement

When performing wound debridement that exceeds what is incidental to a therapy (for example, whirlpool), therapists must bill CPT® **97597**, **97598**, or **97602**.

Electrical stimulation for chronic wounds

In order to pay for electrical stimulation beyond 30 days, licensed medical personnel must document improved wound measurements within the past 30 days.

Payment limits

Debridement

Wound dressings and supplies used in the office are bundled and aren't payable separately.



Links to related topics

If you're looking for more information about...	Then see...
Administrative rules (Washington state laws) for physical medicine	Washington Administrative Code (WAC) 296-21-290
Becoming an L&I Provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Electrical stimulation for chronic wounds	Electrical stimulation for chronic wounds
Fee schedules for all healthcare professional services	Fee schedules on L&I's website
Keeping of records	WAC 296-20-02005
Massage therapy administrative rules	WAC 296-23-250
Occupational therapy administrative rules	WAC 296-23-230
Physical Medicine Progress Report Form	Form F245-453-000
Physical therapy administrative rules	WAC 296-23-220
Powered traction devices for intervertebral decompression	Powered traction devices for intervertebral decompression
L&I's general policies and rules for PT, OT, and massage therapy	PT, OT, and massage rules on L&I's website
Payment policies for supplies, materials, and bundled services	Chapter 28: Supplies, Materials, and Bundled Services
TENS coverage decision	State Health Technology Clinical Committee (HTCC) published TENS decision
Work hardening program at L&I	Program reviewer: 360-902-4480 Worker hardening rules on L&I's website

L&I's coverage decision for Chronic Migraine and Chronic Tension-type Headaches	Chronic migraine headache coverage decision
L&I's coverage decision for low level laser therapy	Low level laser therapy coverage decision
L&I's coverage decision for Cryotherapy Devices with or without Compression	Cryotherapy devices with or without compression coverage decision
L&I's coverage decision for Non-vasopneumatic Devices without a Cryotherapy Component	Non-vasopneumatic devices without cryotherapy component coverage decision

Need more help?

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