Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 19: Naturopathic Physicians and Acupuncture Services

Effective July 1, 2024

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:

Distant site: The location of the provider who performs telehealth services. This provider isn't at the originating site with the worker.

Established patient: One who has received professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years.

L&I uses the CPT® definition for established patients. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

New patient: One who hasn't received any professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years.

L&I uses the CPT® definitions for new patients. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

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.

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 appear in this chapter:

Use	Payment Information
–93 (via telephone or other audio-only telecommunications system)	
Use this modifier to indicate when a service was performed via audio-only. **Note: Limited to certain services.** This modifier is only applicable to certain mental health and behavioral health intervention services. See the applicable audio-only payment policy for more details.	This modifier doesn't affect payment but is necessary to describe the service.
–GT (Via interactive audio and video telecommunication systems)	
Use this modifier to indicate when a service was performed via telehealth. **Note:** Modifier –95 (telehealth service) isn't recognized by the insurer.	This modifier doesn't affect payment but is necessary to describe the service. Payment is based on the Place of Service (POS) billed with the telehealth service and this modifier. See the telehealth payment policy in this chapter for more information.

Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

Payment policy: Acupuncture services

General information

Acupuncture involves the insertion of needles or lancets, with or without electrical stimulation, to directly or indirectly stimulate acupuncture points and meridians.

The insurer only covers acupuncture for allowed claims with an accepted diagnosis of a low back condition.

Note for MARFS 2024

L&I is in the process of revising this payment policy. Sign up for GovDelivery to stay informed of changes. We will notify providers via GovDelivery when this policy is revised. The updated policy will be posted on our updates and corrections page on L&I's website.

Who must perform these services to qualify for payment

Only Acupuncture, Eastern Medicine Practitioners (AEMP) and other providers who are licensed by the Department of Health to perform acupuncture may perform these services.

Prior authorization

Acupuncture requires a referral from the attending provider.

Prior authorization to perform acupuncture is not required. An initial evaluation must be performed prior to beginning treatment.

Services that can be billed

Code	Description	Payment Limits
99202-99215	**Evaluation and Management (E/M) service** for: • Initial evaluations, *or* • Follow up evaluations, *or* • Discharge visits.	See Chapter 10: Evaluation and Management Services for more information.
1582M	**Acupuncture treatment** with one or more needles, with or without electrical stimulation. Initial evaluation required prior to treatment.	**Maximum of 1 unit per day, per worker.** **Maximum of 10 treatments** over the lifetime of the claim.

Link: For more information on conditions of coverage, see WAC 296-23-238 and L&I's Acupuncture Coverage Decision.

Documentation requirements

Chart notes must contain documentation that justifies the level, type, and extent of services billed. See Chapter 2: Information for All Providers for details.

Initial evaluations must include documentation of a treatment plan and follow the documentation requirements in Chapter 10: Evaluation and Management (E/M) Services.

On the final visit, the reason for discharge of the worker must be documented.

In addition to daily chart notes, the provider must submit to the claim file validated functional instruments, including a 2-item GCPS (Graded Chronic Pain Scale) and an Oswestry Disability Index (ODI) form, to track and document the workers' pain and functional status at the following visits:

- The initial office visit/treatment, *and*
- The middle treatment (no later than visit #5), *and*
- The final treatment.

Services that aren't covered

CPT® acupuncture codes **97810-97814** aren't covered.

L&I will not authorize or pay for acupuncture treatment related to conditions other than low back pain.

Acupuncture services can't be performed via **telehealth**.

Payment policy: Naturopathic services

General information

There have been substantial changes made to naturopathic services in this version of MARFS. See the updated policy below, as well as Physical medicine services for naturopathic physicians and Telehealth for naturopathic physicians.

Dual licensures or additional certifications

Naturopaths who are also licensed in another discipline (dual-licensed) must have a separate provider account number to perform and bill for those services.

Naturopaths who hold an additional certification for services outside their typical scope of practice must ensure they've uploaded their certification information into their ProviderOne account in order to perform and bill for services related to that certification.

Providers are expected to bill their services under the correct provider number appropriately, based on the licensure scope of practice.

Link: For more information, see Chapter 2: Information for all Providers.

Prior authorization

Prior authorization is required when billing for:

- More than 20 office visits, *or*
- Visits that occur more than 60 days after the first date you treat the worker.

Medically necessary X-rays may be performed at the initial visit, without prior authorization. All subsequent x-rays require prior authorization.

Prior authorization may also be required for other services and treatments naturopaths provide. See applicable MARFS chapters for details.

Link: For more information, see WAC 296-20-03001 and WAC 296-23-205.

Services that can be billed

Naturopaths may bill services within their scope of practice and that adhere to the department's rules and policies. For more information, including service and documentation requirements and payment limits, see the appropriate policy chapter for the services being provided. These services must be billed using the appropriate CPT®, HCPCS Level II codes or local code. This includes but isn't limited to:

- Evaluation and Management (E/M) Services including; All levels of **New** and **Established patient** Evaluation and Management (E/M) Services (CPT® **99202-99215**), Outpatient prolonged services (CPT® **99417**), and Case Management services including telephone calls (CPT® **99441-99443**), team conferences (CPT® **99637** or **99212-99215**), and online communications (local code **9918M**),
- X-ray and other diagnostic services,
- Manual manipulative treatment, including craniosacral therapy, using Osteopathic Manipulative Treatment (OMT) codes (CPT® **98925-98927**),
- Injections and infusions, including dry needling (CPT® **20560**, **20561**), trigger point injections (CPT® **20552**, **20553**) and other minor office procedures,
- Behavioral Health Interventions (BHI) (Within the context of an E&M or CPT® **96156-96519**, **96127**),
- Durable Medical Equipment (DME) and miscellaneous materials and supplies, *and*
- Reports and forms appropriate for attending providers (see Chapter 27: Reports and Forms for codes).

For more information on coverage of physical medicine services, see Physical medicine services for naturopathic physicians in this chapter.

Link: For more information, see WAC 296-23-205.

Services that aren't covered

The following aren't covered for naturopaths:

- Previous Naturopathic local codes (**2130A -2134A**) for office visits and treatment,
- Consultations (CPT® **99242-99245**),
- Treatment of chronic migraine or chronic tension-type headache with manipulation/manual therapy, massage, and trigger point injections (See L&I's coverage decision),
- Colon hydrotherapy and enemas, even with appropriate training,
- Herbal supplements, minerals, botanical medicines, homeopathic remedies and other similar treatments,
- Acupuncture (local code **1582M**),
- Chiropractic manipulations (CPT® **98940-98943** or local codes **2050A-2052A**), *and*
- Mental Health Treatment.

Diagnostic ultrasound performed in the office is considered bundled into the E/M service.

Link: For additional information on covered and non-covered services, see WAC 296-23-205, WAC 296-20-03002 and WAC 296-20-03012.

Requirements for billing

Chart notes must contain documentation that justifies the level, type, and extent of services billed. Refer to the appropriate chapter for the services being provided for more detailed service and documentation requirements.

To bill the professional component of an x-ray, a written report of radiologic findings and impressions must be included in the worker's chart. See Chapter 26: Radiology Services for more information.

Some services naturopaths may provide, such as IV therapy, dry needling and biofeedback require additional training and/or certification. Providers must meet the minimum education, experience and training qualifications in order to perform these services as determined by the Department of Health (DOH).

Additional information

For more information on services that may be provided by naturopaths, see the applicable MARFS chapters. These include but are not limited to:

- Chapter 2: Information for all providers
- Chapter 6: Biofeedback, EKG, Electrodiagnostic Services, and ESWT
- Chapter 9: Durable Medical Equipment (DME)
- Chapter 10: Evaluation and Management (E/M) Services
- Chapter 16: Medication Administration and Injections
- Chapter 25: Physical Medicine Services
- Chapter 27: Reports and Forms
- Chapter 26: Radiology Services

Payment policy: Physical medicine services for naturopathic physicians

Services that can be billed

Local code **1044M** for physical medicine modalities or procedures must be billed by an attending provider type who isn't board certified/qualified in Physical Medicine and Rehabilitation (PM&R). Naturopaths are required to bill this local code for physical medicine services.

Link: For additional information on covered physical therapy services and requirements, see Chapter 25: Physical Medicine Services.

Services that aren't covered

CPT® physical medicine codes (**97001-97799**) aren't payable to naturopathic physicians.

Documentation requirements

Chart notes must contain documentation that supports billing of local code **1044M**. 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. See Chapter 25: Physical Medicine Services for complete documentation requirements.

All documentation **must be submitted** to support your billing (for example, flow sheets, chart notes, and reports).

Payment limits

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

Only 1 unit is payable per visit, regardless of the length of time the treatment is provided.

Providers who bill for physical medicine services using **1044M** may only perform low-level laser therapy in conjunction with other physical medicine services billable using this code. The insurer won't pay an additional fee for low-level laser therapy beyond the maximum fee for **1044M**. See "Payment limits" under Payment policy: Physical therapy (PT) and occupational therapy (OT) in Chapter 25 for more details.

Payment policy: Telehealth for naturopathic physicians

General information

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

Objective medical findings are required for time loss and other claim adjudication decisions. In-person visits are preferred for gathering objective medical findings; however, **telehealth** may be an appropriate alternative in certain situations where objective medical findings can be gathered via a two-way audio and visual connection.

The provider is expected to make arrangements for in-person evaluation and intervention for certain circumstances. See Services that must be performed in person for additional information.

Telehealth services must occur either from a medical or vocational **origination site** or the worker's home. 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 employer or their designee may not direct or require the worker to use a specific medical provider.

A medical or vocational **origination site** may be:

- A clinic, *or*
- A hospital, *or*
- A nursing home, *or*
- An adult family home.

Per WAC 296-20-065, the selection of a provider is the worker's choice by law. The provider performing **telehealth** services must be licensed in the state where the worker is receiving **telehealth** services. Only vocational rehabilitation counselors are exempt from this requirement.

Services that must be performed in person

In-person services are required, in all cases, when:

- The provider has determined the worker isn't a candidate for **telehealth** either generally or for a specific service, *or*
- The worker doesn't want to participate via **telehealth**, *or*
- The worker has an emergent issue such as re-injury, new injury, or worsening status*, or*
- A worker files a reopening application, *or*
- When the service to be performed requires a hands-on component, *or*
- It is the first visit of the claim, *or*
- Restrictions or changes are anticipated (the APF requires an update), *or*
- A worker requests a transfer of attending provider.

System requirements

Telehealth services require an interactive telecommunication system consisting of special two-way audio and video equipment that permits real time consultation between the worker and provider. Providers are responsible for ensuring complete confidentiality and protecting the privacy of the worker 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 can be billed

Telehealth procedures and services that are covered include most services that don't require a hands-on component. The worker must be present at the time of the **telehealth** service and the evaluation and/or treatment of the worker must be under the control of the **telehealth** provider.

Originating site and store and forward fees are covered, when applicable.

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 is rendered concurrently to the same worker.

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

Q3014 isn't covered when:

- The **originating site** provider performs any service during the **telehealth** visit, *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, except when the same payee owns both sites and the worker is using their equipment for the telehealth service, *or*
- The provider uses an audio-only connection.

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

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.

Because **Q3014** is payable to the **originating site**, any provider employed by the **originating site** may bill for this service, so long as they sign the documentation supporting the **Q3014** service.

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 separately documents the use of their space as part of their bill for **Q3014**.

How to bill for this scenario

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 **distant site** provider bills for the services they provide; they can't bill **Q3014**.

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**.

Note: For Evaluation and Management Services refer to Chapter 10: Evaluation and Management (E/M) Services.

Services that aren't covered

Telephone calls aren't an appropriate replacement for in-person or **telehealth** services. The insurer won't pay for audio-only evaluation or treatment billed using modifier **–93** (audio only).

Telehealth procedures and services that aren't covered include:

- The same services that aren't covered in this chapter,
- The services listed under "Services that must be performed in person",
- Services that require physical hands-on and/or attended treatment of a worker,
- Completion and filing of any form that requires a hands-on physical examination (such as Report of Accident or Provider's Initial Report except for mental health only claims), *and*
- Home health monitoring.

The purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems isn't covered.

Note: Completion of APFs can't occur via **telehealth** when the update will take the worker off work or the provider increases the worker's restrictions. In these situations the visit must be in-person.

Requirements for billing

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

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

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.

Documentation requirements

For the purposes of this policy, the following must be included in the documentation submitted by the **distant site** provider in addition to the documentation and coding requirements for services billed:

- 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. See this chapter and other applicable MARFS chapter(s) for the type of service rendered and the documentation requirements.

Payment limits

The same limits noted in this chapter apply regardless of how the service is rendered to the worker.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for naturopathic physicians	Washington Administrative Code (WAC) 296-23-205
Administrative rules for treatment requiring prior authorization	WAC 296-20-03001(1)
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers and Chapter 27: Reports and Forms
Manipulation/ Manual therapy treatment of chronic tension-type headache coverage decision	Chronic Migraine and Chronic Tension-type Headache coverage decision
Fee schedules for all healthcare services	Fee schedules on L&I's website
Payment Policies for **Evaluation and Management (E&M) and case management services**	Chapter 10: Evaluation and Management (E/M) Services
Payment Policies for **mental health services**	Chapter 17: Mental Health Services
Payment Policies for **diagnostic X-ray services**	Chapter 26: Radiology Services
Payment Policies for **Durable Medical Equipment (DME)**	Chapter 9: Durable Medical Equipment (DME)
Payment Policies for **supplies**	Chapter 28: Supplies, Materials, and Bundled Services
Payment Policies for **physical medicine services**	Chapter 25: Physical Medicine Services

Need more help?

Email L&I's Provider Hotline at PHL@Lni.wa.gov. If you would prefer a phone call, please email us your name and contact number.

