



**Payment Policies for Healthcare Services
Provided to Injured Workers and Crime Victims**

**Chapter 6: Biofeedback, Electrocardiograms
(EKG), Electrodiagnostic services, &
Extracorporeal Shockwave Therapy (ESWT)**

Effective July 1, 2018



Link: Look for possible **updates and corrections** to these payment policies at:

www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2018



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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 one 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 one, three, six, 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

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.



Note: 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.



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.



Note: Also see Requirements for billing, below, about paraprofessionals.

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



Links: For legal definitions of qualified biofeedback provider and certified biofeedback provider, see [WAC 296-21-280](#). 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** and **90911** are payable to any L&I approved biofeedback provider.

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



Note: Also see "Payment limits," below, regarding these codes.

▶ 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** or **90911** with the individual psychotherapy codes.

Use evaluation and management codes for diagnostic evaluation services.

▶ Payment limits

CPT® codes **90901** and **90911** aren't time limited and **only one unit of service per day** is payable, regardless of the length of the biofeedback session or number of modalities.

For HCPSC code **E0746**, use of the device in the office isn't separately payable for RBRVS providers.



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 **360-902-5140**.

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.



Link: The policy for Electrodiagnostic Testing is available at:

www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/ElecTest/.



Note: 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." Also see "Example: Reasonable limits on units required to determine a diagnosis," below.

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.



Note: 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 at [WAC 296-20-01002](#).

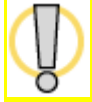
▶ Requirements for billing

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



Link: For the complete requirements for appropriate electrodiagnostic testing, see: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/ElecTest/.

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: As mentioned under “Services that can be billed” (above), 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

	Needle EMG CPT® 95860- 95864, 95867- 95870	NCS CPT® 95907- 95913	Other EMG studies CPT® 95907- 95913		
Indication	# of tests	Motor NCS with and without Fwave	Sensory NCS	H- Reflex	Neuromuscular Junction Testing (repetitive stimulation)
Motor neuronopathy (for example, ALS)	4	4	2	—	2
Plexopathy	2	4	6	2	—
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.



Link: More information is available at:

www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/ESWT.asp



Links: Related topics

If you're looking for more information about...	Then go here:
Administrative rules for biofeedback	Washington Administrative Code (WAC) 296-21-280: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-21-280
Administrative rules for the definitions of "licensed practitioner" and "proper and necessary"	WAC 296-20-01002: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-01002
Administrative rules for the policy on rental equipment	WAC 296-20-1102: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-1102
Administrative rules for the requirements on who may provide electroneuromyographic tests	WAC 246-915-370: http://apps.leg.wa.gov/WAC/default.aspx?cite=246-915-370
Becoming an L&I provider	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/
Billing instructions and forms	Chapter 2: Information for All Providers

Coverage decision for extracorporeal shockwave therapy	L&I's website: www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/ESWT.asp
Fee schedules for all healthcare professional services (including chiropractic)	L&I's website: http://feeschedules.lni.wa.gov
Policy for electrodiagnostic testing	L&I's website: www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/ElecTest/
Sending proper license documentation to perform electrodiagnostic services	L&I's Provider Credentialing: 360-902-5140

► **Need more help?** Call L&I's Provider Hotline at **1-800-848-0811**