Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 25: Physical Medicine Services

Effective July 1, 2024

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

Table of Contents

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 aren't separately payable because they are accounted for and included in the payment of other procedure codes and services.

Link: For the legal definition of Bundled codes, see WAC 296-20-01002.

Distant site: The location of the provider who performs telehealth services. This provider isn't 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 appear in this chapter:

Use	Payment Information
–1S (Surgical dressings for home use)	
Use this modifier to indicate when surgical dressing supplies are dispensed for home use. Bill with the appropriate HCPCS code for each dressing item.	Services with this modifier may be bundled, based on who is providing the dressings. If not bundled, payment is made at **100%** of the fee schedule level or billed charge, whichever is less.
–25 (Significant, separately identifiable evaluation and management (E/M) service by the same provider on the same day of the procedure or other service.)	
Use this modifier to indicate a significant, separately identifiable E/M service that went above and beyond another service provided by the same provider, for the same worker, on the same date of service. **Note**: This modifier should only be used with E/M services.	This modifier allows payment for the significant, separately identifiable E/M service. Payment is made at a maximum of **100%** of the fee schedule level or billed charge, whichever is less.
–52 (Reduced services)	
Use this modifier to indicate when a service is reduced. Under certain circumstances, a service or procedure is partially reduced or eliminated at the discretion of the provider. This modifier provides a means of reporting reduced services without disturbing the identification of the basic service. **Note**: Don't use this modifier for ASC services that require anesthesia. Instead, refer to modifiers **–73** and **–74**.	Payment is made at **50%** of the fee schedule level or billed charge, whichever is less.

Use	Payment Information
–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.

General information: 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).

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.

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.

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 what time counts towards timed codes. Detailed examples can be found below. 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/cm2 ; 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.

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 isn't 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 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 isn't 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: 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.

Note: Use of these therapies will continue to be covered during hospitalization and in clinical 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 isn't 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 evaluations (FCEs)

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

Each provider must bill independently for their time using the following codes:

Code	Description and notes	Maximum fee
1045M	**Standard Functional Capacity Evaluation** Must involve a minimum of 3 hours of face-to-face time between all evaluating providers.	**$286.11** per unit 1 unit = 1 hour Maximum 6 units total per worker, not to exceed **$858.33**.
1098M	**Supplemental Functional Capacity Evaluation** When the Standard FCE evaluation exceeds 6 hours. This may be appropriate when: • Additional testing is required for multiple jobs with opposite physical demands, • Performing a whole body and upper extremity focused evaluation, *or* • Symptomatic neurological conditions impact testing tolerance and/or When follow up testing is indicated after completion of a Standard FCE in order for an Attending Provider or vocational provider to facilitate return to work decisions.	**$143.58** per unit 1 unit = 1 hour Maximum 6 units total per worker.

Example of billing 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:	3 units of **1045M**
PT:	1 unit of **1045M**
Total units billed: 4 Maximum fee of **$858.33**	

Services that can't be billed

Supplemental Functional Capacity Evaluations using **1098M** can't be billed for:

- Additional time to perform missed or forgotten testing, *or*
- Updates to an incomplete or conflicting report.

Requirements for billing

When billing, 1 hour of direct face-to-face time = 1 unit of service. If the service is 31 minutes or greater, this meets the requirement for 1 unit of service. Time accumulates regardless of the number of days the FCE is performed over.

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 they spent performing the evaluation using their individual provider account number.

These services include testing, a summary of findings, and a 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.

Documentation requirements

Documentation for any Functional Capacity Evaluation (FCE) must include:

- Date of service,
- Worker name,
- Claim number,
- Duration of the evaluation. Each provider must also separately document the amount of direct one-on-one time they spent performing the service,
- Signature and date of all evaluators, *and*
- Completed Capacity Form (F245-434-000) for State Fund (in-state claims) or an equivalent summary of findings for out-of-state and self-insured claims.

For a Standard FCE, documentation must also include L&I's minimum evaluation elements.

For a Supplemental FCE, documentation must also include a list of all tests performed and all results of those tests.

Note: Although the department allows joint chart notes for FCEs, the 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.

Payment limits

Standard and Supplemental Functional Capacity Evaluations (**1045M** and **1098M**) may only be billed once per worker every 30 days.

Multiple providers

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.

Multiple claims

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. When this occurs, therapists must appropriately bill the portion of the visit related to each accepted claim. For more information, refer to the physical medicine split billing policy in this chapter.

Multiple days

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 1 and was completed on January 3, the bill will reflect the “From Date of Service” as January 1 and the “To Date of Service” as January 3.

Payment policy: Low level laser therapy (LLLT)

General information

The department has rescinded its coverage decision for low level laser therapy. This modality was previously not covered, but is now a covered benefit when performed in a clinical setting.

Services that can be billed

Physical therapy (PT) providers, occupational therapy (OT) providers, board-qualified physiatrists, and board-certified physiatrists may bill for low level laser therapy using **S8948**.

Non-board certified/qualified physical medicine attending providers may bill for low level laser therapy using local code **1044M**. See PT/OT payment limits for details on billing **1044M**.

Services that aren't covered

Low level laser therapy must be performed in a clinical setting. Low level laser therapy isn't covered outside of a clinical setting or for home use.

CPT® code **97037** isn't covered.

HCPCS code **0552T** isn't covered.

Payment limits

When billed using **S8948**, low level laser therapy is **bundled** with other physical medicine services billed with CPT® codes **97010** through **97799**. The insurer won't pay an additional fee for low level laser therapy billed using **S8948**.

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 PT/OT payment limits for details on billing **1044M**.

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. See additional information about Timed Codes for more details.

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.

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 **$110.98**.

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 (DO) or naturopathic (ND) 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.

Services that aren't covered

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

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, first submit to the insurer:

- A referral for ongoing treatment,
- The initial evaluation report,
- Daily chart notes, *and*
- All progress reports.

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

Only physiatrists and physical therapists may bill **95992**.

If more than 1 patient is treated at the same time, use CPT® code **97150**.

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.

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).

For information on billing for telephone calls, online communications, or team conferences, see Chapter 10: Evaluation and Management Services.

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 "AP provider physical medicine services".

See Payment limits for local code 1044M.

Services that aren't covered

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

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 aren't a covered benefit. For more information, please review L&I's coverage decision for Non-vasopneumatic Devices without a Cryotherapy Component.

Documentation requirements

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.

When billing 1044M

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

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, 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 patient 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.

Bundled items or services

Bundled items or services include, but aren't 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 **$147.97**.

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 rehabilitation services, *or*
- Work evaluations, *or*
- Job modification/pre-job 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.

Link: 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).

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.

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

The insurer prefers that Physical Therapy and Occupational Therapy services be provided in person.

In-person services are required 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.

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 will 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

Speech, physical, and occupational therapists as well as their assistants and students may conduct services via **telehealth**.

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.

Store and Forward

G2250 is covered for worker-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 worker 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

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),
- Home health monitoring,
- **G2010** for store and forward (use **G2250**),
- Work rehabilitation, *and*
- Functional Capacity Evaluations (FCE).

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. In addition to those limits, physical medicine 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 account 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 in skilled nursing facilities) isn't payable.

Students can't independently:

- Make clinical judgements,
- Provide evaluations, re-evaluations or assessments, *or*
- 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 account 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**. This means they must:

- Ensure that the work **students** perform does not exceed their education, skills, and abilities, nor the **supervising therapist's** scope of practice,
- Provide **supervision** to the **student** regardless of what setting care is being rendered in (clinic, hospital, or skilled nursing facility),
- Ensure that all documentation requirements are met,
- Co-sign all documentation for services rendered to injured workers, *and*
- 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.

Link: For more information, see WAC 296-20-015.

Payment policy: Work rehabilitation (WR)

General information

Work rehabilitation (WR) is a special individualized program to assist a worker in meeting the demands of a specific job using progressive exercise, work simulation tasks, and education. It consists of two intensity levels: work rehabilitation – conditioning (WRC) and work rehabilitation – hardening (WRH).

For general program details, visit our work rehabilitation website. You can also find specific information about the program in our work rehabilitation standards.

Prior authorization

Initial evaluations

Initial evaluations for work rehabilitation program eligibility don't require prior authorization.

Work rehabilitation programs

Work rehabilitation programs require a referral from the worker's attending provider (AP). For State Fund, utilization review (UR) is also required. For self-insurance, the self-insured employer's representative grants prior authorization.

Additional services

Providing separate and additional rehabilitation outpatient physical therapy (PT) or occupational therapy (OT) services to the worker while they're participating in a work rehabilitation program is atypical and must be authorized by the insurer. Documentation must support the clinical necessity of additional services.

Program extensions

The insurer must authorize program extensions in advance. Extensions are based on documentation of progress and the worker's ability to benefit from a program extension. Program extensions apply to **1023M**, **1024M**, **97545**, and **97546**. To request a program extension:

- For State Fund claims, use Secure Access Washington (SAW) to email therapy@lni.wa.gov. Don't send confidential worker information via email. You may also fax the Therapy Services unit at **360-902-5035**.
- For self-insured claims, contact the self-insured employer or their representative.

Who must perform these services to qualify for payment

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

Link: Visit our website to apply to become a work rehabilitation provider.

Services that can be billed

Work rehabilitation evaluation

Service	Code	Details
WR evaluation	**1001M**	Work rehabilitation – evaluation and plan of care. 1 unit = 1 hour Doesn't require prior authorization.

Work rehabilitation – conditioning (WRC)

Service	Code	Details
WRC program, first 2 hours	**1023M**	Work rehabilitation – conditioning, first 2 hours of treatment per day. 1 unit = 1 hour Requires prior authorization. A minimum of 2 hours of treatment per day (2 units) is required; see below for details.
WRC program, each additional hour	**1024M**	Work rehabilitation – conditioning, each additional hour of treatment per day. 1 unit = 1 hour Requires prior authorization.

Work rehabilitation – hardening (WRH)

Service	Code	Details
WRH program, first 2 hours	**97545**	Work rehabilitation – hardening, first 2 hours of treatment per day. 1 unit = 2 hours Requires prior authorization. A minimum of 2 hours of treatment per day (1 unit) is required; see below for details.
WRH program, each additional hour	**97546**	Work rehabilitation – hardening, each additional hour of treatment per day. 1 unit = 1 hour Requires prior authorization.

Requirements for billing

Billing portions of an hour using 1001M

Each unit of **1001M** equals 1 hour of evaluation services. If the worker completes less than 38 minutes of a given hour, round down to the nearest whole number unit. If the worker completes 38 or more minutes, round up to the nearest whole number unit. For example, if the worker is evaluated for 2 hours and 47 minutes, the provider would bill 3 units of **1001M**.

Billing less than 2 hours of treatment in a day with CPT® 97545 or 1023M

Services provided for less than 2 hours of total program time (2 units of **1023M** or 1 unit of **97545**) on any day don't meet the work rehabilitation program standards and can't be billed using WR codes. The services must be billed with other physical medicine codes. Failure to complete at least 2 hours of a WR program should be counted as an absence when determining worker compliance with the program.

Billing portions of an additional hour using CPT® 97546 or 1024M

After completion of the requirements for **97545** or **1023M**, each additional hour is billed using **97546** or local code **1024M**. A full hour is billed as 1 unit at your usual and customary rate, but if the worker completes less than 38 minutes of an hour of program work:

- The charged amount for the incomplete hour of service must be prorated, *and*
- You must bill a line of **97546** or **1024M** at the prorated rate with modifier **–52**.

Example: Worker completes 4 hours and 25 minutes of WRH 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**	42% of usual and customary (completed 25 of 60 minutes)	1

Billing for services in multidisciplinary programs

Each provider must bill for the number of hours they perform. Both PT and OT providers may bill for the same date of service.

Examples of billing for services in multidisciplinary programs

Example 1: Standard treatment (Work rehab – Hardening)

Scenario: The OT performs treatment that lasts 4 hours. On the same day, the worker is also treated by the PT for 2 hours.

The providers could bill for the 6 hours of services in the following ways:

Billing example A		
PT:	1 unit **97545**	2 hours
OT:	4 units **97546**	4 hours
Total hours billed:		**6 hours**

Billing example B		
PT:	2 units **97546**	2 hours
OT:	1 unit **97545** + 2 units **97546**	2 hours 2 hours
Total hours billed:		**6 hours**

Example 2: Standard treatment (Work rehab – Conditioning)

Scenario: The OT performs 1 hour of treatment for a worker. A PT provider then performs an additional 2 hours of treatment.

The providers could bill for the 3 hours of services in the following ways:

Billing example A		
PT:	1 unit **1023M** + 1 unit **1024M**	1 hour 1 hour
OT:	1 unit **1023M**	1 hour
Total hours billed:		**3 hours**

Billing example B		
PT:	2 units **1023M**	2 hours
OT:	1 unit **1024M**	1 hour
Total hours billed:		**3 hours**

Example 3: Reduced treatment hours (Work rehab – Conditioning)

Scenario: The PT performs 2 hours of treatment with the worker. The OT performs an additional 1.5 hours of treatment.

The providers could bill for the 3.5 hours of services in the following ways:

Billing example A		
PT:	2 units **1023M**	2 hours
OT:	1 unit **1024M**	1 hour
	1 unit **1024M** (prorated) with modifier **–52**	30 minutes
Total hours billed:		**3.5 hours**

Billing example B		
PT:	1 unit **1023M**	1 hour
	1 unit **1024M**	1 hour
OT:	1 unit **1023M**	1 hour
	1 unit **1024M** (prorated) with modifier **–52**	30 minutes
Total hours billed:		**3.5 hours**

Documentation requirements

Documentation for both WRC and WRH must meet the requirements listed in the Work Rehabilitation Standards. For additional documentation requirements, see Chapter 2: Information for All Providers.

A report is required when billing **1001M**. This report must include any results of tests or measurements performed and/or document the worker's progress through the program.

If a worker fails to complete the minimum treatment duration for WRC or WRH on a given day, this should be documented as an absence from the program for that day. Services will need to be billed using other CPT® physical medicine codes; billing and documentation requirements for these codes can be found in other sections of this chapter.

Payment limits

Providers may only bill for the time that services are performed while the worker is in the clinic participating in their program. The reimbursement rates of CPT® **97545** and **97546** and local codes **1023M** and **1024M** account for the fact that some work occurs outside of the time the worker is present (for example, creation of the initial plan of care or documentation of worker progress).

Code	Description	Daily unit limit	Program unit limit	Notes
1001M	Evaluation	None	6 units	
1023M	Work conditioning, first 2 hours	2 units (2 hours)	80 units	Minimum of 2 units per day.
1024M	Work conditioning, each additional hour	2 units (2 hours)	80 units	Add-on code. Won't be paid as a standalone procedure. Must be billed with **1023M**.
97545	Work hardening program, first 2 hours	1 unit (2 hours)	40 units	Minimum of 1 unit per day.
97546	Work hardening, each additional hour	6 units (6 hours)	240 units	Add-on code. Won't be paid as a standalone procedure. Must be billed with CPT® **97545**.

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 rehabilitation program at L&I	**Program reviewer**: therapy@lni.wa.gov Work 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?

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.

