Washington State Department of
Labor & Industries

Chapter 20: Physical Medicine

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2026

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

Updates and corrections

An annual update of the entire payment policies and fee schedules (MARFS) is published routinely to coincide with the beginning of each state fiscal year (July 1).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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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). See Chapter 2: Information For All Providers for more details.

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.

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
Ultrasound performed with attended E-stim simultaneously	5mA right forearm 1.5 W/cm2 ; 100% right forearm	Increase joint mobility	**12 minutes**
Therapeutic exercise	Active assisted ROM to right wrist; flexion/extension; 15 reps x 2 sets	Increase motion and strength for gripping	**14 minutes**
			Total treatment time = **26 minutes** Total timed intervention (treatment time spent performing timed services) = **26 minutes**

At 26 total minutes of timed services, a maximum of **2 units** of timed services can be billed. When both a timed and untimed service are performed simultaneously, only one of the services can be billed. In this case, only ultrasound would be billed. Correct billing for the services documented is:

- **97110** (Therapeutic exercise) x 1 unit, and
- **97035** (Ultrasound) 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 an untimed service, but 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 an untimed service, but 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 an untimed service, but are considered **bundled**.

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

A provider 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: Chiropractic care visits

General information

Chiropractic care visits are office or other outpatient visits involving subjective and objective assessment of patient status, management, and treatment.

The number of body regions being adjusted is only one of the factors that may contribute to visit complexity along with the components listed on the table below. For the purposes of this policy, body regions include:

- Cervical (includes atlanto-occipital joint),
- Thoracic (includes costovertebral and costotransverse joints),
- Lumbar
- Sacral
- Pelvic (includes sacroiliac joint), *and*
- Extra-spinal (considered one region), which includes:
    - Head (includes temporomandibular joint; doesn't include atlanto-occipital joint),
    - Upper and lower extremities, *and*
    - Rib cage (doesn't include costotransverse and costovertebral joints).

Prior authorization

Prior authorization is required for all types of conservative care, including chiropractic, when billing for:

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

Links: For more information, see WAC 296-20-030(1) and WAC 296-20-03001(1).

Documentation requirements

Chiropractors must document all body regions treated each visit. Documentation must support the level of service billed as described in Determining the level of a chiropractic care visit.

All other standard documentation rules apply for chiropractic care visits performed. See Chapter 2: Information for All Providers for details.

When treating subluxations and/or segmental dysfunction adjacent to areas that have been accepted on a claim, the provider must document how the adjacent areas are related to the injury or if they are a separate area of injury that hasn't already been accepted.

Note: For documentation of E/M services, see Chapter 9: Evaluation and Management (E/M).

Services that can be billed

Local codes **2050A**, **2051A**, and **2052A** account for both professional management (clinical complexity) and the technical service (manipulation and adjustment).

Expectations for chiropractic care visits

When performing a chiropractic care visit, billable using codes **2050A**, **2051A**, and **2052A**, it's expected that the provider will perform the following pre-, intra-, and post- services:

- Education of the patient, which may include:
  - How the treatment will affect the patient,
  - What the patient should do to improve recovery, *and/or*
  - Asking the patient if they understand the intended treatment and consent to it,
- Brief review of employment issues and work restrictions,
- Review of physical abilities/restrictions,
- Pre-manipulation patient assessment, including deciding which areas to adjust,
- Manipulation (adjustment), *and*
- Post-treatment service, which includes:
  - Instructions for patient to help improve their recovery and avoid re-injury,
  - Inform patient of things to watch out for that might indicate a problem,
  - Evaluation of effectiveness of treatment,
  - Evaluation of patient response, *and*
  - Review of the treatment plan with the patient.

Determining the level of chiropractic care visit

Treatment must meet or exceed at least **3** factors in one column to bill that level. The appropriate level of service to bill is equal to the highest 3 out of 5 factors. If no information is documented about a given factor, it defaults to Straightforward.

Factor	Straightforward (2050A)	Low (2051A)	Moderate (2052A)
Severity of condition(s)	Simple condition(s)	Multiple conditions or a single complex condition	Multiple complex conditions and/or a condition with neurological findings
Body regions treated	Up to 2 body regions (incl. spine and/or extremities)	Up to 3 or 4 body regions (incl. spine and/or extremities)	Up to 5 or more regions (incl. spine and/or extremities)
Time spent	Up to 10 minutes of face-to-face time	11-20 minutes of face-to-face time	Over 20 minutes of face-to-face time
Co-morbidities	None or not affecting recovery	One or two comorbidities impeding recovery	Multiple comorbidities or psychosocial factors impeding recovery
Treatment plan	No changes needed to plan	Minor changes needed to plan	Major changes needed to plan

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Factor details

Treatment plan

Minor changes include contact points/segments, method/technique, visit frequency, or home care instruction alterations in a condition progressing as expected.

Major changes include alterations that require new informed consent for expected outcomes or adverse events, new home care routines, or changes because of prior adverse events post-treatment or new data/test results.

Severity of condition

Straightforward: Condition is progressing as expected. Lumbar strain with acute localized back pain and segmental dysfunction.

Low: Uncertain prognosis or challenges in diagnostic certainty, two or more conditions. Lumbar and thoracic strain with referred pain to flank/glute.

Moderate: Severe exacerbation/aggravation of condition, two or more conditions that involve multiple areas and have potential for significant negative outcomes for the patient, which may include neurologic involvement. Diabetic patient with Lumbar strain and pain/tingling in upper leg with myotome/dermatome deficit.

When billing E/M is appropriate

When services provided exceed the expectations for a chiropractic care visit and meet the CPT® criteria, an evaluation and management (E/M) code may be appropriate. For example:

- Establishing a diagnosis, history, and treatment plan during an **initial visit**,
- Reevaluating the patient's physical condition, obtaining interval history, and updating patient progress,
- Reviewing and discussing diagnostic testing results, and/or notes from other providers with the worker, which may result in adjusting the treatment plan,
- Counseling and educating above and beyond what is necessary to complete an adjustment, *and/or*
- Referring for tests or diagnostics.

The E/M code must be billed with modifier **–25** when billed with **2050A**, **2051A**, or **2052A**. The patient must be present for any E/M services to be billable; record review alone isn't sufficient to bill E/M. See Chapter 9: Evaluation and Management (E/M) for additional details.

Billing examples

The following examples illustrate typical chiropractic care visits and how the provider would determine the correct service(s) to bill.

Example 1: Straightforward Chiropractic Care Visit

S: 52y/o female with neck and shoulder pain after lifting a box overhead onto a shelf, slowly improving after a few visits of trapezius muscle work and neck adjustments. Poorly controlled diabetes may be slowing recovery.

O: Tender and taut rt trap and levator scap, pec maj, infraspinatus. Decreased lt lat flexion C7, C2 dec left rotation.

A: Improving, cervical strain with concomitant subluxation.

P: Cervical spine adjustment to C7 and C2 today. Total treatment time for today's visit was 8 minutes. Rhomboid exercises will be introduced next visit. Worker to return as scheduled.

E/R: Discussed modifying work duties to accommodate her neck and shoulder, emphasized need for blood sugar control to improve healing.

How to bill for this scenario

The level of service is based on the highest 3 of 5 criteria. This service meets 0 criteria for Moderate (**2052A**), 1 criteria for Low (**2051A**), and 3 criteria for Straightforward (**2050A**). For this visit, the provider would bill code **2050A**.

Factor	Straightforward (2050A)	Low (2051A)	Moderate (2052A)
Severity of condition(s)	Cervical strain		
Body regions treated	Cervical spine		
Time spent	8 minutes		
Co-morbidities		Diabetes	
Treatment plan	No changes needed to plan		

Example 2: Low Chiropractic Care Visit and 1044M

S: Mr. Johnson is here today for a follow-up on his back and hip pain. Original work injury is a L-foot fracture. Wearing a boot for three weeks subsequently. Rides a knee scooter mainly for mobility. Thoracolumbar junction pain and low back pain from boot/scooter are improving with care. Hip pain is improving.

O: Thoracolumbar paraspinal muscles tender and taut worse on left, dec rt lateral flexion at TL jxn and T12 pl. Hip restricted in external rotation and tight end feel.

A: Lumbar overuse/strain secondary to limping/postural from fracture – Lumbar, thoracic, LE subluxation – guarded prognosis.

P: Adjustment TL jxn and lumbar side posture, hip mobilization. 10 minutes spent in treatment. Following treatment, demonstrated and supervised home exercise plan including dead bugs 3 sets of 10, hip tilts 15 reps x 3 sets – hold 10 sec, and reviewed cat/cow, neutral spine while using scooter. Worker to return as scheduled.

E/R: No light duty offered, working with vocational provider. **Job analysis** signed and APF updated today after visit.

How to bill for this scenario

The level of service is based on the highest 3 of 5 criteria. This service meets 0 criteria for Moderate, 4 criteria for Low, and 1 criteria for Straightforward. For this visit, the provider would bill codes **2051A** and **1044M**.

- **Severity of condition(s)**: Low - Low back strain, hip strain
- **Body regions treated**: Low - 3 (Lumbar, hip, thoracic [adjacent region])
- **Time spent**: Straightforward - 10 minutes
- **Co-morbidities**: Low – Foot fracture
- **Treatment plan**: Low - Adding home exercise program
- **1044M**: Review and demonstration of home exercise program

Link: For more information on billing **1044M**, see Chapter 3: Attending Providers.

Example 3: Moderate Chiropractic Care Visit and 1044M

S: Pt c/o neck pain radiating into right upper extremity that hasn't improved over the past two weeks with care. Pain and tingling in arm/forearm is manageable if carefully controlling arm and neck posture, but worse at night. Activities are more limited than two weeks ago. Felt improvement after last visit in the neck, but upper extremity symptoms remain. Worker very concerned about worsening symptoms and inability to recover.

O: Active csp ROM limited past 20 lat flexion b/l, rotation to rt 70 minimal pain, Lt 45 with local right sided pain, extension past 20 painful into shoulder/arm, flexion to 30 causes neck pain.

A: Mild progression of cervical radiculopathy - worsening

P: Cervical figure 8 mobilization light, scalene, pec and trap myofascial release. Manual cervical distraction performed. Discussed herniation progression and conservative considerations. Added new exercise program to tx plan. Demonstrated and supervised nerve gliding exercises 2-3mins 3x/day and chin tuck hold 10 seconds repeat 20x, shoulder pinch back postural exercises – green band 15rep x 3 sets. Re-evaluate neurologic tests next visit to monitor progression.

E/R: No access to PT for next 3 weeks. Existing referral for BHI – fear avoidance and coping.

How to bill for this scenario

The level of service is based on the highest 3 of 5 criteria. This service meets 3 criteria for Moderate, 0 criteria for Low, and 2 criteria for Straightforward. The provider also performed physical medicine services not included in a chiropractic care visit. For this visit, the provider would bill codes **2052A** and **1044M**.

- **Severity of condition(s)**: Moderate - Neck and right upper extremity pain with neurological involvement; cervical radiculopathy
- **Body regions treated**: Straightforward - 1 (neck)
- **Time spent**: Treatment duration not listed; default to Straightforward
- **Co-morbidities**: Moderate - Worker doesn't have access to PT; worker referred to BHI for fear avoidance and coping
- **Treatment plan**: Moderate - New exercise program added
- **1044M**: Review and demonstration of home exercise program

Link: For more information on billing **1044M**, see Chapter 3: Attending Providers.

Example 4: Straightforward Chiropractic Care Visit and E/M

S: Pt states back and lower extremity pain are improving. Report from MRI performed 1 mo ago received – worker has questions on implications of report and the possibility of surgery.

O: Re-evaluated today: LE DTR 2+ b/l, vibration wnl b/l, small area on rt top of foot & shin decreased sensation to pinwheel – more difficult for worker to discern than prior exam. Myotome: 5/5 hip flex & ext, knee flex & ext, foot dorsi & plantar, 4/5 great toe extension rt, 5/5 lt toe ext. Heel & toe walk wnl b/l. Minimal foot drop with normal gait. Kemps neg, SLR pos @ 30 rt side mild leg pain, neg lt side. Nachlas neg, Ely neg, L5 pr decreased rt rotation and Rt SI jt PA restriction. Forward bending restricted, but other ranges wnl and equal bilaterally. Tender and tight lumbar paraspinals worse rt. Rt glute hypertonicity.

A: Lumbar herniation w/radiculopathy – improving pain, function, and neuro.

P: Lsp side posture adjustment in extension. Reviewed MRI report with worker discussing findings of broad-based disc bulge with annular tear L4-L5. Discussed good prognosis for conservative management thus far and improving neuro findings, addressed surgical concern - no need at this time. 20 minutes for re-examination, review of MRI report with worker, and discussion.

E/R: Discussed APF and updated.

How to bill for this scenario

The level of service is based on the highest 3 of 5 criteria. This service meets 1 criteria for Moderate, 0 criteria for Low, and 4 criteria for Straightforward. The provider also performed services that go beyond the requirements for a chiropractic care visit. For this visit, the provider would bill code **2050A** and **99213**.

Factor	Straightforward (2050A)	Low (2051A)	Moderate (2052A)
Severity of condition(s)			Lumbar herniation with radiculopathy
Body regions treated	Lumbar		
Time spent	Not listed		
Co-morbidities	Not listed		
Treatment plan	Not listed		

- **Evaluation & Management**: **99213 –25**

- Meets the definition of a significantly separately identifiable service (modifier **–25**)
- 20 minutes spent on E/M components (re-examination, review of MRI with worker, discussion), or low medical decision-making above and beyond what was performed in the chiropractic care visit.

Link: For more information on billing evaluation and management services, see Chapter 9: Evaluation and Management (E&M).

Services that aren't covered

CPT® chiropractic manipulative treatment (CMT) codes **98940**-**98943** aren't covered.

Instead of using CMT codes, L&I uses local codes developed in collaboration with the Washington State Chiropractic Association and the University of Washington (see Services that can be billed, above).

Treatment of chronic migraine or chronic tension-type headache with chiropractic manipulation/manual therapy isn't a covered benefit.

Link: The L&I coverage decision for treatment of Chronic Migraine or Chronic Tension-type Headache is available online.

Payment limits

Only 1 chiropractic care visit per day is payable.

Extra-spinal manipulations aren't billed separately from each other (all extremities are considered to be one body region).

Providers can only bill a **new patient** or **established patient** E/M code and a chiropractic care local code (**2050A**, **2051A**, or **2052A**) for the same date of service when the E/M service is significantly separately identifiable and meets the requirements to use modifier **–25**. Time spent or treatment performed as part of a chiropractic care visit can't be counted when determining which level of E/M to bill; all E/M services need to be assessed for billing level separately from the chiropractic care services. For details, see Services that can be billed (above) and Chapter 9: Evaluation and Management (E/M).

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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,** with exception of physiatrists and chiropractors, must bill local code **1044M**. For more information, see the Physical medicine services for **attending providers** policy in Chapter 3: Attending providers.

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 a:

- Physiatrist, *or*
- Physical or occupational therapist.

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.	**$299.78** per unit 1 unit = 1 hour Maximum 6 units total per worker, not to exceed **$899.34**.
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.	**$150.44** 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 **$899.34**	

Services that aren't covered

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 services split billing policy in Chapter 2: Information for All Providers.

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: 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

Massage therapy services require prior authorization after the 6th visit.

Link: For more information, see WAC 296-23-250.

Services that can be billed

Massage therapy services must be billed using 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. All other providers must bill the code most reflective of the technique being used.

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 only a procedure code or a range of time (for example, 8-22 minutes) for a timed service isn't acceptable. Providers must document the actual service and the amount of minutes spent performing the service.

Massage Therapist 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 **$116.28**.

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)

General information

For the purposes of this policy, body regions are defined as:

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

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 medical 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.

For details, see Chapter 9: Evaluation and Management (E/M).

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. For example, if 3 body regions were manipulated, 1 unit of the correct CPT® code would be payable.

Services that aren't covered

Manual therapy billed under CPT® code **97140** or local code **1044M** isn't covered for osteopathic physicians.

Payment policy: Physical medicine

Who must perform these services to qualify for payment

Physical therapy (PT), occupational therapy (OT), and other covered physical medicine services billed using CPT® **97010**-**97799** must be provided by a:

- Medical or osteopathic physician who is board certified or board qualified in the filed of physical medicine and rehabilitation (physiatrist),
- Physical therapist (PT),
- Physical therapy assistant (PTA) serving under the direction of a physical therapist,
- Occupational therapist (OT),
- Occupational therapy assistant (OTA) serving under the direction of an occupational therapist, *or*
- Athletic trainer serving under the direction of another provider.

Links: For more information, see WAC 296-23-220, WAC 296-23-230, and WAC 296-21-290.

Students

For details about **students** performing physical medicine services, see the Therapy student and therapy assistant payment policy. For all other types of **students**, see Chapter 2: Information For All Providers.

Attending provider types

All **attending provider** types may perform physical medicine services and bill under local code **1044M**. Services must be within the provider's scope of practice and code **1044M** is generally limited to 6 visits per claim, per provider. See the "Physical medicine services for **attending providers**" policy in Chapter 3: Attending providers and WAC 296-21-290.

Prior authorization

Physical medicine services billed under CPT® codes **97010**-**97799** require a referral from the worker's **attending provider**. Additional prior authorization may be required.

How physical medicine visits are counted

The total number of visits per claim is calculated separately for physical therapy (PT) and occupational therapy (OT) services; 1 visit of each is allowed per day. Each visit includes all physical medicine services (CPT® **97010**-**97799**) provided to a worker on a single day.

Physical medicine services provided by supervised physical therapy assistants (PTAs) and athletic trainers are accounted for under the worker's PT visit total.

OT visit totals only include visits with occupational therapists and their supervised assistants. For example, a worker could have 12 PT visits with a physical therapist as well as 12 OT visits with an occupational therapist.

New referrals, changes in provider, restart of therapy following surgery, or treatment of new conditions on the same claim don't reset the visit count.

First 12 visits

No authorization is needed for the first 12 visits if the claim is open and allowed and treatment is for an accepted condition on the claim. See WAC 296-20-030 for details.

Submit a Physical Medicine Progress Report form after 12 visits or 1 month, whichever comes first.

Visits 13-24

Prior authorization from the insurer is required for additional visits. To request authorization for visits 13-24, first submit to the insurer:

- The initial evaluation report,
- All daily chart notes,
- At least one completed Physical Medicine Progress Report form, *and*
- A referral from the worker's **attending provider**.

Then complete a Physical/Occupational/Massage Therapy Provider Hotline Service Authorization Request.

Visits 25+

For visits 25 and beyond, request Utilization Review from Comagine Health directly. Learn more about these services on the L&I PT/OT webpage.

Services that can be billed

PT providers, OT providers, and their supervised assistants and athletic trainers must use CPT® **97010-97799** for physical medicine services.

These providers may also bill for miscellaneous materials and supplies using HCPCS codes. Some of these CPT® and HCPCS codes aren't covered or are **bundled**. Refer to the professional provider fee schedule for coverage.

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

Only PTs may bill CPT® code **95992**.

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Evaluation

For an evaluation performed by a therapist to establish a plan of care, use CPT® codes **97161**-**97163** (PT) or **97165**-**97167** (OT).

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

Links: For information on Surgical dressings dispensed for home use, see Chapter 7: Durable Medical Equipment (DME) and Supplies.

For billing requirements for prosthetic and orthotic devices, see Chapter 7: Durable Medical Equipment (DME).

For information on billing for telephone calls, online communications, or team conferences, see Chapter 9: Evaluation and Management (E/M)

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 as **durable medical equipment**. 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-vaso**pneumatic 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.

Services defined by CPT® Category III codes that aren't covered on the professional fee schedule can't be billed using any of the physical medicine codes.

Documentation requirements

All providers must submit chart notes for physical medicine services performed. Progress reports are due following 12 visits or every 1 month, whichever is first.

All providers who perform physical medicine services must use the Physical Medicine Progress Report form (F245-435-000). Request for authorization for visits beyond 24 may be denied if a Physical Medicine Progress Report and chart notes are not on file. See the billing guidance section in this chapter for more details.

Providers can use the Documenting Functional Improvement resource to help prepare these progress reports.

Link: For more information, see WAC 296-23-220 and WAC 296-23-230.

Payment limits

The daily maximum allowable fee for physical medicine services is in WAC 296-23-220 and WAC 296-23-230. When performed for the same claim for the same date of service, the daily maximum applies to CPT® codes **20560**-**61**, **95992**, and **97010**-**97799**.

The daily maximum separately applies once per day for each of the following:

- Services provided by a PT, PTA, athletic trainer, or their **students**, *or*
- Services provided by an OT, OTA, or their **students**.

See the Massage Therapy payment policy in this chapter for the separate daily maximum fee that applies to massage therapists.

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

Daily fee cap exceptions

The daily fee cap doesn't apply to:

- Speech language pathologists,
- Functional capacity evaluations (FCEs),
- Work Rehabilitation services,
- Work evaluations, *or*
- Job modification/pre-job accommodation consult services.

Links: For more information, see WAC 296-23-220 and WAC 296-23-230.

Bundled items or services

Bundled items or services include, but aren't limited to:

- Activity supplies used in Work Rehabilitation, 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 physical medicine treatment.

Split billing for unrelated conditions or treatment of multiple claims

Split billing doesn't apply to physical medicine services. Providers are responsible for billing services related to an accepted work injury to the appropriate claim. For details and examples on how to bill in this scenario, see the Split billing – treating multiple separate conditions payment policy in 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 time-based 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).

Restricted provider types

The following provider types can't bill or be paid for physical medicine services:

- Exercise physiologists,
- Gym supervisors,
- Kinesiologists,
- Therapy **students**,
- Physical or occupational therapist aides or assistants, *or*
- Speech language pathologists.

Payment policy: Powered traction therapy

Services that can be billed

When performed as part of a physical medicine modality, the use of powered traction devices are covered. The insurer won't reimburse separately for the use of the device, only for the service delivery.

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: Physical and occupational therapy 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.

A **student** is a person who is enrolled and participating in an accredited education program as part of their clinical training 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.

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.

A supervising therapist can only supervise a **student** within their discipline and 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. Services may be a single patient or group services.

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.

Direct supervision in accordance with **student** licensures must be provided in-person, even if the service is provided to the worker via **telehealth**. Modifier **–FR** isn't covered.

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Physical therapist assistants and occupational therapy assistants must not act as supervising therapists.

Note: Direct supervision of therapy assistants may occur via **telehealth** (modifier **–FR**) when the service to the worker is allowed via **telehealth**. Certain services require in-person care. These services require in-person direct supervision in alignment with DOH requirements for the assistant licensure.

Requirements for billing

All chart notes and documentation must be signed by the **student** and co-signed by the supervising provider, indicating they have reviewed and approved of the documentation. 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 doesn't 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: Therapeutic laser treatment

General information

Therapeutic laser treatment involves the use of Class III and/or Class IV lasers on specific areas of a worker's body to induce healing and improve recovery. This policy pertains to two forms of therapeutic laser:

- Low level laser therapy (LLLT), also called "cold laser", *and*
- Multiwave locked system (MLS) therapy.

These types of lasers are used for therapeutic purposes only. They're different from ablative lasers, which are used for surgical applications and are discussed in Chapter 23: Surgery.

As of July 1, 2026, some therapeutic laser treatments are covered and are separately payable for certain provider types.

Note: Therapeutic laser treatment is only allowed when performed at the same visit as other physical medicine services.

Who must perform these services to qualify for payment

Therapeutic laser treatment codes **S8948**, **97037**, and **0552T** may only be billed by occupational therapists (OTs), physiatrists, and physical therapists (PTs).

Providers who can be an **Attending Provider** may bill for therapeutic laser treatment using local code **1044M**.

Link: For a list of **Attending Provider** types, see Chapter 3: Attending Providers.

Services that can be billed

Timed billing codes are subject to CPT® rules. See Physical medicine CPT® code billing guidance for more information.

Service	Provider	Code and Details
Low level laser therapy (LLLT)	PT, OT, or physiatrist	**S8948** 1 unit = 15 minutes Maximum 1 unit per day.
	All other AP types	**1044M** 1 unit = 1 visit Maximum 1 unit per day, 6 units total per claim.
Low level laser therapy (LLLT), post-operative	PT, OT, or physiatrist	**97037** 1 unit = 15 minutes Maximum 1 unit per day. May only be performed in the recovery period following surgery.
	All other AP types	**1044M** Untimed code; 1 unit = 1 visit Maximum 1 unit per day, 6 units total per claim. May only be performed in the recovery period following surgery.
Multiwave locked system (MLS) therapy	PT, OT, or physiatrist	**0552T** 1 unit = 15 minutes Maximum 1 unit per day.
	All other AP types	**1044M** 1 unit = 1 visit Maximum 1 unit per day, 6 units total per claim.

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Requirements for billing

Therapeutic laser treatment is covered when performed in a clinical setting.

Therapeutic laser treatment must be performed in conjunction with other physical medicine services at the same visit regardless of provider type and billing code.

Documentation requirements

In addition to standard SOAPER documentation requirements, the provider must note the type of laser used, time spent treating, and body area(s) treated.

Services that aren't covered

Therapeutic laser treatment isn't covered outside of a clinical setting or for home use.

The insurer doesn't cover any form of therapeutic laser other than those specifically described in this policy (LLLT and MLS).

Payment limits

Bills for visits where therapeutic laser is the only treatment performed may result in denial of the bill or recoupment of payment.

The daily PT/OT fee cap applies to therapeutic laser treatment billed using **S8948**, **97037**, or **0552T**.

Maximum 1 unit of any form of therapeutic laser treatment billable per worker per day.

Maximum 6 units of **1044M** billable per claim. Additional units won't be authorized for therapeutic laser. See Chapter 3: Attending Providers for details on **1044M**.

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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 programs 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 My L&I to email WRvisitadditions@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.

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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. Use of this code may be allowed to complete re-evaluations at any point during a work rehabilitation program (limit 6 units total).

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	May be performed at any time throughout the program.
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**.

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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 7: Durable Medical Equipment (DME) and Supplies and Appendix B: Modifiers.

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.

Related links for Chapter 20: Physical Medicine

The following links are related to topics and policies that appear in this chapter. This list is for your convenience only. Always refer to the specific policy for detailed information.

Coverage decisions and treatment guidelines

If you're looking for more information about…	Then see…
Chronic migraine and chronic tension-type headache	Chronic migraine headache coverage decision
Cryotherapy devices with or without compression	Cryotherapy devices with or without compression coverage decision
Dynamic spine visualization	Dynamic spinal visualization coverage decision
Electrical stimulation for chronic wounds	Electrical stimulation for chronic wounds
Low level laser therapy	Low level laser therapy coverage decision
Non-vasopneumatic devices without a cryotherapy component	Non-vasopneumatic devices without cryotherapy component coverage decision
Power traction devices for intervertebral decompression	Powered traction devices for intervertebral decompression coverage decision
Transcutaneous electrical nerve stimulation (TENS)	TENS coverage decision

Documents and forms

If you're looking for the…	Then see…
Physical Medicine Progress Report form	F245-453-000

RCWs and WACs

If you're looking for more information about…	Then see…
Massage therapy	WAC 296-23-250
Naturopathic medicine	WAC 296-23-205
Occupational therapy	WAC 296-23-230
Physical medicine	WAC 296-21-290
Physical therapy	WAC 296-23-220
Prior authorization	WAC 296-20-03001
Record retention	WAC 296-20-02005

Websites

If you're looking for more information about…	Then see…
Becoming a chiropractic **consultant**	Become a Chiropractic Consultant
Becoming an L&I provider	Become A Provider
Fee schedules and payment policies for all services	Fee Schedules and Payment Policies (MARFS)
Industrial Insurance Chiropractic Advisory Committee goals, meetings, and membership	Industrial Insurance Chiropractic Advisory Committee (IICAC)
Rules for PT, OT, and massage therapy	Physical, Occupational & Massage Therapy
Work rehabilitation programs	Work Rehabilitation

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8:15 a.m. and 12 p.m. PT Monday through Friday.

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