Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 19: Naturopathic Physicians and Acupuncture Services

Effective July 1, 2023

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:

Comprehensive office visit per WAC 296-23-215: "A level of service pertaining to an in-depth evaluation of a patient with a new or existing problem, requiring development or complete reevaluation of treatment data; includes recording of chief complaints and present illness, family history, past treatment history, personal history, system review; and a complete exam to evaluate and determine appropriate therapeutic treatment management and progress."

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

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

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

Extended office visit (expanded or detailed) per WAC 296-23-215: "A level of service pertaining to an evaluation of patient with a new or existing problem requiring a detailed history, review of records, exam, and a formal conference with patient or family to evaluate and/or adjust therapeutic treatment management and progress."

New patient: One who hasn't received any professional services from the physician nor another physician of the same specialty who belongs to the same group practice within the past three years.

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

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

Routine office visit (problem-focused) per WAC 296-23-215: "A level of service pertaining to the evaluation and treatment of a condition requiring only an abbreviated history and exam."

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

Modifiers

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

-GT (Via interactive audio and video telecommunication systems)

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

Payment policy: Acupuncture services

General information

The insurer covers acupuncture only for allowed claims with an accepted diagnosis of a low back condition. Acupuncture requires a referral from the attending physician (AP).

Who must perform these services to qualify for payment

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

Services that can be billed

Treatment must be billed with local code **1582M**. No other acupuncture codes will be reimbursed.

- **1582M** (Acupuncture treatment with one or more needles, with or without electrical stimulation)

Providers may bill a maximum of **1 unit per day per worker**.

This code is billable a maximum of **10 times** during the life of a claim.

A provider performing acupuncture and billing the department for this service must perform an initial evaluation and submit a report that includes a treatment plan. This evaluation must be billed using the appropriate level evaluation and management (E/M) code. In addition to the initial visit, the acupuncture provider may schedule an E/M visit for a progress report as well as for a final visit.

At the baseline visit, middle or fifth visit, and on the final visit a 2-item GCPS (Graded Chronic Pain Scale) and an Oswestry Disability Index (ODI) form must be completed with the worker and sent to the insurer.

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

Link: For details about payment criteria and documentation requirements for E/M services, see the payment policies in Chapter 10: Evaluation and Management.

Payment policy: Naturopathic office visits

Who must perform these services to qualify for payment

Naturopathic physicians must perform these services to qualify for payment.

Services that can be billed

For initial office visits (i.e. **new patient**), these local codes can be billed:

- **2130A** (**Routine** face-to-face **office visit** and submission of a report),
- **2131A** (**Extended** face-to-face **office visit** and submission of a report), and
- **2132A** (**Comprehensive** face-to-face **office visit** and submission of a report [in addition to the report of accident]).

For follow up office visits (i.e. **established patient**), these local codes can be billed:

- **2133A** (**Routine** face-to-face **office visit** and submission of a report), *and*
- **2134A** (**Extended** face-to-face **office visit** and submission of a report).

Services that aren't covered

Treatment of chronic migraine or chronic tension-type headache with manipulation/manual therapy is not a covered benefit.

The insurer won't pay naturopathic physicians for services that aren't specifically allowed, including consultations.

Link: For additional information, see WAC 296-23-205 and WAC 296-23-215.

Requirements for billing

When billing for services, naturopathic physicians should use:

- The local codes **2130A-2134A** to bill for office visit services including treatment,
- The CPT® **99080** and local codes appropriate for attending providers,
- Case management service codes including CPT® codes **99367** and **99441-99443**, and local code **9918M** to bill for secure online communication with L&I staff, vocational rehabilitation counselors, TPAs, or employers,
- The appropriate CPT® codes to bill for x-rays and other diagnostic services, and
- The appropriate HCPCS codes to bill for miscellaneous materials and supplies.

Link: For details about payment criteria and documentation requirements for case management services or secure online communication, see the payment policies in Chapter 10: Evaluation and Management.

Payment limits

Only one naturopathic care visit per day per worker is payable.

Note: For details about splitting bills between multiple claims, see Chapter 10: Evaluation and Management.

Payment policy: Telehealth for naturopathic physicians

General information

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

Objective medical findings are required for time loss and other claim adjudication requirements. 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 two-way audio and visual connection.

The provider is expected to make arrangements for in-person evaluation and interventions for certain circumstances. See below for additional information.

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

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

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

The provider performing **telehealth** services must be licensed in the state where the worker is receiving **telehealth** services. Only vocational rehabilitation counselors are exempt from this requirement.

Services that must be performed in person

In-person services are required when:

- It is the first visit of the claim, *or*
- Restrictions or changes are anticipated (the APF requires an update), *or*
- The worker has an emergent issue such as re-injury, new injury, or worsening status, *or*
- Consultations requested to determine if conservative care is appropriate, *or*
- A worker files a reopening application, *or*
- A worker requests a transfer of attending provider, *or*

- The provider has determined the worker is not a candidate for **telehealth** either generally or for a specific service, *or*
- The worker does not want to participate via **telehealth**, *or*
- When the service to be performed requires a hands-on component.

System requirements

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

Services that are covered

When the treatment of the day doesn't require a hands-on component, naturopaths may bill local codes (**2133A-2134A**) when performed via **telehealth**.

Originating Site Fee (Q3014)

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

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

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

Q3014 billing example

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

How to bill for this scenario

For this telehealth visit:

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

Services that aren't covered

Any service that includes a hands-on component isn't covered under this policy, including acupuncture.

The same services that aren't covered for office visits also apply to this policy.

G2010 and **G2250** aren't covered.

Telephonic visits don't replace video two-way communication and can't be billed using non-telephonic E/M services codes. See Chapter 10: Evaluation and Management (E/M) Services.

Telehealth procedures

Telehealth procedures and services that aren't covered include:

- Initial office visits (**2130A**-**2132A**) aren't covered when performed via **telehealth**. These services require an in-person visit.
- The services listed under "Services that must be performed in-person",
- Hands-on services, including acupuncture,
- Completion and filing of any form that requires a hands-on physical examination (e.g. Report of Accident, Provider's Initial Report),
- Purchase, rental, installation, or maintenance of telecommunication equipment or systems,
- Home health monitoring, *and*

- Telehealth transmission, per minute (HCPCS code **T1014**).

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.

Telehealth locations

Q3014 isn't covered when:

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

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

Requirements for billing

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

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

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

Documentation requirements

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

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

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

Chart notes must contain documentation that justifies the level, type and extent of services billed. See this chapter and other applicable MARFS chapter(s) for the type of service rendered and the documentation requirements.

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

Payment limits

The same payment limits noted for office visits apply regardless of whether the service is rendered in person or via telehealth.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for naturopathic physicians	Washington Administrative Code (WAC) 296-23-205 WAC 296-23-215
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare services	Fee schedules on L&I's website
Payment Policies for **Evaluation and Management**	Chapter 10: Evaluation and Management

Need more help?

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