Washington State Department of
Labor & Industries

Chapter 12: Injections and Medication Administration

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

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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Payment policy: Acupuncture services

General information

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

The insurer only covers acupuncture for open and allowed claims with an accepted diagnosis of:

- A low back condition, *and/or*
- Chronic migraine as defined by the International Headache Society.

For the purposes of this policy, a treatment cycle is defined as a repeatable course of care consisting of a period of treatment followed by a period of rest (no treatment), the duration of which is defined by the acupuncture provider.

Who must perform these services to qualify for payment

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

Prior authorization

For chronic migraine

Prior authorization from the insurer and a referral from the **attending provider** are required for each treatment cycle.

The acupuncture provider must include the requested number of visits for the current treatment cycle in their authorization request. The number of visits for a single treatment cycle can’t exceed 24.

For low back

Prior authorization to perform acupuncture for low back is not required. A referral from the **attending provider** is required before starting treatment.

Services that can be billed

Code	Description	Payment Limits
99202-99215	**Evaluation and Management (E/M) service** for: • Initial evaluations, *or* • Follow up evaluations, *or* • Discharge visits.	See Chapter 9: Evaluation and Management Services for more information.
1581M	**Acupuncture treatment** with one or more needles, with or without electrical stimulation, for chronic migraine. Prior authorization is required for each treatment cycle.	**Maximum of 1 unit per day, per worker.** **Initial treatment cycle of up to 24 treatments, which must be completed within 12 months or less.** One additional treatment cycle of up to 24 visits may be considered with a new referral and prior authorization. There is no waiting period required between treatment cycles. **Maximum 48 units** per claim.
1582M	**Acupuncture treatment** with one or more needles, with or without electrical stimulation, for low back.	**Maximum of 1 unit per day, per worker.** **Maximum of 10 units** per claim.

Link: For more information on conditions of coverage, see WAC 296-23-238, L&I's coverage decisions Acupuncture for lumbar conditions and Acupuncture for chronic migraine and chronic tension-type headache.

Documentation requirements

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

Initial and follow up evaluations must meet the documentation requirements in Chapter 9: Evaluation and Management (E/M) Services.

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

Services that aren’t covered

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

L&I will not authorize or pay for acupuncture treatment not related to low back conditions or chronic migraine.

Acupuncture isn’t covered for chronic tension-type headaches or chronic daily headache. See L&I’s coverage decision for details.

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

Payment policy: Anesthesia services

Who must perform these services to qualify for payment

Payment for anesthesia services will only be made to:

- Anesthesiologists, *and*
- Certified registered nurse anesthetists (CRNA).

Services that can be billed

Most anesthesia services are paid with base and time units. These services must be billed with CPT® anesthesia codes **00100** through **01999** and the appropriate anesthesia modifier.

Other services commonly performed, such as evaluation and management (E/M) services, most pain management services, and other selected services, are paid based on maximum provider fee schedule. These services must be billed with the appropriate CPT® code for the service performed.

An E/M service is payable on the same day as a pain management procedure only when:

- The E/M service is significantly, separately identifiable from the pain management procedure performed on the same day, *and*
- Meets the criteria for modifier **–25**.

The use of E/M CPT® codes on the days before and after the procedure is performed are subject to the global surgery package policy.

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

For more information on what is included in the global surgery package, see Chapter 23: Surgery.

Maximum fees for services paid by provider fee schedule are located in the Professional Services Fee Schedule.

Services that aren’t covered

Anesthesia isn’t payable for procedures that aren’t covered.

The insurer doesn’t cover anesthesia assistant services.

Payment for CPT® codes **99100**, **99116**, **99135**, and **99140** is considered **bundled** and isn’t payable separately.

CPT® physical status modifiers (**–P1** to **–P6**) aren't recognized by the insurer. Services billed with these modifiers will be denied.

Requirements for billing

Anesthesia billing code modifiers for anesthesia paid with base and time units

When billing for anesthesia services paid with base and time units, anesthesiologists and CRNAs must use the appropriate anesthesia modifiers (**–AA**, **–QK**, **–QX**, **–QY**, and **–QZ**).

Anesthesia modifiers aren't valid for services paid based on maximum provider fee schedule.

Link: For more information on anesthesia modifiers, see Appendix B: Modifiers.

Anesthesia add-on codes

Anesthesia add-on codes must be billed with a primary anesthesia code. There are 3 anesthesia add-on CPT® codes: **01953**, **01968**, and **01969**:

- Add-on code **01953** should be billed with primary code **01952**,
- Add-on codes **01968** and **01969** should be billed with primary code **01967**,
- Add-on codes **01968** and **01969** should be billed in the same manner as other anesthesia codes paid with base and time units.

Note: Providers should report the total time for the add-on procedure (in minutes) in the Units column (Field 24G) of the **CMS 1500** form (F245-127-000).

Anesthesia for burn excisions or debridement (CPT® add-on code 01953)

The anesthesia add-on code for burn excision or debridement must be billed as follows:

If the total body surface area is…	Then the primary code to bill is:	And the units to bill of add-on CPT® code **01953** is:
Less than 4 percent	**01951**	None
4 - 9 percent	**01952**	None
Up to 18 percent	**01952**	1
Up to 27 percent	**01952**	2
Up to 36 percent	**01952**	3
Up to 45 percent	**01952**	4

If the total body surface area is…	Then the primary code to bill is:	And the units to bill of add-on CPT® code **01953** is:
Up to 54 percent	**01952**	5
Up to 63 percent	**01952**	6
Up to 72 percent	**01952**	7
Up to 81 percent	**01952**	8
Up to 90 percent	**01952**	9
Up to 99 percent	**01952**	10

Anesthesia base units

List only the time in minutes on your bill. Don't include the base units (L&I's payment system automatically adds the base units).

Link: The anesthesia codes, base units, and base sources are listed in the Professional Services Fee Schedule.

Anesthesia time

Anesthesia must be billed in 1-minute time units. Anesthesia time:

- **Begins** when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent), and
- **Ends** when the anesthesiologist or CRNA is no longer in constant attendance (when the patient can be safely placed under postoperative supervision).

Payment limits

Payment for local, regional or digital block, or general anesthesia administered by the surgeon is included in the maximum fee schedule amount for the procedure.

Patient acuity doesn't affect payment levels.

Services billed with modifier **–47** (anesthesia by surgeon) are considered **bundled** and aren't payable separately.

The insurer doesn't recognize physical status modifiers (**–P1** through **–P6**). Services billed with these modifiers will be denied.

Anesthesia modifiers aren't valid for services paid based on maximum provider fee schedule.

Links: For licensed nursing rules, see WAC 296-23-240.

For licensed nursing billing instructions, see WAC 296-23-245.

Anesthesia teaching physicians

Teaching physicians may be paid at the personally performed rate when the physician is involved in the training of physician residents in:

- A single anesthesia case, *or*
- 2 concurrent anesthesia cases involving residents, *or*
- A single anesthesia case involving a resident that is concurrent to another case paid under the Team care (medical direction) policy.

CRNA payment limits

CRNA services shouldn't be reported on the same **CMS-1500** form used to report anesthesiologist services.

Bills from CRNAs that don't contain a modifier are paid based on payment policies for team services. See the Team care (medical direction of anesthesia) supplemental anesthesia policy in this chapter.

Supplemental policy: How to calculate anesthesia payment paid with base and time units

Providers are paid the lesser of their charged amount or L&I's maximum allowed amount.

For services provided on or after July 1, 2025 the anesthesia conversion factor is **$58.65** per 15 minutes (**$3.91** per minute).

The maximum payment for anesthesia services paid with base and time units is calculated using the:

- Base value for the procedure, *and*
- Time the anesthesia service is administered, *and*
- L&I anesthesia conversion factor.

To determine the maximum payment for physician services:

1. Multiply the base units listed in the fee schedule by 15, *then*
2. Add the value from step 1 to the total number of whole minutes, *then*
3. Multiply the result from step 2 by **$3.91**

Example

CPT® code **01382** (anesthesia for knee arthroscopy) has 3 anesthesia base units. If the anesthesia service takes 60 minutes, the maximum physician payment would be calculated as follows:

1. 3 base units x 15 = 45 base units,
2. 45 base units + 60 time units (minutes) = 105 base and time units,
3. Maximum payment for physicians = 105 x **$3.91** = **$410.55**.

Link: The anesthesia conversion factor is published in WAC 296-20-135.

For more information on how to calculate the payment for team care, see the Team care (medical direction of anesthesia) supplemental anesthesia policy in this chapter.

Supplemental policy: Team care (medical direction of anesthesia)

Requirements for medical direction of anesthesia

Physicians directing qualified individuals performing anesthesia must:

- Perform a pre-anesthetic examination and evaluation, *and*
- Prescribe the anesthesia plan, *and*
- Participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence, *and*
- Make sure any procedures in the anesthesia plan that he/she doesn't perform are performed by a qualified individual as defined in program operating instructions, *and*
- Monitor the course of anesthesia administration at frequent intervals, *and*
- Remain physically present and available for immediate diagnosis and treatment of emergencies, *and*
- Provide indicated post anesthesia care.

Direction limitations

Physicians directing anesthesia:

- May direct no more than 4 anesthesia services concurrently, *and*
- May not perform any other services while directing the single or concurrent services.

The physician may attend to medical emergencies and perform other limited services as allowed by Medicare instructions and still be deemed to have medically directed anesthesia procedures.

Note: L&I follows CMS's policy for team care (medical direction of anesthesia).

Documentation requirements

The physician must document in the patient's medical record that the medical direction requirements were met.

Requirements for billing

When billing for team care situations:

- Anesthesiologists and CRNAs must report their services on separate CMS-1500 forms using their own provider account numbers,
- Anesthesiologists must use the appropriate modifier for medical direction or supervision (**–QK** or **–QY**),
- CRNAs should use modifier **–QX**.

Team care payment calculation

To determine the maximum payment for team care services:

- Calculate the maximum payment for solo physician services (see How to calculate anesthesia payment paid with base and time units),
- The maximum payment to the physician is 50% of the maximum payment for solo physician services,
- The maximum payment to the CRNA is 50% of the maximum payment for solo physician services.

Payment policy: Botulinum toxin (BTX)

Prior authorization

Botulinum toxins are payable when authorized.

Coverage of Onabotulinumtoxin A for treatment of chronic migraine is exempt from the 2-course limit based on an HTCC coverage determination. A maximum of 5 courses may be authorized.

Link: Prior authorization criteria and L&I's coverage decision information is available online.

Requirements for billing

Billing codes

Refer to the fee schedule for current fees.

If the **injection** is…	Then the appropriate **HCPCS billing code** is:
Onabotulinumtoxin A, 1 unit (Botox® or Botox Cosmetic®)	**J0585**
Abobotulinumtoxin A, 5 units (Dysport®)	**J0586**
Rimabotulinumtoxin B, 100 units (Myobloc®)	**J0587**
Incobotulinumtoxin A, 1 unit (Xeomin®)	**J0588**

Services that aren't covered

The insurer won't authorize payment for BTX injections for off label indications.

Onabotulinumtoxin A for the treatment of chronic tension-type headache isn't a covered benefit.

Payment policy: Compound drugs

Prior authorization

All compounded drug products require prior authorization. Failure to seek authorization before compounding will risk nonpayment of compounded products.

Compounded drug products include, but aren't limited to:

- Antibiotics for intravenous therapy,
- Pain cocktails for opioid weaning, *and*
- Topical preparations containing multiple active ingredients or any non-commercially available preparations.

Link: For more information, see the L&I coverage decision on compound drugs.

Services that aren't covered

Compounded topical preparations containing multiple active ingredients aren't covered. There are many commercially available, FDA approved alternatives, on the Outpatient Drug Formulary such as:

- Oral generic nonsteroidal anti-inflammatory drugs,
- Muscle relaxants,
- Tricyclic antidepressants,
- Gabapentin, *and*
- Topical salicylate and capsaicin creams.

Requirements for billing

Compounded drug products must be billed by pharmacy providers on the Statement for Compound Prescription with national drug code (NDCs or UPCs if no NDC is available) for each ingredient.

Payment limits

No separate payment will be made for **99070** (Supplies and materials).

Payment policy: Immunizations

Prior authorization

Immunization materials are payable when authorized.

Services that can be billed

CPT® codes **90471** and **90472** are payable, in addition to the immunization materials code(s).

For each additional immunization given, add-on CPT® code **90472** may be billed.

Payment limits

E/M codes aren't payable in addition to the immunization administration service, **unless** the E/M service is:

- Performed for a separately identifiable purpose, *and*
- Billed with a modifier **–25**.

Link: For more information on post exposure prophylaxis and testing (PEP) for bloodborne pathogens and infectious diseases, see L&I's coverage decision for bloodborne pathogens, and WAC 296-20-03005.

For PEP HIV drugs dispensed at a hospital facility, see Chapter 25: Hospitals and Ambulatory Surgical Centers (ASCs).

For PEP HIV drugs dispensed through a pharmacy, see Chapter 19: Pharmacy.

Payment policy: Immunotherapy

Services that aren't covered

Complete service codes aren’t paid.

Requirements for billing

Professional services for the supervision and provision of antigens for allergen immunotherapy must be billed as component services. The provider bills:

- 1 of the injection codes, *and*
- 1 of the antigen/antigen preparation codes.

Payment policy: Infusion therapy services and supplies

Home infusion services provide drug administration, parenteral hydration, and parenteral feeding to a worker in the home, along with nursing services. Home infusion services can be authorized independently or in conjunction with home health services.

The insurer will only pay for proper and necessary services required to address conditions caused by the industrial injury or disease.

Prior authorization

Regardless of who performs the service, prior authorization is required for any scheduled or ongoing infusion therapy services (including supplies) performed in the office, clinic, or home.

Home infusion skilled nurse services will only be authorized when infusion therapy is approved as treatment for the worker's allowed industrial condition. Home infusion services can be authorized independently or in conjunction with home health services.

Regardless of who is providing services, prior authorization is required for:

- Home infusion nurse services, *and*
- Drugs, *and*
- Any infusion supplies.

Note: An exception is **outpatient services**, which are allowed without prior authorization when medically necessary to treat urgent or emergent care situations that arise in an office or clinic. See Services that can be billed.

Services that can be billed

With prior authorization, the insurer may cover:

- Implantable infusion pumps and supplies,
- The implantation of epidural or intrathecal catheters, including their revision, repositioning, replacement, or removal, *and*
- Anti-spasticity medications by any indicated route of administration when spinal cord injury is an accepted condition (for example, some benzodiazepines, baclofen).

Urgent and emergent outpatient services

Outpatient services are allowed when medically necessary to treat urgent or emergent care situations that arise in an office or clinic. The following CPT® codes are payable to physicians, ARNPs, and PAs:

- **96360**,
- **96361**, *and*
- **96365-96368**.

Equipment and supplies

Implantable infusion pumps and supplies that may be covered with prior authorization include these HCPCS codes:

- **A4220**,
- **E0782-E0783**, *and*
- **E0785-E0786**.

Placement of non-implantable epidural or subarachnoid catheters for single or continuous injection of medications is covered.

Home infusion nurse services

Skilled nurses contracted by the home infusion service provide infusion therapy, as well as:

- Education of the worker and family,
- Evaluation and management of the infusion therapy, *and*
- Care for the infusion site.

The following CPT® codes are payable:

- **99601-99602**

Services that aren't covered

Intrathecal and epidural infusions of any substance other than anesthetic or contrast material aren't covered with the following exceptions for accepted conditions:

- To treat pain caused by cancer or other end-stage diseases, *or*
- To administer anti-spasticity drugs when spinal cord injury is an accepted condition.

Link: For more information, see WAC 296-20-03002.

Requirements for billing

Equipment and supplies

Durable medical equipment (DME) providers may bill for equipment and supplies required to provide authorized IV infusion therapy under their L&I **DME** provider account numbers.

If rental or purchase of an infusion pump is medically necessary to treat a patient in the home, the rental or purchase of infusion pumps must be billed with the appropriate HCPCS codes.

Drugs

Drugs for outpatient use, including infusion therapy drugs, must be billed by pharmacy providers, either electronically through the point-of-service (POS) system or on appropriate pharmacy forms (Statement for Pharmacy Services, Statement for Compound Prescription or Statement for Miscellaneous Services) with national drug codes (NDCs or UPCs if no NDC is available).

Note: Total parenteral and enteral nutrition products may be billed by home health providers using the appropriate HCPCS codes.

Payment limits

E/M office visits

Providers will only be paid for E/M office visits in conjunction with infusion therapy if the services provided meet the code definitions.

Opiates

Infusion of any opiates and their derivatives (natural, synthetic or semisynthetic) aren't covered **unless** they are:

- Part of providing anesthesia, *or*
- Short term postoperative pain management (up to 48 hours post discharge), *or*
- Medically necessary in emergency situations.

Link: For more information, see WAC 296-20-03014.

Equipment and supplies

Infusion therapy supplies and related **DME**, such as infusion pumps, aren't separately payable for **RBRVS** providers. Payment for these items is **bundled** into the fee for the professional service.

Diagnostic injections

Intravenous or intra-arterial therapeutic or diagnostic injection codes, CPT® codes **96373** and **96374**, won't be paid separately in conjunction with the IV infusion codes.

Payment policy: Injectable medications

Requirements for billing

Providers must use the HCPCS J codes for injectable drugs that are administered during an E/M office visit or other procedure. The HCPCS J codes aren't intended for self-administered medications.

When billing for a nonspecific injectable drug, the following must be noted on the bill and documented in the medical record:

- Name,
- NDC,
- Strength,
- Dosage, *and*
- Quantity of drug administered.

Although L&I's maximum fees for injectable medications are based on a percentage of AWP and the drug strengths listed in the HCPCS manual, **providers must bill their acquisition cost for the drugs**. To get the total billable units, divide the:

- Total strength of the injected drug, *by*
- The strength listed in the manual.

For example:

- You administer a 100 mg injection.
- The HCPCS manual lists the strength as 10 mg.
- Your billable units are 100 mg (administered) divided by 10 mg (strength) = 10 units.

Payment limits

Payment is made according to the published fee schedule amount, or the **acquisition cost** for the covered drug(s), whichever is less.

Payment policy: Medical foods and co-packs

Services that aren't covered

Medical food products and their convenience packs or "co-packs" aren't covered.

Examples of medical food products include:

- Deplin® (L-methylfolate), *and*
- Theramine® (arginine, glutamine, 5-hydroxytryptophan, and choline).

Examples of "co-packs" include:

- Theraproxen® (Theramine and naproxen), *and*
- Gaboxetine® (Gabadone and fluoxetine).

Link: For more information, see L&I's coverage decision on medical foods and co-packs.

Payment limits

Medical foods and co-packs administered or dispensed during office procedures are considered **bundled** in the office visit.

No separate payment will be made for **99070** (Supplies and materials), which is a **bundled** code.

Payment policy: Non-injectable medications

Services that can be billed

Providers may use distinct HCPCS J codes that describe specific non-injectable medication administered during office procedures. Separate payment will be made for medications with distinct J codes. The HCPCS J codes aren't intended for self-administered medications.

Services that aren't covered

No payment will be made for pharmaceutical samples or repackaged drugs.

Requirements for billing

Providers must bill their acquisition cost for these drugs.

The name, NDC, strength, dosage, and quantity of the drug administered must be documented in the medical record and noted on the bill.

Link: For more information, see the payment policy for **acquisition cost** in Chapter 7: Durable Medical Equipment (DME) and Supplies.

Payment limits

Miscellaneous oral or non-injectable medications administered or dispensed during office procedures are considered **bundled** in the office visit. No separate payment will be made for these medications:

- **A9150** (Nonprescription drug), *or*
- **J3535** (Metered dose inhaler drug), *or*
- **J7599** (Immunosuppressive drug, NOS), *or*
- **J7699** (Noninhalation drug for **DME**), *or*
- **J8498** (Antiemetic drug, rectal/suppository, NOS), *or*
- **J8499** (Oral prescription drug non-chemo), *or*
- **J8597** (Antiemetic drug, oral, NOS), *or*
- **J8999** (Oral prescription drug chemo).

Payment policy: Spinal injections

Prior authorization

Prior authorization, including utilization review, is required for spinal injections.

Services that can be billed

Some spinal injections are covered for accepted conditions when certain criteria is met. For more information, see L&I's coverage decision.

Per L&I's coverage decision, therapeutic or diagnostic sacroiliac joint injections are covered services when all the following criteria are met:

1. Patient has an allowed condition that includes sacroiliac joint pain.
2. Failure of at least 6 weeks of conservative therapy.
3. Fluoroscopic or CT guidance is used.
4. No more than one injection without clinically meaningful improvement, as documented by a validated scale. Additional injections require clinical review.

Payment methods

Physician or CRNA/ARNP

The payment methods for physician or CRNA/ARNP are:

- Injection procedure: **–26** component of Professional Services Fee Schedule, *and*
- Radiology procedure: **–26** component of Professional Services Fee Schedule

A separate payment for the injection **won't be made** when computed tomography (CT) is used for imaging, unless documentation demonstrating medical necessity is provided.

Radiology facility payment methods

The payment methods for radiology facilities are:

- Injection procedure: No facility payment, *and*
- Radiology procedure: **–TC** component of Professional Services Fee Schedule.

Hospital payment methods

The payment methods for hospitals are:

- Injection procedure: APC or POAC (payment method depends on the payer and/or the hospital's classification), *and*
- Radiology procedure: APC, POAC or **–TC** component of Professional Services Fee Schedule. Radiology codes may be packaged with the injection procedure.

Note: See Therapeutic or diagnostic injections for additional details regarding spinal injections (SI) or SI joint requirements.

Payment policy: Therapeutic or diagnostic injections

Prior authorization

These services require prior authorization:

- Trigger point injections and dry needling (refer to guideline for limits), and
- Sympathetic nerve blocks (refer to the CRPS guideline).

Links: See L&I's coverage decision for more information on trigger point and dry needling injections and L&I's CRPS guidelines for more information on sympathetic nerve blocks.

Required along with utilization review

These services require both prior authorization and utilization review:

- Therapeutic epidural and spinal injections for chronic pain,
- Therapeutic sacroiliac joint injections for chronic pain, *and*
- Diagnostic facet and medial branch block injections (refer to neurotomy guideline).

Links: See L&I's coverage decision and guidelines on spinal injections, L&I's neurotomy guidelines, and L&I's coverage decision on discography.

Services that can be billed

These services can be billed without prior authorization:

- E/M office visit services provided on the same day as an injection may be payable if the services are separately identifiable and meet the definition of and are billed with modifier **–25**,
- Professional services associated with therapeutic or diagnostic injections (CPT® code **96372**) are payable along with the appropriate HCPCS J code for the drug,
- Intra-arterial and intravenous diagnostic and therapeutic injection services (CPT® codes **96373** and **96374**) may be billed separately and are payable if they aren't provided in conjunction with IV infusion therapy services (CPT® codes **96360**, **96361**, **96365**-**96368**), *and*
- Spinal injections that don't require fluoroscopy or CT guidance:
    - CPT® code **62270** – diagnostic lumbar puncture,
    - CPT® code **62272** – therapeutic spinal puncture for drainage of CSF, and
    - CPT® code **62273** – epidural injection of blood or clot patch.

Services that aren't covered

If billed with an E/M service, providers will be paid only the injection and the appropriate HCPCS J code for the drug, unless the E/M meets the requirements to append modifier **–25**. CPT® code **99211** won't be paid separately.

Effective March 1, 2024, hyaluronic acid injections are not covered for osteoarthritis of the knee.

Perineural Injection Therapy (PIT), also known as sclerotherapy, neurofascial, subcutaneous or neural prolotherapy, are considered forms of prolotherapy. L&I does not cover any form of prolotherapy per WAC 296-20-03002. Providers may not bill or be paid for PIT. These procedures should not be confused with peripheral nerve blocks (CPT® code **64450**), which are allowed for regional anesthesia and acute pain management.

The insurer doesn't cover:

- Therapeutic medial branch nerve block injections, *or*
- Therapeutic or diagnostic intradiscal injections, *or*
- Therapeutic facet injections, *or*
- Diagnostic sacroiliac joint injections, *or*
- Therapeutic genicular nerve blocks for chronic knee pain, *or*
- Perineural injection therapy.

Links: For more information on:

- Hyaluronic acid injections, see L&I's coverage decision.
- Perinural Injection Therapy (PIT), see L&I's coverage decision.
- Therapeutic genicular nerve block for treating chronic knee pain, see L&I's coverage decision.
- Spinal injections, see L&I's coverage decision.

For information regarding use of modifier **–25**, see Chapter 9: Evaluation and Management (E/M).

Requirements for billing

Dry needling

Dry needling is considered a variant of trigger point injections. It is a technique where needles are inserted directly into trigger point locations without medications injected. Dry needling follows the same rules as trigger point injections in WAC 296-20-03001(7)(d).

Dry needling of trigger points must be billed using CPT® codes **20560** and **20561**. Dry needling isn't considered acupuncture and can't be billed using acupuncture local codes.

Effective January 1, 2025, Physical Therapists (PTs) with intramuscular needing endorsement may bill for dry needling.

Spinal injections that require fluoroscopy

For spinal injection procedures that require fluoroscopy:

- 1 fluoroscopy code must be billed along with the underlying procedure code or the bill for the underlying procedure will be denied, *and*
- Only 1 fluoroscopy code may be billed for each injection (see table below).

Only 1 of these **CPT® fluoroscopy codes** may be billed for each injection…	…and it must be billed along with this underlying **CPT® code**:
77002, **77012**, **76942**	**62268**
77002, **77012**, **76942**	**62269**
77003	**62281**
77003	**62282**
77003, **77012**, **76942**, **72240**, **72255**, **72265**, **72270**	**62284**
72295	**62290**
72285	**62291**
72295	**62292**
77002, **77003**, **77012**, **75705**	**62294**
77003	**62320**
77003	**62322**

Only 1 of these **CPT® fluoroscopy codes** may be billed for each injection…	…and it must be billed along with this underlying **CPT® code**:
77003	**62324**
77003	**62326**

Spinal injection procedures that include fluoroscopy, ultrasound, or CT in the code description

Paravertebral facet joint injections now include fluoroscopic, ultrasound, or CT guidance as part of the description. This includes these CPT® codes:

- **64479-64480**, *and*
- **64483-64484**, *and*
- **64490-64495**.

Fluoroscopic, ultrasound, or CT guidance can't be billed separately.

Links to related topics

If you're looking for more information about…	Then see…
Acupuncture	WAC 296-20-03002(2) Acupuncture guidelines on L&I's website
Administrative rules for acupuncture services non-coverage	Washington Administrative Code (WAC) 296-20-03002(2)
Administrative rules for anesthesia	WAC 296-20
Administrative rules for drug limitations (such as opiates)	WAC 296-20-03014
Administrative rules for licensed nursing	WAC 296-23-240
Administrative rules for licensed nursing billing instructions	WAC 296-23-245
Administrative rules for pharmacy services	WAC 296-20-01002 WAC 296-20-17004 WAC 296-20-03014(6) WAC 296-20-1102 WAC 296-20-02005
Administrative rules for treatment authorization (including prolotherapy)	WAC 296-20-03002
Administrative rules for treatment guidelines for injections	WAC 296-20-03001(7)

If you're looking for more information about…	Then see…
Administrative rules for work related exposure to an infectious disease	WAC 296-20-03005
Anesthesia **conversion factor**	WAC 296-20-135
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Bloodborne pathogens	Bloodborne pathogens guidelines
Botulinum toxin (BTX) injections	Botulinum toxin coverage decision
Complex Regional Pain Syndrome (CRPS) guidelines	Complex Regional Pain Syndrome guidelines
Compound drugs coverage decision	Compound drugs coverage decision
Discography guidelines	Discography guidelines
Drug coverage policies	Drug coverage policies on L&I's website
Dry needling and trigger point injections coverage decision	Dry needling and trigger point injections coverage decision
Hyaluronic acid injections	Hyaluronic acid injections coverage decision
Medical foods and co-packs coverage decision	Medical foods and co-packs coverage decision

If you're looking for more information about…	Then see…
NCPDP payer sheet current version	NCPDP payer sheet
Neurotomy guidelines	Neurotomy guidelines
Opioid Policy	L&I's opioid policy
Outpatient formulary	Outpatient formulary
Payment policies for **acquisition cost policy**	Chapter 7: Durable Medical Equipment (DME)
Payment policies for **global surgery**	Chapter 23: Surgery Services
Payment policies for using **billing code modifier –25**	Chapter 9: Evaluation and Management (E/M) Services
PDL	Drug Formulary Endorsing PDL: Online registration through the Health Care Authority, WA State Endorsing Practitioner Customer Service 1-877-255-4637 Hotline: Open Monday through Friday, 8:00 am to 5:00 pm (Pacific Time) 1-888-443-6798
Professional Services **Fee Schedules**	Fee schedules on L&I's website
Spinal injections coverage decision and guidelines	Spinal injections coverage decision
Therapeutic Interchange Program exception criteria	Therapeutic Interchange Program

If you're looking for more information about…	Then see…
Third Party Pharmacy Supplemental Agreements	Third party pharmacy supplemental agreement form

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 am and 12 pm PT Monday through Friday.

