Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 7: Chiropractic Services

Effective July 1, 2022

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

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Definitions

The following terms are utilized in this chapter and are defined as follows:

Body regions: One of the factors contributing to clinical decision-making complexity for chiropractic care visits. Body regions include:

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

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

Clinical decision-making complexity: The primary component influencing the level of care for a chiropractic care visit. Clinical complexity is similar to established patient evaluation and management services, but emphasizes factors typically addressed with treating workers. Factors that contribute to clinical decision-making complexity for injured workers include:

- The current occupational condition(s),
- Employment and workplace factors,
- Non-occupational conditions that may complicate care of occupational condition,
- Care planning and patient management,
- Chiropractic intervention(s) provided,
- Number of **body regions** involved, *and*
- Response to care.

The number of **body regions** being adjusted is only one of the factors that may contribute to visit complexity, but should be weighted less heavily than other components.

L&I defines clinical decision-making complexity according to the definitions for medical decision-making complexity in the Evaluation and Management Services Guidelines section of the CPT® book.

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Complementary and preparatory services: Interventions used to prepare a body region for or facilitate a response to a chiropractic manipulation/adjustment. For example, the application of heat or cold is considered a complementary and preparatory service.

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.

New patient: One who hasn't received any 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® 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.

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.

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Modifiers

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

–22 (Increased Procedural Services)

Procedures with this modifier will be individually reviewed prior to payment. A report is required for this review and it must include justification for the use of the modifier explaining increased complexity required for proper treatment. Payment varies based on the report submitted.

–25 (Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure)

Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

-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.

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Payment policy: Chiropractic care visits

Prior authorization

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

- More than 20 office visits, *or*
- Visits that occur more than 60 days after the first date you treat the worker (see WAC 296-20-03001(1)).

Services that can be billed

Local codes **2050A**, **2051A**, and **2052A** account for both professional management (clinical complexity) and technical service (manipulation and adjustment). There are three levels of **chiropractic care visits**:

The primary component is clinical decision-making. If it is…	OR the **number of body regions** adjusted or manipulated is…	and typical **face-to-face time** with patient or family is…	Then the **appropriate billing code** and maximum fee is…
Straightforward	Up to 2	Up to 15 minutes	**2050A** (Level 1) **$48.38**
Low complexity	Up to 3 or 4	15-25 minutes	**2051A** (Level 2) **$61.98**
Moderate complexity	Up to 5 or more	Over 25 minutes	**2052A** (Level 3) **$75.52**

Re-evaluations

Depending on the amount of clinical complexity and services rendered, an E/M code may better capture the level of service performed during a re-evaluation.

If a re-evaluation of a patient meets the CPT® criteria for **established patient** E/M, the provider may bill the appropriate E/M code instead of a chiropractic care local code (**2050A**, **2051A**, or **2052A**). See the Chiropractic evaluation and management (E/M) services payment policy for additional details.

Services that aren't covered

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

Instead of using CMT codes, L&I collaborated with the Washington State Chiropractic Association and the University of Washington to develop local codes that can be billed for **chiropractic care visits** (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 coverage decision for Chronic Migraine or Chronic Tension-type Headache is available online.

Requirements for billing

When billing modifier **–22** with **chiropractic care visit** local codes (**2050A**-**2052A**), submit a report detailing the nature of the unusual service or increased complexity of the service provided and the reason it was required. The report will be reviewed individually, and payment will vary based on the review findings.

Payment limits

Only one **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**).

Modifier **–22** isn't payable when used for non-covered or bundled services (for example, application of hot or cold packs).

Providers may not bill an **established patient** E/M code and a chiropractic care local code (**2050A**, **2051A**, or **2052A**) for the same date of service.

Examples of chiropractic care levels of complexity

These examples are for illustration only and aren't clinically prescriptive:

Level 1:	**Straightforward clinical decision-making** (billing code **2050A**)
Patient	26 year old male.
Cause of injury	Lifted a box at work.
Symptoms	Mild, low back pain for several days.
Treatment	Manipulation or adjustment of the lumbar region, anterior thoracic mobilization, and lower cervical adjustment.

Level 2:	**Low complexity clinical decision-making** (billing code **2051A**)
Patient	55 year old male, follow-up visit.
Cause of injury	Slipped and fell on stairs while carrying heavy object at work.
Symptoms	Ongoing complaints of neck and low back pain. New sensation of periodic tingling in right foot. Two days off work.
Treatment	Discuss need to minimize lifting and getting assistance when carrying heavier objects. Five minutes of myofascial release prior to adjustment of the cervical, thoracic, and lumbar regions.

Level 3:	**Moderate complexity clinical decision-making** (billing code **2052A**)
Patient	38 year old female, follow-up visit.
Cause of injury	Moved heavy archive boxes at work over the course of three days.
Symptoms	Low back pain with pain at the sacrococcygeal junction, pain in the sacroiliac regions, and right-sided foot drop. Obesity and borderline diabetes. Tried light-duty work last week, but unable to sit for very long, went home. Tried prescribed stretching from last visit, but worker couldn't continue and didn't stretch because of pain.
Treatment	Review MRI report with the worker. Discussed obesity and diabetes impact on recovery, 10 minutes. 10 minutes of moist heat application, 10 minutes of myofascial work, and manipulation/ adjustment to the lumbar, sacroiliac, and sacrococcygeal regions.

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Payment policy: Chiropractic evaluation and management (E/M) services

Prior authorization

Prior authorization is required when billing for:

- More than 20 office visits, *or*
- Visits that occur more than 60 days after the first date you treat the worker (see WAC 296-20-03001(1)).

Services that can be billed

Case management services

Codes and billing instructions for case management services telephone calls, team conferences, and secure email can be found in the Case management services section of: Chapter 10: Evaluation and Management. These codes may be paid in addition to other services performed on the same day.

Office visits

Chiropractic physicians may bill all levels of office visit codes for **new and established patients**.

For complete code descriptions, definitions, and guidelines, refer to a CPT® book.

Link: Fees appear in the Professional Services Fee Schedule.

Payment limits

A **new patient** E/M office visit code is payable only once for the initial visit.

An **established patient** E/M office visit code isn't payable on same day as a **new patient** E/M.

Modifier **–22** isn't payable with E/M office visit codes for chiropractic services.

For follow-up visits, E/M office visit codes aren't payable when performed on the same day as L&I **chiropractic care visit** codes. Refer to the Chiropractic care visits section of this chapter for policies about the use of E/M office visit codes with L&I codes for chiropractic care visits.

Chiropractic E/M office visits are only payable on the same date as a **chiropractic care visit** when all of the following are met:

- It is the first visit on a new claim, *and*
- The E/M service is a significant, separately identifiable service (it goes beyond the usual pre- and post-service work included in the **chiropractic care visit**), *and*
- Modifier **–25** is added to the E/M code, *and*
- The patient's record contains supporting documentation describing both the E/M and the chiropractic care services.

Link: Additional E/M information is available in Chapter 10: Evaluation and Management Services.

Payment policy: Chiropractic consultations

General information

Consultations are requested by the attending provider. A chiropractic consultant may render a second opinion for any conservative management of musculoskeletal conditions even if the attending provider is not a chiropractor.

Prior authorization

While chiropractic consultations don't require prior authorization, consultations do require prior notification (by electronic communication, letter, or phone call) to the department or self-insurer per WAC 296-23-195.

Who must perform these services to qualify for payment

Only an L&I-approved chiropractic consultant can perform office consultation services to qualify for payment.

Services that can be billed

Approved consultants may bill all levels of CPT® office consultation codes.

Additional information: Chiropractic consultations

L&I periodically publishes:

- A policy on consultation referrals, *and*
- A list of approved chiropractic consultants.

Link: More information about consultations, how to become a chiropractic consultant, and a list of approved chiropractic consultants is available online.

Payment policy: Chiropractic independent medical exams (IMEs) and impairment ratings

Prior authorization

Prior authorization is only required when an IME is scheduled. To get prior authorization for claims that are:

- **State Fund**, use L&I's secure, online Claim & Account Center to see if an IME is scheduled.
- **Self-Insured**, contact the self-insured employer (SIE) or their third party administrator (TPA).
- **Crime Victims**, call **1-800-762-3716**.

Who must perform these services to qualify for payment

Only an L&I-approved IME examiner can perform IMEs or impairment ratings to qualify for payment.

For an impairment rating, an attending chiropractic physician may:

- Perform the rating on their own patients if the physician is an approved IME examiner, *or*
- Refer to an approved IME examiner for a consultant impairment rating.

Link: For more information, see: Chapter 12: Impairment Rating Services

Services that can be billed

Use the CPT® codes, local codes, and the payment policy for IMEs described in Chapter 13: Independent Medical Exams.

Additional information: Becoming an approved IME examiner

To apply for approval, chiropractic physicians must complete:

- Two years as an approved chiropractic consultant, *and*
- Impairment rating course approved by the department.

Links: For more information, see L&I's Become a Chiropractic Consultant webpage.

Payment policy: Chiropractic radiology services (X-rays)

Prior authorization

Medically necessary x-rays performed as part of the initial evaluation don't require prior authorization. All subsequent x-rays require prior authorization.

Who must perform these services to qualify for payment

Chiropractic physicians in the network may bill for radiographs taken as allowed under their license. It is required that a written x-ray report of radiologic findings and impressions be included in the patient's chart.

Only chiropractic physicians on L&I's list of approved radiological consultants may bill for X-ray consultation services. A chiropractic physician must be a Diplomat of the American Chiropractic Board of Radiology and must be approved by L&I to become an approved radiological consultant.

Services that can be billed

Chiropractic physicians must bill diagnostic X-ray services using CPT® radiology codes and the Requirements and Payment limits described in Chapter 26: Radiology Services.

Diagnostic ultrasounds performed by the chiropractor are bundled into the E/M service. See Chapter 26: Radiology Services for additional details on ultrasounds and documentation requirements.

Services that aren't covered

Dynamic Spinal Visualization

Dynamic Spinal Visualization (DSV) refers to several imaging technologies for the purpose of assessing spinal motion, including videofluoroscopy, cineradiology, digital motion x-ray, vertebral motional analysis and spinal x-ray digitization.

DSV isn't a covered benefit. Procedure code **76496** shouldn't be used to the bill the insurer for these services.

Link: For more information about DSV, see the Dynamic Spinal Visualization coverage decision.

Payment policy: Complementary & preparatory services, and patient education or counseling

General information

Patient education or counseling includes discussing or providing written information about:

- Lifestyle, *or*
- Diet, *or*
- Self-care and activities of daily living, *or*
- Home exercises.

The application of heat or cold is an example of a **complementary and preparatory service**.

Payment limits

The following services are bundled into the E/M or chiropractic local codes and aren't separately payable:

- **Complementary and preparatory services**, *or*
- Patient education or counseling.

Payment policy: Physical medicine treatment

Services that can be billed

Local code **1044M** for physical medicine modalities or procedures (including the use of traction devices) may only be billed by an attending provider who is not board certified/qualified in Physical Medicine and Rehabilitation (PM&R).

Link: For more information, see Chapter 25: Physical Medicine Services.

Services that aren't covered

CPT® physical medicine codes (**97001**-**97799**) aren't payable to chiropractic physicians.

Requirements for billing

Documentation of the visit must support billing for local code **1044M**.

Payment limits

Local code **1044M** is limited to six units per claim, except when the attending provider practices in a remote location where no licensed physical therapist is available.

After six units, the patient must be referred to a licensed physical or occupational therapist, or physiatrist for such treatment except when the attending provider practices in a remote location. (Refer to WAC 296-21-290 for more information.)

Only one unit of the appropriate billing code will be paid per visit, regardless of the length of time the treatment is applied.

Powered traction devices

The insurer won't pay any additional cost when powered traction devices are used. This policy applies to all FDA-approved powered traction devices.

Published literature hasn't substantially shown that powered traction devices are more effective than other forms of traction, other conservative treatments, or surgery. Powered traction devices are covered as a physical medicine modality under existing physical medicine payment policy. When powered traction is a proper and necessary treatment, the insurer may pay for powered traction therapy administered by a qualified provider under code **1044M**.

Link: For additional information, see powered traction therapy in Chapter 25: Physical Medicine Services.

Payment policy: Telehealth for chiropractic services

General information

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

Objective medical findings are required for time loss and other claim adjudication 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 intervention 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 evaluation is 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**.

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.

Prior authorization

The prior authorization requirements listed in Chapter 7: Chiropractic Services apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

Services that are covered

Telehealth procedures and services that are covered include services that don't require a hands on component.

The insurer will pay an **originating site** facility fee to a provider when they allow the worker to user their telecommunications equipment for a **telehealth** service with a provider at another location.

To bill for the **originating site** facility fee, use HCPCS code **Q3014**.

Q3014 is payable to the **originating site** provider when no other billable service occurs.

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Q3014 billing examples

Example 1: A worker, whose originating site is their attending provider's office, attends an in-person Evaluation and Management (E/M) appointment. The originating site provider documents all necessary information as part of this visit. Then, the worker requests the use of the provider's space to participate in a telehealth consultation with a distant site provider who is located in another office. The originating site provider or their assistant arranges a secure and private space for the worker to participate in the consultation. The provider at the originating site location with the worker bills the insurer **Q3014** for allowing this worker the use of their space for a visit with a distant site provider, but no other code is payable for this event to the originating site provider. The originating provider is required to separately document the activity as part of their bill for **Q3014**, and they submit separate documentation and a bill for the E/M visit that occurred earlier, noting the two distinct events in each documentation. The distant site consulting provider bills a consultation code, but they can't bill **Q3014**.

Originating site is…	Attending provider's office		
Originating site provider bills…	E/M visit code *and* **Q3014**	Originating site provider documents…	E/M visit *and* originating site visit **Q3014** (separate documentation)
Distant site provider bills…	Consultation code	Distant site provider documents…	Consultation

Example 2: A worker, whose originating site is their physician's office, attends an appointment for a telehealth consultation with a distant site provider. The originating site provider or their assistant arranges a secure and private space for the worker to participate in the consultation. The originating site provider bills the insurer **Q3014** for allowing this worker the use of their space for a visit with a distant site provider. The originating site provider is required to separately document the activity as part of their bill for **Q3014**. This provider can only bill **Q3014**, and the distant site consultant bills for their services provided. This distant site provider can't bill **Q3014**.

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Originating site is…	Attending provider's office		
Originating site provider **bills**…	**Q3014**	Originating site provider **documents**…	Originating site visit **Q3014**
Distant site provider **bills**…	Consultation code	Distant site provider **documents**…	Consultation

Note: For Evaluation and Management Services refer to Chapter 10: Evaluation and Management (E/M) Services and Chapter 10: Evaluation and Management (E/M) Services, Telehealth.

Store and Forward

G2010 is covered for patient-to-provider store and forward of images or video recordings, including interpretation and follow up when it isn't part of an E/M visit. Follow up must occur within 24 business hours of receiving the images or video recordings. Follow up may occur by phone, **telehealth**, or in-person, and isn't separately payable. **G2010** isn't covered if the patient provides the image or video recording as follow-up from an E/M visit in the prior 7 days, nor if the provider's evaluation of the image or video recording leads to an E/M service within the next 24 hours or soonest available appointment. Providers are required to document their interpretation of the image or video recording. Chart notes that don't state the interpretation by the provider are insufficient.

Services that aren't covered

The same services that aren't covered in Chapter 7: Chiropractic Services apply to this policy.

Telephonic visits don't replace video two-way communication and can't be billed using non-telephonic E/M services codes. Case management services may be delivered telephonically (audio only) and are detailed in Chapter 10: Evaluation and Management (E/M) Services.

Telehealth procedures

Telehealth procedures and services that aren't covered include:

- The services listed under "Services that must be performed in-person",
- Services that require physical hands-on and/or attended treatment of a patient, including but not limited to codes **2050A**, **2051A**, or **2052A**,
- 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 any service during a **telehealth** visit, *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.

Q3014 billing examples

Example 1: A worker, whose originating site is their home, attends a telehealth appointment with their provider. **Q3014** isn't payable to the provider in this example. No reimbursement is payable to the worker for using their home or their equipment for this visit.

Originating site is…	Worker's home		
Originating site provider **bills**…	n/a	Originating site provider **documents**…	n/a
Distant site provider **bills**…	No billable services	Distant site provider **documents**…	n/a

Example 2: A worker, whose originating site is their attending provider's office, attends a telehealth consultation. The distant site consulting provider cannot bill **Q3014** because the worker is in a different location than the distant site provider. However, the originating site provider whose space the worker is utilizing may bill **Q3014**, so long as they provide appropriate documentation of the service provided. No other service is payable to the originating site provider.

Originating site is…	Attending provider's office		
Originating site provider **bills**…	**Q3014**	Originating site provider **documents**…	Originating site visit **Q3014**
Distant site provider **bills**…	Consultation code	Distant site provider **documents**…	Consultation

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. **Distant site** providers must use place of service **-10** to denote the **telehealth** visit when the worker is located in their home.

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 Chapter 7: Chiropractic Services 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 limits noted in Chapter 7: Chiropractic Services apply regardless of how the service is rendered to the worker.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for physical medicine	Washington Administrative Code (WAC) 296-21-290
Becoming an Chiropractic Consultant	Become a Chiropractic Consultant on L&I's website
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information For All Providers
Chiropractic Services including Industrial Insurance Chiropractic Advisory Committee, practice, training, consultation resources	IICAC website
Dynamic Spinal Visualization coverage decision	Dynamic Spinal Visualization coverage decision
Fee schedules for all healthcare professional services (including chiropractic)	Fee schedules on L&I's website
Payment policies for **case management services**	Chapter 10: Evaluation and Management Services
Payment policies for **diagnostic X-ray services**	Chapter 26: Radiology Services
Payment policies for **durable medical equipment (DME)**	Chapter 9: Durable Medical Equipment
Payment policies for **IMEs**	Chapter 13: Independent Medical Exams (IMEs)
Payment policies for **impairment ratings**	Chapter 12: Impairment Rating Services
Payment policies for **physical medicine treatment** or **powered traction therapy**	Chapter 25: Physical Medicine Services
Payment policies for **supplies**	Chapter 28: Supplies, Materials, and Bundled Services

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

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