LifeWise
Health Plan of Washington

Payment Policy

cmi_051762

Title	**Acupuncture**		
Number	**CP.PP.020.v3.4**		
Last Approval Date	04/07/25	**Original Effective Date**	09/15/03
Cross Reference	• *Modifier 25- Significant, Separately Identifiable Evaluation &Management (E&M) Service on Same Day of Procedure or Other Service* • *New and Established Patient Guidelines*		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define how the Plan applies limits for Acupuncture services that are submitted on a CMS-1500 paper claim form or an 837P electronic claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company, and Premera Blue Cross HMO lines of business and products.
Policy	The Plan reimburses one initial acupuncture code (code 97810 or 97813, each with one unit) and one add-on acupuncture code (code 97811 or 97814, each with two units) once per provider, per member, per day when covered by the member's benefits. The Plan allows up to a maximum of 45 minutes (3 units total of 15-minute time increments per unit) of personal one-on-one contact on a single date of service. A new patient Evaluation and Management (E&M) office visit code may be reimbursed consistent with the New/Established patient guidelines. E&M services billed on the same day as an acupuncture procedure may be reimbursed when appended with modifier 25 to indicate that the separate E&M service represents a service **above and beyond the usual preservice and post service work** associated with the acupuncture services. The documentation must support the significant, separate and distinct nature of the E&M service. The time of the E&M service is not included in the time of the acupuncture service. Per CPT guidelines, when **both** time-based acupuncture services 97810, 97811, 97813 and 97814 and needle insertion services 20560 or 20561 are **performed** on the same date of service by the same provider, only the time-based acupuncture services should be reported. When **both** the time-based acupuncture services **AND** needle insertion services are **billed** on the same date of service, the time-based acupuncture services (97810, 97811, 97813, 97814) will be denied as inclusive to the needle insertion services (20560 or 20561), per CMS National Correct Coding Initiative (NCCI) edits. No override modifiers allowed per NCCI criteria. The needles used in both the acupuncture and needle insertion procedures are considered inclusive to these services and are not separately reimbursable.

Codes/Coding Guidelines	The following codes are associated with this policy: • **97810** - Acupuncture, 1 or more needles, without electrical stimulation, initial 15 minutes of personal one on one contact with the patient (Do not report 97810 in conjunction with 97813) • **+97811** - Acupuncture, 1 or more needles, without electrical stimulation, each additional 15 minutes of personal one on one contact with the patient, with insertion of needles (List separately in addition to code for primary procedure) (Use 97811 in conjunction with 97810, 97813) • **97813** - Acupuncture, 1 or more needles, with electrical stimulation, initial 15 minutes or personal one on one contact with the patient (Do not report 97813 in conjunction with 97810, 97811) • **+97814** - Acupuncture, 1 or more needles, with electrical stimulation, each additional 15 minutes of personal one on one contact with the patient, with insertion of needles (List separately in addition to code for primary procedure) (Use 97814 in conjunction with 97810, 97813) • **20560** – Needle insertion(s) without injection(s); 1 or 2 muscle(s) • **20561** – Needle insertion(s) without injection(s); 3 or more muscles + = Add-on code which needs to be billed with an appropriate primary code <u>Per criteria in the Modifier 25 Payment Policy:</u> "The Plan recognizes Modifier 25 appended to a professional service to signify that a significant, separately identifiable E&M service was performed by the same physician or other qualified healthcare professional on the same dates of service as a procedure or other service. This E&M service represents a service that is above and beyond the other service(s) provided or beyond the usual pre- and post-operative care associated with the procedure or service that was performed. Appending modifier 25 to an E&M service will not automatically allow payment of the E&M service that is submitted with another procedure or service performed on the same date of service. The documentation must support the significant, separate and distinct nature of the E&M service." <u>Per criteria in the New and Established Patient Guidelines Payment Policy:</u> • A **new patient** is one who has not received any face-to-face professional services from the physician(s) or other qualified healthcare professional(s) or another physician(s) or other qualified health care professional(s) of the same specialty and subspecialty who belongs to the same group practice, <u>within the past three years.</u> • An **established patient** is one who has received face-to-face professional services from the physician(s) or other qualified healthcare professional(s) or another physician(s) or other qualified health care professional(s) of the same specialty and subspecialty who belongs to the same group practice, <u>within the past three years.</u>

Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be appropriate to the seriousness of the violation and shall be determined at Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	None
Laws, Regulations & Standards	**Washington:** Every Category of Provider Legislation went into effect on January 1, 1996. RCW 48-43-045 requires that every health plan permit every category of health care provider to provide health services or care for conditions included in the basic health plan services. Under ESHB 1046, all bundling/payment policies must be blind to provider type.
References	• American Medical Association's Current Procedural Terminology (AMA/CPT); Professional Edition codebook • Acupuncture and Oriental Medicine Alliance (AOM) • American Association of Acupuncture and Oriental Medicine (AAAOM) • Bastyr University Department of Acupuncture and Oriental Medicine • CMS National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) edits

Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.	
Annual Review Dates	04/07/25; 05/14/24; 09/06/23; 07/07/23; 08/18/22; 09/22/21; 10/06/20; 10/30/19; 03/15/19; 03/29/18; 06/13/17; 06/26/16; 08/10/15; 08/10/14; 08/15/13; 08/19/12; 08/29/11; 09/03/10; 05/21/10; 06/01/09; 02/20/09; 03/21/08; 03/20/07; 08/29/05; 10/21/04; 10/08/04; 09/23/03	
Version History	03/29/18	Added news section "Codes/Coding Guidelines"
	03/15/19	Annual review; no changes
	10/30/19	Removed the footnotes and combined the paragraphs on new and established E&M visits into a single paragraph. Added references in the "Codes/Coding Guidelines" section to key information from Payment Policies for "New and Established Patients" and "Modifier 25"
	10/06/20	Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P claim forms; Clarified that one unit is associated with each acupuncture code billed
	09/22/21	In the Policy section: • Clarified the guidelines for billing an E&M service on the same date as an acupuncture service • Added the last paragraph clarifying coding guidelines for coding acupuncture codes along with needle insertion codes In the Codes/Coding Guidelines, added codes and code descriptions for 20560 and 20561
	08/18/22	Paragraph from the Modifier 25 Payment Policy added in the Codes/Coding Guidelines section.

	07/07/23	In the Policy section, clarification is added as follows: • In the second paragraph, indicated that the 2 units of time represent 2–15-minute increments of time; and • In the final paragraph, clarified that the acupuncture needles are considered inclusive of the acupuncture service and not separately reimbursable.
	09/06/23	In the Policy section, further clarification is added as follows: • Expanded the maximum units allowed on the add-on acupuncture codes 97811/97814 to 2 units each code, per provider, per member, per day per CMS MUEs; • Clarified the CPT coding guidelines when both time-based acupuncture services and needle insertion services are performed; • Added a paragraph indicating NCCI edits will be applied when BOTH acupuncture and needle insertion services are billed on the same date of service, for the same member by the same provider; and • Created a separate paragraph to indicate that the needles used in acupuncture and needle insertion services are not separately billable as a supply code but are inclusive to the service.
	05/14/24	Annual review; no changes
	04/07/25	In the Policy section, at the end of the sixth paragraph, the last sentence was added to indicate that per NCCI criteria, bypass modifiers are not allowed to override the edit.