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CORPORATE PAYMENT POLICY 02: ACUPUNCTURE

Next Review: November 2022
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Description

Vermont law (26 V.S.A. § 3401(1)) defines "Acupuncture" or the "practice of acupuncture" as the insertion of fine needles through the skin at certain points on the body, with our without the application of electric current or the application of heat to the needles or skin, or both, for the purpose of promoting health and well-being or to prevent or alleviate pain or unease.

According to 26 V.S.A. § 3401a(a), "[a] licensed acupuncturist may, in addition to the practice of acupuncture employing fine needles, in a manner consistent with acupuncture theory, employ electrical, magnetic, thermal, and mechanical skin stimulation techniques; nonlaboratory diagnostic techniques; nutritional, herbal, and manual therapies; exercise and lifestyle counseling; acupressure; and massage." However, "[a[licensed acupuncturist shall not offer diagnosis of any human pathology except for a functional diagnosis, based upon the physical complaint of a patient or acupuncture theory, for purposes of developing and managing a plan of acupuncture care, or as necessary to document to insurers and other payers the reason a patient sought care." 26 V.S.A. § 3401a(b).

Policy & Guidelines

This policy enforces the code descriptions for acupuncture services, describes documentation requirements, and describes when other service codes (such as evaluation and management codes) may be billed in conjunction with an Acupuncture service. The information contained in this section applies to any Plan-contracted provider.

I. Acupuncture Codes

Table 1, below, lists the Current Procedural Terminology (or CPT®[1]) codes for Acupuncture.

[1] Current Procedural Terminology (CPT®) codes and descriptions are the property of the American Medical Association. Healthcare Common Procedure Coding System (HCPCS) code set and descriptions are the property of the Centers for Medicare and Medicaid services.

Table 1.

Code	Description
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97811	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (list separately in addition to code for primary procedure)
97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97814	Acupuncture, 1 or more needles, with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (list separately in addition to code for primary procedure)

Acupuncture codes are to be reported based on 15-minute increments of personal face-to-face contact with the patient and not the duration of the needle(s) placement or the number of needles inserted initially. It is not appropriate to count time spent away from the patient as part of the code selection and units submitted.

Per CPT® guidelines, only one initial code – either 97810 or 97813 – should be reported per patient per day.

The initial Acupuncture service codes (97810 and 97813) include components such as the assessment provided prior to and after the needle(s) insertion, treatment discussion and recommendations, preparation, documentation, and home instruction. The relative value unit (RVU) attributed to the Acupuncture codes includes up to six (6) minutes of services related to the day's acupuncture treatment, as a portion of each unit of Acupuncture, including: (1) review of the chart, 92) greeting the patient, (3) obtaining a brief account of the results of the previous treatment and any significant changes that have occurred since the last visit, (4) hand washing, (5) palpation of tender points, (6) selecting points for the day's treatment, (7) needle selection, and (8) post service charting instructions to the patient.

CPT® codes 97811 and 97814, for additional 15 minutes of personal one-on-one contact with the patient with reinsertion of needle(s), cover scenarios where a new needle is inserted. Re-insertion, based on clean needle technique, does not cover removing and re-inserting the same needle.

The cost of the needles is included in the Acupuncture service and claims for such costs will be denied if submitted in addition to the Acupuncture service.

II. Documentation requirements for Acupuncture Services

The following should be documented for all Acupuncture services rendered:

- Brief account of chief complaints and results of the previous treatment and any significant changes that have occurred since the last visit, if applicable
- The acupuncture points used
- Patient positioning
- Whether electrical stimulation was used
- Patient's response to treatment
- Progress made (or lack thereof). Note that when Functional Outcome Measures (FOM) are used, they should demonstrate Minimal Clinically Important Difference (MCID) from baseline results through periodic reassessments. If the maximum therapeutic benefit has been reached, this should be documented, and treatment should be stopped.
- Treatment plan, which should:
    - Be individualized with therapeutic goals that are functionally-oriented, realistic, measurable, and evidence-based;
    - Document frequency and duration of service;
    - Be appropriately correlated with clinical findings and clinical evidence; and
    - Be expected to result in significant therapeutic improvement over a clearly defined period of time and identify a proposed date of release/discharge from treatment.

III. Other services provided with Acupuncture Services

Acupuncture services may be rendered by a provider who holds only an acupuncturist license or by a provider who holds an acupuncturist license and another license, or by a provider for whom the practice of acupuncture is within the scope of his or her license. As such, there may be circumstances where it is appropriate for a provider to bill Acupuncture service codes and other types of service codes.

a. Electrical stimulation

Electrical stimulation services should not be reported separately in addition to specific Acupuncture services that include electrical stimulation (i.e., 97813, 97814). A modifier may be appropriate when an electrical stimulation service is performed distinctly and separate from the acupuncture service, the documentation supports the service was not related to the acupuncture, and the provider is qualified to render the service.

b. Evaluation and management services

In some cases, an evaluation and management (E/M) service may be provided in conjunction with Acupuncture services. Specifically, if a significant, separately identifiable E/M service, above and beyond the usual pre-service and post-service work associated with the Acupuncture service, is performed by the same provider on the same day, modifier -25 should be appended to the E/M and the documentation should support billing of that modifier.

Plan expects that a provider rendering Acupuncture services to a new patient for the first time will likely have a need to bill an E/M code in addition to the Acupuncture service code(s) since the evaluation and

assessment will likely consume more time than what is built into the Acupuncture service codes for pre- and post-service review.

Plan expects providers to use the E/M codes listed in Table 2, below. The appropriate code choice depends on whether the patient is new or established, and either the level of complexity in the medical decision-making process or time spent on the date of the encounter.

Table 2.

Code	Description
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

c. Other services within the scope of practice for MD/ND

Plan recognizes that providers may have more than one specialty. Providers who have an Acupuncture taxonomy code and another specialty taxonomy code should bill for services using the Acupuncture taxonomy code if the intent of the visit is for Acupuncture only.

Benefit Determination Guidance

Payment for acupuncture services is determined by the member's benefits. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Acupuncture services are subject to applicable member cost sharing such as co-payments, co-insurance, and deductible.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Inter Plan Programs (IPP): In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (BCBSVT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment it is important to verify the member's benefits **prior** to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®), Health Care Procedure Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

National Drug Code(s)

Health Care Procedure Coding System (HCPCS) codes related to chemotherapy drugs, drugs administered other than oral method, and enteral/parenteral formulas may be subject to National Drug Code (NDC) processing and pricing. The use of NDC on medical claims helps facilitate more accurate payment and better management of drug costs based on what was dispensed and may be required for

payment. For more information on BCBSVT requirements for billing of NDC please refer to the provider portal at http://www.bcbsvt.com/provider-home for the latest news and communications.

Other Information

Claims for acupuncture are only accepted on the CMS-1500 (HIPPA compliant 837P) format for professional claims.

Eligible Providers

Eligible providers are those licensed as an acupuncturist in Vermont pursuant to 26 V.S.A. §3402(a), and who are contracted with the Plan's Network (participating/in-network).

MDs, DOs, DCs, and Naturopaths (who hold an acupuncture license ***in addition to*** their primary medical, chiropractic, or naturopathic licensure) and who are contracted with the Plan's Network (participating/in-network) are also considered eligible providers.

Employer Group Exclusion(s):

This payment policy ***does not*** apply to the following group(s).

- State of Vermont

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the payment policy. If an audit identifies instances of non-compliance with this payment policy, BCBSVT reserves the right to recoup all non-compliant payments.

Legislative Guidelines

N/A

Related Policies

N/A

Document Precedence

The BCBSVT Payment Policy Manual was developed to provide guidance for providers regarding BCBSVT payment practices and facilitates the systematic application of BCBSVT member contracts and employer benefit documents, provider contracts, BCBSVT corporate medical policies, and Plan's claim editing logic. Document precedence is as follows:

1) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and the member contracts or employer benefit documents, the member contract or employer benefit document language takes precedence.
2) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and provider contract language, the provider contract language takes precedence.

3) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and corporate medical policy, the corporate medical policy takes precedence.
4) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and the Plan's claim editing solution, the Plan's claim editing solution takes precedence.

Policy Implementation/Update information

The policy was originally implemented effective October 2012.

The policy was updated effective March 1, 2015.

The November 2020 update expands the list of E/M codes allowable, clarifies guidelines regarding use of the acupuncture service codes, and moves the acupuncture coding table to the body of the policy.

Approved by **Date Approved:** 12/7/2020

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