SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.2 ACUPUNCTURE

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

ACUPUNCTURE

Acupuncture is reported based on 15-minute increments of personal (one-on-one) contact with the patient and not based on the duration of acupuncture needle(s) placement. Personal (one-on-one) contact means the acupuncturist is in the room with the patient performing medically necessary components of the service. The time spent in personal (one-on-one) contact must be clearly documented in the medical record.

Only one initial code should be reported per day. Either code 97810 or 97813 should be reported for the initial 15-minute increment. The initial code includes E&M components such as a pre- post-service assessment, treatment discussion, etc.

Only one code should be reported for each 15-minute increment. If no electrical stimulation is used during a 15-minute increment, code 97810 or 97811 should be used. If electrical stimulation of any needle is used during a 15-minute increment, code 97813 or 97814 should be used.

Blue Cross follows the American Medical Association CPT guidelines for billing time-based codes. Time is considered to be face-to-face contact with a patient delivering skilled services. A unit of time is attained when the mid-point is passed unless specific CPT guidelines state otherwise. For example, 15 minutes is attained when 8 minutes have elapsed. Incremental intervals of the same treatment at the same visit may be accumulated. If the mid-point of the unit of time is not attained, the code should not be billed.

Supplies (e.g., needles) are included in the service. Supplies should not be billed separately or directly to members.

Electrical stimulation services (97014, 97032 and G0283) should not be reported separately when related to acupuncture services.

The following codes will be allowed for licensed acupuncturists: 97810, 97811, 97813 and 97814.