Is dry needling covered by your patient's provider?

Even if dry needling is within a provider's scope of practice, it does not mean that payers will reimburse for this service. Many third party payers consider dry needling to be "experimental and investigational" and consider it an excluded service. Locate and review the Medical Review Policies for any payers your office commonly bills to and verify patients' insurance benefits to confirm if they provide coverage for this service. Some require that patients sign a notice of non-coverage prior to receiving treatment to ensure they are aware of their personal financial responsibility.

Having specific procedure codes for dry needling is extremely helpful for office statistics whether it is a cash or insurance reimbursed service. As with all diagnosis and procedure codes, stay informed on the yearly changes and update your internal paperwork, fee schedule, and billing system as needed.

Administrative Management of Dry Needling

Coding for dry needling is as follows:

- CPT Code 20560: Needle insertion(s) without injection(s), 1-2 muscles
- CPT Code 20561: Needle insertion(s) without injection(s), 3 or more muscles

These procedure codes are based on the number of muscles being treated. The number of needles used, and time spent with the patient is not taken into consideration when determining the appropriate code to use. Only one unit of this code can be billed per encounter. Dry needling can be performed on the same day and same spinal or body region as a manipulation (CPT Codes 98940-98943), massage (CPT Code 97124), or manual therapy (CPT Code 97140) due to the fact that dry needling requires a very different skill set to perform and the post service work, such as documentation and home care instructions, are different from what is required for other chiropractic and soft tissue services.