GOJI GUIDE

Acupuncture CPT codes: complete reference

The needling codes, how your minutes become units, the consultation, preventive and other codes that often join them, payer limits, and the claim pitfalls worth documenting for. A longer companion to the one-page quick reference.

Sources checked 2026-10-12. Payers and codes change, so confirm with each plan.

THE FOUR NEEDLING CODES

Code	In plain words	E-stim?	Which unit	New needle set?
97810	Needling, first 15 minutes of one-on-one time	No	First unit	No
97811	Each further 15 minutes of one-on-one time	No	Add-on to 97810 or 97813	Yes
97813	Needling with electrical stimulation, first 15 minutes	Yes	First unit	No
97814	Each further 15 minutes of one-on-one time	Yes	Add-on to 97810 or 97813	Yes

START WITH THE VISIT, NOT THE CODE

Think of your last treatment. Four things you already know decide the code, and a fifth decides whether it holds up.

1. Did you use electrical stimulation? Without it you are in 97810 and 97811. With it, you are in 97813 and 97814.
2. How long were you actually with the patient? Count face-to-face time, not needle time. 8 minutes earns the first unit; under 8 bills nothing.
3. Did you turn them over and needle a fresh set? Only then can you add 97811 or 97814 for further 15-minute units.
4. Did you do anything else worth billing? A same-day consultation usually needs modifier 25. Herbs, massage and cupping each work differently.
5. Does the note say so, and is there a diagnosis the plan can match? Each line needs a code, units and a diagnosis.

A Tuesday follow-up

You were with the patient for 40 minutes. The needles stayed in for 25. They stayed on their back the whole time, and you did not use electrical stimulation. Bill 97810, one unit. The clock would support three units, but only the first is yours without a second needle set. It is a common surprise.

HOW TIME BECOMES UNITS

The most units that face-to-face time can support. Only the first is yours without a new needle set.

1 unit	2 units	3 units	4 units
8–22 min	23–37 min	38–52 min	53–67 min

The 8-minute rule, and how time rounds

A unit is 15 minutes, and common practice treats it as earned once you reach the midpoint of it: 8 minutes earns the first unit, 23 the second, 38 the third. So 22 minutes is one unit and 23 is two, and 7 minutes bills nothing. This is billing convention rather than something the code descriptions spell out, and payers can apply their own rounding, so check yours. Count minutes of face-to-face time, not needle time.

A new needle set: what it usually means

97811 and 97814 are the codes that depend on a new needle set. The usual example is a patient treated stomach side up (supine) first, then turned back side up (prone) and needled again with a fresh set, or the other way round. Because a used

needle is never reused (Clean Needle Technique), “re-insertion” in practice means new needles. Billing sources differ on whether adjusting needles already in place counts, so do not assume it does. A 2005 CPT Assistant clarification, as reported in trade press, says simply leaving one set in for more than 15 minutes does not support an add-on. Document it in the note: the positions, the time spent on each set and roughly how many needles. A unit with no record of a second set is the one that fails an audit.

Payers cap units differently

Some payers set their own daily limits. UnitedHealthcare’s commercial policy (2026R6006A) allows one unit each of 97810 and 97813 and up to two units each of 97811 and 97814 per date of service. Premera’s policy (last approved April 2026) pays one initial code and one add-on code with two units, and stops at 45 minutes (three units) of one-on-one contact in a day. So even a long visit with fresh needle sets can top out at three units. Look up the policy for each payer you bill.

CONSULTATION (E/M)

Decision-making	New patient	Established
Straightforward	**99202**	**99212**
Low	**99203**	**99213**
Moderate	**99204**	**99214**

Modifier 25, and not every visit

On a day you also needle, a consultation usually needs modifier 25 (written 99203-25) or it is denied as bundled into the acupuncture, and some payers do not pay a same-day consultation at all. A full one is not meant for every visit; one billing source suggests roughly once a month unless there is a new diagnosis or a significant change. The level has to be supported by the note, so do not default to the higher one. Payer policies, such as Blue Cross of Vermont’s, ask that the consultation be significant and separately identifiable from the usual work before and after needling.

PREVENTIVE VISIT CODES 99381 TO 99397, BY AGE

Two questions pick one: is this a new or an established patient, and how old are they on the date of service? The guide page turns each band into birth dates for a visit date you choose.

Patient’s age	New	Established	Birthday test on the visit date
infants (under 1)	**99381**	**99391**	Has not yet had a first birthday
1 to 4	**99382**	**99392**	Has had their 1st birthday, not yet their 5th
5 to 11	**99383**	**99393**	Has had their 5th birthday, not yet their 12th
12 to 17	**99384**	**99394**	Has had their 12th birthday, not yet their 18th
18 to 39	**99385**	**99395**	Has had their 18th birthday, not yet their 40th
40 to 64	**99386**	**99396**	Has had their 40th birthday, not yet their 65th
65 and over	**99387**	**99397**	Has had their 65th birthday

New or established, and when it fits

Under CPT’s rule, a patient is established if you, or someone of your specialty in your group, has seen them face to face in the past three years. The 99381 to 99387 codes are new patients, 99391 to 99397 established. These codes describe a comprehensive preventive visit, not a treatment visit, so they suit a general-health or herbal visit more than a needling one. If you also address a problem that day, a problem-oriented visit code carries modifier 25. Whether a payer accepts a preventive code from an acupuncturist varies, and many practices treat it as patient-pay, so ask before you bill it.

Every code, in one place

The same entries as the searchable code finder on the guide page.

NEEDLING

Code	What it is	Units and modifier	Watch for
97810	**Acupuncture, no e-stim, first 15 min** Acupuncture, without electrical stimulation, first 15 minutes of one-on-one contact.	1 unit once face-to-face time passes 8 minutes	Under 8 minutes bills nothing. A longer visit with the same needles is still one unit.
97811	**Add-on, no e-stim, each added 15 min** Without electrical stimulation, each additional 15 minutes, with re-insertion of needle(s).	One per further 15 minutes, up to what the visit's time supports	Needs a new needle set, noted in the chart. Extra time with the same needles does not count.
97813	**Acupuncture with e-stim, first 15 min** Acupuncture, with electrical stimulation, first 15 minutes of one-on-one contact.	1 unit once face-to-face time passes 8 minutes	Bill one modality family per visit. If you did both, ask the payer how to report it.
97814	**Add-on, e-stim, each added 15 min** With electrical stimulation, each additional 15 minutes, with re-insertion of needle(s).	One per further 15 minutes, up to what the visit's time supports	Needs a new needle set, noted in the chart. Record the positions and the time on each set.

CONSULTATION

Code	What it is	Units and modifier	Watch for
99202	**New patient, straightforward** New patient, straightforward medical decision-making. The lowest new-patient level.	1 Modifier 25 on a day you also needle	The level has to be supported by the note.
99203	**New patient, low complexity** New patient, low medical decision-making. The usual initial consultation for an acupuncture practice.	1 Modifier 25 on a day you also needle	Without modifier 25 it is often denied as bundled into the acupuncture. Some payers do not pay a same-day consultation at all.
99204	**New patient, moderate complexity** New patient, moderate medical decision-making. For a more complex first evaluation.	1 Modifier 25 on a day you also needle	Do not default to the higher level. The note has to show the work behind it.
99212	**Established patient, straightforward** Established patient, straightforward medical decision-making. The lowest established-patient level.	1 Modifier 25 on a day you also needle	A full consultation is not meant for every visit.
99213	**Established patient, low complexity** Established patient, low medical decision-making. The usual review consultation.	1 Modifier 25 on a day you also needle	One billing source suggests roughly once a month unless there is a new diagnosis or a significant change.
99214	**Established patient, moderate complexity** Established patient, moderate medical decision-making. Commonly used for evaluating and managing an herbal prescription.	1 Modifier 25 on a day you also needle	Your state's scope of practice has to include herbal prescribing, and the note has to support the level.

HERBS

Code	What it is	Units and modifier	Watch for
A9150	**Herbal formulas dispensed** The only generic code for the herbs themselves, and it is rarely covered.		Tell patients up front that it is likely out of pocket, and print it marked patient responsibility so it is not a surprise.

MASSAGE & OTHER

Code	What it is	Units and modifier	Watch for
97124	**Massage, per 15 min** Massage, each 15 minutes, billed by units of time.	By time, each 15 minutes Payers often want GP (Medicare and VA do on physical-medicine codes). Others use 59 or KX.	Payers often bundle it with acupuncture. Check yours before assuming it is payable on the same visit.
97140	**Manual therapy, per 15 min** Mobilization or manual techniques, each 15 minutes.	By time, each 15 minutes Billing it separately usually needs a modifier and a note showing a different region or time	Payer edits commonly bundle it with the acupuncture codes. Check your payer first.
97026	**Infrared** The infrared code.		Check the payer before adding it to a superbill.
97016	**Cupping (vasopneumatic device)** There is no code specific to cupping. The evidence that 97016 covers it comes from VA Community Care.		Most other payers do not pay for cupping, so many practices charge for it as a cash-pay line.

WHERE CLAIMS COMMONLY GO WRONG

Patterns from billing guides, not any one payer's policy. Each is something to document or check for.

- **Add-on units with no second set in the note.** The most common one. If the note shows one set, the claim supports one unit of 97810 or 97813, whatever the length.
- **Counting needle retention as time.** The codes are for one-on-one time with the patient. Resting time with needles in place is not part of it.
- **A consultation with no modifier 25.** An E/M billed the same day as needling is often denied as bundled into the acupuncture unless it carries modifier 25. Some payers do not pay a same-day E/M at all.
- **Manual therapy billed alongside acupuncture.** 97140 is commonly bundled with the acupuncture codes by payers' edits. Billing it separately usually needs a modifier and documentation of a different region or time. Check your payer first.
- **A diagnosis the plan does not match.** Whether acupuncture is paid depends on the diagnosis and the plan. A missing or unspecific code is a frequent reason a superbill is sent back.
- **Acupuncture and dry needling on the same day.** Premera's payment policy denies the acupuncture lines when 20560 or 20561 is billed for the same date, and NCCI allows no modifier override. Pick the service that describes what you did, and check each payer.
- **Billing needles or supplies separately.** UnitedHealthcare's policy treats needles (A4212, A4215) as included in the acupuncture service and denies them if submitted in addition.
- **Cupping or moxibustion under an acupuncture code.** There is no code for either. Charge for them separately as a cash-pay line rather than inflating needling units.

QUESTIONS, ANSWERED

What is the difference between 97810 and 97813?
Electrical stimulation. 97810 is acupuncture without it and 97813 is acupuncture with it, and each covers the first 15 minutes of one-on-one time. You report one or the other for the first unit, never both on the same day. The 97813 code says “one or more needles”, so stimulating a single needle is generally enough; record which points and for how long.

How many units can I bill for a 30-minute acupuncture visit?
Up to two: the first-unit code (97810 or 97813) plus one add-on (97811 or 97814), and the add-on only if you needled a new set. With one set of needles it is one unit. Count face-to-face minutes, not how long the needles stayed in. Under common practice 8 minutes earns the first unit and 23 the second, though payers can round differently.

Can I bill 97811 or 97814 for a long visit with one set of needles?
Usually not. Those two add-on codes are defined “with re-insertion of needle(s)”, which billing guidance reads as a new needle set, for example after turning the patient over. A 60-minute visit with a single set is normally one unit of 97810 or 97813. Confirm with each payer, and document the second set in the note.

Do I need modifier 25 to bill a consultation with acupuncture?
Usually yes. A consultation (E/M) billed the same day as needling is often denied as bundled into the acupuncture unless it carries modifier 25, written 99203-25. The note has to show a significant, separately identifiable service, and some payers do not pay a same-day consultation at all. Check each payer.

What can’t I bill on top of acupuncture?
Two common cases. Dry needling: Premera’s payment policy denies acupuncture lines when needle insertion (20560 or 20561) is billed for the same date, with no modifier to override it. Needles: UnitedHealthcare’s policy includes needle supplies (A4212, A4215) in the acupuncture service and denies them if submitted separately. Check how your payers treat each.

Is there a CPT code for cupping or moxibustion?
No CPT code is specific to either. Some sources point to 97016 for cupping, but the evidence is specific to VA Community Care. Many practices charge for cupping and moxibustion as a cash-pay add-on instead of using an unlisted-procedure code, which payers usually want a written policy and a description for.

Does insurance cover these codes?
Not automatically. A code describes what you did; it does not mean a plan pays for it. Coverage, visit limits and which diagnoses qualify are each plan’s decision, and Medicare and Medicaid have their own rules. Patients should check with their plan, and you should check with the payers you bill.

Does Goji pick the codes for me?
Goji suggests the first-unit code (97810 or 97813) from the visit’s recorded minutes and whether electrical stimulation was used. Add-on units are off by default, because the chart has no way to confirm a new needle set. You can turn them on under Settings, Billing if you record that yourself and your payers accept it.

SOURCES

- AAPC Codify: CPT 97810
- Acupuncture Today: Billing for additional sets of needles
- Acupuncture Today: Billing and time matters
- Acupuncture Today: How to bill evaluation and management codes (about every 30 days)
- Blue Cross of Vermont: acupuncture payment policy (modifier 25)
- California Medical Association: CPT reporting for preventive medicine services (age bands, established patient, modifier 25)
- UnitedHealthcare: acupuncture reimbursement policy (units, supplies)
- Premera: acupuncture payment policy (daily limits, dry needling)
- Acupuncture Today: The most common modifier for acupuncture claims

Full guide with the interactive code finder and visit check

A reference, not billing advice. This reflects trade-press billing guidance and the payer policies cited, not a coder’s review. Codes and rules change and payers differ, so confirm codes, modifiers and units with each plan and your billing or compliance advisor.