Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 17: Mental Health Services

Effective July 1, 2022

Link: Look for possible **updates and corrections** to these payment policies on L&I's website.

Table of Contents

Definitions

The following terms are utilized in this chapter and are defined as follows:

Bundled codes: Are procedure codes that are not separately payable because they are accounted for and included in the payment of other procedure codes and services.

Link: For the legal definition of Bundled codes, see WAC 296-20-01002.

Distant site: The location of the provider who performs telehealth services. This provider is not at the originating site with the worker.

Originating site: The place where the worker is located when receiving telehealth. For the purposes of this policy, the worker may be at home when receiving telehealth.

Residential facility for mental health: These facilities provide high level care to workers with long-term or severe mental disorders, or workers with substance-related disorders, with 24-hour medical and nursing services. **Residential facilities for mental health** typically provide less intensive medical monitoring than subacute hospitalization care. Treatment includes a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs. **Residential facilities for mental health** include training in the basic skills of living as determined necessary for each worker. Treatment for psychiatric conditions and residential rehabilitation treatment for alcohol and substance abuse are included in this level of care. Adult family homes, skilled nursing facilities, or boarding homes aren't included in this definition.

Telehealth: Face-to-face services delivered by a qualified medical provider through a real-time, two-way, audio video connection. These services aren't appropriate without a video connection.

Modifiers

The following CPT®, HCPCS, and/or local code modifiers apply to this chapter:

-GT (Via interactive audio and video telecommunication systems)

Used to indicate a telehealth procedure was performed. Documentation to support the service must be submitted. Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

-93 (Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system)

Used to indicate an audio only service occurred between a physician or other qualified health care professional and a patient who is located away from the physician or other qualified health care professional. The totality of the exchange between the health care professional and patient must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction. Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

Payment policy: All mental health services

Who the policies in this chapter apply to

The mental health services payment policies in this chapter apply to workers covered by the State Fund and self-insured employers.

The policies in this chapter don't apply to crime victims.

Links: For more information on **mental health services** for State Fund and self-insured claims, see WAC 296-21-270 and WAC 296-14-300.

For information about mental health services policies for the Crime Victims' Compensation Program, see WAC 296-31.

Who can be an attending provider

Can be attending provider: Psychiatrists and psychiatric ARNPs

A psychiatrist or psychiatric ARNP can be a worker's attending provider only when:

- The insurer has accepted a psychiatric condition, *and*
- It is the only condition being treated.

A psychiatrist or psychiatric ARNP may certify a worker's time loss from work if:

- A psychiatric condition has been allowed, *and*
- The psychiatric condition is the only condition still being treated.

A psychiatrist may also rate mental health permanent partial disability.

A psychiatric ARNP can't rate permanent partial disability.

Can't be attending provider: Psychologists

Psychologists can't be attending providers and can't certify time loss from work or rate permanent partial disability. Psychologists may document worker's return to work issues related to accepted mental health conditions.

Link: For more information on who can be an attending provider, see WAC 296-20-01002.

Social workers and other master's level counselors

Mental health evaluation and treatment services aren't covered when provided by social workers and other master's level counselors, even when delivered under the direct supervision of a clinical psychologist or a psychiatrist.

Link: The Department is currently conducting a Master's Level Therapist (MLT) Pilot. MLTs participating in the pilot may provide limited services.

Payment rates for specific provider types

Licensed clinical psychologists and psychiatrists

Licensed clinical psychologists and psychiatrists are paid at the same rate when performing the same service.

Psychiatric ARNPs

Psychiatric ARNPs are paid at 100% of the values listed in L&I's Professional Services Fee Schedule.

Who must perform these services to qualify for payment

Authorized mental health services must be performed by a:

- Psychiatrist (MD or DO), *or*
- Psychiatric Advanced Registered Nurse Practitioner (ARNP), *or*
- Licensed clinical PhD or PsyD psychologist.

Psychological testing

Staff supervised by a psychiatrist, psychiatric ARNPs, or licensed clinical psychologist may administer psychological testing; however, the psychiatrist, or licensed clinical psychologist must:

- Interpret the results, *and*
- Prepare the reports.
- Bill for the services performed by their staff

Services that aren't covered

These services (CPT® billing codes) aren't covered:

- **90845**,
- **90846**,
- **90849**,
- **90863**.

Psychologists can't bill the E/M codes for office visits.

Link: The coverage decision for Chronic Migraine or Chronic Tension-type Headache is available online.

Payment limits

These services (CPT® billing codes) are **bundled** and aren't payable separately:

- **90885**,
- **90887**,
- **90889**.

Psychiatrists and psychiatric ARNPs may only bill the E/M codes for office visits on the same day psychotherapy is provided if it's medically necessary to provide an E/M service for a condition other than that for which psychotherapy has been authorized.

The provider must submit documentation of the event and request a review before payment can be made.

Link: For additional information see Authorization and Reporting Requirements for Mental Health Specialists. This document provides guidance for mental health specialists on the following:

A. Coverage of Mental Health Conditions
   - Conditions caused or aggravated by an industrial injury or occupational disease
   - Pre-existing or unrelated conditions delaying recovery
   - Services that mental health specialists provide

B. Authorization Requirements
   - Initial evaluation and treatment
   - Ongoing treatment

C. Reporting Requirements
   - Diagnosis of a mental health condition
   - Return to work considerations
   - Identification of barriers to recovery from an industrial injury
   - Documenting a treatment plan with special emphasis on functional recovery
   - Assessment of functional status during treatment

D. Billing Codes

Payment policy: Audio only mental health services

General information

The insurer covers audio only mental health services when prior authorization for mental health has been obtained, and only in specific circumstances. See Chapter 10: Evaluation and Management Services for additional requirements regarding phone calls.

Services that must be performed in person

An in-person evaluation is required once every 6 months. In-person evaluations are always required when:

- Consultations requested to determine if conservative care is appropriate, *or*
- The provider has determined the worker is not a candidate for audio only either generally or for a specific service, *or*
- The worker does not want to participate via audio only.

Prior authorization

The same prior authorization requirements listed in Chapter 17: Mental Health Services apply to this policy update.

Services that are covered

When mental health services are conducted via audio only, the provider is unable to perform a visual assessment of the worker. Therefore the insurer has adopted a modified list of services that may occur via audio only. The requirements for prior authorization, documentation, and payment limits listed in Chapter 17: Mental Health Services apply to the following services covered under this update:

- **90791**
- **90832**
- **90834**
- **90837**
- **90839**
- **90840**
- **90847**
- **90853**

In addition, **90785** may be billed if it is appropriate for the audio visit. **90785** is only payable with **90791**, **90832**, **90834**, **90837**, or **90853** when the visit is audio only. See CPT® for additional requirements when billing **90785**.

Case management services may also be delivered telephonically (audio only) and are detailed in Chapter 10: Evaluation and Management (E/M) Services.

Services that aren't covered

The same services that aren't covered in Chapter 17: Mental Health Services apply to this policy.

Aside from **90791**, mental health codes with an evaluation component aren't covered when performed telephonically (audio only). These services may only be billed if the service is rendered via **telehealth** or in-person.

Audio only procedures

Audio only procedures and services that aren't covered include:

- The services listed under "Services that must be performed in-person",
- Purchase, rental, installation, or maintenance of audio only equipment or systems,
- Neuropsychological testing, *and*
- Home health monitoring.

Q3014 and **T1014** aren't covered under this policy.

Requirements for billing

Bill using modifier **-93** to indicate services rendered via audio only.

Documentation requirements

Providers must document all medical, vocational, or return to work decisions made. For the purposes of this policy, the following must be included in the provider's documentation:

- The date, *and*
- The participants and their titles, *and*
- The length of the call, *and*
- The nature of the call, *and*
- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in audio only services.

Chart notes must contain documentation that justifies the level, type and extent of services billed.

Payment policy: Case management services

Payment limits

Psychiatrists, psychiatric ARNPs, and clinical psychologists may only bill for case management services (telephone calls, team conferences, and secure e-mail) when mental health services are authorized.

Links: For more information about payment criteria and documentation requirements for these services, see the payment policy for case management services in Chapter 10: Evaluation and Management.

Payment policy: Individual and group goal oriented psychotherapy

Prior authorization

Group psychotherapy

Group psychotherapy treatment is authorized on a case by case basis only.

If authorized, the worker may participate in group therapy as part of the individual treatment plan.

Requirements for billing

Individual psychotherapy services

To report individual psychotherapy:

- Don't bill more than one unit per day, *and*
- Use the following timeframes for billing the psychotherapy codes:
  - 16-37 minutes for **90832** and **90833**.
  - 38-52 minutes for **90834** and **90836**.
  - 53 or more minutes for **90837** and **90838**.

Note: Chart notes must document time spent performing psychotherapy. Coverage of these services is different for psychiatrists and psychiatric ARNPs than it is for clinical psychologists (see below).

Psychiatrists and psychiatric ARNPs

Psychotherapy performed with an E/M service may be billed by psychiatrists and psychiatric ARNPs when other services are conducted along with psychotherapy such as:

- Medical diagnostic evaluation, *or*
- Drug management, *or*
- Writing physician orders, *or*
- Interpreting laboratory or other medical tests.

Psychiatrists and psychiatric ARNPs may bill the following individual goal oriented psychotherapy CPT® billing codes without an E/M service:

- **90832**,
- **90834**,
- **90837**.

Psychiatrists and psychiatric ARNPs may bill the following CPT® billing codes when performing an evaluation and management service on the same day:

- **90833**,
- **90836**,
- **90838**.

Psychiatrists and psychiatric ARNPs bill these CPT® billing codes in addition to the code for evaluation and management services.

Clinical psychologists

Clinical psychologists may bill only the individual goal oriented psychotherapy codes without an E/M component **90832**, **90834**, and **90837**. They can't bill psychotherapy codes **90833**, **90836**, or **90838** in conjunction with an E/M component because medical diagnostic evaluation, drug management, writing physician orders, and/or interpreting laboratory or other medical tests are outside the scope of a clinical psychologist's license in Washington.

Prolonged Services

Use the appropriate prolonged services code (**99354**, **99355**, **99356**, **99357**) with **90837** for psychotherapy services of 90 minutes or longer, face to face with the patient, not performed with E/M service.

Group psychotherapy services

If group psychotherapy is authorized and performed on the same day as individual goal oriented psychotherapy (with or without an E/M component), both services may be billed, as long as they meet the CPT® definitions.

The insurer doesn't pay a group rate to providers who conduct psychotherapy exclusively for groups of workers.

Payment policy: Narcosynthesis and electroconvulsive therapy

Prior authorization

Narcosynthesis and electroconvulsive therapy require prior authorization.

Who must perform these services to qualify for payment

Authorized services are payable only to psychiatrists.

Services that can be billed

Use CPT® codes **90865** (narcosynthesis) and **90870** (electroconvulsive therapy).

Link: More information about electroconvulsive therapy is available online.

Payment policy: Neuropsychological testing

What's included in neuropsychological testing

Test data must be sent to L&I by the treating psychologist. Test data includes:

- The injured worker's test results,
- Raw test data,
- Records,
- Written/computer-generated reports,
- Global scores or individual's scale scores, *and*
- Test materials such as:
    - Test protocols,
    - Manuals,
    - Test items,
    - Scoring keys or algorithms, *and*
    - Any other materials considered secure by the test developer or publisher.

The term **test data** also refers to:

- Raw and scaled scores,
- Patient responses to test questions or stimuli, *and*
- Psychologists' notes and recordings concerning patient statements and behavior during an examination.

Note: The psychologist is responsible for releasing test data to the insurer.

Services that can be billed

The following billing codes may be used when performing neuropsychological evaluation:

If the CPT® code is…	Then it may be billed:
90791 or **90792**	Once every 6 months per patient per provider.
96130, **96131**, **96136** or **96137**	Up to a combined 4 hour maximum. In addition to CPT® codes **96138** and **96139**.
96138 or **96139**	Per hour, up to a combined 12 hour maximum.

Note: Reviewing records and/or writing/submitting a report is included in these codes and can't be billed separately.

Payment policy: Pharmacological evaluation and management

Who must perform these services to qualify for payment

Pharmacological evaluation is payable only to psychiatrists and psychiatric ARNPs with pre-authorization.

Requirements for billing

Services conducted on the same day

When a pharmacological evaluation is conducted on the same day as psychotherapy, the psychiatrist or psychiatric ARNP:

- Can bill one of the add on psychotherapy codes **90833**, **90836**, or **90838** *and*
- Can bill a separate code for E/M services (CPT® codes **99202-99215**) at the same time.

Services not conducted on the same day

When a pharmacological evaluation is the only service conducted on a given day, the provider must bill the appropriate E/M code.

Payment policy: Mental health consultations and evaluations

Prior authorization

Prior authorization is required for all mental health care referrals. This requirement includes referrals for mental health consultations and evaluations.

Links: For more information on consultations and consultation requirements, see WAC 296-20-045 and WAC 296-20-051.

Services that can be billed

When an authorized referral is made to a psychiatrist or psychiatric ARNP, they may bill either the:

- Psychiatric diagnostic evaluation code **90791**, *or*
- Psychiatric diagnostic evaluation with medical services code **90792**.

When an authorized referral is made to a clinical psychologist for an evaluation, they may bill only CPT® code **90791** (Psychiatric diagnostic evaluation).

Telehealth psychology services are covered. For more information see link below.

Links: For more information, see the payment policy for teleconsultation and other telehealth services in Chapter 10 Evaluation and Management (E/M) Services.

Payment limits

CPT® codes **90791** or **90792** are limited to one occurrence every six months, per patient, per provider.

Payment policy: Repetitive Transcranial Magnetic Stimulation (rTMS) for treatment-resistant depression

The insurer covers transcranial magnetic stimulation (TMS) on a limited basis. Authorization for this treatment is dependent upon the conditions of coverage noted in the coverage decisions for TMS therapy. The coverage details are available online.

Prior authorization

Prior authorization is required prior to initiating rTMS treatment.

Who must perform these services to qualify for payment

Authorized services must be performed by a:

- Psychiatrist (MD or DO), *or*
- Psychiatric Advanced Registered Nurse Practitioner (ARNP), *or*
- Licensed clinical PhD or PsyD psychologist

Requirements for billing

Documentation must include the specific protocol used. The insurer must receive documentation including a copy of the treatment plan established by the visit billed using **90867.**

Billing of rTMS codes must be in accordance with CPT® code definitions.

Documentation of the treatment must support billing one of the three codes listed below for each date of service.

Chart notes must contain documentation that justifies the level, type and extent of services billed.

When billing a significantly separate identifiable service, using either modifier -25 or -59, the services must be documented separately.

E/M activities related to cortical mapping, motor threshold determination, and/or delivery and management of rTMS aren't separately payable.

Don't bill more than one unit per day to report TMS.

Services that can be billed

Repetitive transcranial magnetic stimulation (rTMS) is covered for workers with unipolar or bipolar diagnosis. This coverage is dependent upon the criteria outlined in the coverage decision.

Only therapies reflected in the CPT® code descriptions for the following codes may be authorized:

- **90867**
- **90868**
- **90869**

If a significant, separately identifiable E/M, medication management, or psychotherapy service is performed, then an E/M or psychotherapy code may be billed in addition to **90867-90869**. Use modifier -25 for a separately identifiable E/M or medication management service. Use modifier -59 for a separately identifiable psychotherapy service.

Payment limits

When billing this code…	The max billable units per day is…	And the max billable units per the life of the claim is…
90867	1	3
90868	1	As proper and necessary
90869	1	6

These three codes may not be billed together on the same date of service.

Multiple claims for the same claimant are subject to split billing.

Services not covered

TMS protocol that isn't FDA approved is not covered.

Services that aren't pre-authorized may be denied.

Payment policy: Residential facility offering treatment for mental health

General information

This policy applies to workers who require admission to a **residential facility for mental health** services. Workers covered under this policy update are either filing the initial claim, or have an open and allowed claim. This includes those who:

- Have an accepted mental health condition, such as occupational posttraumatic stress disorder (PTSD), *or*
- Have mental health treatment authorized, which may include the need for treatment of substance use disorder.

For information on which insurer to bill, see Chapter 2: Information for All Providers.

For additional inpatient or outpatient facility information, see Chapter 35: Hospitals.

For mental health services and authorization requirements, see Chapter 17: Mental Health Services. Supplemental information is defined in WAC 296-21-270.

Requirements for PTSD is defined in RCW 51.08.165. For occupational disease requirements, see RCW 51.08.142 and RCW 51.32.185 (presumptive coverage).

Claim filing

The filing of the initial L&I Report of Accident (ROA) or Provider's Initial Report (PIR) does not require prior authorization. The insurer covers the initial visit and evaluation so long as the L&I ROA or PIR and documentation of the initial evaluation conducted by the facility is submitted within one year from date of service. See Chapter 2: Information for All Providers for additional details on initial visits.

For workers where the facility is filing the L&I Report of Accident (ROA) or Provider's Initial Report (PIR) **and the worker requires treatment**, the following must be submitted to the insurer:

- The ROA or PIR, *and*
- Initial evaluation of the worker, including DSM-5 diagnosis with supporting documentation to support the diagnosis and pre-screening intake, if conducted, *and*
- Request for authorization for ongoing treatment.

The recommended treatment plan and all treatment records must be submitted to the insurer for authorization of ongoing treatment.

Note: Each facility may require their own release of record form, however, the insurer's ROA/PIR requires a signature by the worker to release relevant medical records. The ROA/PIR may be used in lieu of the facility's release of records form.

Claim status

The following are example claim statuses of workers who seek treatment at a **residential facility for mental health**:

1. Initial claim filing, evaluation **without** treatment. In this case, the worker may seek initial evaluation from a facility without prior authorization, but may not receive a mental health diagnosis per DSM-5 or require ongoing treatment. The insurer covers the initial visit and evaluation so long as the L&I ROA or PIR and documentation of the initial evaluation conducted by the facility is submitted within one year from date of service. See Chapter 2: Information for All Providers for additional details on initial visits.
2. Initial claim filing, evaluation **with** treatment. In this case, the worker may seek treatment from a facility and may require ongoing treatment per a DSM-5 diagnosis. The insurer covers the initial visit and evaluation so long as the L&I ROA or PIR and documentation of the initial evaluation conducted by the facility is submitted within one year from date of service. Additionally, prior authorization is required for ongoing treatment. See Mental Health Services, Chapter 17: Mental Health Services, and the prior authorization requirements for additional details.
3. Established claim. In these cases, an L&I worker's compensation claim is open and allowed and requires prior authorization for treatment. See prior authorization requirements for additional details.

In order to assist the worker and their providers, the insurer requires timely documentation. See documentation requirements below for additional details.

Treatment beyond the first visit and evaluation won't be paid when a claim is rejected.

Treatment

A referral from either the attending provider (AP) or a mental health provider (psychiatrist, psychiatric ARNP) is required prior to admission for open and allowed claims.

Prior authorization

Mental health prior authorization treatment requirements apply to claims filed through a **residential treatment facility**. Contact the insurer for prior authorization.

For workers with an open and allowed claim for accepted mental health conditions or treatment has been authorized, the following is required:

Inpatient:

- An evaluation by the facility, including a treatment plan, must be sent to the insurer for authorization **prior** to initiating treatment. The start date for treatment must be submitted as part of the evaluation.
- For treatment lasting longer than 6 weeks additional authorization is required. Contact the insurer for prior authorization. An updated treatment plan is required for additional authorization.

Ongoing treatment:

- Once discharged from inpatient treatment, an AP must be identified by the worker, or alternatively if the worker has identified an AP prior to admission at a facility, then care must be transferred back to the provider upon the worker's discharge. The AP is responsible for managing the overall care of the patient after discharge from a **residential facility for mental health**. The worker has the right to choose their AP.
- Once an AP is obtained or the worker returns to their provider's care, an updated treatment plan is required for additional treatment authorization as part of the worker's ongoing medical management. Facilities aren't required to develop an ongoing treatment plan once the worker has transferred care to an AP.

Payment methods

Bill the insurer usual and customary fees.

In state facilities will be paid POAC, DRG, or APC rate. See Chapter 35: Hospitals for details.

Out of state facilities will be paid at POAC rate. See Chapter 35: Hospitals for details.

Who must perform these services to qualify for payment

Washington State **residential facilities for mental health** must be certified and licensed by the Department of Health.

Out of state **residential facilities for mental health** must be licensed by the state the facility is located in, and accredited by the Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), or any other state-approved accrediting organization.

See Chapter 17: Mental Health Services for additional details on who can provide mental health services.

Services that can be billed

The insurer covers the following codes with prior authorization:

- **H0035**
- **H0047-H0050**
- **H2035**
- **H2036**
- **S9480**

This is in addition the codes found on the fee schedule.

Services that aren't covered

In addition to the codes not covered on the fee schedule, the following services aren't covered:

- **H0031-H0032**
- **H0036-H0040**
- **H0046**
- **H2001**
- **H2010-H2034**
- **H2037-H2038**

Requirements for billing

All charges for hospital inpatient and outpatient services provided to workers must be submitted on a UB-04 billing form using the UB-04 National Uniform Billing Committee Data Element Specifications.

Hospitals are responsible for establishing criteria to define inpatient and outpatient services. Bills for a patient admitted and discharged the same day, however, may be treated as outpatient bills and may be paid via POAC rate.

Documentation requirements

Chart notes and any treatment plan updates, per Chapter 2: Information for All Providers, and Chapter 17: Mental Health Services must be submitted to the insurer.

In addition to the requirements noted in Chapter 2: Information for All Providers, Chapter 17: Mental Health Services, and mental health services, all facilities must provide the insurer with the following documentation:

- Causality statement for the industrial injury or occupational disease (DSM-5 diagnosis) for initial claim filing, *and*
- The initial evaluation from a provider at the facility when the worker is admitted, *and*
- A recommended course of action for the worker, *and*
- Progress reports on a bi-weekly basis, *and*
- Discharge summary, including the proposed ongoing treatment plan for the worker when they return to their AP or mental health provider.

Make sure all documentation includes:

- The worker's full name,
- L&I claim number,
- Time as required per CPT® or HCPC coding,
- Treatment that was provided,
- Treating provider name, address and telephone number.

Don't fax the treatment plans or chart notes with bills. See Chapter 2: Information for All Providers for details on submitting chart notes and treatment plans to the insurer.

Payment limits

Providers may not charge workers for copayments or deductibles. The worker may not be balance billed for any services that are claim related. See RCW 51.04.030(2) and WAC 296-20-020.

Payment policy: Telehealth for mental health services

General information

The insurer reimburses **telehealth** at parity with in-person appointments.

Objective medical findings are required for time loss and other claim adjudication requirements. In-person visits are preferred for gathering objective medical findings, however, **telehealth** may be an appropriate alternative in certain situations where objective medical findings can be gathered via two-way audio and visual connection.

The provider is expected to make arrangements for in-person evaluation and intervention for certain circumstances. See below for additional information.

Telehealth services must occur either from a medical or vocational **origination site** or the worker's home. The selection of a provider is the worker's choice by law. Services may not be delivered from either the employer's worksite or any location owned or controlled by the employer that isn't operated by a Medical Provider Network practitioner.

A medical or vocational **origination site** may be:

- A clinic, *or*
- A hospital, *or*
- A nursing home, *or*
- An adult family home.

The provider performing **telehealth** services must be licensed in the state where the worker is receiving **telehealth** services.

Services that must be performed in person

An in-person evaluation is required once every 6 months. In-person evaluations are always required when:

- Consultations requested to determine if conservative care is appropriate, *or*
- The provider has determined the worker is not a candidate for **telehealth** either generally or for a specific services, *or*
- The worker does not want to participate via **telehealth.**

System requirements

Telehealth services and teleconsultations require an interactive telecommunication system, consisting of special two-way audio and video equipment that permits real time consultation between the patient and provider. Providers are responsible for ensuring complete confidentiality and privacy of the worker is protected at all times.

Prior authorization

The prior authorization requirements listed in Chapter 17: Mental Health Services apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

Services that are covered

The same services that can be billed in Chapter 17: Mental Health Services apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

Mental health examinations to complete a ROA or PIR filing and/or Activity Prescription Forms (even when restrictions or changes are anticipated) are covered when performed via **telehealth**.

The insurer will pay an **originating site** facility fee to a provider when they allow the worker to use their telecommunications equipment for a **telehealth** service with a provider at another location. To bill for the **originating site** facility fee, use HCPCS code **Q3014**.

Q3014 is payable to the **originating site** provider when no other billable service occurs.

Q3014 billing examples

Example 1: A worker, whose originating site is their attending provider's office, attends an in-person Evaluation and Management (E/M) appointment. The originating site provider documents all necessary information as part of this visit. Then, the worker requests the use of the provider's space to participate in a telehealth consultation with a distant site provider who is located in another office. The originating site provider or their assistant arranges a secure and private space for the worker to participate in the consultation. The provider at the originating site location with the worker bills the insurer **Q3014** for allowing this worker the use of their space for a visit with a distant site provider, but no other code is payable for this event to the originating site provider. The originating provider is required to separately document the activity as part of their bill for **Q3014**, and they submit separate documentation and a bill for the E/M visit that occurred earlier, noting the two distinct events in each documentation. The distant site consulting provider bills a consultation code, but they can't bill **Q3014**.

Originating site is…	Attending provider's office		
Originating site provider bills…	E/M visit code *and* **Q3014**	Originating site provider documents…	E/M visit *and* originating site visit **Q3014** (separate documentation)
Distant site provider bills…	Consultation code	Distant site provider documents…	Consultation

Example 2: A worker, whose originating site is their physician's office, attends an appointment for a telehealth consultation with a distant site provider. The originating site provider or their assistant arranges a secure and private space for the worker to participate in the consultation. The originating site provider bills the insurer **Q3014** for allowing this worker the use of their space for a visit with a distant site provider. The originating site provider is required to separately document the activity as part of their bill for **Q3014**. This provider can only bill **Q3014**, and the distant site consultant bills for their services provided. This distant site provider can't bill **Q3014**.

Originating site is…	Attending provider's office		
Originating site provider **bills**…	**Q3014**	Originating site provider **documents**…	Originating site visit **Q3014**
Distant site provider **bills**…	Consultation code	Distant site provider **documents**…	Consultation

Note: See the Audio Only Mental Health Services payment policy for additional details regarding mental health services provided via audio only.

Services that aren't covered

The same services that aren't covered in Chapter 17: Mental Health Services apply to this policy.

Telephonic (audio only) mental health services may be payable in certain circumstances, see the Audio Only Mental Health Services for additional details. Case management services may also be delivered telephonically (audio only) and are detailed in Chapter 10: Evaluation and Management (E/M) Services.

G2010 and **G2250** aren't covered services.

Telehealth procedures

Telehealth procedures and services that aren't covered include:

- The services listed under "Services that must be performed in-person",
- Purchase, rental, installation, or maintenance of telecommunication equipment or systems,
- Neuropsychological testing,
- Home health monitoring, *and*
- Telehealth transmission, per minute (HCPCS code **T1014**).

Telehealth locations

Q3014 isn't covered when:

- The **originating site** provider performs any service during a **telehealth** visit, *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, *or*
- The provider uses audio only.

The worker won't be reimbursed for using home as an **originating site**, or for any other **telehealth** related services.

Q3014 billing examples

Example 1: A worker, whose originating site is their home, attends a telehealth appointment with their provider. **Q3014** isn't payable to the provider in this example. No reimbursement is payable to the worker for using their home or their equipment for this visit.

Originating site is…	Worker's home		
Originating site provider **bills**…	n/a	Originating site provider **documents**…	n/a
Distant site provider **bills**…	No billable services	Distant site provider **documents**…	n/a

Example 2: A worker, whose originating site is their attending provider's office, attends a telehealth consultation. The distant site consulting provider cannot bill **Q3014** because the worker is in a different location than the distant site provider. However, the originating site provider whose space the worker is utilizing may bill **Q3014**, so long as they provide appropriate documentation of the service provided. No other service is payable to the originating site provider.

Originating site is…	Attending provider's office		
Originating site provider **bills**…	**Q3014**	Originating site provider **documents**…	Originating site visit **Q3014**
Distant site provider **bills**…	Consultation code	Distant site provider **documents**…	Consultation

Requirements for billing

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person.

Distant site providers must use place of service **-02** to denote the **telehealth** visit when the worker isn't located in their home. **Distant site** providers must use place of service **-10** to denote the **telehealth** visit when the worker is located in their home.

Bill using the **–GT** modifier to indicate **telehealth.**

Documentation requirements

For the purposes of this policy, the following must be included in addition to the documentation and coding requirements for services billed, as noted in MARFS:

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in **telehealth** services. This must be noted for each **telehealth** visit.

If treatment is to continue via **telehealth**, the evaluation report must include a detailed plan for implementing **telehealth** as agreed upon in a collaborative manner between the provider and worker.

Chart notes must contain documentation that justifies the level, type and extent of services billed.

When **Q3014** is the only code billed, documentation is still required to support the service. When a provider bills **Q3014** on the same day they render in-person care to a worker, separate documentation is required for both the in-person visit and the **Q3014** service. The **originating site** provider billing **Q3014** must submit separate documentation indicating who the **distant site** provider is and that the service is separate from the in-person visit that occurred on the same day.

Payment limits

The same limits noted in Chapter 17: Mental Health Services apply regardless of how the service is rendered to the worker.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for attending providers	Washington Administrative Code (WAC) 296-20-01002
Administrative rules for consultations and consultation requirements	WAC 296-20-045 WAC 296-20-051
Administrative rules for mental health services	WAC 296-21-270 WAC 296-14-300
Authorization and Reporting Requirements for Mental Health Specialists	Authorization and reporting rules on L&I's website
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare facility services (including ASCs)	Fee schedules on L&I's website
Mental health services website	Mental health services on L&I's website
Payment policies for **case management services**	Chapter 10: Evaluation and Management (E/M) Services
Payment policies for **teleconsultations and other telehealth services**	Chapter 10: Evaluation and Management (E/M) Services
Mental health services payment policies for **crime victims**	Crime Victims program on L&I's website WAC 296-31

Need more help?

Call L&I's Provider Hotline at **1-800-848-0811** or email **PHL@lni.wa.gov**

