Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 10: Evaluation and Management (E/M) Services

Effective July 1, 2022

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

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Definitions

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

Consultant: A consultant is a physician or other qualified health care professional who has not agreed to accept transfer of care before an initial evaluation.

Consultation: A type of evaluation and management service provided at the request of an attending provider, the department, self-insurer, or authorized department representative to either recommend care for a specific condition or problem, or to determine whether to accept a patient for further treatment. See WAC 296-20-045.

L&I doesn't use the CPT® definitions for consultation services with respect to who can request a consultation service, when a consultation can be requested, and requirements for when to bill a consultation vs. an established or new patient codes. In addition, while chiropractic consultations don't require prior authorization, they do require prior notification (by electronic communication, letter, or phone call) to the department or self-insurer per WAC 296-23-195.

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

Established patient: One who has received professional services from the physician/qualified health care professional, or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

When advance registered nurse practitioners and physician assistants are working with physicians they are considered as working in the exact same specialty and exact same subspecialties as the physician.

L&I uses the CPT® definition for established patients. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

New patient: One who hasn't received any professional services from the physician/qualified health care professional, or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

L&I uses the CPT® definitions for new patients. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

Online communications: Electronic communication conducted over a secure network, including but not limited to electronic mail (email), patient portals, or Claim and Account Center (CAC). Must be related to the worker and for the purposes of discussing or coordinating care, treatment, or return to work activities.

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.

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:

–24 (Unrelated evaluation and management (E/M) services by the same physician during a postoperative period)

Used to indicate an E/M service unrelated to the surgical procedure was performed during a postoperative period. Documentation to support the service must be submitted. Payment is made at one hundred percent of the fee schedule level or billed charge, whichever is less.

–25 (Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure)

Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

–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.

Payment policy: All E/M services

Prior authorization

Prior authorization is required when billing for:

- More than 20 office visits, *or*
- Visits that occur more than 60 days after the first date you treat the worker.

Link: For more information, see WAC 296-20-030(1).

Requirements for billing

All E/M services

Chart notes must contain documentation that justifies the level, type and extent of service billed. (See Documentation guidelines, below.)

Determining level of visit: New, established or consultation evaluation and management service

If a patient presents with a work related condition and meets the definition in a provider's practice as:

- A **new patient**, then a **new patient** E/M service should be billed, *or*
- An **established patient**, then an **established patient** E/M service should be billed, even if the provider is treating a new work related condition for the first time, *or*
- A **consultation** that has been requested by the attending physician, the department, self-insurer or authorized department representative and all requirements for a **consultation** service has been met, then a **consultation** E/M service should be billed.

Per WAC 296-20-051 providers may **not** bill **consultation** codes for **established patients**.

Links: For more information about coverage for **consultation** services, see WAC 296-20-045, WAC 296-20-051 and WAC 296-20-01002.

Using CPT® billing code modifier –25

Modifier **–25** must be appended to an E/M code when reported with another procedure on the same date of service. This applies to all E/M services.

The E/M visit and the procedure must be documented separately.

To be paid, modifier **–25** must be reported in the following circumstances:

- Same patient, same day encounter, *and*
- Same or separate visit, *and*
- Same provider, *and*
- Patient condition required a **significant separately identifiable E/M service above and beyond the usual pre and post care** related to the procedure or service.

Scheduling back-to-back appointments doesn't meet the criteria for using modifier **–25**.

Consultations

In accordance with WAC 296-20-051, in cases presenting diagnostic or therapeutic problems to the attending provider, a **consultation** with a specialist may be requested without prior authorization. Consultations can only be requested by the attending provider, the department, self-insurer, or authorized department representative.

The **consultant** must submit their findings and recommendations to the attending provider and the department or self-insurer. The report must be received by the insurer within 15 days from the date of the **consultation**, per WAC 296-20-051. Note that this is different from the requirement noted in Chapter 2: Information for All Providers which states that documentation to support the service billed must be received prior to bill submission or within 30 days of the date of service, whichever comes first.

Consultation codes may only be reported by a physician or other qualified health care professional who has not agreed to accept transfer of care before an initial evaluation. **Consultation** services will not be reimbursed for workers who are currently, or have been, under the provider's care within the last three years or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. Such services should be billed as **established patient** E/M services, as listed in the fee schedules.

Note: Prior notification to the insurer is required for chiropractic consultants. Refer to Chapter 7: Chiropractic Services for more information regarding the requirements for Chiropractic Consultants.

Behavioral Health Interventions

Behavioral Health Interventions are a brief course of care with a focus on addressing psychosocial barriers that impede a worker's recovery and improve their ability to return to work. For more information, see Chapter 22: Other Services.

Documentation guidelines

SOAP-ER note requirements

As outlined in Chapter 2: Information for All Providers, the insurer requires the addition of ER (Employment and Restrictions) to the SOAP format. Chart notes must document the worker's status at the time of each visit.

Providers are required to submit notes that contain the information necessary for the insurer to make decisions regarding coverage and payment. Medical documentation for an injury in workers' compensation must contain the pertinent history and the pertinent findings found during an exam. These requirements apply regardless of which guidelines the provider is following.

The American Medical Association (AMA) made substantial changes to the **New** and **established patient** E/M services effective January 1, 2021. The insurer has chosen to adopt these changes with slight modification as of July 1, 2021. For example, separately billable services and split billing have their own policies. The insurer doesn't allow shared billing. All other E/M services follow the "1995 Documentation Guidelines for Evaluation and Management Services," or the "1997 Documentation Guidelines for Evaluation and Management Services."

New and established patients (CPT® 99202-99215)

Select the appropriate level of E/M service based on either:

- Time, *or*
- Medical decision making.

As defined by AMA, Physician/other qualified healthcare professional time includes the following activities, when performed:

- Preparing to see patient (e.g., review of tests),
- Obtaining and/or reviewing separately obtained history,
- Performing a medically appropriate exam and/or evaluation,
- Counseling and educating the patient/family/caregiver,
- Ordering medications, tests, or procedures,
- Referring and communicating with other health care professionals,

- Documenting clinical information in the electronic or other health record,
- Independently interpreting results (when not represented by its own CPT® code),
- Communicating results to the patient/family/caregiver,
- Care coordination.

Only time spent in covered activities by the physician on the calendar day of the visit (midnight to 11:59pm) can be counted toward the E/M visit time. Check-in and check-out time can't be used when determining the length of a visit as this may include ancillary staff time, wait time, etc.

Documentation must describe the covered activities performed. Generalized statements, such as "provided care coordination" aren't acceptable.

Examples of services that cannot be included in the time used to determine the level of E/M service, include but are not limited to:

- The performance of other services that are reported separately. See Separately Billable Services,
- Travel,
- Teaching that is general and not limited to discussion that is required for the management of a specific patient,
- Discussion of L&I claims process with the patient/family/caregiver.

Note: All questions, discussions, and/or concerns regarding the administrative process of L&I claims should be directed to the insurer.

All other E/M visits

The 1995 Documentation Guidelines for Evaluation & Management Services or the 1997 Documentation Guidelines for Evaluation and Management Services guidelines are still applicable to all other E/M visits including but not limited to, **consultations** and emergency room visits.

The key components in determining the level of these types of E/M services are:

- The history,
- The examination, *and*
- Medical decision making.

Office visits that consist predominately (more than 50 percent of the visit) of counseling and/or coordination of care activities are the exception. For these visits, time is the key or controlling factor for selecting the level of evaluation and management service. If the level of service is reported based on counseling and/or coordination of care, the chart note must have the total length of the visit documented, as well as what portion of the time was spent performing covered counseling and/or coordinating care activities. The chart note must also describe the counseling and/or the activities to coordinate care. CPT® defines counseling as a discussion with a patient and/or family concerning one or more of the following areas:

- Diagnostic results, impressions, and/or recommended diagnostic studies,
- Prognosis,
- Risk and benefits of management (treatment) options,
- Instructions for management (treatment) and/or follow up,
- Importance with compliance with chosen management (treatment) options,
- Risk factor reduction,
- Patient and family education.

Consultation reports

In addition to the above, **consultation** reports must include the elements listed in WAC 296-20-01002. These requirements are separate from those outlined in Chapter 2: Information for All Providers. Documentation of the referral must be present in either the attending physician notes or the **consultant's** report. The report must be received by the insurer within 15 days from the date of the **consultation**, per WAC 296-20-051.

Links: The following resources contain useful documentation guidelines and requirements:

- American Medical Association Guideline Changes
- The 1995 Documentation Guidelines for Evaluation & Management Services,
- The 1997 Documentation Guidelines for Evaluation and Management Services.

For more information about coverage for **consultation** services, see WAC 296-20-045, WAC 296-20-051 and WAC 296-20-01002.

For more information about chiropractic **consultation** services, see WAC 296-23-195.

Separately billable services

Any procedure represented by their own CPT®, HCPCS, or local codes must be billed separately, and the time spent on these services cannot be included in the time used to determine the level of E/M service. This is applicable to all E/M services, regardless of which guideline the provider is required to follow.

This includes but is not limited to services, such as:

- Care coordination (e.g., telephone calls or online communications), *or*
- Completing forms such as a Report of Accident (ROA) or Activity Prescription Form (APF), *or*
- Independently interpreting results(when represented by its own CPT® code), *or*
- Injections, *or*
- Any treatment-based service.

When these services are performed in conjunction with an E/M service, you must append modifier **–25.**

CPT® modifier –25

When billing with modifier -25, the insurer follows CPT® guidelines for the billing of an E/M service on the same day as performing a procedure or service identified by a CPT® code.

An E/M can only be billed if the patient's condition required a significant separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.

Note: Evaluation and reporting is bundled into the payment of many services.

Examples of billing with modifier –25 (time-based)

Example 1 (new or established)

A worker goes to the physician's office for a follow-up of their work related elbow and shoulder injury. The physician evaluates and documents findings of the shoulder injury and suggests a steroid injection based on their findings. The physician also evaluates and documents findings related to the elbow injury and determines that physical therapy may provide benefit and provides a referral.

The physician performs the pre-service work (e.g., cursory history, palpatory examination, discusses side effects). The physician then performs the steroid injection, discusses self-care and follow up with the worker, and completes the other necessary post-service work.

The physician documents the steroid injection (including pre-, intra- and post service work), totaling 25 minutes and an additional separately identifiable E/M service including record review, history, exam, counseling provided and charting time, totaling 30 minutes.

How to bill for this scenario

For this office visit, the physician would bill the appropriate:

- CPT® code for the steroid injection, and
- CPT® code **99214**, with the **–25** modifier.

The physician can't include the time or activities spent performing the steroid injection (including the associated pre, intra and post service work) in selecting the appropriate E/M level. The provider must clearly document each service, including time spent on each service.

Example 2 (new or established)

A worker goes to the physician's office for a follow-up of their work related head injury. After reviewing the notes from the worker's neurologist the physician finds that they have questions regarding the current treatment plan. The physician documents a 10 minute telephone conversation with the neurologist on the day of the visit including all required documentation elements of that CPT® code. The physician evaluates and documents findings of the head injury as well as the treatment plan.

The physician documents 10 minutes for the telephone call as noted above. The physician also documents the separately identifiable E/M service including record review, history and exam, and charting, totaling 40 minutes.

How to bill for this scenario

For this office visit, the physician would bill the appropriate:

- CPT® code for the telephone call, *and*
- CPT® code **99215**, with the –**25** modifier.

The physician can't include the time or activities spent performing or documenting the telephone call in selecting the appropriate E/M level as this service is required to be billed separately. The provider must clearly document each service, including time spent on each service.

Examples of billing with modifier –25 (not time-based)

Example 1 (new or established patient)

A worker goes to an osteopathic physician's office to be treated for back pain. The physician performs an E/M visit, including a multi-system examination, reviewing the patient's prior records and counseling the patient on the importance of appropriate lifting techniques for when they return to work. Based on their findings the physician then advises the worker that osteopathic manipulative treatment (OMT) is a therapeutic option for treatment of the condition.

The physician obtains verbal consent, determines the appropriate technique for the worker and performs other pre-service work (e.g., cursory history, palpatory examination, discusses side effects). The physician then performs the manipulation, discusses self-care and follow up with the worker, and completes the other necessary post-service work.

The physician documents the OMT, including the pre, intra and post service work, in their chart note along with the separately identifiable E/M service (e.g., multi- system examination above and beyond the palpatory exam completed for the OMT service, reviewing records and counseling the patient on return to work).

How to bill for this scenario

For this office visit, the physician would bill the appropriate:

- CPT® code for the OMT service, and
- **New** or **established patient** E/M code, with the –**25** modifier.

The physician can't include the activities or time spent performing OMT services (including the associated pre, intra and post service work) in selecting the appropriate E/M level. The provider must clearly document each service.

Link: More information on billing for OMT is available in Chapter 25: Physical Medicine Services.

Example 2 (new or established patient)

The worker goes to the physician's office for a work related 2cm laceration of the worker's scalp. The physician evaluates the laceration and determines sutures are needed. The evaluation of the scalp laceration is considered inclusive of the pre-service work for the laceration repair and therefore is included in the payment of the surgical code.

The worker is also complaining of dizziness. The physician performs an exam to determine if the worker sustained a concussion. The physician places the patient off work and makes a phone call after the encounter to the worker's employer to notify them of the work restriction.

The physician documents the surgical procedure performed (including pre-, intra- and post service work), all required elements of the telephone call placed to the worker's employer, and the separately identifiable E/M service performed for the dizziness.

How to bill for this scenario

For this office visit, the physician would bill the appropriate:

- CPT® code for the laceration repair procedure, and
- Level of telephone call based on the documented length of the call, and
- Level of **new** or **established patient** E/M code with the **–25** modifier.

The physician can't include any of the activities or time spent performing the laceration repair service (including the associated pre, intra and post service work) in selecting the appropriate E/M level. The physician also can't include the time or activities spent performing or documenting the telephone call as this service is required to be billed separately. The provider must clearly document each service.

Example 3 (multiple visits same day)

A worker arrives at a physician's office in the morning for a scheduled follow up visit for a work related injury.

That afternoon, the worker's condition worsens and the worker seeks immediate medical attention and returns to the office without an appointment. The office staff or triage nurse agrees that the worker needs to be seen. The provider sees the worker for a second office visit.

How to bill for this scenario

Since the 2 visits were completely separate, both E/M services may be billed:

- The scheduled visit would be billed with the appropriate level of **established patient** E/M code for this visit alone, with no modifier appended, and
- The unscheduled visit would be billed with the appropriate level of **established patient** E/M code for this visit alone, with the **–25** modifier.

The activities or time spent performing each separate E/M service can't overlap between the two visits, including charting or any other time spent in covered activities conducted on the same calendar day of the encounters (e.g., review of records, referrals). You can only count these activities under the applicable visit.

Example 4 (consultation)

The worker presents to the physician's office, at the request of their attending provider, as the patient has been experiencing changing chronic symptoms. The referral states the patient has a history of chronic low back pain since their work-related accident. Records were available in advance and are reviewed by the provider with the patient during the course of the visit. The physician obtains an additional history from the patient, completes a review of systems and performs a detailed examination. The physician determines an MRI has not been performed recently and one is necessary based on their findings, so they order an MRI. The physician also recommends a steroid injection today.

The physician obtains verbal consent and performs other pre-service work associated with the injection (e.g., preparation of equipment, prepping the patient, discusses side effects). The physician then performs the injection, discusses self-care and follow up with the worker, and completes the other necessary post-service work.

The physician documents the injection performed (including pre-, intra- and post service work), and the separately identifiable E/M service.

How to bill for this scenario

For this office visit, the physician would bill the appropriate:

- CPT® code for the injection procedure, and
- Appropriate level **consultation** E/M code with the **–25** modifier.

The physician can't include the activities or time spent performing the injection (including the associated pre, intra and post service work) in selecting the appropriate E/M level. The provider must clearly document each service.

Payment policy: Care plan oversight

Who must perform these services to qualify for payment

The attending provider (not staff) must perform these services.

Services that can be billed

The insurer allows separate payment for care plan oversight services (CPT® codes **99375**, **99378**, and **99380**).

Requirements for billing

Payment for care plan oversight to a provider providing post-surgical care during the postoperative period will be made only:

- If the care plan oversight is documented as unrelated to the surgery, and
- Modifier **–24** is used.

The medical record must document the medical necessity as well as the level of service performed.

Payment limits

Payment is limited to one unit:

- Per attending provider,
- Per patient,
- Per 30 day period.

Care plan services (CPT® codes **99374**, **99377**, and **99379**) of less than 30 minutes within a 30 day period are considered part of E/M services and aren’t separately payable.

Payment policy: Case management services – Online communications

Requirements for online communications

Online communications must be conducted over a secure network, developed and implemented using guidelines from reputable industry sources such as those published by:

- The American Medical Association, *or*
- The Federation of State Medical Boards, *or*
- The eRisk Working Group for Healthcare.

Who must perform these services to qualify for payment

Online communications are payable only to providers who have an existing relationship with the worker and personally provide and bill for the service.

Services that can be billed

Payable **online communications** are billed using local code **9918M** and include:

- Follow up resulting from a face to face visit that doesn't require a return to the office,
- Non-urgent services for an accepted condition when the equivalent service provided in person would have resulted in a charge,
- Reporting and interpreting diagnostic tests that require counseling and adjustments to treatment or medications,
- Discussing care or treatment, for example, in-depth conversations on medical rationale and employability, or detailed notification of non-compliance to the claims manager, *and*
- Discussions of return to work activities with workers, employers, or the claim manager.

Payable **online communications** must be related to the worker and for the purposes of discussing or coordinating care, treatment, or return to work activities. The **online communications** must be with:

- The worker,
- L&I staff,
- Attending Provider,
- Vocational rehabilitation counselors,
- PT, OT, speech language pathologist,
- Nurse case managers,
- L&I medical **consultants**,
- Other physicians,
- Other providers,
- TPAs, *or*
- Employers.

Services that aren't covered

CPT® codes **99421**-**99423** are not covered. The provider must bill local code **9918M**.

Services that aren't payable include:

- Administrative communications,
- Authorization,
- Resolution of billing issues,
- Routine communications related to appointments (including, but not limited to requests and reminders),
- Ordering prescriptions, including requests for refills,
- Test results that are informational only, *or*
- Communications with office staff.

Requirements for billing

Online communication documentation must include:

- The date, *and*
- The participants and their titles, *and*
- The details of the **online communication** (see Services that can be billed, above), *and*
- All medical, vocational or return to work decisions made.

A copy of the **online communication** must be sent to L&I.

Providers are not required to submit a separate document for **online communications** with an L&I claim manager made through the Claims and Account Center (CAC). CAC meets the documentation requirements for secure messaging.

Payment limits

9918M is limited to once per day per claim per provider.

Payment policy: Case management services – Team conferences

Who must perform team conferences to qualify for payment

Team conferences may be payable when the current or former attending providers, **consultants**, or concurrent care providers meets with one or more of the following:

- An interdisciplinary team of health professionals, such as:
  - Vocational rehabilitation counselors, *or*
  - Nurse case managers, *or*
  - PTs, OTs, and speech language pathologists, *or*
  - Psychologists.
- L&I staff, *or*
- L&I medical **consultants**, *or*
- Employers, *or*
- SIEs/TPAs.

The Department doesn't follow CPT® by requiring all providers to have seen or treated the patient in the previous 60 days.

Requirements for billing

Team conferences must be in-person or follow telehealth guidelines. See Payment Policy: Telehealth.

The following criteria must be met for team conferences:

- The need for a conference exceeds the day-to-day correspondence/communication among providers, and
- The worker isn't participating in a program in which payment for conference is already included in the program payment (For example, head injury program, or pain clinic), and
- 2 or more disciplines/specialties need to participate.

The insurer won't reimburse PT/OT and/or speech language pathologists for team conferences with members of the same clinic or care organization's physical medicine team.

Use correct CPT® billing codes. ARNPs, PAs, psychologists, speech-language pathologists, PTs, and OTs must bill using non-physician codes.

If the **patient status** is…	And you are **physician**, then bill CPT® code:	And you are a **non-physician**, then bill CPT® code:
Patient present	Appropriate level E&M	**99366**
Patient not present	**99367**	**99368**

For conferences **exceeding 30 minutes**, multiple units of **99366**, **99367**, and **99368** may be billed. For example, if the duration of the conference is:

- 1-30 minutes, then bill 1 unit, *or*
- 31-60 minutes, then bill 2 units.

Documentation requirements

Each provider must submit their own team conference documentation; joint documentation isn't allowed for any provider. Each team conference participant's documentation must include:

- The date, *and*
- The participants and their titles, *and*
- The length of the visit, *and*
- The nature of the visit, *and*
- All medical, vocational or return to work decisions made.

In addition to the documentation requirements noted above, team conference documentation must also include a goal oriented, time limited treatment plan covering:

- Medical,
- Surgical,
- Vocational or return to work activities, *or*
- Objective measures of function.

The treatment plan must allow a determination whether a previously created plan is effective in returning the worker to an appropriate level of function. For PTs and OTs, the team conference documentation must include an evaluation of the effectiveness of the previous therapy plan.

Additionally, if the patient is present, and you are a physician, you must comply with Evaluation and Management (E/M) coding guidelines, including the requirements to bill based off of time, medical decision-making, or key components (history, exam and medical decision making), depending on which guidelines the provider is required to follow for the E/M service. Please note, the department follows CPT® in covered counseling topics with the addition of the discussion of medical, surgical, vocational or return to work activities for Team Conferences **only** when billing for services that fall under the "1995 Documentation Guidelines for Evaluation and Management Services," or the "1997 Documentation Guidelines for Evaluation and Management Services."

Providers in a hospital setting may only be paid if the services are billed on a **CMS-1500** with an individual provider account number.

Payment policy: Case management services – Telephone calls

Who must perform these services to qualify for payment

Telephone calls are payable to the attending provider, **consultant**, psychologist, or other provider only when they personally participate in the call.

Services that can be billed

Payable telephone calls include:

- Follow up resulting from a face to face visit that doesn't require a return to the office,
- Non-urgent services for an accepted condition when the equivalent service provided in person would have resulted in a charge,
- Reporting and interpreting diagnostic tests that require counseling and adjustments to treatment or medications,
- Discussing care or treatment, for example, in-depth conversations on medical rationale and employability, or detailed notification of non-compliance to the claims manager, *and*
- Discussions of return to work activities with workers, employers, or the claims manager.

These services are payable when discussing or coordinating care or treatment with the following covered participants:

- The worker,
- L&I staff,
- Attending Provider
- Vocational rehabilitation counselors,
- Nurse case managers,
- Health services coordinators (COHE),
- L&I medical **consultants**,
- Other physicians,
- Other providers,
- TPAs, *or*
- Employers.

Telephone calls are payable regardless of when the previous or next office visit occurs. The insurer will pay for telephone calls if the provider leaves a detailed message for the recipient and meets all of the documentation requirements.

Services that aren't covered

Telephone calls aren't payable if they are for:

- Administrative communications,
- Authorization,
- Resolution of billing issues,
- Routine requests for appointments,
- Ordering prescriptions, including requests for refills,
- Test results that are informational only,
- Communications with the worker's attorney, or
- Communications with office staff.

The physician can't include the time spent performing or documenting the telephone call in selecting the appropriate E/M level as this service is required to be billed separately.

Requirements for billing

Any provider who isn't a physician (e.g. ARNPs, PAs, psychologists, PTs, and OTs) must bill using non-physician codes.

If the **duration** of the telephone call is…	And you are a **physician**, then bill CPT® code:	And you are a **non-physician,** then bill CPT® code:
1-10 minutes	**99441**	**98966**
11-20 minutes	**99442**	**98967**
21+ minutes	**99443**	**98968**

Note: Only 1 unit of **99443** or **98968** is payable for calls over 20 minutes. Billing a combination of these codes is not allowed.

Documentation requirements

Each provider must submit comprehensive documentation for the telephone call that must include:

- The date, *and*
- The participants and their titles, *and*
- The length of the call, *and*
- The details of the call (see Services that can be billed, above), *and*
- All medical, vocational or return to work decisions made.

Mental health services must be authorized for psychiatrists and clinical psychologists to bill these services, per WAC 296-21-270. In addition, please see the Chapter 17: Mental Health Services for additional information on mental health services provided via audio only.

Payment policy: End stage renal disease (ESRD)

General information

L&I follows CMS's policy regarding the use of E/M services along with dialysis services.

Services that can be billed

Separate billing and payment will be allowed when billed on the same date as an inpatient dialysis service for:

- An initial hospital visit (CPT® codes **99221**-**99223**),
- An initial inpatient **consultation** (CPT® codes **99251**-**99255**), *or*
- A hospital discharge service (CPT® code **99238** or **99239**).

Payment limits

E/M services (CPT® codes **99231**-**99233** and **99307**-**99310**) aren't payable on the same date as hospital inpatient dialysis (CPT® codes **90935**, **90937**, **90945**, and **90947**). These E/M services are bundled in the dialysis service.

Payment policy: Medical care in the home or nursing home

General information

L&I allows attending providers to charge for E/M services in:

- Nursing facilities,
- Domiciliary, boarding home, or custodial care settings, *and*
- The home.

Who must perform these services to qualify for payment

The attending provider (not staff) must perform these services.

Requirements for billing

The medical record must document the medical necessity, the level, type and extent of services billed and the location of the service.

Payment policy: Prolonged E/M

Requirements for billing

Refer to the table below for prolonged services billing requirements. Refer to CPT® for further details, including documentation requirements.

If you are billing for this **CPT® code**…	Then you **must also bill this (or these) other CPT® code(s)** on the **same date of service**:
99417	**99205** or **99215**
99354	**90837, 90847, 99241-99245, 99324-99337, 99341-99350** or **99483**
99355	**99354** and 1 of the CPT® codes required to bill **99354**
99356	**90837**, **90847**, **99218-99226**, **99231-99236**, **99251-99255**, or **99304-99310**
99357	**99356** and 1 of the CPT® codes required to bill **99356**

Prolonged Services Example

Prolonged service for an established patient (with or without direct patient contact).

For an 84-minute **established patient** E/M service bill **99215** and **99417** x 2.

To calculate this, the first 40 minutes are applied to the **99215**, which leaves a remaining 44 minutes of prolonged service. This equates to 2 units of **99417**. Do not report **99417** for any additional time increment of less than 15 minutes.

Prolonged service for a consultation.

For a 100-minute **consultation** E/M service bill **99244** and **99354** x 1.

To calculate this, the first 60 minutes are applied to **99244**, which leaves a remaining 40 minutes of prolonged service. This equates to 1 unit of **99354**.

Separately billable services and the time spent on those services can't be included in the calculation for the E/M service, including prolonged services. See also separately billable services section.

Payment limits

Payment of prolonged E/M is allowed with a maximum of 3 hours per day per patient.

Prolonged E/M service codes are payable only when another time-based E/M code or applicable psychotherapy code is billed on the same day.

The following prolonged services are not payable:

- Prolonged services without direct patient contact, except for **new** or **established patients**, (CPT® **99358**, **99359**), *or*
- Prolonged clinical staff services (CPT® **99415**, **99416**).

Links: For more information on prolonged E/M services, see the 1995 Documentation Guidelines for Evaluation and Management Services, the 1997 Documentation Guidelines for Evaluation and Management Services or the CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99417) Code and Guideline Changes.

Payment policy: Split billing – Treating two separate conditions

Requirements for billing

If the worker is treated for two unrelated conditions at the same visit, the charge for the service must be divided equally between the payers and/or claims.

If evaluation and treatment of the two injuries increases the complexity of the visit:

- A higher level E/M code might be billed, *and*
- If this is the case, the applicable guidelines must be followed and the documentation must support the level of service billed.

For State Fund claims, when submitting:

- Paper bills to L&I, list all workers' compensation claims treated in Box 11 of the **CMS-1500** form (F245-127-000) *or*
- Electronic claims, list all workers' compensation claims treated in the remarks section of the **CMS-1500** form.

L&I will divide charges equally to the claims.

If part of the visit is for a condition unrelated to an accepted L&I or self-insured claim and part is for the accepted condition:

- Providers must apportion their usual and customary charges equally between L&I or the SIE and the other payer based on the level of service provided during the visit.

Payment limits

A physician would only be paid for more than one evaluation and management visit if there were two separate and distinct visits on the same day (see Example 3, below).

Scheduling back-to-back appointments doesn't meet the criteria for using the **–25** modifier. See more about Using billing code modifier **–25** in the All E/M services payment policy section of this chapter.

Examples of split billing

Example 1

A worker goes to a provider to be treated for a work related shoulder injury and a separate work related knee injury. The provider treats both work related injuries.

How to bill for this scenario

For State Fund claims, the provider bills for one visit listing both workers' compensation claims in Box 11 of the **CMS-1500** form (F245-127-000).

L&I will divide charges equally to the claims. For self-insured claims, contact the SIE or their TPA for billing instructions.

Example 2

A worker goes to a provider's office to be treated for work related injury. During the examination, the worker mentions that he was in a car accident yesterday and now has neck pain. The provider treats the work related injury and the neck pain associated with the motor vehicle accident.

How to bill for this scenario

The provider would bill:

- 50% of their usual and customary fee to L&I or the SIE, and
- 50% to the insurance company paying for the motor vehicle accident.

L&I or self-insurer would only be responsible for the portion related to the accepted work related injury.

Example 3

In the morning, a worker arrives at a physician's office for a scheduled follow up visit for a work related injury. That afternoon, the worker's condition worsens and the worker seeks immediate medical attention and returns to the office without an appointment. The office staff or triage nurse agrees that the worker needs to be seen.

The provider sees the patient for a second office visit.

How to bill for this scenario

Since the two visits were completely separate, both E/M services may be billed as follows:

- The scheduled visit would be billed with the appropriate level of E/M code for this visit alone, with no modifier appended and
- The unscheduled visit would be billed with the appropriate level of E/M code for this visit alone, with the **–25** modifier.

Payment policy: Standby services

Requirements for billing

A report is required when billing for standby services.

The insurer pays for standby services when all the following criteria are met:

- Another provider requested the standby service, *and*
- The standby service involves prolonged provider attendance without direct face-to-face patient contact, *and*
- The standby provider isn't concurrently providing care or service to other patients during this period, *and*
- The standby service doesn't result in the standby provider's performance of a procedure subject to a "surgical package," *and*
- Standby services of 30 minutes or more are provided.

Payment limits

Subsequent periods of standby beyond the first 30 minutes may be reported and are payable only when a full 30 minutes of standby was provided for each unit of service reported.

Round all fractions of a 30-minute period downward.

Payment policy: Telehealth for evaluation and management 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. Only vocational rehabilitation counselors are exempt from this requirement.

Services that must be performed in person

In-person evaluation is required for non-mental health services when:

- It is the first visit of the claim, *or*
- Restrictions or changes are anticipated (the APF requires an update), *or*
- A worker requests a transfer of attending provider, *or*
- The worker has an emergent issue such as re-injury, new injury, or worsening status, *or*
- Consultations requested to determine if conservative care is appropriate.

An in-person evaluation is required in all cases when:

- A worker files a reopening application, *or*
- The provider has determined the worker is not a candidate for **telehealth** either generally or for a specific service, *or*
- Consultations in accordance with the restrictions noted below, *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 this chapter apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

Teleconsultations

All consultations must be requested by the attending provider, department, self-insurer or authorized department representative.

The insurer covers teleconsultations when the following conditions have been met:

- The **telehealth** provider must be a(n): doctor as described in WAC 296-20-01002; ARNP; PhD clinical psychologist; or Consulting DC who is an approved consultant with L&I. This provider must note which provider referred the worker, *and*
- The referring provider must be one of the following: MD; DO; ND; DPM; OD; DMD; DDS; DC; ARNP; PA; or PhD clinical psychologist, *and*
- The patient must be present at the time of the consultation, *and*
- Interactive audio and video telecommunications must be used allowing real time communication between the patient and the **telehealth** provider, *and*
- The exam of the patient must be under the control of the **telehealth** provider, *and*
- The **telehealth** provider must submit a written report documenting this service to the referring provider, and must send a copy to the insurer.

Links: Learn more about coverage of these services in WAC 296-20-045, WAC 296-20-051, and WAC 296-20-01002.

Services that are covered

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

Store and Forward

G2010 is covered for patient-to-provider store and forward of images or video recordings, including interpretation and follow up when it isn't part of an E/M visit. Follow up must occur within 24 business hours of receiving the images or video recordings. Follow up may occur by phone, **telehealth**, or in-person, and isn't separately payable. **G2010** isn't covered if the patient provides the image or video recording as follow-up from an E/M visit in the prior 7 days, nor if the provider's evaluation of the image or video recording leads to an E/M service within the next 24 hours or soonest available appointment. Providers are required to document their interpretation of the image or video recording. Chart notes that don't state the interpretation by the provider are insufficient.

Services that aren't covered

Telephonic visits don't replace video two-way communication and can't be billed using non-telephonic E/M services codes. Case management services may be delivered telephonically (audio only) and are detailed in Chapter 10: Evaluation and Management (E/M) Services.

Telehealth procedures

Telehealth procedures and services that aren't covered include:

- The services listed under "Services that must be performed in-person",
- Hands-on services,
- Completion and filing of any form that requires a hands-on physical examination (e.g. Report of Accident, Provider's Initial Report),

- Purchase, rental, installation, or maintenance of telecommunication equipment or systems,
- Home health monitoring, *and*
- Telehealth transmission, per minute (HCPCS code **T1014**).

Note: Completion of APFs can't occur via **telehealth** when the update will take the worker off work or the provider increases the worker's restrictions. In these situations the visit must be in-person.

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 or expenses.

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. See the documentation requirements in this chapter and other applicable MARFS chapter(s) for the type of service rendered and the documentation requirements.

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 payment limits listed in this chapter 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 E/M services	Washington Administrative Code (WAC) 296-20-045 WAC 296-20-051 WAC 296-20-01002 WAC 296-23-195 WAC 296-20-030
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
CMS 1500 form	F245-127-000
The **1995 Documentation Guidelines for Evaluation & Management Services**	1995 guidelines
The **1997 Documentation Guidelines for Evaluation and Management Services**	1997 guidelines
The **2021 Documentation Guidelines for Evaluation and Management Services**	2021 guidelines
Fee schedules for all healthcare professional services (including chiropractic)	Fee schedules on L&I's website
Payment policies **Chiropractic Services**	Chapter 7: Chiropractic Services
Payment Policies **Physical Medicine Services**	Chapter 25: Physical Medicine Services

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