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, 2024**

**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:**

**Attending Provider (AP):** A person licensed to independently practice one or more of the following professions: Medicine and surgery; osteopathic medicine and surgery; chiropractic; naturopathic physician; podiatry; dentistry; optometry; and advanced registered nurse practitioner. An Attending Provider actively treats an injured or ill worker. Typically, this is the primary care provider for a worker, although the worker may elect to change their attending provider and select another attending provider of their choosing. At times, the Attending Provider may be a concurrent care provider instead of the primary care provider. References throughout MARFS apply to Attending Provider types and not solely the attending provider on the claim.

**Link**: For the legal definition of AP, see WAC 296-20-01002. For information on transferring care between APs, see WAC 296-20-065.

**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 isn't 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 appear in this chapter:**

| Use | Payment Information |
|---|---|
| **–93 (Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system)** | |
| Use this modifier to indicate when a service was performed via audio-only.<br><br>**Note: Limited to certain services.** This modifier is only applicable to certain mental health and behavioral health intervention services. See the audio-only payment policy for more details. | This modifier doesn't affect payment but is necessary to describe the service. |
| **–GT (Via interactive audio and video telecommunication systems)** | |
| Use this modifier to indicate when a service was performed via telehealth.<br><br>**Note:** Modifier –95 (telehealth service) isn't recognized by the insurer. | This modifier doesn't affect payment but is necessary to describe the service.<br><br>Payment is based on the Place of Service (POS) billed with the telehealth service and this modifier. See the telehealth payment policy in this chapter for more information. |

**Note**: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

# Payment policy: All mental health services

## Prior authorization

All outpatient mental health services require prior authorization, unless it is the initial visit to open a mental health only claim.

## 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 or behavioral health services.**

**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.

For information about behavioral health services policies see Chapter 22: Other Services.

## 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 psychologist (PhD or PsyD), *or*
- Social workers and other Master's Level Therapists (MLTs).

### Mental Health Providers

A mental health provider may only be an **attending provider** when the insurer has accepted a psychiatric condition and it is the only condition being treated.

**Attending providers** can complete the Report of Accident (ROA), Time loss certification and other reports and forms applicable to **attending providers**. For more information on who can be an **attending provider** and what forms are applicable, see WAC 296-20-01002 and Chapter 27: Reports and Forms.

| | Psychiatrist (MD/DO) | Psychiatric ARNP | Psychologist (PsyD or PhD) | Social workers and other master's level therapists (MLTs) |
|---|---|---|---|---|
| **Attending Provider** | Yes | Yes | **No** | **No** |
| **Mental Health Counseling** | Yes | Yes | Yes | Yes |
| **Prescribing Medication** | Yes | Yes | **No** | **No** |
| **IME Examiner** | Yes | **No** | **No** | **No** |
| **Impairment Rating/Permanent Partial Disability** | Yes | **No** | **No** | **No** |

**Note**: Psychologists must document workers' return to work issues related to accepted mental health conditions in chart notes or reports.

### Social workers and other Master's Level Therapists

Mental health evaluation isn't covered when provided by Licensed Clinical Social Workers (LICSWs), Licensed Marriage and Family Therapists (LMFTs), and Licensed Mental Health Counselors (LMHCs), even when delivered under the direct supervision of a clinical psychologist or a psychiatrist. These providers may provide treatment only, after the worker has seen an appropriate provider for evaluation.

### Psychological and Neuropsychological testing

Technicians supervised by a psychiatrist or licensed clinical psychologist may administer psychological or neuropsychological testing and scoring. The psychiatrist or licensed clinical psychologist must:

- Interpret the results, *and*
- Prepare the reports, *and*
- Bill for the psychological or neuropsychological test administration and scoring performed by their technicians.

# Services that can be billed

## Brief Emotional/Behavioral Screens & Risk Assessments

For initial or repeat screening (such as the PHQ-9 or GAD-7) to determine if a worker should be referred for mental health treatment, use CPT® code **96127** Brief emotional/behavioral assessment. **96127** is limited to 3 assessments per day, per provider, with a maximum of 6 assessments per provider, per worker.

This code can't be used during active mental health treatment. These assessments aren't for diagnosing a mental health condition, but may be necessary to determine the need for more in-depth assessment or further intervention. For re-assessments during active mental health treatment of a diagnosed mental health condition, use the appropriate evaluation CPT® code.

**96127** can't be billed with other mental health CPT® codes, such as psychotherapy and evaluations.

## Interactive complexity

The add-on code for interactive complexity (**90785**) is only payable according to the limits found in CPT®. It isn't payable solely for the use of a language access provider. Documentation must include an explanation of the increased complexity and why it is required for proper treatment. Must be billed with **90791**, **90792**, **90832**, **90833**, **90834**, **90836**, **90837**, **90838**, or **90853**.

# Services that aren't covered

The following CPT® codes and their services aren't covered:

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

Psychologists and MLTs can't bill E/M CPT® codes for office visits.

MLTs can't bill for mental health evaluations or consultations.

**Link**: See L&I's coverage decision for treatment of Chronic Migraine or Chronic Tension-type Headache.

## Requirements for billing

Psychiatrists and psychiatric ARNPs may only bill an E/M service (CPT® **99202-99255, 99304-99316, 99341-99350**) for office visits on the same day psychotherapy is provided.

The time spent performing psychotherapy can't be included in selecting the E/M level of service. The provider must clearly document each service (E/M and psychotherapy), including time spent on each service.

Mental health providers must follow the reporting requirements in CPT® for the service billed.

## Documentation requirements

Mental health providers are required to submit documentation to the insurer and the **attending provider**.

The documentation requirements for mental health services can be found in the following locations:

- Treating Mental Health Conditions webpage
- Chapter 2: Information for All Providers
- Specific service documentation requirements in this chapter.

Mental health providers must submit documentation on the following schedule:

| Frequency | Documentation | Additional Information |
|---|---|---|
| Every visit | Chart notes | Must contain all required information, as noted above, in order for the insurer to make appropriate decisions regarding coverage and payment. |
| Every 30 days | Report | Submitted only when treating an unrelated mental health condition that is retarding recovery of an accepted condition. **This report isn't required if this information is submitted within visit chart notes.** Refer to Mental Health Authorization and Reporting for report requirements. |
| Every 60 days | Report | A separate report is required when treating an accepted mental health condition and visit chart notes do not contain enough information to provide a clear picture of progress to the insurer. **This report isn't required if this information is submitted within visit chart notes.** Refer to Mental Health Authorization and Reporting for report requirements. |

## Payment limits

These following CPT® codes and their services are **bundled** and aren't payable separately:

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

# Payment policy: Audio-only mental health services

## General information

The insurer covers mental health treatment via audio only when prior authorization for mental health has been obtained, and only in specific circumstances.

For telephone calls related to but not used to render treatment, see Chapter 10: Evaluation and Management Services, case management services.

**Audio-only shouldn't be used in place of telehealth or in-person services.**

## Services that must be performed in person

**An in-person visit is required once every 6 months. An in-person visit is also required when:**

- The provider has determined the worker isn't a candidate for audio only either generally or for a specific service, *or*
- The worker doesn't want to participate via audio only, *or*
- A worker files a reopening application, *or*
- A worker needs neuropsychological (CPT® **96132**, **96133**) or psychological testing (CPT® **96130**, **96131**), *or*
- A consultation is necessary to satisfy the 6-month in person requirement.

In-person visits consultations can occur with a non-treating mental health provider in place of the current treating provider. Non-treating mental health providers must:

- Document a referral from the treating provider for an in-person consultation, and
- Submit documentation of the visit to the insurer as well as the treating provider.

**Note**: MLTs must refer to a psychologist, psychiatric ARNP, or psychiatrist for the in-person 6-month visit for mental health services.

## Prior authorization

The same prior authorization requirements listed in this chapter apply to this policy.

## Services that can be billed

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 following CPT® codes are covered when performed via audio only:

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

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

## Services that aren't covered

In addition to services listed in the telehealth services that aren't covered policy, audio-only services that aren't covered include:

- Services that require visual treatment of a worker,
- Mental health codes with an evaluation component, with the exception of CPT® **90791**,
- Evaluation and Management (E/M) visits,
- Audio-only services done for the convenience of the provider or worker,
- Neuropsychological testing,
- Psychological testing, *and*
- **Q3014** originating site fees.

The purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems aren't covered.

## Requirements for billing

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

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

Providers billing for audio only services must use place of service **02** to denote the audio only visit when the worker isn't located in their home and will be reimbursed at the facility rate. Providers billing for audio only services must use place of service **10** to denote the audio only visit when the worker is located in their home and will be reimbursed at the non-facility rate.

## Documentation requirements

For the purposes of this policy, the following must be included in the documentation submitted by the provider in addition to the documentation and coding requirements for services billed:

- The date of the call, *and*
- The participants and their titles, *and*
- The length of the call, *and*
- The nature of the call, *and*
- All medical, vocational, or return to work decisions made, *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. See this chapter and other applicable MARFS chapter(s) for the type of service rendered and the documentation requirements.

## Payment limits

The same limits noted in this chapter apply regardless of how the service is rendered to the worker.

# Payment policy: Case management services

## Payment limits

Psychiatrists (MD or DO), psychiatric Advanced Registered Nurse Practitioners (ARNP), or licensed clinical psychologists (PhD or PsyD) may only bill for case management services (telephone calls, team conferences, and online communications) 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 only authorized in conjunction with mental health or psychotherapy treatment.

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 1 unit per day, *and*
- Use the following timeframes for billing the psychotherapy codes:
  - 16-37 minutes for CPT® **90832** and **90833**.
  - 38-52 minutes for CPT® **90834** and **90836**.
  - 53 or more minutes for CPT® **90837** and **90838**.

**Note**: In addition to the other CPT® requirements, 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.

The time spent performing psychotherapy can't be included in selecting the E/M level. The provider must clearly document each service, including time spent on each service.

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 CPT® **90832**, **90834**, and **90837**. They can't bill psychotherapy codes with an E/M component CPT® **90833**, **90836**, or **90838** 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 State.

### Master's Level Therapists

Master's Level Therapists (MLTs) may only provide individual psychotherapy without an E/M component (CPT® **90832**, **90834**, and **90837**). MLTs can't diagnose a mental health condition.

### Prolonged Services

Prolonged services for psychotherapy are no longer allowed per CPT®.

### 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 and documentation requirements for each service.

The insurer doesn't pay a group rate to providers who conduct psychotherapy exclusively for groups of workers. Individual psychotherapy must occur in conjunction with group therapy.

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# Payment policy: Mental health consultations and evaluations

## General information

When mental health services performed concurrently with one or more providers, the **attending provider** must coordinate care.

## Who must perform these services to qualify for payment

Authorized mental health consultations and evaluations must be performed by a:

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

## 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 CPT® **90791**, *or*
- Psychiatric diagnostic evaluation with medical services CPT® **90792**, *or*
- Appropriate level evaluation and management (E/M) service.

Psychologists can only bill CPT® **90791** for psychiatric diagnostic evaluations.

Some **telehealth** mental health services are covered, see telehealth for mental health services in this chapter.

## Services that aren't covered

Master's level therapists (MLTs) can't evaluate or consult on a mental health evaluation. MLTs must refer to a psychiatrist, psychiatric ARNP, or a psychologist for these services.

MLTs aren't authorized to provide mental health evaluations. CPT® **90791** and **90792** aren't covered for MLTs.

## Requirements for billing

Once every 6 months, workers receiving **telehealth**-based mental health care must receive an in-person mental health visit to continue **telehealth**-based mental health care.

**Note**: MLTs must refer to a psychologist, psychiatric ARNP, or psychiatrist for a consultation to satisfy the in-person 6-month telehealth visit as part of ongoing therapy.

For the purposes of mental health consultations only, the following must be included in addition to the documentation and coding requirements for services billed:

- The exam of the worker must be under the control of the provider, *and*
- The consulting provider must submit a written report documenting this service to the referring provider, and must send a copy to the insurer.

## Documentation requirements

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

## Payment limits

Psychiatric diagnostic evaluation CPT® codes **90791** and **90792** are limited to 1 occurrence every 6 months, per worker, per provider.

# 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**: See L&I's coverage decision for electroconvulsive therapy.

# Payment policy: Neuropsychological testing and evaluation

## General information

Neuropsychological testing consists primarily of individually administered tests that comprehensively sample domains that are known to be sensitive to the functional integrity of the brain. See the Psychological testing and evaluation policy for details on psychological testing.

Neuropsychological testing involves administration of standardized tests, for intellectual function, attention, executive function, language and communication, memory, visual-spatial function, sensoriomotor function, emotional and personality features, and/or adaptive behavior to evaluate the worker's neurocognitive abilities. The assumption is that these processes have been altered due to a change in the worker's neurological condition as a result of their injury.

The specific tests required to complete the evaluation is at the discretion of the provider, but requires a minimum of 2 tests.

## Who must perform these services to qualify for payment

Only psychiatrists (MD or DO), or licensed clinical psychologist (PhD or PsyD) may provide neuropsychological evaluation.

## Prior authorization

Prior authorization applies for all mental health services. Additional prior authorization is required to perform neuropsychological testing services.

## Requirements for billing

Neuropsychological testing will be considered for authorization when it is medically necessary based on one or more of the following indications:

- Cognitive or behavioral deficits related to known or suspected central nervous system impairment, trauma, or neuropsychiatric disorders (such as brain hypoxia, or due to toxic or chemical exposures) , *or*
- A treatment plan is required to measure functional abilities or impairments in individuals with known or suspected central nervous system impairment, *or*
- Substance impact on cognitive impairment, *or*
- Pre-surgery or treatment-related measurements of cognitive function to determine if it's appropriate to proceed with a medical or surgical procedure (such as deep brain stimulation, epilepsy surgery, stem cell or organ transplant) that may affect brain function, *or*

- Determine through measurement of cognitive abilities if a worker's medical condition impairs their ability to comprehend and participate in treatment regiments, or to function independently after treatment, *or*
- Testing the outcomes of cognitive rehabilitative procedures, *or*
- Evaluate primary symptoms of impaired attention and concentration that can occur due to neurological or psychiatric conditions.

**Note**: Occupational therapists (OT) or Speech Language Pathologists (SLP) may provide standardized cognitive performance testing (CPT® **96125**) to assist in identifying the worker's baseline and treatment strategies. Formal neuropsychological testing may be referred to a psychiatrist (MD or DO) or licensed clinical psychologist (PhD or PsyD).

### Neurobehavioral Status Examination

A neurobehavioral status examination (CPT® **96116** and **96121**) may be performed prior to neuropsychological testing and evaluation in order to help determine what type of tests are needed and how to administer them. This exam includes a clinical interview. A neurobehavioral status examination isn't required in order to complete a neuropsychological evaluation but is insufficient to diagnose mild cognitive impairment. Mini mental state examinations (MMSE) or MoCA cognition or other similar tests, when done without additional neurobehavioral testing, don't meet the definition of CPT® **96116** or **96121**.

**Neuropsychological testing and evaluation includes separate services: the evaluation (CPT® 96132 and 96133) and test administration and scoring (CPT® 96136-96139 and 96416).**

### Neuropsychological Testing Evaluation

Neuropsychological testing evaluation (CPT® **96132** and **96133**) includes:

- Record review, *and*
- Test selection, at the provider's discretion based on the individual worker's need, goals of the evaluation, and clinical decision making during the evaluation, *and*
- Clinical decision making, *and*
- Interpretation and integration of test results with other sources of clinical data (including relevant history and collateral information from other sources), *and*
- Creation of a clinical report, *and*
- Medical management and treatment planning, *and*
- Interactive feedback to worker, family member(s) or caregiver(s).

### Neuropsychological Test Administration & Scoring

Test administration and scoring is separately billable and includes the administration and scoring of 2 or more neuropsychological tests.

For test administration and scoring, use the following CPT® codes:

- **96136** and **96137** if performed by a qualified provider, *or*
- **96138** and **96139** if performed by a technician, *or*
- **96416** for automated testing and scoring via an electronic platform.

Time spent administering and scoring neuropsychological tests (CPT® **96138-96139**) can't be included in the time spent performing the neuropsychological testing evaluation service (CPT® **96132-96133**), such as interpretation of test results.

The qualified provider must bill and is responsible for technician supervision, test selection, data oversight, clinical interview, feedback session, interpretation and analysis, reporting and consultation.

Reviewing records and/or writing a report is included in the codes above and can't be billed separately.

**Note**: Additional resources for service requirements may be available from the American Medical Association, Centers for Medicare and Medicaid Services (CMS), or professional psychological associations.

## Services that can be billed

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

| CPT® code(s) and Description | Additional Information | Limit |
|---|---|---|
| Neurobehavioral Status Examination;<br>**96116** (1st hour)<br>**+96121** (each additional hour) | May be completed independent of or prior to a neuropsychological testing evaluation to help determine type of tests and how to administer them, including clinical interview.<br>When performing independently, this test isn't sufficient to diagnose mild cognitive impairment. | Up to a 4-hour maximum.<br>The time for this service doesn't apply to the 12-hour maximum set for CPT® codes **96136**, **96137**, **96138** and **96139** for test administration and scoring. |
| Neuropsychological Testing Evaluation;<br>**96132** (1st hour)<br>**+96133** (each additional hour) | The assumption is that the processes being examined have been altered due to a change in a neurological condition as a result of the worker's injury. | Up to a 4-hour maximum.<br>The time for this service doesn't apply to the 12-hour maximum set for CPT® codes **96136**, **96137**, **96138** and **96139** for test administration and scoring. |
| Neuropsychological Test Administration and Scoring **by a qualified provider**;<br>**96136** (1st 30 minutes)<br>**+96137** (each additional 30 minutes) | Billed with neuropsychological testing on same or different days.<br>Not appropriate when simply administering and/or scoring a PHQ-9 or GAD-7. | Up to a combined 12-hour maximum for test administration and scoring. **96136** or **96137** can't be billed with **96138** or **96139**. |
| Neuropsychological Test Administration and Scoring **by a technician**;<br>**96138** (1st 30 minutes)<br>**+96139** (each additional 30 minutes) | Billed with neuropsychological testing on same or different days.<br>Not appropriate when simply administering and/or scoring a PHQ-9 or GAD-7. | Up to a combined 12-hour maximum for test administration and scoring. **96138** or **96139** can't be billed with **96136** or **96137**. |

| CPT® code(s) and Description | Additional Information | Limit |
|---|---|---|
| Automated test administration and scoring via an electronic platform;<br>**96146** | Billed when providing a limited, single psychological or neuropsychological automated test (such as PHQ-9 or GAD-7). | Limited to 1 unit per day, per provider, per worker, regardless of the number of tests administered. Can't be billed with any other test administration and scoring codes. |

Time spent performing the activities associated with each service is cumulative over the entire episode of evaluation, even if the service is spread out over multiple visits. The cumulative time for each service must be reported at the completion of the entire episode of evaluation. Don't bill using a range of dates of service if the services were spread out over multiple days.

**Time calculated for each service represented by it's own CPT®, HCPCS, or local code can't be included in the time spent performing other billable services.** For example, test administration (CPT® **96136-96139**) time can't be included in the face-to-face time the provider spent evaluating and communicating the test results under neuropsychological testing evaluation (CPT® **96132-96133**).

## Documentation requirements

The following documentation and test data must be sent to L&I or self-insured employer by the provider who performs the service:

- Relevant medical and psychosocial history,
- Sources of information (such as worker interview, record review, behavioral observations),
- Tests administered,
- Clinical decision making,
- Interpretation of test data and other clinical information, including:
    - The worker's test results with scores, scales, and profiles,
    - Raw test data that is sufficient to allow reassessment by a panel or independent medical examiner (IME),
    - Records,
    - Written/computer-generated reports,
    - Global scores or individual's scale scores,
    - Worker responses to test questions or stimuli,
    - Providers' notes concerning worker statements and behavior during an examination, *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.
- Integration of sources of information (such as summary and impressions),
- Diagnosis,
- Treatment planning, *and*
- The time of each service (such as neurobehavioral status examination, neuropsychological evaluation, and test administration and scoring) provided.

**Note**: The provider is responsible for releasing test data to the insurer per WAC 296-21-270.

# Payment policy: Pharmacological evaluation and management

## Prior authorization

All mental health services require prior authorization.

## Who must perform these services to qualify for payment

Pharmacological evaluation is payable only to psychiatrists and psychiatric ARNPs.

## 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 (CPT® **90833**, **90836**, or **90838**) *and*
- Appropriate level evaluation and management (E/M) service.

### 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: Psychological testing and evaluation

## General information

Psychological testing is intended to test general psychological processes which are assumed to have an emotional, behavioral, environmental, and/or health etiology but are not directly mediated by the central nervous system as result of the worker's injury. See the Neuropsychological testing and evaluation policy for details on neuropsychological testing.

Psychological testing involves administration of several types of psychometric standardized tests for measuring emotional and interpersonal functioning, intellectual functioning, thought processes, personality and psychopathology. A mini mental state examination (MMSE) or MoCA cognition or similar tests may be appropriate but can't be the only tests performed.

The specific tests a worker requires to complete the evaluation is at the discretion of the provider, but requires a minimum of 2 tests.

## Who must perform these services to qualify for payment

Only psychiatrists (MD or DO) or licensed clinical psychologists (PhD or PsyD) may provide psychological testing.

## Prior authorization

Prior authorization applies for all mental health services. Additional prior authorization is required to perform psychological testing services.

## Requirements for billing

Psychological testing will be considered for authorization when it is medically necessary based on one or more of the following indications:

- To aid in determining psychological disorder and its severity and functional impairments to determine a psychiatric diagnosis when a mental illness is suspected, or to achieve a differential diagnosis from a range of medical or psychological disorders that present with similar symptoms,
- Measure behavioral factors that impact disease management, including but not limited to: pre-surgical evaluation, assessment of emotional or personality factors impacting physical disease management, assessment of psychological factors in chronic pain workers, or compliance to treatment regimens,
- Measure functional capacity to delineate specific cognitive, emotional or behavioral bases of functional complaints or disability,
- Measure psychological barriers and strengths to aid in treatment planning,
- Measure risk factors to determine a workers' risk of harm to self and/or others,
- Perform symptom measurement to objectively measure treatment effectiveness, and/or determine the need for referral for pharmacological treatment,
- Measure and confirm or refute clinical impressions obtained from interactions with the worker,
- Evaluate primary symptoms of impaired attention and concentration that can occur in many neurological and psychiatric conditions.

### Psychiatric Diagnostic Evaluation

A psychiatric diagnostic evaluation (CPT® **90791**) may be performed prior to psychological testing and evaluation in order to help determine what type of tests are needed. This type of evaluation may also be performed as a stand-alone clinical interview in the absence of a corresponding psychological testing evaluation (CPT® **96130** or **96131**).

**Psychological testing and evaluation includes separate services; the evaluation (CPT® 96130 and 96131) and test administration and scoring (CPT® 96136-96139 and 96416).**

### Psychological Testing Evaluation

Psychological testing evaluation (**96130** and **96131**) includes:

- Record review, and
- Test selection, at the provider's discretion based on the individual worker's need, goals of the evaluation, and clinical decision making during the evaluation, and
- Clinical decision making, and
- Interpretation and integration of test results with other sources of clinical data (including relevant history and collateral information from other sources), and
- Creation of a clinical report, and
- Medical management and treatment planning, and
- Interactive feedback to worker, family member(s) or caregiver(s).

### Psychological Test Administration & Scoring

Test administration and scoring is separately billable and includes:

- Administration of 2 or more psychological tests, *and*
- Scoring of 2 or more psychological tests.

For test administration and scoring, use the following CPT® codes:

- **96136** and **96137** if performed by a qualified provider, *or*
- **96138** and **96139** if performed by a technician, *or*
- **96416** for automated testing and scoring via an electronic platform.

Time spent administering and scoring psychological tests (CPT® **96138**-**96139**) can't be included in the time spent performing the psychological testing evaluation service (CPT® **96132**-**96133)**, such as interpretation of test results.

The qualified provider must bill and is responsible for technician supervision, test selection, data oversight, interpretation and analysis, reporting and consultation.

Reviewing records and/or writing a report is included in the codes above and can't be billed separately.

## Services that can be billed

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

| CPT® code(s) and Description | Additional Information | Limit |
|---|---|---|
| Psychiatric Diagnostic Evaluation;<br>**90791** | May be completed independent of or prior to psychological testing evaluation to help determine type of tests needed, including clinical interview. | 1 occurrence every 6 months, per worker, per provider. |
| Psychological Testing Evaluation;<br>**96130** (1st hour)<br>**+96131** (each additional hour) | The assumption is that the processes being examined have an emotional, behavioral, environmental and/or health etiology related to the worker's injury but are not directly mediated by the central nervous system. | Up to a 4-hour maximum.<br>The time for these services doesn't apply to the 12-hour maximum set for CPT® codes **96136**, **96137**, **96138**, and **96139** for test administration and scoring. |
| Psychological Test Administration and Scoring **by a qualified provider**;<br>**96136** (1st 30 minutes)<br>**+96137** (each additional 30 minutes) | Billed with psychological testing on same or different days.<br>Not appropriate when simply administering and/or scoring a PHQ-9 or GAD-7. | Up to a combined 12-hour maximum for test administration and scoring. **96136** or **96137** can't be billed with **96138** or **96139**. |
| Psychological Test Administration and Scoring **by a technician**;<br>**96138** (1st 30 minutes)<br>**+96139** (each additional 30 minutes) | Billed with psychological testing on same or different days.<br>Not appropriate when simply administering and/or scoring a PHQ-9 or GAD-7. | Up to a combined 12-hour maximum for test administration and scoring. **96138** or **96139** can't be billed with **96136** or **96137**. |

| CPT® code(s) and Description | Additional Information | Limit |
|---|---|---|
| Automated test administration and scoring via an electronic platform;<br>**96146** | Billed when providing a limited, single psychological or neuropsychological automated test (such as PHQ-9 or GAD-7). | Limited to 1 unit per day per provider per worker, regardless of the number of tests administered. Can't be billed with any other test administration and scoring codes. |

Time spent performing the activities associated with each service is cumulative over the entire episode of evaluation, even if the service is spread out over multiple visits. The cumulative time for each service must be reported at the completion of the entire episode of evaluation. Don't bill using a range of dates of service if the services were spread out over multiple days.

**Time calculated for each service represented by it's own CPT®, HCPCS, or local code can't be included in the time spent performing other billable services.** For example, test administration (CPT® **96136**-**96139**) time can't be included in the face-to-face time the provider spent evaluating and communicating the test results under psychological testing evaluation (CPT® **96130**-**96131**).

## Documentation requirements

The following documentation and test data must be sent to L&I or self-insured employer by the provider who performs the service:

- Relevant medical and psychosocial history,
- Sources of information (such as worker interview, record review, behavioral observations),
- Tests administered,
- Clinical decision making,
- Interpretation of test data and other clinical information, including:
    - The worker's test results with scores, scales, and profiles,
    - Raw test data that is sufficient to allow reassessment by a panel or independent medical examiner (IME),
    - Records,
    - Written/computer-generated reports,
    - Global scores or individual's scale scores, *and*
    - Worker responses to test questions or stimuli,
    - Providers' notes concerning worker statements and behavior during an examination, *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.
- Integration of sources of information (such as summary and impressions),
- Diagnosis,
- Treatment planning.

**Note**: The provider is responsible for releasing test data to the insurer per WAC 296-21-270.

# 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 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 the information in this chapter. 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 self-insured 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 self-insured PIR and documentation of the initial evaluation conducted by the facility is submitted within 1 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 self-insured 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 insurer determines 'relevant'. 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 services**:

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 self-insured PIR and documentation of the initial evaluation conducted by the facility are submitted within 1 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 self-insured PIR and documentation of the initial evaluation conducted by the facility is submitted within 1 year from date of service. Prior authorization is required before initiating treatment. See the Mental Health Services webpage, this chapter, and the prior authorization requirements below 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 below 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 and 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.
- Initial authorization is up to 6 weeks. 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 outpatient treatment:

- Continuation of mental health treatment by the facility in an outpatient setting requires authorization. The facility must submit an updated treatment plan as part of the authorization request. Facilities aren't required to develop an updated treatment plan once the worker has transferred care to an AP.

Discharge:

- Upon discharge, the facility must coordinate and transfer the worker's care back to the AP and/or referring provider. If the worker does not have an AP prior to admission, the facility must help the worker identify an AP prior to discharge and then coordinate and transfer the worker's care to the identified AP. The AP is responsible for managing the overall care of the worker after discharge from a **residential facility for mental health services**. The worker has the right to choose their 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.

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

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## Who must perform these services to qualify for payment

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

Out of state **residential facilities for mental health** services 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 All 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 to the codes found in L&I's professional provider 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.

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## Documentation requirements

Per Chapter 2: Information for All Providers, chart notes and any treatment plan updates, must be submitted to the insurer.

In addition to the requirements noted in Chapter 2: Information for All Providers and this chapter, 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 but not limited to, ongoing treatment plan for the worker when they return to their AP or mental health provider; assessment of worker's psychological status especially as related to reintegration in the workplace, home and community; and communication with the AP, referring provider, claim manager, assigned vocational counselor or family to support the worker's continued management of mental health condition, *and*
- The worker's full name, *and*
- L&I claim number, *and*
- Time as required per CPT® or HCPC coding, *and*
- Treatment that was provided, *and*
- 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.

## Additional information

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 decisions. 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 a two-way audio and visual connection.

The provider is expected to make arrangements for in-person evaluation and intervention for certain circumstances. See Services that must be performed in person for additional information.

**Telehealth** services must occur either from a medical or vocational **origination site** or the worker's home. 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. The employer or their designee may not direct or require the worker to use a specific medical provider.

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

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

Per WAC 296-20-065, the selection of a provider is the worker's choice by law. 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

**An in-person visit is required once every 6 months. An in-person visit is also required when:**

- The provider has determined the worker isn't a candidate for **telehealth** either generally or for a specific service, *or*
- The worker doesn't want to participate via **telehealth**, *or*
- A worker files a reopening application, *or*
- A worker needs neuropsychological (CPT® **96132**, **96133**) or psychological testing (CPT® **96130**, **96131**), *or*
- A consultation is necessary to satisfy the 6-month in-person requirement.

In-person consultations may occur with a non-treating mental health provider in place of the current treating provider. Non-treating mental health providers must:

- Document a referral from the treating provider for an in-person consultation, and
- Submit documentation of the visit to the insurer as well as the treating provider.

**Note**: MLTs must refer to a psychologist, psychiatric ARNP, or psychiatrist for the in-person 6-month visit for mental health services.

## System requirements

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

No payment will be made to the worker or provider for obtaining or maintaining equipment for a **telehealth** appointment.

## 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**.

## Services that can be billed

**Telehealth** procedures and services that are covered include most services that don't require a hands-on component. The worker must be present at the time of the **telehealth** service and the evaluation and/or treatment of the worker must be under the control of the **telehealth** provider.

Originating site fees are covered, when applicable.

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**. Re-opening examinations must be completed in person.

Mental health services may be payable via audio-only in certain circumstances, see the Audio-Only Mental Health Services for additional details. Telephone calls related to but not used to render treatment, see Chapter 10: Evaluation and Management Services, case management services.

## Originating Site Fee (Q3014)

The insurer will pay an **originating site** 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** fee, use HCPCS code **Q3014**. **Q3014** is payable to the **originating site** provider when no other billable service is rendered concurrently to the same worker.

**Note**: If the **distant site** and the **originating site** are owned or rented by the same entity, **Q3014** is payable as long as billing and documentation requirements are met.

**Q3014** isn't covered when:

- The **originating site** provider performs any service during the **telehealth** visit, *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, except when the same payee owns both sites and the worker is using their equipment for the telehealth service, *or*
- The provider uses an audio-only connection.

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

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.

Because **Q3014** is payable to the **originating site**, any provider employed by the **originating site** may bill for this service, so long as they sign the documentation supporting the **Q3014** service.

### Q3014 billing example

A worker attends an in-person Evaluation and Management (E/M) appointment at their **attending provider's** office. The **attending provider** documents all necessary information as part of this visit and bills for the E/M service. The **originating site** (**attending provider's** office) also arranges a secure and private space for the worker to participate in a consultation with their cardiologist at another location (**distant site** provider). The **originating site** provider separately documents the use of their space as part of their bill for **Q3014**.

**How to bill for this scenario**

The **originating site** provider may bill the insurer **Q3014** for allowing the worker to use their space for their telehealth visit with the **distant site** provider. The **distant site** provider bills for the services they provide; they can't bill **Q3014**.

For this **telehealth** visit:

- The distant site provider would bill the appropriate CPT® E/M code with modifier **–GT**.
- The originating site provider would bill **Q3014**.

**Note**: For Evaluation and Management Services refer to Chapter 10: Evaluation and Management (E/M) Services.

## Services that aren't covered

**Telehealth** procedures and services that aren't covered include:

- The same services that aren't covered in this chapter,
- The services listed under "Services that must be performed in person",
- Services that require physical hands-on and/or attended treatment of a worker,
- Home health monitoring,
- Neuropsychological testing,
- Psychological testing, *and*
- **G2010** and **G2250** Store and forward.

The purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems isn't covered.

**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.

## Requirements for billing

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

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

**Distant site** providers must use place of service **02** to denote the **telehealth** visit when the worker isn't located in their home and will be reimbursed at the facility rate. **Distant site** providers must use place of service **10** to denote the **telehealth** visit when the worker is located in their home and will be reimbursed at the non-facility rate.

## Documentation requirements

For the purposes of this policy, the following must be included in the documentation submitted by the **distant site** provider in addition to the documentation and coding requirements for services billed:

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

## Payment limits

The same limits noted in this chapter apply regardless of how the service is rendered to the worker.

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# Payment policy: Transcranial Magnetic Stimulation (TMS) for treatment-resistant depression

## General information

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 decision for TMS therapy.

## Prior authorization

Prior authorization is required before initiating TMS treatment. Each course of treatment requires separate prior authorization.

## Who must perform these services to qualify for payment

TMS must be performed by a:

- Psychiatrist (MD or DO), *or*
- Psychiatric Advanced Registered Nurse Practitioner (ARNP), *or*
- Certified technician under the supervision of one of the provider types above.

## Requirements for billing

Billing of TMS codes must be in accordance with CPT® code definitions and requirements.

Evaluation and Management (E/M) service activities related to cortical mapping, motor threshold determination, and/or delivery and management of TMS aren't separately payable.

## Services that can be billed

Transcranial magnetic stimulation (TMS) is covered for workers with treatment resistant major depressive disorder when the conditions of coverage are met as outlined in L&I's coverage decision.

Bill TMS using CPT® codes **90867**, **90868**, or **90869**.

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

## Services that aren't covered

TMS protocol that isn't FDA-approved isn't covered.

Bills for services performed without prior authorization will be denied.

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## Documentation requirements

Documentation must include the specific protocol used. The insurer must receive documentation including a copy of the treatment plan.

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

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

## Payment limits

The total number of combined sessions allowed for CPT® codes **90867**, **90868** and **90869** is 30 per course of treatment. Each course of treatment requires separate prior authorization. Additional treatment courses must meet the guidelines described in L&I's coverage decision.

CPT® **90869** may be billed up to a max of 2 units per treatment course.

Treatment related to multiple claims for the same worker is subject to split billing. See Chapter 2: Information for All Providers for more information.

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# 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<br>WAC 296-20-051 |
| **Administrative rules** for mental health services | WAC 296-21-270<br>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<br>WAC 296-31 |

## Need more help?

Email L&I's Provider Hotline at PHL@lni.wa.gov. If you would prefer a phone call, please email us your name and contact number.

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