Washington State Department of Labor & Industries

UPDATED 3/4/2022

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Behavioral Health Services

Effective January 1, 2020

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 document and are defined as follows:

Behavioral Health Services: Used to identify biopsychosocial barriers influencing recovery related to the prevention, treatment or management of physical injuries or occupational diseases. The focus is not on mental health but on services to improve the patient's health and well-being using cognitive, behavioral, and social interventions.

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

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

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

-GT (Via interactive audio and video telecommunication systems)

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

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

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

Payment policy: Audio only behavioral health services (BHS)

General information

The insurer covers audio only behavioral health services (BHSs). Refer to the Masters Level Therapists pilot policy for information on BHSs provided by Masters Level Therapists (MLTs).

Services that are covered

When behavioral health services are conducted via audio only, the provider is unable to perform a visual assessment of the worker. Therefore, the insurer has created a local code for behavioral health services that may occur via audio only. See requirements for billing. The requirements for prior authorization, documentation, and payment limits listed in Chapter 22: Other Services apply to the following services covered under this update.

Bill using code **9959M** when BHS occurs over audio only. This code is only payable to psychologists, or MLTs who are participating in the pilot.

Note: Refer to Chapter 10: Evaluation and Management Services and CPT® coding for telephone calls for behavioral health counseling services that are included as part of E/M.

Services that aren’t covered

If a mental health condition has been accepted or denied on a claim, BHSs aren’t appropriate and can’t be billed. Don’t perform or bill BHSs on claims with accepted or denied mental health conditions. Refer to Chapter 17: Mental Health Services for details on treating mental health conditions.

Requirements for billing

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

Documentation requirements

Providers must document all medical, vocational, or return to work decisions made.

For the purposes of this policy, the following must be included in the provider's documentation:

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

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

Payment limits

A maximum of 16 HBAI services, including **9959M**, may be performed during the life of the claim for MLTs.

Payment policy: Behavioral health services

General information

The **behavioral health services** payment policies in this section apply to workers covered by the State Fund and self-insured employers who have opted to participate in the MLT pilot. This payment policy applies only to those providers who are participating in the pilot.

The policies in this section don't apply to crime victims. For information about mental health services' policies for the Crime Victims' Compensation Program, see WAC 296-31.

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.

The fee schedule is available online.

Who must perform these services to qualify for payment

Authorized **behavioral health services** must be performed by a:

- LMFT Licensed Marriage and Family Therapist,
- LICSW Licensed Independent Social Worker, *or*
- LMHC Licensed Mental Health Counselor.

These services must be documented and submitted to the department on our required forms:

- Assessment: F245-461-000
- Intervention/Reassessment: F245-462-000

Services that can be billed

These Health and Behavior Assessment/Intervention (HBAI) CPT® billing codes may be billed: **96156**, **96158**, and **96159**.

Only HBAI services referred by the attending provider are covered.

Telephone calls to employers, vocational counselors and attending physicians use CPT® billing codes **98966**, **98967**, and **98968**.

Payment limits

Behavioral health treatment will be reimbursed and is authorized only when ordered by the worker's attending provider and rendered by a licensed masters level therapist (MLT) or psychologist.

The department or self-insurer will pay for up to a maximum of **16 visits** for the life of the claim using CPT® codes **96156**, **96158**, **96159** for a total daily maximum of one combined hour.

A behavioral health progress report must be submitted to the attending provider and the department or the self-insurer following each visit. Forms are available on the MLT pilot website.

Coverage of psychotherapy services is only authorized after mental health evaluation recommends continued treatment with an MLT.

Link: For additional information regarding mental health, see the Authorization and Reporting Requirements for Mental Health Specialists.

Payment policy: Case management services – Telephone calls

Who must perform these services to qualify for payment

Telephone calls are payable to the masters level therapist only when they personally participate in the call.

Services that can be billed

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

These services are payable when discussing or coordinating care or treatment with:

- 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.

Note: L&I doesn't adhere to the CPT® limits for telephone calls.

Services that aren't covered

Telephone calls aren't payable if they are for:

- Authorization, or
- Resolution of billing issues, or
- Ordering prescriptions.

Requirements for billing

If the duration of the telephone call is…	And you are a non-physician, then bill CPT® code:
1-10 minutes	**98966**
11-20 minutes	**98967**
21-30 minutes	**98968**

Documentation requirements

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

- The date, *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.

Payment policy: Case management services – Team conferences

Who must perform these services to qualify for payment

Team conferences may be payable when the **masters level therapist** meets with one or more of the following:

- An interdisciplinary team of health professionals,
- Attending Provider,
- L&I staff,
- Vocational rehabilitation counselors,
- Nurse case managers,
- L&I medical consultants,
- Masters level therapists,
- SIEs/TPAs, *or*
- PTs, OTs, and speech language pathologists.

Requirements for billing

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

For conferences **exceeding 30 minutes**, multiple units of **99366** and **99368** may be billed. 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 conference report; joint reports aren't allowed. Each conference report 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,
- Psychosocial barriers,
- 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.

Services that aren’t covered

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

90845,
90846,
90849,
90863
90885,
90887,
90889,
90899,
96153,
96154, *and*
96155.

Psychological testing

Neuropsychological testing is considered outside the scope of behavioral health services provided by MLTs. Providers may choose to track symptom severity across time using symptom scales (e.g. PHQ-9 or BDI for depression, GAD-7 or BAI for anxiety). These instruments are not diagnostic.

Payment policy: Telehealth for Masters Level Therapists

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 when:

- The provider has determined the worker is not a candidate for **telehealth** either generally or for a specific service, *or*
- The worker does not want to participate via **telehealth**, *or*
- The worker has an emergent issue such as re-injury, new injury, or worsening status.

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.

Services that are covered

Health and Behavior Assessment/Intervention (HBAI) CPT® billing codes **96156**, **96158**, **96159** are covered when **telehealth** is performed.

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** visit 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.

Services that aren't covered

The same services that aren't covered in the pilot payment policy for MLTs apply to this policy.

Telephonic visits don't replace video two-way communication and can't be billed using non-telephonic services codes. Case management services may be delivered telephonically (audio only) and are detailed in the pilot payment policy for MLTs. See the audio only behavioral health policy when providing treatment via audio only.

Telehealth procedures

Telehealth procedures and services that aren't covered include:

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

Telehealth locations

Q3014 isn't covered when:

- The **originating site** provider performs another 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.

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 service billed. See 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.

Payment limits

The same limits noted in the pilot payment policy for MLTs 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 mental health services	WAC 296-21-270 WAC 296-14-300
Authorization and Reporting Requirements for Mental Health Specialists	Authorization and Reporting Requirements on L&I's website
Fee schedules for all healthcare facility services (including ASCs)	Fee schedules on L&I's website
Mental health services	Mental health services on L&I's website
Mental health services **payment policies for crime victims**	Crime Victims resources on L&I's website WAC 296-31

Need more help?

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

