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, 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:

Consultant: A consultant is a provider who has not agreed to accept transfer of care before an initial evaluation.

Consultation: A type of evaluation and management (E/M) 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 worker 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. established or new patient codes.

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 provider, or another provider of the same specialty 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 provider, or another provider of the same specialty 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).

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 appear in this chapter:

Use	Payment Information
–24 (Unrelated evaluation and management (E/M) services by the same physician during a postoperative period)	
Use this modifier to indicate when an E/M service is performed during a postoperative period that was unrelated to the surgical procedure.	This modifier allows payment for the unrelated service. Payment is made at **100%** of the fee schedule level or billed amount, whichever is less.
–25 (Significant, separately identifiable evaluation and management (E/M) service by the same provider on the same day of the procedure or other service.)	
Use this modifier to indicate a significant, separately identifiable E/M service that went above and beyond another service provided by the same provider, for the same patient, on the same date of service. **Note**: This modifier should only be used with E/M services.	This modifier allows payment for the significant, separately identifiable E/M service. Payment is made at a maximum of **100%** of the fee schedule level or billed charge, whichever is less.
–93 (via telephone or other audio-only telecommunications system)	
Use this modifier to indicate when a service was performed via audio-only. **Note: Limited to certain services.** This modifier is only applicable to certain mental health and behavioral health intervention services. See the applicable audio-only payment policy for more details.	This modifier doesn't affect payment but is necessary to describe the service.

Use	Payment Information
–GT (Via interactive audio and video telecommunication systems)	
Use this modifier to indicate when a service was performed via telehealth. **Note:** Modifier –95 (telehealth service) is not recognized by the insurer.	This modifier doesn't affect payment but is necessary to describe the service. 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 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) and WAC 296-20-03001(1).

Requirements for billing

All medical records must contain documentation that justifies the level, type and extent of service billed. See Documentation requirements for more details.

Determining type 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 must be billed, *or*
- An **established patient**, then an **established patient** E/M service must 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 provider, the department, self-insurer or authorized department representative and all requirements for a **consultation** service has been met, then a **consultation** E/M service must 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 or service on the same day. 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 worker, same day encounter, *and*
- Same or separate visit, *and*
- Same provider, *and*
- Worker's 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. This timeframe is shorter than 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 (**99242-99245**) may only be reported by a provider who has not agreed to accept transfer of care before an initial evaluation. **Consultation** services won't be reimbursed for workers who are currently, or have been, under the provider's care within the last 3 years or another provider of the exact same specialty and subspecialty who belongs to the same group practice, within the past 3 years. Such services should be billed as **established patient** E/M services, as listed in the fee schedules.

Note: Per WAC 296-23-195, prior notification (by electronic communication, letter, or phone call) to the insurer is required for chiropractic consultations. Refer to Chapter 7: Chiropractic Services for more information regarding the requirements for chiropractic consultations.

Documentation requirements

The American Medical Association (AMA) made substantial changes to the **New** and **established patient** E/M services effective January 1, 2021 and expanded those guidelines to all other E/M services (including **consultations**) effective January 1, 2023. The insurer has chosen to adopt these updated changes with slight modification as of July 1, 2023.

Modifications include policies on separately billable services and admissions within the course of an encounter at another site. Additionally, the insurer doesn't allow shared billing for visits in which multiple providers contribute to an E/M service.

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 medical records that contain the information necessary for the insurer to make decisions regarding coverage and payment. Medical documentation for an injury in workers' compensation or crime victims must contain the pertinent history and the pertinent findings found during an exam.

Consultation reports

In addition to the above, **consultation** reports must include the elements listed in WAC 296-20-01002. Documentation of the referral must be present in either the attending physician notes or the **consultant's** report.

Links: For additional guidelines and requirements see 2021 and 2023 American Medical Association (AMA) E/M Code and Guideline Changes.

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.

Selecting the level of service

Select the appropriate level of E/M service based on coding guidelines in the CPT® book. This information can also be found in the 2021 AMA E/M new and established outpatient visit guideline updates or the 2023 AMA E/M guideline updates for all other E/M services.

Only time spent in covered activities by the provider 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.

When billing based on time, documentation must describe the covered activities performed. Generalized statements, such as "provided care coordination" aren't acceptable.

Examples of services that can't 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 can be reported separately. See Separately Billable Services,
- Travel,
- Teaching that is general and not limited to a discussion that is required for the management of a specific worker,
- Discussions of the L&I claims process with the worker/family/caregiver.

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

Separately billable services

Any procedure represented by its own CPT®, HCPCS, or local codes must be billed separately, and the time spent on these services can't be included in the time used to determine the level of E/M service.

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

- Care coordination (such as 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*
- Procedures (such as injections or Osteopathic Manipulative Treatment), *or*
- Any treatment-based service.

When these services are performed in conjunction with an E/M service, you must append modifier **–25.** See Using CPT® billing code modifier –25.

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

Examples of billing with modifier –25

Example 1: Minor procedure and time-based E/M service

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

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

The provider 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 provider would bill the appropriate:

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

The provider 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: Case management service and time-based E/M service

A worker goes to the provider's office for a follow-up of their work related head injury. After reviewing the notes from the worker's neurologist the provider finds that they have questions regarding the current treatment plan. The provider 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 provider evaluates and documents findings of the head injury as well as the treatment plan.

The provider documents 10 minutes for the telephone call as noted above. The provider 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 provider would bill the appropriate:

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

The provider 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.

Example 3: OMT and E/M service

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

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

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

How to bill for this scenario

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

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

The provider 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 4: Multiple E/M visits performed on the same day

A worker arrives at a provider'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 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 modifier **–25**.

The activities or time spent performing each separate E/M service can't overlap between the 2 visits, including charting or any other time spent in covered activities conducted on the same calendar day of the encounters (such as review of records, referrals). You can only count these activities under the applicable visit.

Additional information

Hospital admissions in the course of an encounter at another site

If a provider sees a worker at a location (initial site) and then sends them to the hospital to be admitted and performs the admission on the same date of service, only the initial hospital inpatient or observation care CPT® code can be billed (99221-99223). Any E/M performed at the initial site is considered bundled into the initial hospital inpatient visit and isn't payable separately. L&I follows CMS (Centers for Medicare and Medicaid Services) in regards to hospital admissions in the course of encounter at another site for E/M services.

Behavioral Health Interventions

Behavioral health interventions (BHI) performed by an attending provider as part of the evaluation and management service should be billed per CPT®. See Chapter 22: Other Services for more information regarding BHI payment policies.

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 once per attending provider, per worker, in a 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

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.

Requirements for billing

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.

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 or coordinating 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.

Documentation requirements

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. If a communication pertains 2 or more open claims, providers are expected to split the billing between the claims. See Split Billing Policy for billing instructions.

Payment policy: Case management services – Team conferences

Who must perform team conferences to qualify for payment

Payable **team conferences** must be related to the worker and for the purposes of discussing or coordinating care, treatment, or return to work activities. The **team conference** must include 2 or more of the following:

- Current or former medical providers,
- Concurrent care providers, *or*
- Consulting providers, *or*
- Vocational rehabilitation counselors, *or*
- Nurse case managers, *or*
- PTs, OTs, and speech language pathologists, *or*
- Psychologists, *or*
- L&I staff, *or*
- L&I medical **consultants**, *or*
- Employers, *or*
- SIEs/TPAs.

The insurer doesn't follow CPT® by requiring all providers to have seen or treated the worker in the previous 60 days. However, all participating providers, with the exception of **consultants**, must have an established relationship with the worker.

Requirements for billing

Team conferences must be in-person or performed via telehealth. Team conferences performed via telehealth must follow the 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 a conference is already included in the program payment (such as brain injury rehab program, or pain clinic), and
- Two or more disciplines/specialties need to participate.

ARNPs, PAs, psychologists, MLTs, speech-language pathologists, PTs, and OTs must bill using non-physician codes.

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

For conferences **exceeding 30 minutes**, multiple units of CPT® codes **99366**, **99367**, or **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.

Services that aren't covered

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 unless part of an approved work rehabilitation program care conference.

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 worker is present, and you are a physician, you must comply with all Evaluation and Management (E/M) requirements, including documentation requirements.

Payment limits

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

Team Conferences are limited to once per day, per claim, per provider. If a conference pertains 2 or more open claims, providers are expected to split the billing between the claims. See Split Billing Policy for billing instructions.

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 and only when the provider personally participates 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 or coordinating 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,
- SIEs/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 or reminders,
- Ordering prescriptions, including requests for refills,
- Test results that are informational only,
- Communications with the worker's attorney, *or*
- Communications with office staff.

The provider 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.

Audio-Only Services

Telephone calls aren't an appropriate replacement for in-person or telehealth services. The insurer won't pay for audio-only services using modifier –93 (audio-only), with the exception of some mental health services. See Chapter 17: Mental Health Services for more information.

Requirements for billing

ARNPs, PAs, psychologists, MLTs, speech-language pathologists, 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 CPT® code **99443** or **98968** is payable for calls over 20 minutes. Billing a combination of these codes is not allowed.

Mental health services must be authorized for psychiatrists and clinical psychologists to bill for these services, per WAC 296-21-270.

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), *and*
- All medical, vocational or return to work decisions made.

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 inpatient or observation visit (CPT® codes **99221**-**99223**),
- An inpatient or observation **consultation** (CPT® codes **99252**-**99255**), *or*
- A hospital inpatient or observation 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 facility

General information

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

- Nursing facilities, *and*
- Home or residence.

Who must perform these services to qualify for payment

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

Documentation requirements

In addition to the documentation requirements for E/M services, the medical record must document the location where the service was performed.

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**, **99215, 99245, 99345, 99350** or **99483**
99418	**99223, 99233, 99236, 99255, 99306** or **99310**

Prolonged Services Example

Prolonged service for an established patient visit

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.

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

E/M office visits are limited to a maximum of 3 hours per day. Payment of prolonged services is allowed within the maximum.

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

The following prolonged services are not payable:

- Prolonged services on date other than the face-to-face evaluation and management service without direct patient contact, (CPT® **99358**, **99359**), *or*
- Prolonged clinical staff services (CPT® **99415**, **99416**).

Links: For more information on prolonged E/M services, see the 2021 and 2023 American Medical Association (AMA) E/M Code and Guideline Changes.

Payment policy: Split billing – Treating 2 separate conditions

Requirements for billing

If the worker is treated for 2 separate conditions at the same visit, the charge for the service must be divided equally between the payers and/or claims.

If evaluation of the 2 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 claim numbers treated in Box 11 of the **CMS-1500** form (F245-127-000) *or*
- Electronic claims, list all claim numbers treated in the remarks section of the **CMS-1500** form.

L&I will divide charges equally between 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 an accepted L&I or self-insured claim:

- 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.

Note: For physical medicine split billing exceptions, see Chapter 25: Physical Medicine Services, Unrelated conditions.

Payment limits

A provider would only be paid for more than 1 evaluation and management visit if there were 2 separate and distinct visits on the same day (see Example 4 in Separately Billable Services).

Scheduling back-to-back appointments doesn't meet the criteria for using modifier **–25**. See Using billing code modifier –25 in this chapter for more information.

Examples of split billing

Example 1: Two work-related injuries

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 1 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: Work injury and automobile injury

A worker goes to a provider's office to be treated for the 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% of their usual and customary fee to the insurance company paying for the motor vehicle accident.

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

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 worker contact, *and*
- The standby provider isn't concurrently providing care or service to other workers 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 (E/M) 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

Non-mental health services are required to be in-person when:

- It is the first visit of the claim, *or*
- Restrictions or changes are anticipated (the APF requires an update), *or*
- Consultations requested to determine if continued conservative care is appropriate (including but not limited to 60 and 120 day consults), *or*
- A worker requests a transfer of attending provider.

In-person services are required, in all cases, 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*
- The worker has an emergent issue such as re-injury, new injury, or worsening status*, or*
- A worker files a reopening application.

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 shall 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**.

Teleconsultations

Teleconsultations are **consultations** requested by the attending provider, department, self-insurer, or authorized department representative that are performed via **telehealth**. Per WAC 296-20-051, providers may not bill **consultation** codes for **established patients**.

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 approved chiropractic **consultant**, *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 consulting provider must note the name of the provider who referred the worker, *and*
- The **telehealth** provider must submit a written report that meets all in-person consultation and telehealth documentation requirements 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.

For more information regarding requirements for approved chiropractic **consultant**'s, see Chapter 7: Chiropractic Services.

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 and store and forward fees are covered, when applicable.

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 patient.

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**.

Store and Forward

G2010 is covered for worker-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 worker 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

Telephone calls aren't an appropriate replacement for in-person or **telehealth** services. The insurer won't pay for audio-only E/M services billed using modifier **–93** (audio only).

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 patient,
- Completion and filing of any form that requires a hands-on physical examination (such as Report of Accident or Provider's Initial Report, except for mental health only claims), *and*
- Home health monitoring.

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.

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 **2021 American Medical Association (AMA) E/M Code and Guideline Changes** for new and established outpatient office visits	2021 AMA E/M guidelines
The **2023 American Medical Association (AMA) E/M Code and Guideline Changes** for all other E/M services	2023 AMA E/M 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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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.

