Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 33: Brain Injury Rehabilitation 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

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.

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

Modifiers

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

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) isn't 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: Brain injury rehabilitation services

Prior authorization

Prior authorization is required for post-acute brain injury rehabilitation evaluation and treatment.

State Fund claims

To determine whether or not to authorize post-acute brain injury rehabilitation for a claim, both an occupational nurse consultant (ONC) and L&I claim manager will review the claim separately. (See Approval criteria, below.)

The Provider Hotline can't authorize brain injury treatment; however, the Provider Hotline can advise if a prior authorization has been entered into the L&I claim system.

Self-insured claims

Contact the SIE or TPA for authorization (see Approval criteria, below).

Link: Contact information for the SIE or TPA is available via L&I's self-insured lookup tool.

Approval criteria

Before a worker can receive treatment, all of the following conditions must be met:

- The insurer has allowed brain injury as an accepted condition under the claim,
- The brain injury is related to the industrial injury or is retarding recovery,
- The worker is physically, emotionally, cognitively and psychologically capable of full participation in the rehabilitation program,
- The screening evaluation done by the brain injury program demonstrates the worker is capable of new learning following the brain injury, *and*
- The screening evaluation report by the program identifies specific goals to help the worker improve function or accommodate for lost function.

Who must perform these services to qualify for payment

Only providers approved by the department can provide post-acute brain injury rehabilitation services for workers.

Providers must maintain CARF accreditation in Outpatient Medical Rehabilitation Program – Interdisciplinary with Brain Injury Specialty designation and provide the Department of Labor and Industries (L&I) with documentation of satisfactory recertification including the latest CARF Accreditation Report. This information is required to be submitted to the Department within 30 days of receipt of the report. A provider's account will be inactivated if CARF accreditation expires or this information is not received from the provider. It is the provider's responsibility to notify L&I when an accreditation visit is delayed.

Qualifying programs

Post-acute brain injury rehabilitation programs must include the following phases:

- Evaluation,
- Treatment, *and*
- Follow up.

When a complete course of evaluation and treatment is required, L&I requires providers treating a patient on a State Fund claim to submit that plan to:

Department of Labor and Industries

Provider Accounts Unit
PO Box 44261
Olympia, WA 98504-4261

Specific L&I provider account number required

Providers will be issued a provider-specific ID number (separate from any provider ID they may already have with L&I) which will enable payment via the brain injury program billing codes. Providers billing for individual services and therapies don't need to obtain a special provider account number.

Providers may request a provider application or find out if they have a qualifying provider account number by calling the Provider Hotline at 1-800-848-0811 or by emailing PHL@lni.wa.gov.

Services that can be billed

Nonhospital based programs

The following local codes and payment amounts for nonhospital based outpatient post-acute brain injury rehabilitation treatment programs:

Local code	Description	Maximum fee
8950H	Comprehensive brain injury evaluation	**$5,119.15**
8951H	Post-acute brain injury rehabilitation full-day program, per day (minimum of 6 hours per day)	**$1,161.25**
8952H	Post-acute brain injury rehabilitation half-day program, per day (minimum 4 hours per day)	**$808.78**

Hospital based programs

The following revenue codes and payment amounts for hospital-based outpatient post-acute brain injury rehabilitation treatment programs:

Local rev code	Description	Maximum fee
0014	Comprehensive brain injury evaluation	**$5,119.15**
0015	Post-acute brain injury rehabilitation full-day program, per day (minimum of 6 hours per day)	**$1,161.25**
0016	Post-acute brain injury rehabilitation half-day program, per day (minimum 4 hours per day)	**$808.78**

Meals

L&I will reimburse the brain injury provider for 1 meal per day provided there is an onsite meal offered to the worker, and the worker is participating in more than 4 hours of treatment that day. Don't bill L&I for meals not provided to or paid by the worker.

Code	Description	1 unit of service equals…	Maximum fee per unit
5934M	Outpatient Day Program - Lunch	1 meal per authorized person	**State Rate** (includes taxes & gratuity)

Current **State Rates** can be found on the Office of Financial Management's (OFM) website.

The brain injury provider should bill L&I their usual and customary charges for the meal provided. Reimbursement will be at your usual and customary charge or the **State Rate**, whichever is less. For more information about billing for meals, see Chapter 22: Other Services.

Services that aren't covered

Brain injury rehabilitation program services performed in the worker's home aren't covered.

Requirements for billing

For State Fund claims billing, providers participating in the Brain Injury Program must bill for brain rehabilitation services using the special post-acute brain injury rehabilitation program provider account number assigned by L&I. (See who must perform these services to qualify for payment, above.)

Comprehensive brain injury evaluation requirements

A comprehensive brain injury evaluation must be performed for all workers who are being considered for inpatient services or for an outpatient post-acute brain injury rehabilitation treatment program. This evaluation is multidisciplinary and contains an in depth analysis of the worker's cognitive, psychological, emotional, social, physical status and functioning. It should also include the review of the workers' medical records, assessment of any important associated conditions that may hinder recovery, identification of the worker's family and support resources, and identification of factors that may affect participation. The evaluation must be provided by a multidisciplinary team that includes all of the following:

- Medical physician,
- Psychologist,
- Neuropsychologist,
- Vocational rehabilitation specialist,
- Physical therapist,
- Occupational therapist, and
- Speech therapist

Additional medical consultations are referred through the program's physician. For State Fund claims, each consultation may be billed under the provider account number of the consulting physician. Services must be preauthorized by an L&I claim manager or the self-insured employer.

Documentation requirements

The following documentation is required of providers when billing for evaluation and/or treatment services within the post-acute brain injury rehabilitation program:

- Daily record of a workers' attendance, activities, treatments and progress
- All test results and scoring
- Documentation of interviews with family, *and*
- Any coordination of care contacts (for example, phone calls and letters) made with providers or case managers not directly associated with the facility's program.

Progress reports must be sent to the insurer regularly, including all preadmission and discharge reports.

Payment limits

Comprehensive Brain Injury Program Evaluation

The following tests and services are included in the price of performing a Comprehensive Brain Injury Program Evaluation, may be performed in any combination depending on the worker's condition, and **can't be billed separately**:

- Neuropsychological Diagnostic Interview(s), testing, and scoring,
- Initial consultation and exam with the program's physician,
- Occupational and Physical Therapy evaluations,
- Vocational Rehabilitation evaluation,
- Speech and language evaluation, *and*
- Comprehensive report.

The complementary and/or preparatory work that may be necessary to complete the Comprehensive Brain Injury Evaluation is **considered part of the provider's administrative overhead**. It includes but isn't limited to:

- Obtaining and reviewing the workers' historical medical records,
- Interviewing family members, if applicable,
- Phone contact and letters to other providers or community support services,
- Writing the final report, *and*
- Office supplies and materials required for service(s) delivery.

Treatment

These therapies, treatments, and/or services are included in the Brain Injury Program maximum fee schedule amount for the full day or half-day brain injury rehabilitation treatment and **can't be billed separately**:

- Psychotherapy,
- Behavioral modification,
- Behavioral Health Interventions, see Chapter 22: Other Services for more details,
- Individual or group therapy counseling,
- Physical therapy and occupational therapy,
- Speech and language therapy,
- Nursing and health education and pharmacology management,
- Activities of daily living management,
- Recreational therapy (including group outings),
- Vocational counseling, *and*
- Follow up interviews with the worker or family, which may include home visits and phone contacts.

Ancillary work, materials, and preparation that may be necessary to carry out Brain Injury Program functions and services are considered part of the provider's administrative overhead and **aren't payable separately**. These include, but aren't limited to:

- Daily charting of patient progress and attendance,
- Report preparation,
- Case management services,
- Coordination of care,
- Team conferences and interdisciplinary staffing, *or*
- Educational materials (for example, workbooks and tapes).

Follow up care is included in the cost of the full day or half-day program. This includes, but isn't limited to:

- Telephone calls,
- Home visits, *and*
- Therapy assessments.

Payment policy: Telehealth for brain injury rehabilitation 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 below 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

In-person services are 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*
- The worker has an emergent issue such as re-injury, new injury, or worsening status.

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.

Post-acute brain injury rehabilitation, full day (**8951H,** rev code 0015) and half-day (**8952H,** rev code 0016) are covered via **telehealth**.

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.

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 evaluation or treatment 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 worker,
- Completion and filing of any form that requires a hands-on physical examination (such as Report of Accident or Provider's Initial Report),
- Home health monitoring,
- **G2010** and **G2250** Store and forward, *and*
- Comprehensive brain injury evaluations (**8950H**, rev code **0014**).

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.

Do not bill using the **–GT** modifier to indicate **telehealth** for local codes.

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 billing procedures	Washington Administrative Code (WAC) 296-20-125
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	Fee schedules on L&I's website

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.

