Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 34: Chronic Pain Management

Effective July 1, 2024

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

Table of Contents Page

Definitions 34-2

Modifiers 34-4

Payment policy: Structured, intensive, multidisciplinary program (SIMP) 34-5

Payment policy: Telehealth for chronic pain management 34-19

Payment policy: Vocational services for SIMP workers 34-23

Links to related topics 34-26

CPT® codes and descriptions only are © 2023 American Medical Association

Definitions

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

Distant site: The location of the provider who performs telehealth services. This provider isn't at the originating site with the worker.

Important associated conditions: Medical or psychological conditions (often referred to as co-morbid conditions) that hinder functional recovery from chronic pain.

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.

State Rate: The reimbursement rate for travel reimbursement set by the Office of Financial Management (OFM) within the State of Washington.

Link: For the current **State Rate**, see the per diem tables on the OFM website.

SIMP (structured intensive multidisciplinary program): A chronic pain management program with the following 4 components:

- **Structured** means care is delivered through regular scheduled modules of assessment, education, treatment, and follow up evaluation where workers interact directly with licensed healthcare practitioners. Workers follow a **treatment plan** designed specifically to meet their needs, *and*
- **Intensive** means the Treatment Phase is delivered on a daily basis, 6 to 8 hours per day, 5 days per week, for up to 4 consecutive weeks. Slight variations can be allowed if necessary to meet the worker's needs, *and*
- **Multidisciplinary** (interdisciplinary) means that structured care is delivered and directed by licensed healthcare professionals with expertise in pain management in at least the areas of medicine, psychology, and physical therapy or occupational therapy. The **SIMP** may add vocational, nursing, and additional health services depending on the worker's needs and covered benefits, *and*
- **Program** means an interdisciplinary pain rehabilitation program that provides outcome focused, coordinated, goal oriented team services. Care coordination is included within and across each service area. The program benefits workers who have impairments associated with pain that impact their participation in daily activities and their ability to work. This program measures and improves the functioning of persons with pain and encourages their appropriate use of healthcare systems and services.

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.

CPT® codes and descriptions only are © 2023 American Medical Association

Treatment plan: An individualized plan of action and care developed by licensed healthcare professionals that addresses the worker's identified needs and goals. It describes the intensity, duration, frequency, setting, and timeline for treatment and addresses the elements described in the Treatment Phase. It is established during the Evaluation Phase and may be revised during the Treatment Phase.

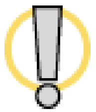
Valid tests and instruments: Those that have been shown to be scientifically accurate and reliable for tracking functional progress over time.

CPT® codes and descriptions only are © 2023 American Medical Association

Modifiers

The following CPT®, HCPCS, and/or local code modifiers appear in 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: Structured, intensive, multidisciplinary program (SIMP)

General requirements

Injured workers eligible for benefits under RCW Title 51 may be evaluated for and enrolled in a comprehensive treatment program for chronic non-cancer pain if it meets the definition of a **SIMP**.

Prior authorization is required for all workers to participate in a **SIMP** for functional recovery from chronic pain. See details about prior authorization requirements later in this Payment policy section.

The goals for this program are to help workers recover their function, reduce or eliminate disability, and improve the quality of their lives by helping them cope effectively with chronic, non-cancer pain.

Program design: Phases of an approved SIMP

An approved **SIMP** has 3 phases:

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

See below for details about each of these 3 phases.

CPT® codes and descriptions only are © 2023 American Medical Association

1. Evaluation Phase

The Evaluation Phase occurs before the Treatment Phase and includes **treatment plan** development and a report. Only 1 evaluation is allowed per authorization but it can be conducted over 1 to 2 days.

The Evaluation Phase includes all of the following components:

- A history and physical exam along with a medical evaluation by a physician. Advanced registered nurse practitioners and certified physician assistants can perform those medical portions of the pretreatment evaluation that are allowed by the Commission on Accreditation of Rehabilitation Facilities (CARF), *and*
- Review of medical records and reports, including diagnostic tests and previous efforts at pain management, *and*
- Assessment of any **important associated conditions** that may hinder recovery, such as opioid dependence and other substance use disorders, smoking, significant mental health disorders, and unmanaged chronic disease, *and*
- Assessment of past and current use of all pain management medications, including over the counter, prescription, scheduled, and illicit drugs. This must include checking the Prescription Monitoring Program Database *and*
- Psychological and social assessment by a licensed clinical psychologist using **valid tests and instruments**, *and*
- Identification of the worker's family and support resources, *and*
- Identification of the worker's reasons and motivation for participation and improvement, *and*
- Identification of factors that may affect participation in the program, *and*
- Assessment of pain and function using **valid tests and instruments**; it should include the current levels, future goals, and the estimated treatment time to achieve them for each of the following areas:
    - Activities of Daily Living (ADLs),
    - Range of Motion (ROM),
    - Strength,
    - Stamina, *and*
    - Capacity for and interest in returning to work, *and*
- If the claim manager has assigned a vocational counselor, the **SIMP** vocational provider must coordinate with the vocational counselor to assess the likelihood of the worker's ability to return to work and in what capacity (see Vocational services for **SIMP** workers section of this chapter), *and*

- A summary report of the evaluation and a preliminary recommended **treatment plan**. If there are any barriers preventing the worker from moving on to the Treatment Phase, the report should explain the circumstances.

2. Treatment Phase

Treatment Phase services may be provided for up to 20 consecutive days (excluding weekends and holidays) depending on individual needs and progress toward treatment goals. Each treatment day lasts 6 to 8 hours. Services are coordinated and provided by an interdisciplinary team of physicians, psychologists, physical or occupational therapists, and may include nurses, vocational counselors, and care coordinators. Treatment must include all the following elements:

- **Graded exercise**: Progressive physical activities guided by a physical or occupational therapist that promote flexibility, strength, and endurance to improve function and independence, *and*
- **Cognitive behavioral therapy**: Individual or group cognitive behavioral therapy with the psychologist, psychiatrist, or psychiatric advanced registered nurse practitioner, *and*
- **Coordination of health services**: Coordination and communication with the attending provider, claim manager, family, employer, and community resources as needed to accomplish the goals set forth in the **treatment plan**, *and*
- **Education and skill development** on the factors that contribute to pain, responses to pain, and effective pain management, *and*
- **Tracking of Pain and Function**: Individual medical assessment of pain and function levels using **valid tests and instruments** consistent with those at evaluation, *and*
- **Ongoing assessment** of **important associated conditions**, medication tapering, and clinical assessment of progress toward goals; opioid and mental health issues can be treated concomitantly with pain management treatment. This must include checking the Prescription Monitoring Program Database. *and*
- **Performance** of real or simulated work or daily functional tasks, *and*
- **SIMP vocational services**: these may include instruction regarding workers' compensation requirements. Vocational services with return to work goals are needed in accordance with the Return to Work Action Plan when a vocational referral has been made, *and* a discharge care plan for the worker to continue exercises, cognitive and behavioral techniques and other skills learned during the Treatment Phase.
- At time of discharge, the SIMP physician must call the attending provider to discuss the workers treatment in the program, progress, barriers, and discharge plan. *and*

- **A summary report** at the conclusion of the Treatment Phase that addresses all the following questions:
  - To what extent did the worker meet his or her treatment goals?
  - What changes if any, have occurred in the worker's medical and psychosocial conditions, including dependence on opioids and other medications?
  - What changes if any, have occurred in the worker's pain level and functional capacity as measured by **valid tests and instruments** (consistent with the tools used during evaluation)?
  - What changes if any, have occurred in the worker's ability to manage pain?
  - What is the status of the worker's readiness to return to work or daily activities?
  - What is the status of progress in achieving the goals listed in the Return to Work Action Plan if applicable?
  - How much and what kind of follow up care does the worker need?

3. Follow up Phase

So long as the claim remains open, a Follow up Phase may occur within 6 months after the Treatment Phase has concluded. This phase isn't a substitute for and can't serve as an extended Treatment Phase.

The goals of the Follow up Phase are to:

- Improve and reinforce the pain management gains made during the Treatment Phase;
- Help the worker integrate the knowledge and skills gained during the Treatment Phase into his or her job, daily activities, and family and community life;
- Evaluate the degree of improvement in the worker's condition at regular intervals and produce a written report describing the evaluation results.
- Address the goals listed in the Return to Work Action Plan if one was developed.

Follow up Phase site

The activities of the Follow up Phase may occur at the:

- Original multidisciplinary clinic (clinic based), or
- Worker's home, workplace, or healthcare provider's office (community based).

This approach permits maximum flexibility for workers whose needs may range from intensive, focused follow up care at the clinic, to more independent episodes of care closer to home. It also enables workers to establish relationships with providers in their communities so they have increased access to healthcare resources.

CPT® codes and descriptions only are © 2023 American Medical Association

Follow up Phase services: Face-to-face vs. non face-to-face

Follow up services are payable as face-to-face and non face-to-face services.

- Face-to-face services are when the provider interacts directly with the worker, the worker's family, employer, or other healthcare providers.
- Non face-to-face services are when the SIMP provider uses the telephone or other electronic media to communicate with the worker, worker's family, employer, or other healthcare providers to coordinate care in the worker's home community.

Both are subject to the following limits:

- Face-to-face services: up to 24 hours are allowed with a maximum of 4 hours per day
- Non face-to-face services: up to 40 hours are allowed.

Follow up Phase reporting requirements

If a worker has been receiving follow up services, a summary report must be submitted to the insurer that provides the following information:

- The worker's status, including whether the worker returned to work, how pain is being managed, medication use, whether the worker is getting services in his or her community, activity levels, and support systems,
- What was done during the Follow up Phase,
- What resulted from the follow up care, and
- Measures of pain and function using **valid tests and instruments** (consistent with the tools used during the SIMP program)

This summary report must be submitted at the 1, 3, and 6 month marks; if applicable.

Follow up Phase activities

According to the worker's identified needs and goals, the Follow up Phase should include the following kinds of activities listed below, and may be done either:

- Face-to-face at the clinic or in the community, *or*
- As non face-to-face coordination of community based services.

Evaluation and assessment activities include:

- Assessing pain and function with **valid tests and instruments**, *and*
- Evaluating whether the worker is complying with his or her home and work program that was developed at the conclusion of the Treatment Phase, *and*

- Evaluating the worker's dependence, if any, on opioids and other medications for pain, *and*
- Assessing **important associated conditions** and psychological status especially as related to reintegration in the workplace, home, and community, *and*
- Assessing what kind of support the worker has in the work place, home, and community, *and*
- Assessing the worker's current activity levels, limitations, mood, and attitude toward functional recovery.

Treatment activities include:

- Providing brief treatment by a psychologist, physician, nurse, vocational counselor, or physical or occupational therapist, *and*
- Adjusting the worker's home and work program for management of chronic pain and reactivation of activities of daily living and work, *and*
- Reinforcing goals to improve or maintain progress made during or since the Treatment Phase, *and*
- Teaching new techniques or skills that weren't part of the original Treatment Phase, *and*
- Addressing the goals listed in the Return to Work Action Plan if one was developed.

Community care coordination includes:

- Communicating with the attending provider, surgeon, other providers, the claim manager, insurer assigned vocational counselor, employer, or family and community members to support the worker's continued management of chronic pain, *and*
- Making recommendations for assistance in the work place, home, or community that will help the worker maintain or improve functional recovery.

Support activities include:

- Contacting or visiting the worker in his or her community to learn about the worker's current status and needs and help him/her find the needed resources, *and*
- Holding case conferences with the:
- Interdisciplinary team of clinicians, *and/or*
- Worker's attending provider, *and/or*

- Other individuals closely involved with the worker's care and functional recovery.

Follow up Phase special considerations

When determining what follow up services the worker needs, **SIMP** providers should consider the following:

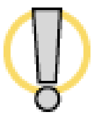
- Meeting with the worker, the worker's family, employer, or other healthcare providers who are treating the worker is subject to the 24 hour limit on face-to-face services, *and*
- If a **SIMP** provider plans to travel to the worker's community to deliver face-to-face services, travel time isn't included in the 24 hour time limit and the trip must be prior authorized for mileage to be reimbursed, *and*
- The required follow up evaluations must be done face-to-face with the worker and are subject to the 24 hour limit on face-to-face services, *and*
- When the **SIMP** provider either meets with treating providers or coordinates services with treating providers, the treating providers bill their services separately, *and*
- Authorized follow up services can be provided, even if the worker has surgery during the follow up period, *and*
- If a **SIMP** provider wishes to coordinate the delivery of physical or occupational therapy services in the worker's home community, they should be aware that these therapies are often subject to prior authorization and utilization review for workers covered by the State Fund.

Link: More information about Helping Workers Get Back to Work is available online.

Prior authorization

General referral and prior authorization requirements

All **SIMP** services require prior authorization by the claim manager and a referral from the worker's attending provider. An occupational nurse consultant, claim manager, or insurer-assigned vocational counselor may recommend a **SIMP** for the worker, but only the attending provider can make a referral.



Note: Only the attending provider can refer a worker for a **SIMP**.

SIMP referral

SIMP services are authorized on an individual basis. If there are extenuating circumstances that warrant additional treatment or a restart of the program, providers must submit this request along with supporting documentation to the claim manager.

When the attending provider refers a worker to a **SIMP**, the claim manager may authorize an evaluation if the worker:

- Has had unresolved chronic pain for longer than 3 months despite conservative care, *and*
- Has one or more of the following conditions:
  - Is unable to return to work due to the chronic pain, *or*
  - Has returned to work but needs help with chronic pain management, *or*
  - Has significant pain medication dependence, tolerance, abuse, or addiction

Evaluation Phase

Prior authorization for the Evaluation Phase occurs first and includes only one evaluation. Once authorized, the **SIMP** provider verifies the worker meets the requirements described in the Worker requirements in this Payment policy section (see below), and can fully participate in the program.

If the worker:

- **Meets the requirements** and the **SIMP** provider recommends the worker move on to the Treatment Phase, the **SIMP** provider must provide the insurer with a report and **treatment plan** as described under the Evaluation Phase, *or if the worker*
- **Doesn't meet the requirements**, the **SIMP** provider must provide the insurer with a report explaining:
  - What requirements aren't met, *and*
  - The goals the worker must meet before he or she can return and participate in the program, *also*
  - If the worker is found to have **important associated conditions** during the Evaluation Phase that prevent him or her from participating in the Treatment Phase, the **SIMP** provider must either treat the worker or recommend to the worker's attending provider and the claim manager what type of treatment the worker needs.

Treatment Phase and Follow up Phase

The Treatment Phase must be prior authorized separately from the Evaluation Phase. Treatment Phase authorization includes authorization for the Follow up Phase.

CPT® codes and descriptions only are © 2023 American Medical Association

SIMP provider requirements

To provide chronic pain management program services to eligible workers, **SIMP** service providers must meet all these requirements:

- Meet the definition of a **Structured Intensive Multidisciplinary Program** (see Definitions at the beginning of this chapter), *and*
- Be accredited as an interdisciplinary pain rehabilitation program by the Commission on Accreditation of Rehabilitation Facilities (CARF; also see Note below this list), *and*
- Provide the services described in each phase, *and*
- Communicate with providers who are involved with the worker's care, *and*
- Ensure care is coordinated with the worker's attending provider, *and*
- Inform the claim manager if the worker:
    - Stops services prematurely,
    - Has unexpected adverse occurrences, or
    - Doesn't meet the worker requirements.
- Communicate with the worker during treatment to ensure he or she understands and follows the prescribed treatment, *and*
- Act as a resource for the worker, insurer, and providers to ensure treatment is progressing as planned and any gaps in care are addressed, *and*
- Provide the insurer with the required documentation in a timely manner (Evaluation Summary Report, all daily chart notes, Treatment Phase Summary Report including the discharge care plan, Follow up visit notes, and Follow Up Summary Report).
- Coordinate the worker's transition and reintegration back to his or her home, community, and place of employment.
- Provide the Department with the SIMP organization structure annually.
- Notify the Department in writing of key organization changes within 30 days.
- New programs must provide the Department contact information with the provider application and be available to provide additional information, as needed.
    - For applicable programs, the Department must be notified of substantial material changes to the program description in writing within 30 days.

Providers must maintain CARF accreditation and provide the Department 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 isn't received from the provider. It is the provider's responsibility to notify the Department when an accreditation visit is delayed.

For any existing SIMP provider wanting to add a new site to the SIMP program, they must provide the L&I's Provider Accounts and Credentialing unit with a copy of the completed *CARF OCForm_Relocation_Expansion_Elimination* to be added to your provider account file.

CPT® codes and descriptions only are © 2023 American Medical Association

Worker requirements

An injured worker must make a good faith effort to participate and comply with the **treatment plan** prescribed for him or her by the **SIMP** provider. To complete a **SIMP** successfully, the worker must meet all these requirements:

- Be medically and physically stable enough to safely tolerate and participate in all physical activities and treatments that are part of his or her **treatment plan**, *and*
- Be psychologically stable enough to understand and follow instructions and to put forth an effort to work toward the goals that are part of his or her **treatment plan**, *and*
- Agree to be evaluated and comply with treatment prescribed for any **important associated conditions** that hinder progress or recovery (for example, opioid dependence and other substance use disorders, smoking, significant mental health disorders, and other unmanaged chronic disease), *and*
- Attend each day and each session that is part of his or her **treatment plan**. Sessions may be made up if, in the opinion of the provider, they don't interfere with the worker's progress toward **treatment plan** goals, *and*
- Cooperate and comply with his or her **treatment plan**, *and*
- Not pose a threat or risk to himself or herself, to staff, or to others, *and*
- Review and sign a participation agreement with the provider, *and*
- Participate with coordination efforts at the end of the Treatment Phase to help him or her transition back to his or her home, community, and workplace.

Services that can be billed

SIMP fee schedule

The fee schedule and procedure codes for Evaluation, Treatment, and Follow up Phases are listed in the following table. The fee schedule applies to injured workers only in an outpatient program:

Description	Local code	Duration / limits	Units of service	Maximum fee
SIMP Evaluation Services	**2010M**	1 evaluation per authorization, which may be conducted over 1 to 2 days.	Bill only 1 unit for evaluation even if conducted over 2 days	**$1,329.96**

Description	Local code	Duration / limits	Units of service	Maximum fee
SIMP Treatment Services, each 6-8 hour day	**2011M**	Not to exceed 20 treatment days (6-8 hours per day).	1 day equals 1 unit of service	**$851.87** per day
SIMP Follow up Services: Face-to-face services with the worker, the worker's family, employer, or healthcare providers, either in the clinic or in the worker's community	**2014M**	Not to exceed 4 hours per day and not to exceed 24 hours total (time must be billed in 1 minute units).	1 minute equals 1 unit of service	**$1.79** per minute (**$107.40** per hour)
SIMP Follow up Services: Non face-to-face coordination of services with the worker, the worker's family, employer, or healthcare providers in the worker's community	**2015M**	Not to exceed 40 hours (time must be billed in 1 minute units).	1 minute equals 1 unit of service	**$1.40** per minute (**$84.00** per hour)

CPT® codes and descriptions only are © 2023 American Medical Association

Description	Local code	Duration / limits	Units of service	Maximum fee
Outpatient Day Program - Lunch for meal reimbursement	**5934M**	Worker must be onsite for treatment of more than 4 hours. Prior authorization required. Don't bill for meals not provided to or paid for by the worker.	1 meal per authorized person	**State Rate** (includes taxes & gratuity)
Mileage for traveling to and from the worker's community	**0392R**	Mileage requires a separate prior authorization. Travel time isn't included in the 24 hours allotted for face-to-face services.	1 mile equals 1 unit of service	Current Washington State mileage rate

Requirements for billing

Outpatient chronic pain management programs must bill using the local codes listed in the fee schedule (see above) on a **CMS-1500** form (F245-127-000).

Billing for partial days for the treatment phase

Clinics can bill only for that percent of an 8 hour day that has been provided, (even if the worker was scheduled for less than 8 hours). Example:

- The worker has an unforeseen emergency and has to leave the clinic after 2 hours (25% of the treatment day). The clinic would bill **$851.87** x 25% = **$212.97**

Payment limits

SIMP evaluation services

Only 1 evaluation per authorization is allowed, which may be conducted over the course of 1 to 2 days. If the evaluation is conducted over a 2 day period, bill only 1 unit and span the dates.

SIMP treatment services

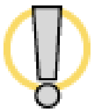
These services can't exceed 20 treatment days (6-8 hours per day).

SIMP follow up services

Non face-to-face services (local code **2015M**) can't exceed 40 hours.

Face-to-face services (local code **2014M**) can't:

- Exceed 4 hours per day, *and*
- 24 hours total.



Note: Mileage for travelling to and from the worker's community isn't included in the 24 hour limit.

Payment policy: Telehealth for chronic pain management

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

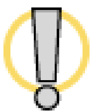
Telehealth procedures and services that are covered include most services that don't require a hands-on component. The worker must be present at the time of the **telehealth** service and the evaluation and/or treatment of the worker must be under the control of the **telehealth** provider.

Originating site fee is covered, when applicable.

SIMP treatment services (**2011M**) and follow up face-to-face services (**2014M**) 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.

CPT® codes and descriptions only are © 2023 American Medical Association

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

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*
- SIMP evaluation services (**2010M**).

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

SIMP follow up that doesn't occur face-to-face (**2015M**) is covered via audio only under the regular local code, based on its description. It wouldn't be appropriate to use this code for SIMP follow up via **telehealth**.

Other than **2015M**, 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).

Requirements for billing

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

Don't bill using the modifier **–GT** 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. In addition to those limits, physical medicine services including exercise and work rehabilitation activities conducted via **telehealth** are limited to 2 hours per day per worker.

CPT® codes and descriptions only are © 2023 American Medical Association

Payment policy: Vocational services for SIMP workers

Prior authorization

Vocational referrals

Prior to authorizing participation in a **SIMP**, the claim manager will determine, based on the facts of each case, whether to make a vocational referral.

The claim manager may assign a vocational counselor if the worker needs assistance in returning to work or becoming employable.

The claim manager won't make a vocational referral when the worker:

- Is working, *or*
- Is scheduled to return to work, *or*
- Has been found employable or not likely to benefit from vocational services.

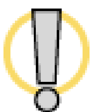
Requirements for a Return to Work Action Plan

A Return to Work Action Plan is required when vocational services are needed in conjunction with **SIMP** treatment and the claim manager assigns a vocational counselor. The Return to Work Action Plan:

- Provides the focus for vocational services during a worker's participation in a chronic pain management program, *and*
- May be modified or adjusted during the Treatment or Follow up Phase as needed.

At the end of the program, the **outcomes** listed in the Return to Work Action Plan **must be included** with the Treatment Phase summary report.

If a vocational counselor is assigned, he or she will work with the **SIMP** vocational counselor to agree upon a Return to Work Action Plan with a return to work goal.



Note: Don't forget to include the outcomes from the Return to Work Action Plan in your Treatment Phase Summary Report.

CPT® codes and descriptions only are © 2023 American Medical Association

Return to Work Action Plan roles and responsibilities

In the development and implementation of the Return to Work Action Plan, the insurer assigned vocational counselor, the **SIMP** vocational counselor, the attending provider, and the worker are involved.

The specific roles and responsibilities of each are as follows:

The SIMP vocational counselor will:

- Co-develop the Return to Work Action Plan with the insurer assigned vocational counselor, *and*
- Present the Return to Work Action Plan to the claim manager at the completion of the Evaluation Phase if the **SIMP** recommends the worker move on to the Treatment Phase and needs assistance with a return to work goal, *and*
- Communicate with the insurer assigned vocational counselor during the Treatment and Follow up Phases to resolve any problems in implementing the Return to Work Action Plan.

The insurer assigned vocational counselor will:

- Co-develop the Return to Work Action Plan with the **SIMP** vocational counselor, *and*
- Attend the chronic pain management program discharge conference and other conferences as needed either in person or by phone, *and*
- Negotiate with the attending provider when the initial Return to Work Action Plan isn’t approved in order to resolve the attending providers concerns, *and*
- Obtain the worker’s signature on the Return to Work Action Plan, *and*
- Communicate with the **SIMP** vocational counselor during the Treatment and Follow up Phases to resolve any problems in implementing the Return to Work Action Plan, *and*
- Implement the Return to Work Action Plan following the conclusion of the Treatment Phase.

The attending provider will:

- Review and approve or disapprove the initial Return to Work Action Plan within 15 days of receipt, *and*
- Review and sign the final Return to Work Action Plan at the conclusion of the Treatment Phase within 15 days of receipt, *and*
- Communicate with the insurer assigned vocational counselor during the Treatment and Follow up Phases to resolve any issues affecting the return to work goal.

CPT® codes and descriptions only are © 2023 American Medical Association

The worker will:

- Participate in the selection of a return to work goal, *and*
- Review and sign the final Return to Work Action Plan, *and*
- Cooperate with all reasonable requests in developing and implementing the Return to Work Action Plan.

Link: For more information about what can happen if the worker refuses to cooperate, see RCW 51.32.110.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules supporting **SIMP** payment policies	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
Crime Victims Compensation Program contact information	**Phone**: 1-800-762-3716 (toll free) **Fax**: 1-360-902-5333 Crime Victims on L&I's website
Fee schedules for all healthcare services	Fee schedules on L&I's website
Return to work: "Helping Workers Return to Work"	Helping Workers Return to Work on L&I's website
Self-insured claims authorization from the self-insured employer (SIE) or their third party administrator (TPA)	Contact list of SIE/TPAs on L&I's website
Worker refuses to cooperate with care plan: Legal issues defined in Washington state laws	Revised Code of Washington (RCW) 51.32.110

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.