Washington State Department of Labor & Industries

Chapter 24: Telehealth, Remote, and Mobile Services

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

Updates and corrections

An annual update of the entire payment policies and fee schedules (MARFS) is published routinely to coincide with the beginning of each state fiscal year (July 1).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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Payment policy: All telehealth services

General information

This payment policy applies to all services provided via telehealth, except:

- **Independent Medical Exams (IME).** Refer to the payment policy: **Telehealth** for independent medical exams (IME) in this chapter.
- **Vocational services.** Refer to the **Remote** services policy in Chapter 25: Vocational Services.
- **Interpretive services.** Refer to Chapter 14: Language Access Services for Spoken Language or the Sign language interpretation policy in Chapter 18: Other Services.

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 an in-person evaluation and intervention(s) in certain circumstances. See Services that must be performed in person in this policy and the service-specific policies in this chapter for additional details.

When scheduling the **telehealth** visit, the provider is responsible for ensuring **telehealth** is the appropriate method of service delivery to effectively conduct the services.

The worker must be present at the time of the **telehealth** service and the evaluation and/or intervention of the worker must be under the control of the **telehealth** provider.

System requirements

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

Services provided without a video connection (audio-only) aren't considered **telehealth**. Audio-only evaluation and/or intervention isn't covered for most services. See the Audio-only services policy in this chapter for exceptions.

Note: L&I doesn't follow the Center for Medicare and Medicaid Services (CMS) definition of **telehealth** which includes audio-only.

Originating site requirements

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.

Links: For more information about billing **originating site** fee **Q3014**, see the Originating site fee for telehealth policy in this chapter.

Prior authorization

The prior authorization requirements listed in the applicable service chapters apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

Services that must be performed in person

The provider is expected to make arrangements for in-person evaluation and/or intervention in certain circumstances.

In-person services are always required when:

- The provider has determined the worker isn't a candidate for **telehealth** either generally or for a specific service, *or*
- The worker doesn't want to participate via **telehealth**, *or*
- A worker files a reopening application, *or*
- A **consultation** is requested to determine if continued conservative care is appropriate (including but not limited to 60 and 120 day consults) or to satisfy the 6-month in person requirement for mental health, *or*
- When the service to be performed requires a hands-on component.

Except for mental health services, in-person services are also required when:

- It is the first visit of the claim, *or*
- The worker has an emergent issue such as re-injury, new injury, or worsening status*, or*
- Restrictions or changes are anticipated (the APF requires an update), *or*
- A worker requests a transfer of **attending provider**.

The insurer prefers that physical and occupational therapy services be provided in person.

Links: For information on in-person requirements for specific services, including mental health, see the supplemental policies in this chapter.

Services that can be billed

Telehealth is covered for most services that don't require a hands-on component, with exception of those listed in Services that must be performed in person.

Due to the medico-legal nature of workers compensation, only the following types of services may be covered via **telehealth**. This list includes links to service-specific supplemental **telehealth** policies in this chapter detailing additional or differing service requirements. Unless otherwise noted, the All telehealth services payment policy applies.

- Activity coaching (PGAP®),
- Brain Injury Rehabilitation Programs (BIRP),
- Chronic Pain Management (SIMP) services,
- Evaluation and Management (E/M) Services, including teleconsultations,
- Mental health services and Behavioral Health Interventions (BHI),
- Nurse Case Management (NCM),
- Obesity treatment, *and*
- Physical medicine services.

Originating site and store and forward fees are covered, when applicable. See the payment policies in this chapter for additional details.

Supervision via telehealth

Direct supervision of **students** may be provided via **telehealth**, but only when the service to the worker is allowed via **telehealth**, except for physical (PT) and occupational (OT) therapy **students**. When performing this type of direct supervision, the provider must bill the service using modifier **–FR** (supervisor present via **telehealth**), in addition to modifier **–GT**. Don't bill modifiers with local codes.

Certain services require in-person care. These services require in person direct supervision, in alignment with Department of Health (DOH) requirements for **student** and assistant licensures. PT/OT **students** must always have in person direct supervision, even if the service is provided via **telehealth**.

Links: For more information on **students** and **student** supervision, see Chapter 2: Information for All Providers and Chapter 20: Physical Medicine.

For information on **telehealth** vocational services, IMEs, and video **remote** interpretation, see the links at the beginning of this policy.

Services that aren't covered

Telehealth procedures and services that aren't covered include:

- An examination to complete a Report of Accident (ROA/PIR). A Report of Accident (ROA/PIR) may **only** be filed as part of an in-person physical examination of the injured worker. This service may not be done via **telehealth**, except for mental health only claims.
- All re-opening examinations,
- The same services that aren't covered in the applicable service chapters,
- The services listed in Services that must be performed in person in this policy and the service-specific supplemental policies in this chapter,
- Services that require physical hands-on and/or attended treatment of a worker,
- Examinations to complete an Activity Prescription Form (APF) when the update will take the worker off work or the provider increases the worker's restrictions, except when completed by a mental health provider, *and*
- Home health monitoring.

No payment will be made to the worker or provider for obtaining or maintaining equipment for a **telehealth** appointment. Including but not limited to the purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems.

Evaluation and/or treatment via app-based services or texting isn't covered.

Links: Telephone calls (audio-only) aren't an appropriate replacement for most in-person and/or **telehealth** services. The insurer won't pay for audio-only evaluation and/or intervention (modifier **–93**), except for those listed in the audio-only services policy in this chapter.

For telephone calls related to but not used to render treatment (case management), see Chapter 5: Care Coordination.

Requirements for billing

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person, unless otherwise specified in the service-specific supplemental policies in this chapter.

The insurer doesn't recognize modifier **–95**. Bill using modifier **–GT** to indicate **telehealth**, except when billing L&I 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.

The insurer reimburses **telehealth** based on where the worker is at the time of service. The insurer doesn't reduce payment for **telehealth** appointments.

Place of service **27** (outreach site/streets) isn't covered. When **telehealth** is provided to a worker that is not in a facility, POS **10** (home) should be used.

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 in each **telehealth** visit.

If evaluation and/or intervention is to continue via **telehealth**, evaluation reports 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 the applicable chapter apply regardless of how the service is rendered to the worker.

Supplemental payment policy: Telehealth for activity coaching (PGAP®)

General information

In addition to the information within the all telehealth services policy, the following is applicable to activity coaching (PGAP®).

Services that can be billed

Activity coaching (PGAP®), including **1400W**-**1402W** and **1160M**, may be performed in person, via audio only, or **telehealth**.

Links: For more information about PGAP® services performed via an audio-only connection, see the Audio-only services payment policy in this chapter. For telephone calls related to but not used to render treatment, see Chapter 5: Care Coordination and Chapter 17: Mental Health and Behavioral Health Interventions (BHI).

Requirements for billing

The insurer doesn't recognize modifier **–95**. Do not bill using modifier **–GT** to indicate **telehealth** with local codes.

Supplemental payment policy: Telehealth for brain injury rehab programs (BIRP)

General information

In addition to the information within the all telehealth services policy, the following is applicable to brain injury rehab programs (BIRP).

Services that must be performed in person

Comprehensive brain injury evaluations (**8950H**, rev code **0014**) must be performed in person, even if the equivalent stand-alone service is allowed via **telehealth**.

Services that can be billed

Telehealth services that can be billed for BIRP include post-acute brain injury rehabilitation:

- Full day (**8951H**, rev code 0015), *and*
- Half-day (**8952H**, rev code 0016).

Requirements for billing

The insurer doesn't recognize modifier **–95**. Do not bill using modifier **–GT** to indicate **telehealth** with local codes.

Supplemental payment policy: Telehealth for chronic pain management (SIMP)

General information

In addition to the information within the all telehealth services policy, the following is applicable to chronic pain management (**SIMP**).

Services that must be performed in person

SIMP evaluation services (**2010M**) must be performed in person, even if the equivalent stand-alone service is allowed via **telehealth**.

Services that can be billed

Telehealth services that can be billed for **SIMP** include:

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

Requirements for billing

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 would not be appropriate to use this code for **SIMP** follow up via **telehealth**.

The insurer doesn't recognize modifier **–95**. Do not bill using modifier **–GT** to indicate **telehealth** with local codes.

Links: For more information about **SIMP** follow-up non-face-to-face services (**2015M**), see the chronic pain management policy in Chapter 27: Rehabilitation Facilities and Programs.

Payment limits

Physical medicine services including exercise and work rehabilitation activities conducted via **telehealth**, including as part of a chronic pain management program (**SIMP**), are limited to 2 hours per day per worker.

Supplemental payment policy: Telehealth for evaluation and management (E/M) services

General information

In addition to the information within the all telehealth services policy, the following is applicable to evaluation and management (E/M) services.

Services that can be billed

New & established outpatient office visits

The American Medical Association (AMA) made substantial changes to **new** and **established patient** evaluation and management (E/M) office visits provided via **telehealth**, effective January 1, 2025. The insurer has chosen to **not** adopt these changes, including CPT® codes (**98000**-**98007**).

Providers must continue to use in-person **new** and **established** outpatient CPT® codes (**99202**-**99215**) appended with modifier **–GT**, for these services provided via **telehealth**.

Teleconsultations

Teleconsultations are **consultations** requested by the **attending provider**, department, self-insurer, or authorized department representative that are performed via **telehealth**.

Only **attending providers** who have E/M in their scope of practice can report teleconsultations using E/M codes (**99242**-**99245**, **99252**-**99255**). Psychologists must use the mental health evaluation CPT® code **90791** to report these services.

The insurer covers teleconsultations in alignment with L&I's in-person **consultations** policies.

Team conferences

Team conferences (CPT® **99367**, **99366**, **99368**, or E/M code) may be performed via **telehealth**.

Links: Learn more about coverage and requirements for **consultation** services in Chapter 3: Attending Providers, WAC 296-20-045, WAC 296-20-051, and WAC 296-20-01002.

For more information on team conferences, see Chapter 5: Care Coordination.

For more information on audio-only services, see the Audio-only services policy in this chapter.

Services that aren't covered

Per WAC 296-20-01501, teleconsultations can't be performed by physician assistants (PA).

Per WAC 296-20-051, providers can't bill **consultation** codes for **established patients**.

New and **established** outpatient **telehealth** visits billed using synchronous audio-video CPT® codes (**98000**-**98007**) aren't covered.

Consultations performed by psychologists using E/M **consultation** codes (**99242**-**99245**, **99252**-**99255**) aren't covered. Psychologists must use the mental health evaluation CPT® code **90791** to report these services.

Documentation requirements

For teleconsultations, the **telehealth** provider must submit a written report that meets all in-person **consultation** and telehealth documentation requirements including the name of the referring provider, to the insurer and referring provider.

Links: For more information on **consultation** documentation requirements, see Chapter 3: Attending Providers. For more information on other E/M visits, see Chapter 9: Evaluation and Management (E/M).

Supplemental payment policy: Telehealth for mental health services and behavioral health interventions (BHI)

General information

In addition to the information within the all telehealth services policy, the following is applicable to mental health services and behavioral health interventions (BHI).

Services that must be performed in person

Mental health services

Mental health **consultations** performed via **telehealth** follow the same requirements as L&I's in-person policies. For complete details, see the **consultations** policy in Chapter 3: Attending Providers.

In-person visits aren't required for mental health when:

- It is the first visit of the claim, *or*
- The worker has an emergent issue such as re-injury, new injury, or worsening status*, or*
- Restrictions or changes are anticipated (the APF requires an update), *or*
- A worker requests a transfer of **attending provider**.

However, an **in-person visit is required once every 6 months for mental health services.** In-person mental health visits may occur with another mental health provider in place of the current treating provider. The evaluating mental health provider must:

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

Note: MLTs must refer to a psychologist, psychiatric ARNP, or psychiatrist for an in-person mental health evaluation to satisfy the 6-month in-person visit requirement to continue **telehealth**-based mental health care.

Services that can be billed

Behavioral Health Interventions (BHI)

Establishing BHI care and performing interventions via **telehealth** is covered.

Mental health services

Mental health examinations to complete an initial ROA or PIR filing and/or Activity Prescription Forms (even when restrictions or changes are anticipated) are covered when performed via **telehealth**.

Mental health teleconsultations and **telehealth** evaluations must be performed by a psychiatrist (MD or DO), psychiatric ARNP, or licensed clinical psychologist (PhD or PsyD) and in line with the payment policies in Chapter 17: Mental Health and Behavioral Health Interventions (BHI). MLTs can't perform mental health evaluations in person or via **telehealth**.

Neuropsychological (**96132**, **96133**) and psychological evaluation (**96130**, **96131**) may be performed via **telehealth**. The test administration and scoring (**96137**-**96139**, **96147**) must be completed in-person.

Neurobehavioral status examinations (**96116**, **96121**) may be performed via **telehealth**.

Links: Mental health services and BHI may be payable via audio-only in certain circumstances. For additional details, see the Audio-only payment policy in this chapter. Telephone calls related to but not used to render treatment, see Chapter 5: Care Coordination.

Services that aren't covered

Neuropsychological and psychological test administration and scoring (**96137**-**96139**, **96147**) isn't covered via **telehealth**. The evaluation (**96130**-**96133**) may be completed in-person or via **telehealth**.

All re-opening examinations must be completed in person.

App-based and texting therapy, such as Better Help, Talkiatry, Talkspace, and other similar services, isn't covered.

Supplemental payment policy: Telehealth for nurse case management (NCM)

General information

In addition to the information within the all telehealth services policy, the following is applicable to nurse case management (NCM).

Services that can be billed

NCM casework (**1297M**) may be performed in person, via audio only, or **telehealth**.

Requirements for billing

The insurer doesn't recognize modifier **–95**. Don't bill using modifier **–GT** to indicate **telehealth** with local codes.

Supplemental payment policy: Telehealth for obesity treatment

General information

In addition to the information within the all telehealth services policy, the following is applicable when providing obesity treatment .

Services that can be billed

Telehealth services that can be billed for obesity treatment include:

- Nutrition counseling – **initial visit** (**97802**), *and*
- Nutrition counseling – re-assessment (**97803**).

Supplemental payment policy: Telehealth for physical medicine services

General information

In addition to the information within the all telehealth services policy, the following is applicable to physical medicine services.

Speech (SLP), physical (PT), and occupational therapists (OT) as well as their assistants, athletic trainers, and **students** may conduct services via **telehealth**.

Direct supervision in accordance with **student** licensures must be provided in-person, even if the service is provided to the worker via **telehealth**.

Direct supervision of therapy assistants may occur via **telehealth** (modifier **–FR**) when the service to the worker is allowed via **telehealth**. Certain services require in-person care. These services require in-person direct supervision in alignment with DOH requirements for the assistant licensure.

Services that must be performed in person

Physical medicine services that must be performed in person also include:

- Work rehabilitation (**1001M**, **1023M**, **1024M**, **97545**, **97546**),
- Functional Capacity Evaluations (**1045M**, **1098M**)

Direct supervision of physical medicine **students** must occur in-person (Modifier **–FR** is not covered).

Payment limits

Physical medicine services conducted by **telehealth** are limited to 2 hours per day per worker, regardless of the service provided.

Payment policy: Audio-only services

General information

This payment policy applies to all evaluation and interventions provided via audio only, except for vocational and spoken interpretive services. See the separate policies for these services.

Audio-only shouldn't be used in place of telehealth or in-person services. The insurer won't pay for audio-only evaluation and/or interventions billed using modifier **–93** (audio-only), except for those listed in this policy and that meet specific requirements. The services covered in this policy are only allowed via-audio only when a documented attempt has been made to conduct the service via an audio-visual connection. Audio-only isn't covered for any service, except those noted in Services that can be billed, even when an audio-visual connection has been attempted or in any circumstance where the worker refuses to conduct the service using the video connection.

Links: Services that are customarily delivered by audio-only technology, such as case management telephone calls (**9919M**) and **SIMP** follow-up non-face-to-face services (**2015M**) aren't considered audio-only.

For telephone calls related to but not used to render treatment (case management telephone calls), see Chapter 5: Care Coordination.

For **SIMP** follow-up non-face-to-face services, see the chronic pain management policy in Chapter 27: Rehabilitation Facilities and Programs.

System requirements

Audio-only services involve delivery of treatment through use of audio-only technology that permits real-time connection between the worker and provider. Providers are responsible for ensuring complete confidentiality and protecting the privacy of the worker at all times.

Note: L&I doesn't follow the Centers for Medicare and Medicaid Services (CMS) definition of **telehealth** which includes audio-only.

Originating site requirements

Audio-only 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 audio-only services must be licensed in the state where the worker is receiving audio-only services. Only vocational rehabilitation counselors are exempt from this requirement.

Prior authorization

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

For all other services, the prior authorization requirements listed in the applicable service chapters apply regardless of how the service is rendered to the worker, either in person or via audio only, or **telehealth**.

Services that must be performed in person

The provider is expected to make arrangements for in-person evaluation and/or intervention in certain circumstances. Audio-only services follow the same in-person requirements as **telehealth**.

Services that can be billed

Audio-only is covered for the following services, except for the circumstances linked above in Services that must be performed in person.

Activity coaching (PGAP®)

Activity coaching (PGAP®), including **1400W-1402W** and **1160M**, may be performed in person, via audio only, or **telehealth**.

Behavioral Health Interventions (BHI)

Behavioral health interventions (BHI) may be performed via audio-only, but only if **telehealth** isn't available for the worker.

When BHI are conducted via audio only, the provider is unable to perform a visual assessment of the worker. Therefore, the insurer has created a local codes specific to BHI audio-only services.

Local Code	Description and notes
9959M	**Audio-only Individual Behavioral Health Interventions (BHI)** Interventions performed by psychologists and MLTs. Must have an established relationship with the worker, regardless of how it has been established (such as in person or via **telehealth**).

Links: BHI doesn't include components of a diagnosed mental health condition and shouldn't be used in place of a mental health referral or intervention. For more information on how mental health and BHI may intersect, see Chapter 17: Mental Health and Behavioral Health Interventions (BHI).

Mental Health Services

When mental health services are conducted via audio only, the provider is unable to perform a visual assessment of the worker. Therefore, the insurer has adopted a modified list of services that may occur via audio only.

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

- Psychiatric diagnostic evaluation (**90791**),
- Psychotherapy, without an E/M (**90832**, **90834**, **90837**),
- Crisis psychotherapy (**90839**, **90840**),
- Family psychotherapy with worker (**90847**), *and*
- Group psychotherapy (**90853**).

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

Nurse case management

NCM casework (**1297M**) may be performed in person, via audio only, or **telehealth**.

Services that aren't covered

Audio-only services that aren't covered include:

- Services that require visual intervention of a worker,
- Audio-only services done for the convenience of the provider or worker,
- Any service not listed in Services that can be billed above,

- Services listed in Services that must be performed in person, *and*
- Audio-only outpatient evaluation and management (E/M) services (**98008**-**98015** or in-person E/M codes with modifier **–93**).

Originating site fees (**Q3014**) aren't covered for audio-only services.

Requirements for billing

When billing audio-only delivery of...	Bill using...
PGAP® (**1400W**-**1402W** or **1160M**)	No modifier.
Behavioral Health Interventions (**9959M**)	No modifier.
Mental health evaluation (**90791**) or psychotherapy (**90832**, **90834**, **90837**, **90839**, **90840**, **90847**, **90853**, **90785**)	Modifier **–93**.

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

Documentation requirements

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

- The date of the call, *and*
- The participants and their titles, *and*
- The length of the call, *and*
- The nature of the call, *and*
- All medical, vocational, or return to work decisions made, *and*
- A notation of the worker's **originating site**,
- Documentation of attempt made to conduct the service via an audio-visual connection, *and*
- Documentation of the worker's consent to participate in audio-only services.

Chart notes, including BHI assessment forms, 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 the applicable chapter apply regardless of how the service is rendered to the worker.

Only 1 unit of **9959M** may be billed per day, per worker.

Payment policy: Mobile clinic services

General Information

Mobile clinics must obtain a group provider account using the location address on their business license for their application in ProviderOne. Each licensed provider rendering services via the mobile clinic must be individually credentialed under the mobile clinic's group provider account. Professional services must be billed under the individual provider's account who rendered the service with their usual and customary fees. Technicians of any kind are not eligible to be credentialed. Services provided by technicians, when appropriate, must be billed by the supervising provider.

The mobile clinic is considered to be the provider's usual and customary location. Providers who are traveling to provide services outside of their usual and customary location aren't considered to be providing service in a mobile clinic. **IME** providers can't provide services via a mobile clinic and must follow the policies outlined in Chapter 11: Impairment ratings and Independent Medical Exams (IMEs).

Filing of a Report of Accident/Provider's Initial Report (ROA/PIR) is required for occupational illness or injuries requiring treatment beyond basic first aid as defined in WAC 296-800-099.

Workers have the right to choose their healthcare providers and file a claim if they have reason to believe their injury or illness is work related, even if the provider or employer disagrees.

Link: For more information on provider accounts and billing instructions, see WAC 296-20-010, and WAC 296-20-125.

For more information on provider and worker responsibilities, see WAC 296-20-065, WAC 296-20-025, Chapter 2: Information for All Providers, and our website.

Prior authorization

Prior authorization may be required for services provided. See the applicable MARFS chapters for details.

Link: For more information, see WAC 296-20-030(1) and WAC 296-20-03001.

Services that can be billed

Providers rendering services out of a mobile clinic may bill for services within their scope of practice and that adhere to the department's rules and policies.

Mobile clinics qualify as an appropriate **originating site** for **telehealth** coverage.

Note: For more information on specific service requirements and limitations, see the appropriate MARFS chapter.

Services that aren't covered

Services provided via a mobile clinic are subject to the coverage requirements for the service being provided.

The mobile clinic or it's providers can't charge the worker or the insurer for:

- Appointment hold fees,
- Mileage (including **1046M**),
- Transportation and set up of radiology services (**R0070**, **R0075**, **R0076**, or **Q0092**). For additional information on portable x-rays, see the Portable radiology services policy in this chapter,
- Diagnostic ultrasound performed on the same day as an Evaluation and Management (E/M) office visit as it is considered **bundled** into the E/M CPT® code, *or*
- Basic first aid as defined by WAC 296-800-099.

Providers may bill workers for missed appointments, only if their established policy equally applies to all patients per WAC 296-20-010(6). For additional information on missed appointments, see Chapter 2: Information for All Providers.

Requirements for billing

Services provided via a mobile clinic are subject to the billing requirements for the service being provided.

When scheduling a mobile clinic visit, the provider is responsible for ensuring it is an appropriate environment to effectively conduct the services. The services must be rendered in a private space within the mobile clinic to allow for confidentiality.

In order to bill for rapid testing or other labs, the mobile clinic is required to obtain a Medical Test Site (MTS) license through the Department of Health.

Place of Service

When services are furnished in a mobile clinic, they are often provided to serve an entity for which another Place of Service (POS) exists. The following describes how to identify the appropriate POS code and associated requirements for billing.

- The appropriate POS code is based on the capacity in which the mobile clinic is serving. See the table below for more details.

- Services will be paid at the facility or non-facility rate based on the appropriate POS code. For a complete list of payment rates for each POS code, see Chapter 2: Information for All Providers.
- All services must be appropriate to render in the location of the applicable POS code and must be safe to perform in a mobile environment. Surgeries and procedures required to be performed at certain types of facilities aren't covered when performed in a mobile clinic, even if the appropriate facility POS code is used.

When the mobile clinic is…	Use POS Code…	Additional information:
Serving an entity for which another POS exists. Example: A mobile clinic is sent to a physician's office and is serving that entity.	Applicable POS for entity mobile clinic is serving. Example: The appropriate POS code is 11 (office) and would be reimbursed at the non-facility rate.	Reimbursement based on the payment rate for the POS code billed.
Not serving an entity for which another POS exists. Example: A mobile clinic providing urgent care in a grocery store parking lot.	POS 15 (mobile clinic).	POS 15 is reimbursed at the non-facility rate.
Acting as a **distant site** for a **telehealth** provider.	POS 02 (**telehealth** – worker is not at home) POS 10 (**telehealth** – worker is at home)	For more details on **telehealth** requirements, see the appropriate MARFS chapter for the services being provided.

Link: For a complete list of POS codes and their full descriptions, see CMS Place of Service Code Set.

Documentation requirements

In addition to the documentation requirements for the service being provided, providers rendering services via a mobile clinic also must document:

- A notation that the visit is being rendered via a mobile clinic,
- The entity in which the mobile clinic is servicing, if applicable, *and*
- The address of the location where the visit takes place.

Payment Limits

Services provided via a mobile clinic are subject to the payment limits for the service provided.

Drive-through clinics using POS 15 are limited to the lowest level E/M CPT® code **99211**. Higher-level E/M codes billed with POS 15 aren't covered.

Payment policy: Originating site fee for telehealth

General information

The insurer may 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.

Services can be billed

Originating site fees (**Q3014**) include only the use of the provider's **telehealth** equipment. The **distant site** provider conducting the services via **telehealth** must bill for the professional services rendered.

Q3014 is payable when the **originating site** provider (clinic or facility payee) owns the **distant site** where the provider is conducting the **telehealth** service. In this case, it may be appropriate for the **distant site** provider to bill for **Q3014**.

Q3014 is only payable to independent medical examiners in certain circumstances. See Telehealth for independent medical exams (IME) for details.

Services that aren't covered

Q3014 isn't covered when:

- The **originating site** provider performs any service to the worker 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.

Requirements for billing

To bill for the **originating site** fee, use HCPCS code **Q3014**.

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

Q3014 Billing Example

A worker attends an in-person Evaluation and Management (E/M) appointment at their **attending provider**'s office. The **attending provider** documents all necessary information

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

How to bill for this scenario

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

For this **telehealth** visit:

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

Note: For more information on E/M service requirements, refer to Chapter 9: Evaluation and Management (E&M).

Documentation requirements

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 (distinctly separate visit) to a worker, separate documentation is required for both the in-person visit and the **Q3014** service.

Documentation by the **originating site** provider for **Q3014** must include:

- The location of the **originating site**,
- A notation of who the **distant site** provider is, *and*
- That the service is separate from any in-person visits that occurred on the same day, if applicable.

Payment limits

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.

Payment policy: Portable radiology services

General information

This policy applies only to the transportation and set up of portable radiology equipment, not the radiology services provided. For information regarding radiology services and their requirements, see Chapter 8: Electrodiagnostics and Radiology.

Services that can be billed

Portable X-ray services (transportation and set up of equipment) are only payable when the worker can't access or otherwise be examined on fixed conventional X-ray equipment and the X-ray service is furnished in the worker's place of residence, which includes:

- The workers' home,
- Assisted living, adult family, or boarding home, *and*
- Skilled Nursing Facilities.

All tests must be performed under the general supervision of a physician and are limited to:

- Skeletal films involving extremities, pelvis, vertebral column, *or* skull,
- Chest or abdominal films that don't involve the use of contrast media, *and*
- Diagnostic mammograms.

Code	Description	Modifier (if applicable)	**Maximum fee**
R0070	Transportation of portable x-ray equipment to a worker's residence, per trip; 1 patient served		**$202.47**
R0075	Transportation of portable x-ray equipment to a worker's residence, per trip, 2 patient served	**–UN**	**$101.24**
	3 patients served	**–UP**	**$67.50**
	4 patients served	**–UQ**	**$50.60**
	5 patients served	**–UR**	**$40.49**
	6 patients served	**–US**	**$33.75**
Q0092	Set-up of portable x-ray equipment, each procedure		**$50.16**

Services that aren't covered

R0070, **R0075** or **Q0092** for portable X-ray services aren't covered when:

- Performed in a location other than the workers' place of residence,
- The equipment was stored in the location the service was performed (such as a mobile clinic or stored at the worker's place of residence).

Transportation of portable EKGs (**R0076**) to any location is **bundled** into the EKG procedure and isn't separately payable.

There are no codes for transportation of portable ultrasound equipment. This is not a covered benefit.

Documentation requirements

Portable radiology services documentation must include:

- Date of service,
- Worker name and L&I claim number,
- Location and address where the portable radiology service was performed,
- Number of patients served during the visit to the location,
- Description of radiology service performed, *and*
- Reasoning why the worker wasn't able to access or otherwise be examined on fixed conventional X-ray equipment.

Separate documentation is required by the performing provider to support the radiology service provided.

Link: For more information on service and documentation requirements for the X-ray service, see Chapter 8: Electrodiagnostics and Radiology.

Payment limits

R0075 will pay based on the number of patients served and the modifier billed.

HCPCS codes for transportation of portable X-ray equipment **R0070** (1 patient) or **R0075** (multiple patients), and set up of portable X-ray equipment **Q0092**, if appropriate, may be paid in addition to the appropriate X-ray CPT® code(s). The X-ray service is payable as long as the service and documentation requirements are met, regardless of whether portable radiology service codes are payable.

Split billing

Only a single transportation charge (**R0070** or **R0075**) is allowed for each trip the portable X-ray supplier makes to a location. When more than one worker is served, the charge must be split equally among all patients, even if the other patient(s) isn't a worker with an open L&I claim.

Set up of the X-ray equipment (**Q0092**) is separately billable for each radiological procedure performed on each patient. Bill the appropriate number of units of **Q0092** under each claim separately.

Link: For more information on split billing procedures and requirements, see the Split billing – treating multiple separate conditions payment policy in Chapter 2: Information for All Providers.

Payment policy: Remote monitoring

Services that aren't covered

The following **remote** monitoring services aren't a covered benefit:

- **Remote** therapeutic monitoring (RTM) to support monitoring of the respiratory system, musculoskeletal system, or cognitive behavioral therapy (CPT® **98975**-**98978**),
- **Remote** physiologic monitoring (RPM) such as weight, blood pressure, pulse oximetry, and respiratory flow rate (CPT® **99453**-**99454**) and treatment management services (CPT® **99457**-**99458**), *and*
- Self-Measured Blood Pressure (SMBP) (CPT® **99473**-**99474**).

Phone, computer, or other digital applications, such as phone applications, for **remote** monitoring aren't covered.

Payment Limits

Collection and interpretation of physiologic data, such as ECG and glucose monitoring (CPT® **99091**) is **bundled** and not separately payable.

Payment policy: Store and forward fees

General information

The insurer may pay a store and forward fee to a provider for **remote** assessment of recorded video and/or images submitted by an **established patient** to determine if a visit is required.

This service doesn't include recording reviews requested by the insurer. See **1066M** in Chapter 21: Reports and Forms.

Services that can be billed

Store and forward fees include interpretation and worker follow up. **G2010** or **G2250** is only payable when the following service requirements are met:

- The service is initiated by an **established patient**,
- The service being provided is not PGAP®, BIRP, **SIMP**, mental health, BHI, or obesity treatment,
- Follow up with the worker (phone, **telehealth**, or in person) occurs within 24 business hours of receiving the images and/or video recordings,
- The **remote** assessment of video and/or images isn't part of another service already performed in the prior 7 days, *and*
- The provider's evaluation of the image or video recording doesn't lead to a visit within the next 24 hours or soonest available appointment.

Code	Description
G2010	Worker-initiated **remote** assessment of video and/or images by provider who has Evaluation and Management (E/M) services in their scope of practice.
G2250	Worker-initiated **remote** assessment of video and/or images by a non-physician provider who can't independently bill for Evaluation and Management (E/M) services; however, the service must be consistent with their scope of practice.

Services that aren't covered

These services are not covered for providers rendering:

- Activity coaching (PGAP®),
- Behavioral health interventions (BHI),
- Brain injury rehab program (BIRP) services,
- Chronic pain management (**SIMP**) services,
- Mental health services, *or*
- Obesity treatment.

Documentation requirements

Store and forward documentation must include:

- Permanent storage (electronic or hard paper copy) of the images and/or recordings,
- The patient verbally consented to the service,
- The service was medically necessary,
- Follow-up communication with the patient occurred within 24 business hours, including the nature, method (phone, **telehealth** or in person), and total time of the discussion,
- The patient initiated use of the **remote** evaluation of the video or images, *and*
- The clinical decision making that occurred as a result of the **remote** evaluation, including the provider's interpretation of the images and/or recording.

Payment Limits

G2010 and **G2250** are limited to 1 unit per day per provider.

Follow up isn't separately payable.

Payment policy: Telehealth for independent medical exams (IME)

General information

The insurer reimburses **telehealth** at parity with in-person **Independent Medical Exam** (**IME**) 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 examination in certain circumstances. See Services that must be performed in person in this policy.

When scheduling the **telehealth** visit, the provider is responsible for ensuring **telehealth** is the appropriate method of service delivery to effectively conduct the **IME**.

The worker must be present at the time of the **telehealth** service and the evaluation of the worker must be under the control of the **telehealth** provider. Per WAC 296-23-358, when an **IME** provider isn't in a reasonably convenient location for the worker, the insurer may make alternative arrangements for the examination, including using **telehealth** where appropriate.

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.

Services provided without a video connection (audio-only) aren't considered **telehealth**. Audio-only IMEs aren't covered.

Note: L&I doesn't follow the Center for Medicare and Medicaid Services (CMS) definition of **telehealth** which includes audio-only.

Originating site requirements

IME telehealth services must occur from an appropriate **originating site**. **IME telehealth** services may not be delivered from the employer's worksite, any location owned or controlled by the employer, or any other medical or vocational site.

An appropriate **origination site** for an **IME** must be:

- The worker's home, *or*
- An **IME** firm's location.

The provider performing **telehealth** services must be licensed in the state where the worker is receiving **telehealth** services.

Prior authorization

The prior authorization requirements listed in Chapter 11: Impairment Ratings and Independent Medical Exams (IMEs) applies regardless of how the service is rendered to the worker, either in person or via **telehealth**.

Services that must be performed in person

The provider is expected to make arrangements for in-person examination in certain circumstances.

In-person examinations IMEs 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 has an emergent issue such as re-injury, new injury, or worsening status*, or*
- When the service to be performed requires a hands-on component.

Services that can be billed

Telehealth is covered for most services that don't require a hands-on component, with exception of those listed in Services that must be performed in person. The following IMEs may be conducted via **telehealth**:

- Mental health,
- Dermatology,
- Speech, when there is no documented hearing loss,
- Kidney function,
- Hematopoietic system, *and*
- Endocrine.

Per WAC 296-23-359, additional **IME** specialties not on this list may be approved on a case-by-case basis, upon request to the insurer and with agreement of the worker.

Originating site fee (Q3014)

The insurer may pay an **originating site** fee to an **IME** firm when they allow the worker to use their telecommunications equipment for a **telehealth** service with a provider at another location. **Originating site** fees (**Q3014**) include only the use of the provider's **telehealth** equipment. The **distant site** provider conducting the **IME** via **telehealth** must bill for the professional services rendered. **Q3014** is only payable to **IME** providers when:

- The worker is in Washington State and the **telehealth IME** provider is in another state, *and*
- The worker has an in-person exam at the **originating site** that happens the same day as an **IME telehealth** exam at the **distant site**, *and*
- The worker requires the use of the firm's space for the **telehealth** visit with an approved **IME** provider for an exam, *and*
- The firm isn't using that space for another worker, *and*
- No other in-person service is being provided to the worker concurrently during the **telehealth** exam.

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.

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 (distinctly separate visit) to a worker, separate documentation is required for both the in-person visit and the **Q3014** service. Documentation by the **originating site** provider for **Q3014** must include:

- The location of the **originating site**,
- A notation of who the **distant site** provider is, *and*

That the service is separate from any in-person visits that occurred on the same day, if applicable.

Services that aren't covered

Audio-only telemedicine can't be used in place of telehealth or in-person IME services. The insurer won't pay for audio-only **IME** billed using modifier **–93** (audio-only), even when an audio-visual connection has been attempted or if the worker refuses to conduct the service using a video connection.

Telehealth procedures and services that aren't covered for IMEs include:

- The services listed under Services that must be performed in person in this policy,

- The following services,
    - **1104M**, **IME** addendum report,
    - **1105M**, **IME** Physical Capacities Estimate,
    - **1124M**, **IME**, other, **by report**,
    - **1125M**, physician travel per mile,
    - **1129M**, **IME**, extensive file review by examiner,
    - **1147M**, Correctional facility **IME**,
- Completion and filing of any form that requires a hands-on physical examination, *and*
- Store and forward fees (**G2010** or **G2250**).

No payment will be made to the worker or provider for obtaining or maintaining equipment for a **telehealth** appointment, including but not limited to the purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems.

Requirements for billing

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

Do not bill using modifier **–GT**. The insurer doesn't recognize modifier **–95**.

Distant site providers must use place of service **02** to denote the **telehealth** visit when the worker isn't located in their home. **Distant site** providers must use place of service **10** to denote the **telehealth** visit when the worker is located in their home.

Place of service **27** (outreach site/streets) isn't covered. When **telehealth** is provided to a worker that is not in a facility, POS **10** (home) should be used.

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, *and*
- Documented consent from the insurer regarding the appropriateness of the **IME** to be conducted via **telehealth**.

IME reports must contain documentation that justifies the level, type, and extent of services billed. See this policy and Chapter 11: Impairment Ratings and Independent Medical Exams (IMEs) for the **type of service** rendered and the documentation requirements.

Payment limits

The same limits noted in Chapter 11: Impairment Ratings and Independent Medical Exams (IMEs) apply regardless of how the service is rendered to the worker.

Payment policy: Virtual reality services and devices

General information

Virtual reality involves a computer-generated simulation that immerses the worker in a virtual world for therapy.

Virtual reality devices may be used as a delivery mechanism for a covered therapeutic service, such as physical therapy exercises delivered with virtual reality tasks or cognitive behavioral therapy with virtual reality exposure therapy.

Services that aren’t covered

Providers can’t charge an additional fee for the use of virtual reality devices to deliver the service.

Purchase or rental of virtual reality **DME** isn’t covered for clinical or home use.

Payment limits

The cost of virtual reality as a modality for treatment in a clinical setting is **bundled** into the cost of therapy services and isn’t separately payable.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for basic first aid	Washington Administrative Code (WAC) 296-800-099
Administrative rules for billing instructions	WAC 296-20-125
Administrative rules for consultation requirements	WAC 296-20-045 WAC 296-20-051 WAC 296-20-01002 WAC 296-20-01501
Administrative rules for prior authorization	WAC 296-20-030(1) WAC 296-20-03001
Administrative rules for provider accounts and missed appointments	WAC 296-20-010
Administrative rules for provider and worker responsibilities	WAC 296-20-065 WAC 296-20-025 Chapter 2: Information for All Providers L&I's website
Administrative rules for transfer of providers	WAC 296-20-065
Interpretive Services	Chapter 14: Language Access Services for Spoken Language Chapter 18: Other Services
Payment policy for attending providers	Chapter 3: Attending Providers

If you're looking for more information about…	Then see…
Payment policy for evaluation and management (E/M) services	Chapter 9: Evaluation and Management (E/M)
Payment policy for impairment ratings and IMEs	Chapter 11: Impairment Ratings and Independent Medical Exams (IMEs)
Payment policy for mental health and behavioral health interventions (BHI)	Chapter 17: Mental Health and Behavioral Health Interventions (BHI)
Payment policy for rehabilitation facilities	Chapter 27: Rehabilitation Facilities and Programs
Payment policy for remote vocational services	Chapter 25: Vocational Services
Payment policy for student supervision, split billing, and other information for all providers	Chapter 2: Information for All Providers
Payment policy for telephone calls	Chapter 5: Care Coordination
Place of service	Appendix C: Place of Service (POS) Codes CMS Place of Service Code Set
Updates and corrections to payment policies and fee schedules	Updates and corrections tab of the L&I website

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

