Washington State Department of
Labor & Industries
Workers' Compensation Services

Payment Policies for Healthcare Services
Provided to Injured Workers and Crime Victims

Chapter 10: Evaluation and Management (E/M) Services

Effective July 1, 2016

Link: Look for possible **updates and corrections** to these payment policies at

http://www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2016/

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Definitions

- **CPT® and HCPCS code modifiers mentioned in this chapter:**

  –24 Unrelated evaluation and management (E/M) services by the same physician during a postoperative period

  Used to indicate an E/M service unrelated to the surgical procedure was performed during a postoperative period. *Documentation must be submitted with the billing form when this modifier is used.* Payment is made at one hundred percent of the fee schedule level or billed charge, whichever is less.

  –25 Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure

  Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

  –GT Interactive telecommunication

  Teleconsultations via interactive audio and video telecommunication systems.

- **Established patient:** One who has received professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.

  L&I uses the CPT® definition for established patients. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

- **New patient:** One who hasn't received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.

  L&I uses the CPT® definitions for new patients. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

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Payment policy: All E/M services

Requirements for billing

All E/M services

Chart notes must contain documentation that justifies the level of service billed. (See Documentation guidelines, below.)

Determining level of visit: New or established patient

If a patient presents with a work related condition and meets the definition in a provider's practice as:

- A **new patient**, then a new patient E/M should be billed, *or*
- An **established patient**, then an established patient E/M service should be billed, even if the provider is treating a new work related condition for the first time.

Note: L&I uses the CPT® definitions of **new patient** and **established patient**. Also, see definitions of both terms in Definitions at the beginning of this chapter.

Using CPT® billing code modifier –25

Modifier –25 must be appended to an E/M code when reported with another procedure on the same date of service.

The E/M visit and the procedure must be documented separately.

To be paid, **modifier –25** must be reported in the following circumstances:

- Same patient, same day encounter, *and*
- Same or separate visit, *and*
- Same provider, *and*
- Patient condition required a **significant separately identifiable E/M service above and beyond the usual pre and post care** related to the procedure or service.

Scheduling back-to-back appointments doesn't meet the criteria for using **modifier –25**.

Documentation guidelines

The key components in determining the level of E/M service are:

- The history,
- The examination, *and*
- Decision making.

Note: Office visits that consist predominately (more than 50 percent of the visit) of counseling and/or coordination of care activities are the exception. For these visits, time is the key or controlling factor for selecting the level of evaluation and management service. If the level of service is reported based on counseling and/or coordination of care, the chart note must have the total length of the visit documented, as well as what portion of the time was spent counseling and/or coordinating care. The chart note must also describe the counseling and/or the activities to coordinate care.

To determine the appropriate level of service, providers must use one of the following guidelines in conjunction with Evaluation and Management (E/M) Services Guidelines noted in CPT®:

- The "1995 Documentation Guidelines for Evaluation & Management Services," *or*
- The "1997 Documentation Guidelines for Evaluation and Management Services."

Links: Both guidelines are available on Medicare's website. The 1995 version is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf

The 1997 version is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf

Examples of using billing code modifier –25

Example 1

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A worker goes to an osteopathic physician's office to be treated for back pain.

The physician:

- Reviews the history,
- Conducts a review of body systems, *and*
- Performs a clinical examination.

The physician then advises the worker that osteopathic manipulation is a therapeutic option for treatment for the condition. The physician performs the manipulation during the office visit. This is a significant separately identifiable procedure performed at the time of the E/M service.

How to bill for this scenario

For this office visit, the physician may bill the appropriate:

- CPT® code for the manipulation, *and*
- E/M code with the **–25 modifier**.

Example 2

A worker goes to a physician's office for a scheduled follow up visit for a work related injury.

During the examination, the physician determines that the worker's condition requires a course of treatment that includes a trigger point injection at this time. The trigger point injection wasn't scheduled previously as part of the E/M visit. The physician gives the injection during the visit. This is a significant separately identifiable procedure performed at the time of the E/M service.

How to bill for this scenario

For the same time and date of service, the physician may bill the appropriate:

- CPT® code for the injection, *and*
- E/M code with the **–25 modifier**.

Example 3

A worker arrives at a physician's office in the morning for a scheduled follow up visit for a work related injury.

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That afternoon, the worker's condition worsens and the worker seeks immediate medical attention and returns to the office without an appointment. The office staff or triage nurse agrees that the worker needs to be seen. The provider sees the patient for a second office visit.

How to bill for this scenario

Since the 2 visits were completely separate, both E/M services may be billed:

- The scheduled visit would be billed with the E/M code alone, *and*
- The unscheduled visit would be billed with the E/M code with the **–25 modifier**.

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Payment policy: Care plan oversight

Who must perform these services to qualify for payment

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

Services that can be billed

The insurer allows separate payment for care plan oversight services (CPT® codes **99375**, **99378**, and **99380**).

Requirements for billing

Payment for care plan oversight to a provider providing post surgical care during the postoperative period will be made only:

- If the care plan oversight is documented as unrelated to the surgery, *and*
- **Modifier –24** is used.

The medical record must document the medical necessity as well as the level of service.

Payment limits

Payment is limited to one:

- Per attending provider,
- Per patient,
- Per 30 day period.

Care plan services (CPT® codes **99374**, **99377**, and **99379**) of less than 30 minutes within a 30 day period are considered part of E/M services and aren't separately payable.

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Payment policy: Case management services – Team conferences

Prior authorization

Physical and occupational therapists (PT and OT), and speech language pathologists

PTs, OTs, and speech language pathologists may be paid for attendance at a team conference only when the Medical Director/Associate Medical Director at L&I or the SIE/TPA authorizes the conference in advance.

To be authorized all of the following criteria must be met:

- There is a moderate to high probability of severe, prolonged functional impairment. This may be addressed with the development of a multidisciplinary approach to the plan of care, *and*
- The need for a conference exceeds the expected routine correspondence/communication among healthcare/vocational providers, *and*
- The worker isn't participating in a program in which payment for conference is already included in the program payment (For example, head injury program, pain clinic, work hardening), *and*
- 3 or more disciplines/specialties need to participate, including PT, OT, or speech.

Who must perform team conferences to qualify for payment

Team conferences may be payable when the **attending provider**, **consultant**, or **psychologist** meets with one or more of the following:

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

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Requirements for billing

Using correct CPT® billing codes

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

For conferences **exceeding 30 minutes**, multiple units of **99366**, **99367**, and **99368** may be billed. If the duration of the conference is:

- 1-30 minutes, then bill 1 unit, *or*
- 31-60 minutes, then bill 2 units.

Documentation requirements

Each provider must submit their own conference report; joint reports aren't allowed. Each conference report must include:

- The date, *and*
- The participants and their titles, *and*
- The length of the visit, *and*
- The nature of the visit, *and*
- All medical, vocational or return to work decisions made.

In addition to the documentation requirements noted above, team conference documentation must also include a goal oriented, time limited treatment plan covering:

- Medical,
- Surgical,
- Vocational or return to work activities, *or*
- Objective measures of function.

The treatment plan must allow a determination whether a previously created plan is effective in returning the worker to an appropriate level of function.

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PTs and OTs

To be paid for the conference the therapists must:

- Bill using CPT® code **99366** if the patient is present or **99368** if the patient isn't present.
- Bill on a **CMS-1500** form (F245-127-000)
- Submit a separate report of the conference; joint reports aren't allowed. The conference report must include:
  - Evaluation of the effectiveness of the previous therapy plan, *and*
  - New goal oriented, time limited treatment plan, *or*
  - Objective measures of function that address the return to work process, *and*
  - The duration of the conference

Providers in a hospital setting

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

Psychiatrists and clinical psychologists

Psychiatrists and clinical psychologists may only bill for these services when also providing consultation or evaluation services.

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Payment policy: Case management services – Telephone calls

Who must perform these services to qualify for payment

Telephone calls are payable to the attending provider, consultant, psychologist, or other provider only when they personally participate in the call.

Services that can be billed

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

- The worker,
- L&I staff,
- Attending Provider
- Vocational rehabilitation counselors,
- Nurse case managers,
- Health services coordinators (COHE),
- L&I medical consultants,
- Other physicians,
- Other providers,
- TPAs, *or*
- Employers.

Note: The insurer will pay for telephone calls if the provider leaves a detailed message for the recipient and meets all of the documentation requirements.

Telephone calls are payable regardless of when the previous or next office visit occurs.

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

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Services that aren't covered

Telephone calls aren't payable if they are for:

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

Requirements for billing

Using correct CPT® billing codes

If the **duration** of the telephone call is…	And you are a **physician,** then bill CPT® code:	And you are a **non-physician** (see Note below table), then bill CPT® code:
1-10 minutes	**99441**	**98966**
11-20 minutes	**99442**	**98967**
21-30 minutes	**99443**	**98968**

Note: ARNPs, PAs, psychologists, PTs, and OTs must bill using non-physician codes.

Documentation requirements

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

- The date, *and*
- The participants and their titles, *and*
- The length of the call, *and*
- The nature of the call *and*
- All medical, vocational or return to work decisions made.

Psychiatrists and clinical psychologists

Psychiatrists and clinical psychologists may only bill for these services when mental health services are authorized.

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Payment policy: Case management services – Online communications and consultations

Requirements for online communications

Online communications must be conducted over a secure network, developed and implemented using guidelines from reputable industry sources such as those published by:

- The American Medical Association,
- The Federation of State Medical Boards, *and*
- The eRisk Working Group for Healthcare.

Who must perform these services to qualify for payment

Electronic online communications (email) with the worker are payable only when personally made by the:

- Attending provider, *or*
- Consultant, *or*
- Psychologist, *or*
- Physical or occupational therapist, *and*
- Who has an existing relationship with the worker.

Services that can be billed

Services that are payable for communications with workers include:

- Follow up care resulting from a face to face visit that doesn't require a return to the office,
- Non-urgent consultations regarding an accepted condition when the equivalent service provided in person would have resulted in a charge,
- Reporting and interpreting diagnostic tests that require counseling and adjustments to treatment or medications, *and*
- Discussions of return to work activities with workers and employers.

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Note: L&I doesn't follow the CPT® limits for online communications.

Electronic communications are also payable when discussing or coordinating care, treatment, or return to work activities with:

- L&I staff,
- Vocational rehabilitation counselors,
- Case managers,
- L&I medical consultants,
- TPAs, *or*
- Employers.

Services that aren't covered

Services that aren't payable include:

- Routine requests for appointments,
- Test results that are informational only,
- Requests for prescription refills, *and*
- Consultations that result in an office visit.

Requirements for billing

Using correct CPT® billing codes

As a **provider**, if you are a…	Then bill **CPT® code**:	And the **non-facility maximum fee** is:	Or the **facility maximum fee** is:
Physician	**99444**	**$46.04**	**$43.62**
Non-physician	**98969**	**$46.04**	**$43.62**

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Documentation Requirements

Documentation for electronic communications must include:

- The date, *and*
- The participants and their titles, *and*
- The nature of the communication, *and*
- All medical, vocational or return to work decisions made.

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Payment policy: End stage renal disease (ESRD)

Note: L&I follows CMS's policy regarding the use of E/M services along with dialysis services.

Services that can be billed

Separate billing and payment will be allowed when billed on the same date as an inpatient dialysis service for:

- An initial hospital visit (CPT® codes **99221-99223**),
- An initial inpatient consultation (CPT® codes **99251-99255**), *or*
- A hospital discharge service (CPT® code **99238** or **99239**).

Payment limits

E/M services (CPT® codes **99231-99233** and **99307-99310**) aren't payable on the same date as hospital inpatient dialysis (CPT® codes **90935**, **90937**, **90945**, and **90947**). These E/M services are bundled in the dialysis service.

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Payment policy: Medical care in the home or nursing home

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

- Nursing facilities,
- Domiciliary, boarding home, or custodial care settings, *and*
- The home.

Who must perform these services to qualify for payment

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

Requirements for billing

The medical record must document the medical necessity as well as the level of service.

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Payment policy: Prolonged E/M

Requirements for billing

A report is required when billing for prolonged evaluation and management services. The provider must document in the medical record that they personally furnished the direct face-to-face time with the worker.

Use the following CMS payment criteria:

If you are billing for this **CPT® code**…	Then you **must also bill this (or these) other CPT® code(s)** on the **same date of service:**
99354	**99201-99205, 99212-99215, 99241-99245 or 99324-99350**
99355	**99354** and 1 of the E/M codes required for **99354**
99356	**99221-99223, 99231-99233, 99251-99255, 99304-99310**
99357	**99356** and 1 of the E/M codes required for **99356**

Payment limits

Payment of prolonged E/M is allowed with a maximum of 3 hours per day per patient.

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

The time counted toward payment for prolonged E/M services includes only direct face to face contact between the provider and the patient (whether the service was continuous or not).

Prolonged physician services without direct contact are bundled and aren't payable in addition to other E/M codes.

Links: For more information on E/M services, refer to either the:

"1995 Documentation Guidelines for Evaluation & Management Services," available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf

or

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"1997 Documentation Guidelines for Evaluation and Management Services," available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf

Payment policy: Split billing – Treating two separate conditions

Requirements for billing

If the worker is treated for two separate conditions at the same visit, the charge for the service must be divided equally between the payers.

If evaluation and treatment of the two injuries increases the complexity of the visit:

- A higher level E/M code might be billed, *and*
- If this is the case, CPT® guidelines must be followed and the documentation must support the level of service billed.

For State Fund claims, when submitting:

- **Paper bills** to L&I, list all workers' compensation claims treated in Box 11 of the **CMS-1500** form (F245-127-000) or
- **Electronic claims**, list all workers' compensation claims treated in the remarks section of the **CMS-1500** form.

Note: L&I will divide charges equally to the claims.

If part of the visit is for a condition unrelated to an accepted L&I or self-insured claim and part is for the accepted condition:

- Providers must apportion their usual and customary charges equally between L&I or the SIE and the other payer based on the level of service provided during the visit, *and*
- In this case, separate chart notes for the accepted condition should be sent to the insurer.

Note: Employers don't have the right to see information about an unrelated condition.

Payment limits

A physician would only be paid for more than one evaluation and management visit if there were two separate and distinct visits on the same day (see Example 3, below).

Scheduling back-to-back appointments doesn't meet the criteria for using the **–25 modifier**.

Note: See more about Using billing code **modifier –25** in the All E/M services payment policy section of this chapter.

Examples of split billing

Example 1

A worker goes to a provider to be treated for a work related shoulder injury and a separate work related knee injury. The provider treats both work related injuries.

How to bill for this scenario

For State Fund claims, the provider bills for one visit listing both workers' compensation claims in Box 11 of the **CMS-1500** form (F245-127-000).

L&I will divide charges equally to the claims.

Note: For self-insured claims, contact the SIE or their TPA for billing instructions.

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Example 2

A worker goes to a provider's office to be treated for work related injury. During the examination, the worker mentions that he was in a car accident yesterday and now has neck pain. The provider treats the work related injury and the neck pain associated with the motor vehicle accident.

How to bill for this scenario

The provider would bill:

- 50% of his usual and customary fee to L&I or the SIE, *and*
- 50% to the insurance company paying for the motor vehicle accident.

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

Example 3

In the morning, a worker arrives at a physician's office for a scheduled follow up visit for a work related injury. That afternoon, the worker's condition worsens and the worker seeks immediate medical attention and returns to the office without an appointment. The office staff or triage nurse agrees that the worker needs to be seen.

The provider sees the patient for a second office visit.

How to bill for this scenario

Since the two visits were completely separate, both E/M services may be billed as follows:

- The scheduled visit would be billed with the E/M code alone, *and*
- The unscheduled visit would be billed with the E/M code with the **–25 modifier**.

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Payment policy: Standby services

Requirements for billing

A report is required when billing for standby services.

The insurer pays for standby services when all the following criteria are met:

- Another provider requested the standby service, *and*
- The standby service involves prolonged provider attendance without direct face-to-face patient contact, *and*
- The standby provider isn't concurrently providing care or service to other patients during this period, *and*
- The standby service doesn't result in the standby provider's performance of a procedure subject to a "surgical package," *and*
- Standby services of 30 minutes or more are provided.

Payment limits

Subsequent periods of standby beyond the first 30 minutes may be reported and are payable only when a full 30 minutes of standby was provided for each unit of service reported.

Note: Round all fractions of a 30 minute period downward.

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Payment policy: Teleconsultations and other telehealth services

System requirements

Telehealth services and teleconsultations require an interactive telecommunication system, consisting of special audio and video equipment that permits real time consultation between the patient and consultant. Providers are responsible for ensuring the complete confidentiality and privacy of the worker is protected at all times.

Note: L&I adopted a modified version of CMS's policy on teleconsultations and other telehealth services.

Coverage of teleconsultations

Teleconsultations are covered in the same manner as face-to-face consultations, but in addition, all of the following conditions must be met:

- The **consultant** must be a:
  - Doctor as described in WAC 296-20-01002, or
  - ARNP, *or*
  - PhD Clinical Psychologist, *or*
  - Consulting DC who is an approved consultant with L&I, *and*
- The **referring provider** must be one of the following:
  - MD, *or*
  - DO, *or*
  - ND, *or*
  - DPM, *or*
  - OD, *or*
  - DMD, *or*
  - DDS, *or*

  - DC, *or*
  - ARNP, *or*
  - PA, *or*
  - PhD Clinical Psychologist, *and*
- The patient must be present at the time of the consultation, *and*
- The exam of the patient must be under the control of the consultant, *and*
- Interactive audio and video telecommunications must be used allowing real time communication between the patient and the consultant, *and*
- The consultant must submit a written report documenting this service to the referring provider, and must send a copy to the insurer, *and*
- A referring provider who isn't the attending must consult with the attending provider before making the referral.

Links: For more information about coverage of these services, see WAC 296-20-045 and WAC 296-20-051. Also, see WAC 296-20-01002.

Services that can be billed

Originating facility

The insurer will pay an originating site facility fee for the use of the telecommunications equipment.

Providers

Providers (acting within their scope of practice) may bill for these services:

- Consultation codes,
- Office or other outpatient visits,
- Follow up visits after the initial consultation,
- Psychiatric intake and assessment,
- Individual psychotherapy,
- Pharmacologic management,

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- End stage renal disease (ESRD) services, *and*
- Team conferences.

Services that aren't covered

Telemedicine procedures and services that aren't covered include:

- "Store and Forward" technology, asynchronous transmission of medical information to be reviewed by the consultant at a later time,
- Facsimile transmissions,
- Purchase, rental, installation, or maintenance of telecommunication equipment or systems,
- Telerehabilitation services,
- Home health monitoring, *and*
- Telehealth transmission, per minute (HCPCS code **T1014**).

Requirements for billing

Originating facility

For the use of the telecommunications equipment, bill HCPCS code **Q3014,** which has a maximum fee of **$36.40** (effective July 1, 2016).

Documentation must be identified clearly and separately in the medical record.

Providers

Providers must append a **–GT modifier** to one of the appropriate services (see the list of services under Services that can be billed, above).

Payment limits

No separate payment will be made for the:

- Review and interpretation of the patient's medical records, *or*
- Required report that must be submitted to the referring provider and to the insurer.

The insurer will only pay for a professional service by the referring provider if it is:

- A separately identifiable service, *and*

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- Provided on the same day as the telehealth service.

Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for E/M services	Washington Administrative Code (WAC) 296-20-045: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-045 WAC 296-20-051: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-051 WAC 296-20-01002: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-01002
Becoming an L&I provider	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/default.asp
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare professional services (including chiropractic)	L&I's website: http://feeschedules.Lni.wa.gov
The 1995 Documentation Guidelines for Evaluation & Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf
The 1997 Documentation Guidelines for Evaluation and Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf

Need more help? Call L&I's Provider Hotline at **1-800-848-0811**

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