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 October 1, 2020

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

https://lni.wa.gov/patient-care/billing-payments/fee-schedules-and-payment-policies/policy-2020

Table of contents

Page

CPT® codes and descriptions only are © 2019 American Medical Association

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.

- **Consultations:** A type of evaluation and management service provided at the request of an attending provider to either recommend care for a specific condition or problem, or to determine whether to accept a patient for further treatment.

  L&I doesn't use the CPT® definitions for consultation services with respect to who can request a consultation service, when a consultation can be requested, and requirements for when to bill a consultation vs. an established patient codes. In addition, while chiropractic consultations don't require prior authorization, they do require prior notification (by electronic communication, letter, or phone call) to the department or self-insurer per WAC 296-23-195.

- **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.

- **Online communications:** Electronic communication conducted over a secure network, including but not limited to electronic mail (email), patient portals, or Claim and Account

CPT® codes and descriptions only are © 2019 American Medical Association

Center (CAC). Must be related to the worker and for the purposes of discussing or coordinating care, treatment, or return to work activities.

Payment policy: All E/M services

Prior authorization

Prior authorization is required when billing for:

- More than 20 office visits, *or*

Visits that occur more than 60 days after the first date you treat the worker.

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

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, established or consultation evaluation and management service

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

- A **new patient**, then a new E/M should be billed, *or*
- An **established patient**, then an established E/M service should be billed, even if the provider is treating a new work related condition for the first time, *or*
- A consultation is requested by the attending physician, and all requirements for a consultation service has been met, then a consultation E/M service should be billed.

Per WAC 296-20-051 providers may **not** bill consultation codes for established patients.

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

CPT® codes and descriptions only are © 2019 American Medical Association

Link: For more information about coverage for consultation services, see WAC 296-20-045, WAC 296-20-051 and WAC 296-20-01002.

Using CPT® billing code modifier –25

Modifier –25 must be appended to an E/M code when reported with another procedure 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**.

Consultations

In accordance with WAC 296-20-051, in cases presenting diagnostic or therapeutic problems to the attending provider, a consultation with a specialist may be requested without prior authorization. Prior notification to the insurer is required for chiropractic consultants. Refer to Chapter 7: Chiropractic Services for more information regarding the requirements for Chiropractic Consultants.

The consultant must submit his/her findings and recommendations to the attending provider and the department or self-insurer. The report must be received by the insurer within 15 days from the date of the consultation.

Consultation codes may only be reported by a physician or other qualified health care professional who has not agreed to accept transfer of care before an initial evaluation. Consultation services will not be reimbursed for workers who are currently, or have been, under the provider's care within the last three years. Such services should be billed as established patient E/M services, as listed in the fee schedules.

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 performing covered counseling and/or coordinating care activities. The chart note must also describe the counseling and/or the activities to coordinate care. CPT® defines counseling as a discussion with a patient and/or family concerning one or more of the following areas:

- Diagnostic results, impressions, and/or recommended diagnostic studies,
- Prognosis,
- Risk and benefits of management (treatment) options,
- Instructions for management (treatment) and/or follow up,
- Importance with compliance with chosen management (treatment) options,
- Risk factor reduction,
- Patient and family education.

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

CPT® codes and descriptions only are © 2019 American Medical Association

For more information about coverage for consultation services, see WAC 296-20-045, WAC 296-20-051 and WAC 296-20-01002.

For more information about chiropractic consultation services, see WAC 296-23-195.

In addition to the above, consultation reports must include the elements listed in WAC 296-20-01002 and the consultation service requirements noted in CPT® including who requested the consultation.

Examples of using billing code modifier –25

Example 1

A worker goes to an osteopathic physician's office to be treated for back pain. The physician performs all components of an E/M visit (history, exam, and medical decision -making). Based on his findings the physician then advises the worker that the osteopathic manipulation (OMT) is a therapeutic option for treatment for the condition. The physician obtains verbal consent, determines the appropriate technique for the worker and performs other pre-service work (e.g., cursory history and palpatory examination).

The physician then performs the manipulation, discusses side effects, self-care and follow up with the worker, and completes the other necessary post-service work.

In order for the E/M visit to be separately identifiable, the physician must document both the osteopathic manipulation (including pre, intra, and post service work) and the history, exam and medical decision-making components of the E/M visit performed for back pain that exceeded the usual pre- and post-service work included with OMT performed during the visit. For more information regarding OMT services, refer to Chapter 25: Physical Medicine Services.

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.** The level of E/M service is selected based on the work performed and documented above and beyond the pre and post service work associated with the manipulation.

Link: More information on billing for OMT is available in Chapter 25: Physical Medicine Services.

Example 2

The worker goes to the physician's office for a work related 2cm laceration of his scalp. The physician evaluates the laceration and determines sutures are needed. The evaluation of the scalp laceration is considered inclusive of the pre-service work for the laceration repair and therefore is included in the billing of the surgical code.

The worker is also complaining of dizziness. The physician also performs an exam to determine if the worker sustained a concussion.

For the E/M visit to be separately identifiable, the physician must document both the surgical procedure performed (including pre-service and post service work) and the history, exam, and medical decision-making components of the E/M visit performed for the dizziness.

How to bill for this scenario

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

- CPT® code for the laceration repair procedure, *and*
- E/M code with the **–25 modifier**. The level of E/M service is selected based on the work performed and documented above and beyond the pre and post service work associated with the laceration repair procedure.

Example 3

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

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

How to bill for this scenario

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

- The scheduled visit would be billed with the appropriate level of E/M code for this visit alone, with no modifier appended *and*
- The unscheduled visit would be billed with the appropriate level of E/M code for this visit alone, with the **–25 modifier**.

CPT® codes and descriptions only are © 2019 American Medical Association

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.

CPT® codes and descriptions only are © 2019 American Medical Association

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, such as:
  - Vocational rehabilitation counselors,
  - Nurse case managers,
  - PTs, OTs, and speech language pathologists.
- L&I staff,
- L&I medical consultants, *or*
- SIEs/TPAs.

CPT® codes and descriptions only are © 2019 American Medical Association

Note: The Department doesn't follow CPT® by requiring all providers to have seen or treated the patient in the previous 60 days.

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**

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

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

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

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.

Additionally, if the patient is present, the physician must comply with Evaluation and Management (E/M) coding guidelines, including the requirements to bill based off of time (when counseling and/or coordination of care dominates more than 50% of the visit) or based off of the key components (history, exam and medical decision making). Please note, the department follows CPT® in covered counseling topics with the addition of the discussion of medical, surgical, vocational or return to work activities for Team Conferences **only**.

PTs and OTs (Additional requirements)

Joint reports aren't allowed; submit a separate report of the conference. In addition to the documentation requirements noted above, the conference report must include an evaluation of the effectiveness of the previous therapy plan.

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.

CPT® codes and descriptions only are © 2019 American Medical Association

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

Payable telephone calls include:

- Follow up 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,
- Discussing care or treatment, for example, in-depth conversations on medical rationale and employability, or detailed notification of non-compliance to the claims manager, *and*
- Discussions of return to work activities with workers, employers, or the claims manager.

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

- The 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.

Services that aren't covered

Telephone calls aren't payable if they are for:

- Administrative communications, *or*
- Authorization, *or*
- Resolution of billing issues,
- Routine requests for appointments, *or*
- Ordering prescriptions.

Telephone calls aren't payable if they are with:

- Any party not stated under the section **Services that can be billed** including discussions with office staff.

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

CPT® codes and descriptions only are © 2019 American Medical Association

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

To provide mental health treatment, prior authorization is required, per WAC 296-21-270.

Payment policy: Case management services – Online communications

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

Online communications are payable only to providers who have an existing relationship with the worker and is personally made by the:

- Attending provider, *or*
- Consultant, *or*
- Psychologist, *or*
- Physical or occupational therapist*, or*
- Nurse case managers.

Services that can be billed

Bill using local code **9918M**.

Payable **online communications** include:

- Follow up 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,

CPT® codes and descriptions only are © 2019 American Medical Association

- Discussing care or treatment, for example, in-depth conversations on medical rationale and employability, or detailed notification of non-compliance to the claims manager, *and*
- Discussions of return to work activities with workers, employers, or the claims manager.

Payable **online communications** must be related to the worker and for the purposes of discussing or coordinating care, treatment, or return to work activities. The online communications must be with:

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

Services that aren't covered

Services that aren't payable include:

- Administrative communications,
- Authorization,
- Resolution of billing issues,
- Routine requests for appointments,
- Test results that are informational only,
- Requests for prescription refills, *and*
- Consultations that result in an office visit.

CPT® codes and descriptions only are © 2019 American Medical Association

Requirements for billing

Online communication documentation 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.

A copy of the **online communication** must be sent to L&I.

Providers are not required to submit a separate document for online communications with an L&I claims manager made through the Claims and Account Center (CAC). CAC meets the documentation requirements, for secure messaging. Services are only billable if the communication is for the purposes of discussing or coordinating care, treatment, or return to work activities.

Payment limits

9918M is limited to once per day per claim per provider.

CPT® codes and descriptions only are © 2019 American Medical Association

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.

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, the level of service and the location of the service.

CPT® codes and descriptions only are © 2019 American Medical Association

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 worker (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 www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf

or

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

CPT® codes and descriptions only are © 2019 American Medical Association

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.

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.

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

 CPT® codes and descriptions only are © 2019 American Medical Association

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 appropriate level of E/M code for this visit alone, with no modifier appended *and*
- The unscheduled visit would be billed with the appropriate level of E/M code for this visit alone, with the **–25 modifier**.

CPT® codes and descriptions only are © 2019 American Medical Association

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.

CPT® codes and descriptions only are © 2019 American Medical Association

Payment policy: Teleconsultations and other telehealth services

Note: L&I has published additional temporary telehealth policies that are in effect until June 30, 2021. See **Updates and Corrections** for additional information.

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,

 CPT® codes and descriptions only are © 2019 American Medical Association

- Psychiatric intake and assessment,
- Individual psychotherapy,
- Pharmacologic management,
- 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,
- Completion and filing of any form that requires a hands-on physical examination (e.g. Report of Accident, Provider's Initial Report, Activity Prescription Form),
- Purchase, rental, installation, or maintenance of telecommunication equipment or systems,
- Telerehabilitation services,
- Telehealth with home as an origination site,
- 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.**

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

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.

CPT® codes and descriptions only are © 2019 American Medical Association

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

- A separately identifiable service, *and*
- Provided on the same day as the telehealth service.

CPT® codes and descriptions only are © 2019 American Medical Association

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 WAC 296-23-195: https://apps.leg.wa.gov/wac/default.aspx?cite=296-23-195 WAC 296-20-030: https://apps.leg.wa.gov/wac/default.aspx?cite=296-20-030
Becoming an L&I provider	L&I's website: https://lni.wa.gov/patient-care/provider-accounts/become-a-provider/
Billing instructions and forms	Chapter 2: Information for All Providers
CMS 1500 form	CMS 1500 form: F245-127-000
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
Fee schedules for all healthcare professional services (including chiropractic)	L&I's website: http://www.lni.wa.gov/FeeSchedules
Payment policies **Chiropractic Services**	Chapter 7: Chiropractic Services

Payment Policies **Physical Medicine Services**	Chapter 25: Physical Medicine Services

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

CPT® codes and descriptions only are © 2019 American Medical Association