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, 2021

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-2021

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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 to support the service must be submitted.* 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.

- **Consultant**: A consultant is a physician or other qualified health care professional who has not agreed to accept transfer of care before an initial evaluation.

- **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 or new 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 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**.

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. This applies to all E/M services.

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.

The consultant must submit their 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, per WAC 296-20-051. Note that this is different from the requirement noted in Chapter 2: Information for All Providers which states that documentation to support the service billed must be received prior to bill submission or within 30 days of the date of service, whichever comes first.

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.

Note: 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.

Behavioral Health Interventions

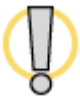
Behavioral Health Interventions are a brief course of care with a focus on addressing psychosocial barriers that impede a worker's recovery and improve their ability to return to work. For more information, see Chapter 22: Other Services.

Documentation guidelines

SOAP-ER note requirements

As outlined in Chapter 2: Information for All Providers, the insurer requires the addition of ER (Employment and Restrictions) to the SOAP format. Chart notes must document the worker's status at the time of each visit.

Providers are required to submit notes that contain the information necessary for the insurer to make decisions regarding coverage and payment. Medical documentation for an injury in workers' compensation must contain the pertinent history and the pertinent findings found during an exam. These requirements apply regardless of which guidelines the provider is following.



Note: The American Medical Association (AMA) made substantial changes to the New and Established patient E/M services effective January 1, 2021. The insurer has chosen to adopt these changes with slight modification as of July 1, 2021. For example, separately billable services and split/shared visits have their own policies (see Chapter 2: Information for All Providers). All other E/M services follow the 1995/1997 guidelines.

New and established patients (CPT® 99202-99215)

Select the appropriate level of E/M service based on either:

- Time, *or*
- Medical decision making.

As defined by AMA, Physician/other qualified healthcare professional time includes the following activities, when performed:

- Preparing to see patient (e.g., review of tests),
- Obtaining and/or reviewing separately obtained history,
- Performing a medically appropriate exam and/or evaluation,
- Counseling and educating the patient/family/caregiver,

- Ordering medications, tests, or procedures,
- Referring and communicating with other health care professionals,
- Documenting clinical information in the electronic or other health record,
- Independently interpreting results,
- Communicating results to the patient/family/caregiver,
- Care coordination.

Note: Only time spent in covered activities by the physician on the calendar day of the visit (midnight to 11:59pm) can be counted toward the E/M visit time. Check-in and check-out time can't be used when determining the length of a visit as this may include ancillary staff time, wait time, etc. Documentation must describe the covered activities performed. Generalized statements, such as "provided care coordination" aren't acceptable.

2021 E/M Time Based Billing Examples

Example #1

A worker goes to the physician's office for a follow-up of their work related elbow and shoulder injury. The physician evaluates and documents findings of the shoulder injury and suggests a steroid injection based on their findings. The physician also evaluates and documents findings related to the elbow injury and determines that physical therapy may provide benefit and provides a referral.

The physician performs the pre-service work (e.g., cursory history, palpatory examination, discusses side effects). The physician then performs the steroid injection, discusses self-care and follow up with the worker, and completes the other necessary post-service work.

The physician documents the steroid injection (including pre-, intra- and post service work), totaling 25 minutes and the separately identifiable E/M service including record review, history, exam, counseling provided and charting time, totaling 30 minutes all performed on the day of the office visit.

How to bill for this scenario

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

- CPT® code for the steroid injection, and

- CPT® code **99214**, with the **–25 modifier**.

Note: The physician can't include the time or activities spent performing the steroid injection (including the associated pre, intra and post service work) in selecting the appropriate E/M level. The provider must clearly document each service.

Example #2

A worker goes to the physician's office for a follow-up of their work related head injury. After reviewing the notes from the worker's neurologist the physician finds that they have questions regarding the current treatment plan. The physician documents a 10 minute telephone conversation with the neurologist on the day of the visit including all required elements of that CPT® code. The physician evaluates and documents findings of the head injury as well as the treatment plan.

The physician documents that 15 minutes was spent in record review, 10 minutes in the phone call, 15 minutes on history and exam, and 10 minutes charting all performed on the day of the office visit. This results in 40 minutes of a separately identifiable E/M service.

How to bill for this scenario

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

- CPT® code for the telephone call, and
- CPT® code **99215**, with the **–25 modifier**.

Note: The physician can't include the time or activities spent performing or documenting the telephone call in selecting the appropriate E/M level as this service is required to be billed separately. The provider must clearly document each service.

To determine the appropriate level of service, providers must use the following guidelines:

- For Outpatient E/M (New or Established patients), use the "American Medical Association Guideline Changes".

All other E/M visits

All other E/M visits includes but is not limited to, consultations and emergency room visits. The 1995/1997 guidelines are still applicable to these E/M visits.

The key components in determining the level of these types of E/M services are:

- The history,
- The examination, and
- Medical 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 the following guidelines in conjunction with Evaluation and Management (E/M) Services Guidelines noted in CPT®:

- For all other E/M visits that don't fall within the 2021 AMA requirements for CPT® codes 99202-99205 or 99211-99215, use the "1995 Documentation Guidelines for Evaluation & Management Services," or the "1997 Documentation Guidelines for Evaluation and Management Services."

Consultation reports

In addition to the above, consultation reports must include the elements listed in WAC 296-20-01002. Documentation of the referral must be present in either the

attending physician notes or the consultant's report. The report must be received by the insurer within 15 days from the date of the consultation, per WAC 296-20-051.

Note: Consultation report requirements are different from the requirements noted in Chapter 2: Information for All Providers.

Links:

American Medical Association Guideline Changes is available at https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

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

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.

Separately billable services

Any services represented by their own CPT®, HCPCs, or local codes must be billed separately, and the time spent on those services cannot be included in the time calculated for the level of E/M service. This is applicable to all E/M services, regardless of which guidelines the provider is required to follow.

This includes but is not limited to services, such as:

- Care coordination (e.g., telephone calls or online communications), *or*
- Completing forms such as a Report of Accident (ROA) or Activity Prescription Form (APF), *or*
- Independently interpreting results, *or*
- Injections, *or*

- Any treatment-based service.

Examples of using billing code modifier –25 for new or established patients

Example 1 (new or established patient)

A worker goes to an osteopathic physician's office to be treated for back pain. The physician performs an E/M visit, including a multi-system examination, reviewing the patient's prior records and counseling the patient on the importance of appropriate lifting techniques for when they return to work. Based on their findings the physician then advises the worker that osteopathic manipulative treatment (OMT) is a therapeutic option for treatment of the condition.

The physician obtains verbal consent, determines the appropriate technique for the worker and performs other pre-service work (e.g., cursory history, palpatory examination, discusses side effects). The physician then performs the manipulation, discusses self-care and follow up with the worker, and completes the other necessary post-service work.

The physician documents the OMT, including the pre, intra and post service work, in their chart note along with the separately identifiable E/M service (e.g., multi- system examination above and beyond the palpatory exam completed for the OMT service, reviewing records and counseling the patient on return to work).

How to bill for this scenario

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

- CPT® code for the OMT service, *and*
- Appropriate level new or established patient E/M code, with the **–25 modifier.**

Note: The physician can't include the time or activities spent performing OMT services (including the associated pre, intra and post service work) in selecting the appropriate E/M level. The provider must clearly document each service. See also separately billable services section.

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

Example 2 (new or established patient)

The worker goes to the physician's office for a work related 2cm laceration of the worker's 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 payment 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. The physician places the patient off work and makes a phone call after the encounter to the worker's employer to notify them.

The physician documents the surgical procedure performed (including pre-, intra- and post service work), all required elements of the telephone call placed to the worker's employer, and the separately identifiable E/M service performed for the dizziness.

How to bill for this scenario

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

- CPT® code for the laceration repair procedure, *and*
- Appropriate level telephone call based on the length of the call, *and*
- Appropriate level new or established patient E/M code with the **–25 modifier**.

Note: The physician can't include the time or activities spent performing the laceration repair service (including the associated pre, intra and post service work) in selecting the appropriate E/M level. The physician also can't include the time or activities spent performing or documenting the telephone call as this service is required to be billed separately. The provider must clearly document each service. See also separately billable services section.

Example 3 (multiple visits same day)

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

Note: The time and activities spent performing each separate E/M service can't overlap between the two visits, including charting or any other time spent in covered activities conducted on the same calendar day of the encounters (e.g., review of records, referrals). You can only count these activities under the applicable visit.

Example 4 (consultation)

The worker presents to the physician's office, at the request of their attending provider, as the patient has been experiencing changing chronic symptoms. The referral states the patient has a history of chronic low back pain since their work-related accident. Records were available in advance and are reviewed by the provider with the patient during the course of the visit. The physician obtains an additional history from the patient, completes a review of systems and performs a detailed examination. The physician determines an MRI has not been performed recently and one is necessary based on their findings, so they order an MRI. The physician also recommends a steroid injection today.

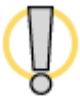
The physician obtains verbal consent and performs other pre-service work associated with the injection (e.g., preparation of equipment, prepping the patient, discusses side effects). The physician then performs the injection, discusses self-care and follow up with the worker, and completes the other necessary post-service work.

The physician documents the injection performed (including pre-, intra- and post service work), and the separately identifiable E/M service.

How to bill for this scenario

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

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



Note: The physician can't include the time or activities spent performing the injection (including the associated pre, intra and post service work) in selecting the appropriate E/M level. The provider must clearly document each service. See also separately billable services section.

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 performed.

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.

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 current or former **attending providers**, **consultants,** or concurrent care providers meets with one or more of the following:

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

- SIEs/TPAs.

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 team conference report; joint reports aren't allowed for any provider. 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. For PTs and OTs, the conference report must include an evaluation of the effectiveness of the previous therapy plan.

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, medical decision-making, or key components (history, exam and medical decision making), depending on which guidelines the provider is required to follow for the E/M service. 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** when billing for services that fall under the 1995 or 1997 E/M guidelines.

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

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 services for 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,
- Authorization,
- Resolution of billing issues,
- Routine requests for appointments,
- Ordering prescriptions, including requests for refills,
- Test results that are informational only, *or*
- Communications with office staff.

Note: The time spent performing a telephone call can't be used towards the determination of the E/M level.

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.

Documentation requirements

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

- The date, *and*
- The participants and their titles, *and*
- The length of the call, *and*
- The details of the call (see Services that can be billed, above), *and*
- All medical, vocational or return to work decisions made.

Note: Mental health services must be authorized for psychiatrists and clinical psychologists to bill these services, 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, *or*
- The Federation of State Medical Boards, *or*
- 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 are personally made by the billing provider.

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 services for 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 claim 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,
- Ordering prescriptions, including requests for refills,
- Test results that are informational only, *or*
- Communications with office staff.

Requirements for billing

Online communication documentation must include:

- The date, *and*
- The participants and their titles, *and*
- The details of the online communication (see Services that can be billed, above), *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.

Payment limits

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

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.

Payment policy: Prolonged E/M

Requirements for billing

Refer to the table below for prolonged services billing requirements.

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:**
99417	**99205** or **99215**
99354	**90837, 90847, 99241-99245, 99324-99337, 99341-99350** or **99483**
99355	**99354** and 1 of the CPT® codes required to bill **99354**
99356	**90837, 90847, 99218-99226, 99231-99236, 99251-99255,** or **99304-99310**
99357	**99356** and 1 of the CPT® codes required to bill **99356**

Note: Refer to CPT® for further details, including documentation requirements.

Prolonged Services Example

Prolonged service for an established patient (with or without direct patient contact).

For an 84-minute established patient E/M service bill 99215 and 99417 x 2.

To calculate this, the first 54 minutes are applied to the 99215, which leaves a remaining 30 minutes of prolonged service. This equates to 2 units of 99417.

Prolonged service for a consultation.

For a 100-minute consultation E/M service bill 99244 and 99354 x 1.

To calculate this, the first 60 minutes are applied to 99244, which leaves a remaining 40 minutes of prolonged service. This equates to 1 unit of 99354.

Note: Separately billable services and the time spent on those services can't be included in the calculation for the E/M service, including prolonged services. See also separately billable services section.

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 time-based E/M code or applicable psychotherapy code is billed on the same day.

The following prolonged services are not payable:

- Prolonged services without direct patient contact, except for new or established patients, (CPT® **99358**, **99359**), *or*
- Prolonged clinical staff services (CPT® **99415**, **99416**).

Links: For more information on prolonged E/M services, 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

Information on prolonged services is available at CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99417) Code and Guideline Changes

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, the applicable 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 their 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 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**.

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.

Payment policy: Teleconsultations and other telehealth services

Note: L&I has published additional temporary telehealth policies that are in effect until December 31, 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 telehealth provider. 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 telehealth provider 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 telehealth provider , *and*
- Interactive audio and video telecommunications must be used allowing real time communication between the patient and the telehealth provider, *and*
- The telehealth provider 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,
- 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 telehealth provider 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.

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.

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
The **2021 Documentation Guidelines for Evaluation and Management Services**	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.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** or email **PHL@lni.wa.gov**