Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 10: Evaluation and Management Services

Supplemental telehealth policy information

Effective March 4, 2022

We're updating Chapter 10: Evaluation and Management Services. The policy below supersedes the "Teleconsultations and other telehealth services" payment policy. This policy will be added to the complete chapter in July 2022. Any existing MARFS payment policy requirements, such as prior authorization, apply to this update.

Definitions

Distant site: The location of the provider who performs telehealth services. This provider is not at the originating site with the worker.

Originating site: The place where the worker is located when receiving telehealth. For the purposes of this policy, the worker may be at home when receiving telehealth.

Telehealth: Face-to-face services delivered by a qualified medical provider through a real-time, two-way, audio video connection. These services aren't appropriate without a video connection.

Modifiers

-GT (Via interactive audio and video telecommunication systems)

Used to indicate a telehealth procedure was performed. Documentation to support the service must be submitted. Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

Payment policy: Telehealth for evaluation and management services

General information

The insurer reimburses **telehealth** at parity with in-person appointments.

Objective medical findings are required for time loss and other claim adjudication requirements. In-person visits are preferred for gathering objective medical findings, however, **telehealth** may be an appropriate alternative in certain situations where objective medical findings can be gathered via two-way audio and visual connection.

The provider is expected to make arrangements for in-person evaluation and intervention for certain circumstances. See below for additional information.

Telehealth services must occur either from a medical or vocational **origination site** or the worker's home. The selection of a provider is the worker's choice by law. Services may not be delivered from either the employer's worksite or any location owned or controlled by the employer that isn't operated by a Medical Provider Network practitioner.

A medical or vocational **origination site** may be:

- A clinic, *or*
- A hospital, *or*
- A nursing home, *or*
- An adult family home.

The provider performing **telehealth** services must be licensed in the state where the worker is receiving **telehealth** services. Only vocational rehabilitation counselors are exempt from this requirement.

Services that must be performed in person

In-person evaluation is required for non-mental health services when:

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

An in-person evaluation is required in all cases when:

- A worker files a reopening application, *or*
- The provider has determined the worker is not a candidate for **telehealth** either generally or for a specific service, *or*
- Consultations in accordance with the restrictions noted below, *or*
- The worker does not want to participate via **telehealth**.

System requirements

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

Prior authorization

The prior authorization requirements listed in Chapter 10: Evaluation and Management (E/M) Services apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

Teleconsultations

The insurer covers teleconsultations when the following conditions have been met:

- The **telehealth** provider must be a(n): doctor as described in WAC 296-20-01002; ARNP; PhD clinical psychologist; or Consulting DC who is an approved consultant with L&I. This provider must note which provider referred the worker, *and*
- The referring provider must be one of the following: MD; DO; ND; DPM; OD; DMD; DDS; DC; ARNP; PA; or PhD clinical psychologist, *and*
- The patient must be present at the time of the consultation, *and*
- Interactive audio and video telecommunications must be used allowing real time communication between the patient and the **telehealth** provider, *and*
- The exam of the patient must be under the control of 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.

Links: Learn more about coverage of these services in WAC 296-20-045, WAC 296-20-051, and WAC 296-20-01002.

Services that are covered

The insurer will pay an **originating site** facility fee to a provider when they allow the worker to use their telecommunications equipment for a **telehealth** service with a provider at another location. To bill for the **originating site** facility fee, use HCPCS code **Q3014**.

Q3014 is payable to the **originating site** provider when no other billable service occurs.

Store and Forward

G2010 is covered for patient-to-provider store and forward of images or video recordings, including interpretation and follow up when it isn't part of an E/M visit. Follow up must occur within 24 business hours of receiving the images or video recordings. Follow up may occur by phone, **telehealth**, or in-person, and isn't separately payable. **G2010** isn't covered if the patient provides the image or video recording as follow-up from an E/M visit in the prior 7 days, nor if the provider's evaluation of the image or video recording leads to an E/M service within the next 24 hours or soonest available appointment. Providers are required to document their interpretation of the image or video recording. Chart notes that don't state the interpretation by the provider are insufficient.

Services that aren't covered

Telephonic visits don't replace video two-way communication and can't be billed using non-telephonic E/M services codes. Case management services may be delivered telephonically (audio only) and are detailed in Chapter 10: Evaluation and Management (E/M) Services.

Telehealth procedures

Telehealth procedures and services that aren't covered include:

- The services listed under "Services that must be performed in-person",
- Hands-on services,
- Completion and filing of any form that requires a hands-on physical examination (e.g. Report of Accident, Provider's Initial Report),
- Purchase, rental, installation, or maintenance of telecommunication equipment or systems,
- Home health monitoring, *and*
- Telehealth transmission, per minute (HCPCS code **T1014**).

Note: Completion of APFs can't occur via **telehealth** when the update will take the worker off work or the provider increases the worker's restrictions. In these situations the visit must be in-person.

Telehealth locations

Q3014 isn't covered when:

- The **originating site** provider performs any service during a **telehealth** visit, *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, *or*
- The provider uses audio only.

The worker won't be reimbursed for using home as an **originating site**, or for any other **telehealth** related services or expenses.

Requirements for billing

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

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

Bill using the **–GT** modifier to indicate **telehealth**.

Documentation requirements

For the purposes of this policy, the following must be included in addition to the documentation and coding requirements for services billed, as noted in MARFS:

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in **telehealth** services. This must be noted for each **telehealth** visit.

If treatment is to continue via **telehealth**, the evaluation report must include a detailed plan for implementing **telehealth** as agreed upon in a collaborative manner between the provider and worker.

Chart notes must contain documentation that justifies the level, type and extent of services billed. See Chapter 10: Evaluation and Management (E/M) Services and other applicable MARFS chapter(s) for the type of service rendered and the documentation requirements.

When **Q3014** is the only code billed, documentation is still required to support the service.

Payment limits

The same payment limits listed in Chapter 10: Evaluation and Management Services apply regardless of how the service is rendered to the worker.