Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 17: Mental Health Services

Supplemental telehealth policy information

Effective March 4, 2022

We're updating Chapter 17: Mental Health Services. The policies below are in addition to the payment policy and will be added to the complete chapter in July 2022. They aren't intended to replace chapter 17. Any existing MARFS payment policy requirements, such as prior authorization, apply to this update.

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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.

-93 (Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system)

Used to indicate an audio only service occurred between a physician or other qualified health care professional and a patient who is located away from the physician or other qualified health care professional. The totality of the exchange between the health care professional and patient must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction. Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

Payment policy: Telehealth for mental health 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

An in-person evaluation is required once every 6 months. In-person evaluations are always required when:

- Consultations requested to determine if conservative care is appropriate, *or*
- The provider has determined the worker is not a candidate for **telehealth** either generally or for a specific services, *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 17: Mental Health Services apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

Services that are covered

The same services that can be billed in Chapter 17: Mental Health Services apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

Mental health examinations to complete a Report of Accident or Physician Initial Report filing and/or Activity Prescription Forms (even when restrictions or changes are anticipated) are covered when performed via **telehealth**.

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.

Note: See the Audio Only Mental Health Services payment policy for additional details regarding mental health services provided via audio only.

Services that aren't covered

The same services that aren't covered in Chapter 17: Mental Health Services apply to this policy.

Telephonic (audio only) mental health services may be payable in certain circumstances, see the Audio Only Mental Health Services for additional details. Case management services may also be delivered telephonically (audio only) and are detailed in Chapter 10: Evaluation and Management (E/M) Services.

G2010 and **G2250** aren't covered services.

Telehealth procedures

Telehealth procedures and services that aren't covered include:

- The services listed under "Services that must be performed in-person",
- Purchase, rental, installation, or maintenance of telecommunication equipment or systems,
- Neuropsychological testing,
- Home health monitoring, *and*
- Telehealth transmission, per minute (HCPCS code **T1014**).

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.

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 17: Mental Health 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 limits noted in Chapter 17: Mental Health Services apply regardless of how the service is rendered to the worker.

Payment policy: Audio only mental health services

General information

The insurer covers audio only mental health services when prior authorization for mental health has been obtained, and only in specific circumstances. See Chapter 10: Evaluation and Management Services for additional requirements regarding phone calls.

Services that must be performed in person

An in-person evaluation is required once every 6 months. In-person evaluations are always required when:

- Consultations requested to determine if conservative care is appropriate, *or*
- The provider has determined the worker is not a candidate for audio only either generally or for a specific service, *or*
- The worker does not want to participate via audio only.

Prior authorization

The same prior authorization requirements listed in Chapter 17: Mental Health Services apply to this policy update.

Services that are covered

When mental health services are conducted via audio only, the provider is unable to perform a visual assessment of the worker. Therefore the insurer has adopted a modified list of services that may occur via audio only. The requirements for prior authorization, documentation, and payment limits listed in Chapter 17: Mental Health Services apply to the following services covered under this update:

- **90791**
- **90832**
- **90834**
- **90837**
- **90839**
- **90840**
- **90847**
- **90853**

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

Case management services may also be delivered telephonically (audio only) and are detailed in Chapter 10: Evaluation and Management (E/M) Services.

Services that aren't covered

The same services that aren't covered in Chapter 17: Mental Health Services apply to this policy.

Aside from **90791**, mental health codes with an evaluation component aren't covered when performed telephonically (audio only). These services may only be billed if the service is rendered via **telehealth** or in-person.

Audio only procedures

Audio only procedures and services that aren't covered include:

- The services listed under "Services that must be performed in-person",
- Purchase, rental, installation, or maintenance of audio only equipment or systems,
- Neuropsychological testing, *and*
- Home health monitoring.

Q3014 and **T1014** aren't covered under this policy.

Requirements for billing

Bill using modifier **-93** to indicate services rendered via audio only.

Documentation requirements

Providers must document all medical, vocational, or return to work decisions made.

For the purposes of this policy, the following must be included in the provider's documentation:

- The date, *and*
- The participants and their titles, *and*
- The length of the call, *and*
- The nature of the call, *and*
- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in audio only services.

Chart notes must contain documentation that justifies the level, type and extent of services billed.