Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 22: Other Services

Supplemental telehealth policy information

Effective March 4, 2022

We're updating Chapter 22: Other 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 activity coaching (PGAP®)

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 when:

- The provider has determined the worker is not a candidate for **telehealth** either generally or for a specific service, *or*
- The worker does not want to participate via **telehealth**, *or*
- The worker has an emergent issue such as re-injury, new injury, or worsening status.

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.

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** visit 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.

Services that aren't covered

G2010 isn't a covered service.

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",
- Purchase, rental, installation, or maintenance of telecommunication equipment or systems,
- Home health monitoring, *and*
- Telehealth transmission, per minute (HCPCS code **T1014**).

Telehealth locations

Q3014 isn't covered when:

- The **originating site** provider performs another 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 service billed. See Chapter 22: Other 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 22: Other Services apply regardless of how the service is rendered to the worker.

Payment policy: Audio only behavioral health interventions (BHI)

General information

The insurer covers audio only behavioral health interventions (BHIs). Refer to the Master Level Therapists pilot policy for information on BHIs provided by Master Level Therapists (MLTs).

Services that are covered

When behavioral health interventions are conducted via audio only, the provider is unable to perform a visual assessment of the worker. Therefore, the insurer has created a local code for behavioral health intervention services that may occur via audio only. See requirements for billing. The requirements for prior authorization, documentation, and payment limits listed in Chapter 22: Other Services apply to the following services covered under this update.

Bill using code **9959M** when BHI occurs over audio only. This code is only payable to psychologists.

Note: Refer to Chapter 10: Evaluation and Management Services and CPT® coding for telephone calls for behavioral health counseling services that are included as part of E/M.

Services that aren’t covered

If a mental health condition has been accepted or denied on a claim, BHIs aren’t appropriate and can’t be billed. Don’t perform or bill BHIs on claims with accepted or denied mental health conditions. Refer to Chapter 17: Mental Health Services for details on treating mental health conditions.

Requirements for billing

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

Documentation requirements

Psychologists 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.