Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Update – Chapter 22: Other Services

Behavioral Health Interventions

Effective 1/1/2024

This update applies to *Chapter 22: Other Services.* All requirements and details outlined in Chapter 22 still apply. The following text replaces the Behavioral Health Interventions and Behavioral Health Interventions: Audio Only policies in Chapter 22:

Definitions

Behavioral health interventions (BHI): Brief courses of care with a focus on improving the worker's ability to return to work by addressing psychosocial barriers that impede their recovery. These psychosocial barriers are not components of a diagnosed mental health condition; instead, they are typically the direct result of an injury, although they can also arise due to other factors.

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.

Payment policy: Behavioral health interventions (BHI)

General information

The insurer covers **behavioral health interventions (BHI)** if the attending provider has reason to believe that psychosocial factors may be affecting the worker's medical treatment or medical management of an injury. Identification of psychosocial factors and recommendation of **BHI** services can be from any claim party, but the referral must come from the attending provider. This doesn't include components of a diagnosed mental health condition and shouldn't be used in place of a mental health referral or treatment.

Behavioral health intervention can take many forms. Cognitive behavioral therapy and motivational interviewing are two popular methods. An overview of other common modalities is available from the University of Washington.

How mental health and BHI may intersect

During **behavioral health interventions**, a provider may identify apparent symptoms of a DSM-5 diagnosable mental health condition. This may be related to the industrial injury, and in such situations, it may be appropriate to ask the attending provider to refer the worker for a mental health evaluation. See Chapter 17: Mental Health Services and the authorization and reporting requirements for mental health specialists for details.

Links: For additional details about **behavioral health interventions**, see L&I's Behavioral Health resources and Psychosocial Determinants Influencing Recovery (pages 24-27).

Who must perform these services to qualify for payment

Attending providers, consultants, psychologists, and Masters Level Therapists (MLTs) may provide **BHI** services. See "Services that can be billed" for details.

An MLT must have one of the following licenses:

- Licensed Marriage and Family Therapist (LMFT), *or*
- Licensed Independent Clinical Social Worker (LICSW), *or*
- Licensed Mental Health Counselor (LMHC)

Note: When MLTs are credentialed or certified in either vocational or activity coaching, they may not provide dual services for a worker. MLTs may assist the worker with finding the appropriate provider for the other service. MLTs, vocational providers, and activity coaches all require separate L&I provider account numbers. For details, see Chapter 2: Information for All Providers.

Students and student supervision

See Chapter 2: Information for All Providers for details about students and student supervision.

Services that can be billed

CPT® Code(s)	Description and notes
96156, 96158, 96159	**Individual Behavioral Health Interventions (BHI)** No prior authorization required. 16 visits per worker. Up to 8 additional visits maximum may be allowed with prior authorization if the provider has demonstrated improvement through prior treatment and established sufficient medical necessity to the insurer in advance of the additional visits. For State Fund claims, the request is submitted to the claim manager. For Self-Insured claims, the request is submitted to the self-insured employer or their third party administrator. **Note: 96159** is an add-on code and is not included in the 16-visit maximum.
96127	**Brief emotional/behavioral assessment** 6 assessments per worker. This maximum is separate to the individual therapy limit noted above.
96164, 96165, 96167, 96168	**Group or Family Behavioral Health Interventions (BHI) Therapy** No prior authorization required. 16 visits max per worker. This maximum is separate from the individual therapy limit noted above.
Bundled	**Pain Management and Brain Injury Rehabilitation** **BHI** is a bundled service when performed as part of a Structured, Intensive, Multidisciplinary Program (SIMP) or a Brain Injury Rehabilitation Services. In these cases, **BHI** isn't separately payable. See Chapter 33: Brain Injury Rehabilitation Services and Chapter 34: Chronic Pain Management for details. L&I is in the process of reviewing

	SIMP and Brain Injury Rehabilitation Services. Changes may be published with 30 days' notice on the Updates and Corrections webpage.

Services that aren't covered

Services beyond 16 visits per worker aren't covered. Prior authorization is required for up to 8 additional visits, as described in Services that can be billed.

Treating diagnosable mental health conditions using **BHI** therapy isn't appropriate and can't be billed. Refer to Chapter 17: Mental Health Services for details on treating mental health conditions. 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 for BHIs on claims with accepted or denied mental health conditions.

The following services aren't covered as part of **BHI**:

- **90885**
- **96130-96131**
- **96136-96137**
- **96170-96171**
- **98961-98962**

96160 isn't covered for any provider.

Requirements for billing

BHI is billed using the approved physical diagnosis or diagnoses on the claim as the condition causing the need for treatment.

If you are…	Then bill…
A psychologist or a Masters Level Therapist (MLT) such as an LMFT, LICSW, or LMHC	CPT® **96156**, **96158**, and/or **96159**, as appropriate, for individual **BHI** therapy. CPT® **96164**, **96165**, **96167**, and **96168**, as appropriate, for group and family **BHI** therapy. CPT® **96127** for brief emotional/behavioral assessments.
An attending provider or a consultant	The appropriate evaluation and management service procedure code(s). Stand-alone **BHI** follows the same limits as MLTs and psychologists above.

Link: See Chapter 10: Evaluation and Management Services for additional information.

Documentation requirements

All providers must document progress and improvement in function throughout the visits.

Attending providers and consultants

Attending providers and consultants performing **BHI** as part of an Evaluation and Management (E/M) service must use the documentation guidelines noted in Chapter 10: Evaluation and Management Services to document these services.

Stand-alone **BHI** follows the same documentation requirements below.

MLTs and psychologists

MLTs and psychologists must use the following form to document **BHI** services:

- Behavioral Health Initial Assessment form.

MLTs and psychologists must document outcomes from the following when performing an initial or re-assessment for individual **BHI** therapy:

- Patient Health Questionnaire 4 (PHQ-4)
- Two-item Graded Chronic Pain Scale (2-item GCPS)

Payment policy: Behavioral health interventions (BHI) audio only

General information

The insurer covers some audio-only **behavioral health interventions (BHI).**

Services that are covered

When **behavioral health interventions (BHI)** are conducted via audio only, the provider is unable to perform a visual assessment of the worker. Therefore, the insurer has created local code **9959M** for **BHI** therapy performed by psychologists and MLTs that occur via audio only. The requirements for prior authorization, documentation, and payment limits listed under Behavioral Health Interventions apply to the services covered under this policy.

MLTs and psychologists must bill using local code **9959M** when **BHI** occurs via audio only. Audio-only should only be used if **telehealth** isn't available for the worker. Don't use **9959M** in place of **telehealth** or in place of in-person services. This code is only payable to MLTs and psychologists for individual **BHI** therapy, when there is an established patient relationship.

Note: MLTs and psychologists may bill for team conferences. See Chapter 10: Evaluation and Management Services for details.

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 for **BHIs** on claims with accepted or denied mental health conditions. Refer to Chapter 17: Mental Health Services for details on treating mental health conditions.

Group or family **BHI** audio only services aren't covered.

Brief emotional assessments (**96127**) aren't covered when performed via audio only.

9959M isn't covered when establishing care, or for the convenience of the provider or worker.

Documentation requirements

The same documentation requirements noted under Behavioral Health Interventions: Documentation requirements apply for audio-only **BHI** services. In addition, the documentation must include the following when the service is provided via audio only:

- The date of the call, *and*
- The participants and their titles, *and*

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in audio-only services.

Chart notes (such as the assessment forms for **BHI** therapy in the policy above) must contain documentation that justifies the level, type and extent of services billed.

Payment limits

The same limits for individual therapy apply to **9959M**.

Only 1 unit of **9959M** may be billed per day per worker.

Payment policy: Behavioral health interventions, telehealth

General information

Services can be offered in person or via **telehealth**. The insurer reimburses **telehealth** at parity with in-person appointments.

Telehealth services must occur either from a medical or vocational **origination site** or from the worker's home. 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.

The provider performing **telehealth** services must be licensed in the state where the worker is receiving **telehealth** services.

System requirements

Telehealth services 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. No payment shall be made to the worker or provider for obtaining or maintaining equipment for a **telehealth** appointment.

Services that are covered

The same services noted under Behavioral Health Interventions: Services that can be billed applies regardless of how the service is rendered to the worker, either in person or via **telehealth**.

Establishing care via **telehealth** is covered.

Originating Site Fee (Q3014)

The insurer will pay an **originating site** 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** fee, use HCPCS code **Q3014**.

Q3014 is payable to the **originating site** provider when no other billable service, provided to the same patient, is rendered concurrently.

Note: If the **distant site** and the **originating site** are owned or rented by the same entity, **Q3014** is payable as long as billing and documentation requirements are met.

Q3014 billing example

A worker attends an in-person Evaluation and Management (E/M) appointment at their attending provider's office. The attending provider documents all necessary information as part of this visit and bills for the E/M service. The originating site (attending provider's office) also arranges a secure and private space for the worker to participate in a BHI visit with an MLT at another location (distant site provider). The originating site provider may bill the insurer **Q3014** for allowing the worker to use their space for their telehealth visit with the distant site provider. The originating site provider is required to separately document the use of their space as part of their bill for **Q3014**. The distant site provider bills for the services they provide; they can't bill **Q3014**.

How to bill for this scenario

For this telehealth visit:

- The distant site provider would bill the appropriate CPT® BHI code, with modifier **–GT**.

The originating site provider would bill **Q3014**.

Services that aren't covered

The same services that aren't covered in this chapter apply to this policy.

G2010 isn't a covered service.

Telehealth procedures

Telehealth procedures and services that aren't covered include:

- 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 and will be reimbursed at the facility rate. **Distant site** providers must use place of service **-10** to denote the **telehealth** visit when the worker is located in their home and will be reimbursed at the non-facility rate.

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

Documentation requirements

For the purposes of this policy, the following must be included in the documentation submitted by the **distant site** provider in addition to the documentation and coding requirements for services billed:

- 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.

See Behavioral Health Interventions 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. When a provider bills **Q3014** on the same day they render in-person care to a worker, separate documentation is required for both the in-person visit and the **Q3014** service. The **originating site** provider billing **Q3014** must submit separate documentation indicating who the **distant site** provider is and that the service is separate from the in-person visit that occurred on the same day.

Payment limits

The same payment limits noted in this policy apply regardless of whether the service is rendered in-person or via **telehealth**.