Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 13: Independent Medical Exams (IME)

Effective July 1, 2024

Link: Look for possible **updates and corrections** to these payment policies on L&I's website.

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Definitions

The following terms are utilized in this chapter and are defined as follows:

Body areas: The following body areas are recognized:

- Head, including the face,
- Neck,
- Chest, including breasts and axilla,
- Abdomen,
- Genitalia, groin, buttock,
- Back, *and*
- Each extremity (each extremity is counted once per extremity examined when determining standard or complex codes)

By report: A code listed in the fee schedule as "By Report" which doesn't have an established fee because the service is too unusual, variable, or new. When billing for the code, the provider must provide a report that defines or describes the services or procedures. The insurer will determine an appropriate fee based on the report.

Link: For the legal definition of By Report see WAC 296-20-01002.

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

Organ systems: For IMEs, the following organ systems are recognized:

- Eyes,
- Ears, nose, mouth, and throat,
- Cardiovascular,
- Gastrointestinal,
- Genitourinary,
- Respiratory,
- Musculoskeletal,
- Skin,
- Neurologic,
- Psychiatric, and

- Hematologic/ Lymphatic/ Immunologic.

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, 2-way, audio video connection. These services aren't appropriate without a video connection.

Modifiers

The following CPT®, HCPCS, and/or local code modifiers appear in this chapter:

Use	Payment Information
–7N (Services in conjunction with an IME)	
Use this modifier to indicate when services are requested for an IME.	This modifier doesn't affect payment but is necessary to describe the service performed.
–26 (Professional component)	
Use this modifier to indicate when only the professional component of a service is performed and reported separately. Certain procedures are a combination of a provider's professional component (**–26**) and a technical component (**–TC**). When the provider's professional component is reported separately, the service may be identified by adding this modifier. When a global service is performed, the **–26** or the **–TC** modifier can't be used. **Note**: Procedure codes that are applicable to these components are listed in the L&I Professional Services Fee Schedules.	These services are represented by their own line on the professional services fee schedule. Payment will be made at **100%** of the professional component (**–26**) rate for each specific radiology service performed or billed charge, whichever is less.
–93 (via telephone or other audio-only telecommunications system)	
Use this modifier to indicate when a service was performed via audio-only. **Note: Limited to certain services.** This modifier is only applicable to certain mental health and behavioral health intervention services. See the applicable audio-only payment policy for more details.	This modifier doesn't affect payment but is necessary to describe the service.

Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

Payment policy: Independent medical exams (IMEs)

General information

Independent medical exams (IMEs) are medical examinations requested by the department or self-insured employers to answer medical and legal questions about the claim. Performing IMEs or impairment ratings requires considerable judgement and understanding of specialized terms and a mastery of skills that aren't always part of a doctor's original training. IME providers must be familiar with and follow the Medical Examiners' Handbook.

Per RCW 51.36.070(2), the department or self-insurer shall provide the physician performing the exam all relevant medical records from the worker's claim file.

Who must perform services to qualify for payment

Only **department-approved** IME Providers with an IME provider account number can bill IME codes. Applications are available on our website.

For more information on **becoming an approved IME provider** or to perform impairment ratings, see the Medical Examiners' Handbook.

To receive email updates on IMEs, subscribe to the ListServ.

Services that can be billed

Interpretation services during IMEs

Interpreter services are covered during IMEs. All interpreter requests must be scheduled through the scheduling system. For additional information regarding interpreter services, see Chapter 14: Language Access Services. For Sign Language interpretation, see Chapter 22: Other Services.

IME fee schedule

Local code	Description and notes	Maximum fee
1104M	**IME, addendum report.** Must be requested and authorized by claim manager. Addendum report is for additional information that isn't requested in original assignment, which necessitates review of records. Additional charges aren't payable. Not to be used in place of a new IME, if requested by the insurer. Fee already includes additional reimbursement for file review. To bill for review of job analysis, only use when records are re-reviewed and a report attesting to that re-review is submitted with the job analysis. The review of diagnostic testing or study results ordered by the examiner isn't payable under this code. Not payable with **1066M**.	**$168.19**
1105M	**IME Physical Capacities Estimate** (F242-387-000) Must be requested by the insurer. If an exam is performed by multiple examiners, bill under only one of the performing examiner's provider account number. (Bill once per exam.)	**$36.81**

Local code	Description and notes	Maximum fee
1108M	**IME, standard exam – 1-3 body areas or organ systems** Use this code if there are only 1-3 **body areas** or **organ systems** examined for sufficient evaluation of the accepted condition(s). L&I expects that these exams will typically involve at least 30 minutes of face-to-face time with the worker. Use of this code requires: • Records reviewed by examiner and a report included with detailed chronology of the injury or condition as described in the Medical Examiners' Handbook. • Physical exam is directed only towards the affected body area(s) or organ system(s). • Appropriate diagnostic tests needed are ordered and interpreted. • Impairment rating performed if requested. • The IME report containing the required elements noted in the Medical Examiners' Handbook. • Report conclusions address how the examined body areas **or** organ systems relate to the accepted or contended work related injury(s) or condition(s). • Review of up to 2 job analyses. **Note**: Additional examiners use **1112M**. **Note**: Compensation for downloading, printing and sorting files is bundled into the reimbursement for the examination fees.	**$728.06**

Local code	Description and notes	Maximum fee
1109M	**IME, complex exam – 4 or more body areas or organ systems** Use this code if there are 4 or more **body areas** or **organ systems** examined for sufficient evaluation of the accepted condition(s) or contended conditions. L&I expects that these exams will typically involve at least 45 minutes of face-to-face time with the worker. Use of this code requires: • Records reviewed by examiner and a report included with detailed chronology of the injury or condition as described in the Medical Examiners' Handbook. • Physical exam is directed only toward the affected **body areas** or **organ systems**. • Appropriate diagnostic tests needed are ordered and interpreted. • Impairment rating performed if requested. • The IME report containing the required elements noted in the Medical Examiners' Handbook. • Report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). • Review of up to 2 job analyses. **Note**: Additional complex examiners use **1126M**. **Note**: Compensation for downloading, printing and sorting files is bundled into the reimbursement for the examination fees.	**$910.07**

Local code	Description and notes	Maximum fee
1112M	**IME, additional examiner for Standard IME** Use where input from more than 1 examiner is combined into 1 report. Includes: • Record review, • Exam, *and* • Contribution to combined report. L&I expects these exams will typically involve at least 30 minutes of face-to-face time with the worker. **Note**: 1 examiner on IMEs with a combined report should bill a standard (**1108M**). **Note**: Compensation for downloading, printing and sorting files is bundled into the reimbursement for the examination fees.	**$728.06**
1118M	**IME by psychiatrist** Psychiatric diagnostic interview with or without direct observation of a physical exam. L&I expects these exams will typically involve at least 60 minutes of face-to-face time with the worker. Includes: • Review of records, other specialist's or provider's exam results, if any. • Consultation with other examiners and submission of a joint report if scheduled as part of a panel. • The IME report containing the required elements noted in the Medical Examiners' Handbook. • Impairment rating performed if requested. • Review of up to 2 job analyses. Also includes impairment rating, if applicable. **Note**: Compensation for downloading, printing and sorting files is bundled into the reimbursement for the examination fees.	**$1,319.61**

Local code	Description and notes	Maximum fee
1123M	**IME, communication issues** Exam was unusually difficult due to expressive problems, such as a stutter, aphasia or need for an interpreter in a case that required an extensive history as described in the report. If an interpreter is needed, verify and record name of interpreter in report. Bill once per examiner per exam. Isn't payable with a no show fee (1144M).	**$241.37**
1124M	**IME, other, by report** Requires prior authorization and prepay review: • For State Fund claims, contact the claims manager, or • For self-insured claims, contact the self-insured employer or third party administrator. Billable services under this code are limited to: • Research and review for chemically related illness (CRI) claims to be billed only by contracted providers authorized to perform CRI IMEs, • Security services for potentially violent workers, or • Guard services for incarcerated workers.	**By Report**
1125M	**Physician travel per mile** Allowed when roundtrip exceeds 14 miles using Personally Owned Vehicles. Code usage is limited to extremely rare circumstances, such as IMEs in correctional facilities. Requires prior authorization and prepay review: • For State Fund claims, call Provider Quality and Compliance at **800-468-7870**, or • For self-insured claims, contact the self-insured employer or third party administrator.	**$5.90**

Local code	Description and notes	Maximum fee
1126M	**IME, additional examiner for Complex IME** Use where input from more than 1 examiner is combined into 1 report. Includes: • Record review, • Exam, and • Contribution to combined report. L&I expects these exams will typically involve at least 45 minutes of face-to-face time with the worker. **Note**: One examiner on an IME with a combined report should bill a complex IME (1109M). The IME report must meet the criteria required for a complex IME (**1109M**). **Note**: Compensation for downloading, printing and sorting files is bundled into the reimbursement for the examination fees.	**$910.07**
1128M	**Occupational disease report** (Doctor's Assessment of Work Relatedness for Occupational Diseases) Must be requested by insurer. Examples of conditions which L&I considers occupational diseases are: • Occupational carpal tunnel syndrome, • Noise-induced hearing loss, • Occupational dermatitis, and • Occupational asthma. The legal standard is different for occupational diseases from occupational injuries. Refer to RCW 51.080.140 on the definition for occupational disease. This is a detailed assessment of work relatedness, with the exact content presented in the Medical Examiners' Handbook. An examiner may bill this code **only once for each worker.** **Note:** An examiner can't use **1055M. 1055M** is used by attending providers and consultants.	**$223.21**

Local code	Description and notes	Maximum fee
1129M	**IME, extensive file review by examiner** Units of service are based on the number of hardcopy pages reviewed by the IME examiner on microfiche, paper, Claim and Account Center, or other medium. Review of the **first 400 hardcopy pages** is included in the base exam fee (**1108M**, **1109M**, **1112M**, **1118M**, **1126M, 1130M, 1141M, 1142M, 1146M** or **1147M**). Bill for each additional page reviewed beyond the first 400 hardcopy pages. Isn't payable with IME late cancellations (**1143M**) or IME no show fee (**1144M**)**.** Only the following document categories will be paid for **unless** the authorizing letter requests a review of **all** documents: • Medical files, • History, • Report of Accident, • Reopen Application, *and* • Other documents specified by claim manager or requestor. Bill per examiner. Not payable for review of duplicate documents. **Note**: To be eligible for payment, a detailed chronology of the injury or condition must be included in the report as defined by the Medical Examiners' Handbook.	**$1.22**

Local code	Description and notes	Maximum fee
1130M	**IME, terminated exam** Bill for exam ended prior to completion. Requires file review, partial exam by the examiner and report (including reasons for early termination of exam). Bill per examiner. Terminated exams don't include failure to obtain an interpreter. Terminated exams are payable when the worker is uncooperative, becomes obstructive (for example, the exam starts and the worker insists on recording but hadn't provided required notice), or becomes ill in the middle of the exam. **Note**: A partial exam is face-to-face time between the examiner and the worker where, at a minimum, the worker's history is obtained. **Note**: **1130M** or **1143M** can't be billed together. Only one code can be billed per the determination on whether it was a termination or cancellation.	**$427.58**
1139M	**No show fee for missed neuropsychological testing.** Must be scheduled or approved by department or self-insurer in conjunction with an independent medical examination. (For more information, see: WAC 296-20-010(5).) This code is payable only once per independent medical examination assignment. Must notify department or self-insurer of no-show as soon as possible. Bill only if worker fails to show and appointment can't be filled.	**$1,073.30**

Local code	Description and notes	Maximum fee
1140M	**No show fee for missed Functional Capacity Evaluation (FCE).** Must be scheduled or approved by department or self-insurer in conjunction with an independent medical examination. (For more information, see: WAC 296-20-010(5) This code is payable only once per independent medical examination assignment. Must notify department or self-insurer of no show as soon as possible. Bill only if worker fails to show and appointment can't be filled.	**$343.34**

Local code	Description and notes	Maximum fee
1141M	**IME, rare specialty exam – 1-4 or more body areas or organ systems** Use this code in lieu of 1108M or 1109M when exam is performed by 1 of the following rare provider specialties: • Allergy and Immunology • Cardiology • Dermatology • Endocrinology • Gastroenterology • Hematology • Obstetrics and Gynecology • Oncology • Ophthalmology • Pain Medicine/Dolorology • Pulmonology • Thoracic surgery • Urology • Vascular surgery L&I expects these exams will typically involve at least 30 minutes of face-to-face time with the worker. **Note**: Follow the exam requirements for either 1108M or 1109M depending on number of body areas or organ systems involved. This specialty list may be updated depending on the number of examiners available. For additional rare specialty examiners use 1142M. 1108M or 1109M may be billed with an 1141M if 1 of the examiners is completing a standard or complex exam, and the other is completing a rare specialty exam. Only the rare specialty examiner may bill 1141M. **Note**: Compensation for downloading, printing and sorting files is bundled into the reimbursement for the examination fees.	**$1,319.61**

Local code	Description and notes	Maximum fee
1142M	**IME, additional examiner for Rare Specialty IME** Use where input from more than 1 rare specialty examiner is combined into 1 report. Includes: • Record review, • Exam, *and* • Contribution to combined report. L&I expects these exams will typically involve at least 30 minutes of face-to-face time with the worker. **Note**: 1 rare specialty examiner on IMEs with a combined report should bill a rare specialty IME exam (**1141M**). **Note**: Compensation for downloading, printing and sorting files is bundled into the reimbursement for the examination fees.	**$1,319.61**
1143M	**IME late cancellation fee, per examiner** Bill only if worker cancels the appointment within 5 business days prior to exam May be billed if worker arrives for exam but the exam can't start due to obstructive behavior (for example, worker insists on recording exam but didn't provide required notice). Billable if appointment time can't be filled. (Business days are Monday through Friday.) Isn't payable for no shows of IME related testing (for example, neuropsychological) or when IME provider cancels exam (for example, provider wants to co-record and worker doesn't allow) Must notify department or self-insurer of no show as soon as possible. **Note**: **1130M** or **1143M** can't be billed together. Only one code can be billed per the determination on whether it was a termination or cancellation.	**$395.92**

Local code	Description and notes	Maximum fee
1144M	**IME no show fee, per examiner** Bill only if worker fails to show, and appointment time can't be filled. Isn't payable for no shows of IME related services (for example, neuropsychological evaluations). Must notify department or self-insurer of no show as soon as possible. For more information, see WAC 296-20-010.	**$395.92**
1145M	**IME, 1 or more additional claims included in evaluation, up to 5 additional claims total**. Requires prior authorization Bill by unit (1 unit = 1 additional claim). This code is used in addition to the primary IME exam code (**1108M, 1109M, 1112M, 1118M, 1126M, 1130M, 1141M, 1142M, 1146M** or **1147M**) only. This can't be reported as a stand-alone code A maximum of 5 additional claims (units) are billable with this code. Anytime 6 or more additional claims are included, special review and authorization is required by the insurer. Not payable when only 1 claim is examined. Bill per examiner. **Note:** Don't bill a unit for the first claim. The first claim must be billed using a base exam code (such as **1108M)**.	**$139.14 per unit**
1146M	**Forensic IME** Requires prior authorization Bill only if the worker is unavailable for the physical portion of the IME exam. Isn't payable for no shows of IME related services (for example, neuropsychological evaluations). **Note**: Compensation for downloading, printing and sorting files is bundled into the reimbursement for the examination fees.	**$427.58**

Local code	Description and notes	Maximum fee
1147M	**Correctional facility IME** Bill for IMEs conducted at a correctional facility, if the examiner travels to the facility. This code requires prior authorization. Examiners may also bill travel for IMEs conducted at a correctional facility; bill using **1125M**, which requires prior authorization.	**$2,730.22**

Requirements for billing

State Fund (L&I) provider account number requirements for IMEs

For IMEs, examiners need 1 IME provider account number for each payee they wish to designate.

An IME examiner who isn't working through any IME firms will need just 1 IME number, which will also serve as their payee number.

Bills for testing or other services performed in conjunction with an IME must be submitted by the provider who rendered the service (WAC 296-20-125(3)(o)). These services include:

- X-ray, diagnostic laboratory tests in conjunction with IME (append modifier **–26** and **–7N**).
- Psychological/neurological testing CPT® codes – **90791**, **96136, 96137, 96138, 96139.** Automated testing and results for psychological/neurological CPT® code **96146**. (For more detailed information on psychological/neurological services, refer to Chapter 17: Mental Health Services.)
- Functional Capacity Evaluations (FCE) – **1045M.**

Standard and complex coding

The exam should be sufficient to achieve the purpose and reason the exam was requested.

Choose the code based on the number of **body area(s)** or **organ system(s)** that are examined to fully evaluate the accepted condition(s) or the condition(s) contended as work related.

Be sure the report documents the relationship of the areas examined to the accepted work related injury(s) or contended condition(s).

The definitions of **body areas** and **organ systems** from the definitions section of this chapter must be used to distinguish between standard and complex IMEs.

Payment limits

Limit on total scheduled exams per day

L&I has placed a limit of 12 independent medical examinations scheduled per examiner per day. For psychiatrist examiners, the limit is 8 per day.

This limit includes IMEs scheduled for State Fund and self-insured claims. The applicable codes include:

- **1108M IME**, standard exam – 1-3 **body areas** or **organ systems**,
- **1109M IME**, complex exam – 4 or more **body areas** or **organ systems**,
- **1112M IME**, additional examiner for Standard IME,
- **1118M IME** by psychiatrist,
- **1126M IME** additional examiner for Complex IME,
- **1130M IME**, terminated exam,
- **1141M IME,** rare specialty exam,
- **1142M IME,** additional examiner for Rare Specialty IME,
- **1143M IME,** late cancellation fee,
- **1144M IME,** no show fee,
- **1146M IME,** forensic exam,
- **1147M IME,** correctional facility exam

Payment policy: Radiology reporting requirements for IMEs

Requirements for billing

Documentation for the professional interpretation of radiology procedures is required for all professional component billing.

Documentation includes:

- Charting of justification,
- Findings,
- Diagnoses, *and*
- Test result integration, including a comparison between repeat radiology studies where applicable.

When billing for the professional component of radiology services, bill using modifier **–26** and modifier **–7N**.

IME providers who read imaging studies they order in relation to an IME, or reinterpret imaging studies previously performed, are required to document their findings within the IME report. Each imaging study must be separately documented in its own section and include all of the following:

- Date the imaging study was performed, *and*
- The anatomic location of the procedure and type of procedure (lumbar spine plain films, abdomen CT, cervical spine MRI, etc.), *and*
- Specific views (AP, lateral, oblique, weight bearing, axial, sagittal, coronal, with or without contrast, etc., as applicable), *and*
- When ordering imaging studies, a brief sentence describing the reason for the study, such as:
    - “Lower back pain; evaluate for degenerative changes and rule out leg length inequality.”
    - “Neck pain radiating to upper extremity; rule out disc protrusion,” *and*
- Description of, or listing of, imaging findings:
    - **Advanced imaging reports** should follow generally accepted standards to include relevant findings related to the particular type of study, *and*
    - Radiology **reports on plain films of skeletal structures** should include evaluation of osseous density and contours, important postural/mechanical

considerations, assessment of any joint space abnormalities, and assessment of any important abnormal soft tissue findings, *and*

- Radiology **reports on chest plain films** should include assessment of lung fields, bronchovascular markings, apices, tracheal air shadow, mediastinal and hilar contours, cardiovascular contours, costophrenic recesses, any abnormalities below the diaphragm, and assessment of any important osseous abnormalities shown incidentally (ribs, clavicles, scapulae, proximal humeri, spine), *and*

- Imaging impressions, which summarize and provide significance for the imaging findings described in the body of the IME report. If the same imaging study was performed on multiple dates of service, the provider must document a comparison between the studies, in sequential order, noting any significant changes that occurred. For example:
  - For a neck comparison where there is a difference between the original imaging study and the most recent findings, the impression could be: “A comparison of this recent study from 7/1/2019 is made to the study of 5/1/2018. 5/1/2018 which noted narrowing of the disc space at C-5 with bony protuberance at right facet causing impingement. New image from 7/1/2019 shows bony protuberance has grown 5mm and is contributing to increased impingement of the nerve root. This appears to be a continuation of a natural growth process.”

In addition to the above information, when reinterpreting imaging studies, the IME provider must document whether they are or aren’t in agreement with original interpretation of the imaging study.

Note: Documentation such as "X-rays are negative" or "X-rays are normal", or documentation that just restates the notes/recommendations of the radiologist doesn’t fulfill the reporting requirements described in this section and the insurer **won’t pay** for the professional component in these circumstances. The provider reviewing the radiologist’s report must document their own interpretation of the diagnostic service.

Payment limits

Reinterpretation of imaging studies

Reinterpretation of imaging studies may only be billed once per panel exam. The reinterpretation is only payable for studies related to the accepted or contended condition.

In addition, services must be billed with the correct CPT® code for the specific imaging study reinterpreted, along with modifier **-26** and modifier **-7N**.

Example of how to bill for IME services including reinterpretation of imaging studies

The following example demonstrates how to bill when IME providers perform a reinterpretation of imaging studies. This example isn't reflective of the documentation requirements for an IME.

Example: A panel IME is performed on 7/1/21 meeting the documentation criteria for a complex IME. The IME providers review and appropriately document the review of the following imaging studies, all related to the accepted conditions:

- 1 – 3 view knee x-ray performed 6/1/19
- 2 – 2 view shoulder x-rays performed 6/1/19 and 8/2/20
- 1 – Shoulder MRI without contrast

The correct billing for the services is:

Examiner 1

Line item	Procedure code (and modifiers)	Number of Units
1	**1109M**	1
2	CPT® **73562-26-7N**	1
3	CPT® **73030-26-7N**	2
4	CPT® **73221-26-7N**	1

Examiner 2

Line item	Procedure code (and modifiers)	Number of Units
1	**1126M**	1

Note: Reinterpretation is only payable once per panel exam.

Payment policy: Telehealth for independent medical exams (IMEs)

General Information

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

Objective medical findings are required for time loss and other claim adjudication decisions. 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 Services that must be performed in person for additional information.

Telehealth services must occur either from an IME firm's location, or the worker's home (**originating site**). IME telehealth services can't be delivered from the employer's worksite, any location owned or controlled by the employer or any other medical or vocational site.

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

Services that must be performed in person

In-person examination is required for IMEs when:

- The provider has determined the worker isn't a candidate for **telehealth** either generally or for a specific service, *or*
- The worker doesn't want to participate via **telehealth**, *or*
- The worker has an emergent issue such as re-injury, new injury, or worsening status, *or*
- When the service to be performed requires a hands-on component.

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 worker and provider. Providers are responsible for ensuring complete confidentiality and privacy of the worker is protected at all times.

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

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Prior authorization

The prior authorization requirements listed in this chapter apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

Services that can be billed

Telehealth procedures and services that are covered include most services that don't require a hands-on component. The worker must be present at the time of the **telehealth** service and the evaluation and/or treatment of the worker must be under the control of the **telehealth** provider.

Originating site fees are covered, when applicable.

The following IMEs may be conducted via **telehealth**:

- Mental health,
- Dermatology,
- Speech when there is no documented hearing loss,
- Kidney function,
- Hematopoietic system,
- Endocrine.

Upon request of the department or self-insured employer and with agreement of the worker, a telehealth IME may be approved on a case-by-case basis for additional specialties not listed above per WAC 296-23-359.

When scheduling the **telehealth** visit, the provider is responsible for ensuring **telehealth** is the appropriate method of service delivery to effectively conduct an IME.

Originating Site Fee (Q3014)

The insurer will pay an **originating site** fee to an IME provider when they allow the worker to use their telecommunications equipment for a **telehealth** service with a different IME provider at another location (**distant site** provider). To bill for the **originating site** fee, use HCPCS code **Q3014**. **Q3014** is payable to the **originating site** provider when no other billable service is rendered concurrently to the same worker.

An IME **originating site** may only bill **Q3014 when:**

- When the worker is in Washington State and the **telehealth** IME provider is in another state, *and*
- The worker has an in-person exam at the **originating site** that happens the same day as a **telehealth** exam at the **distant site**, *and*
- The worker requires the use of the firm's space for the **telehealth** visit with an approved IME provider for an exam, *and*
- The firm isn't using that space for another worker, *and*
- No other service may be provided to the worker concurrently during the **telehealth** exam.

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 isn't covered when:

- The **originating site** provider performs any service concurrently during the **telehealth** visit, *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, except when the same payee owns both sites and the worker is using their equipment for the telehealth service, *or*
- The IME firm uses an audio-only connection.

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

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 an in-person exam 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.

Because **Q3014** is payable to the **originating site**, any IME provider employed by the **originating site** may bill for this service, so long as they sign the documentation supporting the **Q3014** service.

Q3014 billing example

A worker attends an in-person IME with a neurologist at an IME firm's office in Yakima. The IME provider documents all necessary information as part of this visit and bills for the examination. The originating site (Yakima) also arranges a secure and private space for the worker to participate in a mental health IME with a psychiatrist at one of their other firm locations (Seattle). The **originating site** provider may bill the insurer **Q3014** for allowing the worker to use their Yakima location for their **telehealth** visit with the **distant site** provider in Seattle. 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 exam provided, but can't bill **Q3014**.

How to bill for this scenario

For this **telehealth** visit:

- The **distant site** provider would bill the appropriate IME code.
- The **originating site** provider would bill **Q3014**.

Services that aren't covered

Telephone calls aren't an appropriate replacement for in-person or **telehealth** services. The insurer will not pay for audio-only IME services billed using modifier **–93** (audio only).

Telehealth procedures and services that aren't covered include:

- The services listed under Services that must be performed in-person, including:
  - **1104M**, IME addendum report,
  - **1105M**, IME Physical Capacities Estimate,
  - **1124M**, IME, other, by report,
  - **1125M**, physician travel per mile,
  - **1129M**, IME, extensive file review by examiner,
  - **1147M**, Correctional facility IME,
- Services that require physical hands-on and/or attended treatment of a worker, *and*
- Completion and filing of any form that requires a hands-on physical examination.

The purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems isn't covered.

Requirements for billing

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

Don't bill using the **–GT** modifier. **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.

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** IME, *and*
- Documented consent from the insurer regarding the appropriateness of the IME to be conducted via **telehealth**.

The IME report must contain documentation that justifies the level, type, and extent of services billed. See this chapter and other applicable MARFS chapter(s) for the type of service rendered and the documentation requirements.

Payment limits

The same payment limits listed in this chapter apply regardless of how the exam is rendered to the worker.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for Billing procedures	Washington Administrative Code (WAC 296-20-125)
Administrative rules for IME no shows	WAC 296-20-010
Administrative rules and other Washington state laws for impairment ratings	WAC 296-20-19000 through WAC 296-20-690 available in WAC 296-20 Revised Code of Washington (RCW) 51.32.080
Application to become an IME provider	F245-046-000
Becoming an L&I IME provider	Become an IME Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare professional services	Fee schedules on L&I's website
Mental Health Services	Chapter 17: Mental Health Services
Receiving **email updates on IMEs**	Subscribe to L&I's ListServ
Performing **impairment ratings**	Medical Examiner's Handbook

Need more help?

Email L&I's Provider Hotline at PHL@lni.wa.gov. If you would prefer a phone call, please email us your name and contact number.

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