Washington State Department of
Labor & Industries

# Chapter 9: Evaluation and Management (E/M)

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

## Effective July 1, 2026

## How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

## Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

## Updates and corrections

An annual update of the entire payment policies and fee schedules (MARFS) is published routinely to coincide with the beginning of each state fiscal year (July 1).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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# Payment policy: All E/M services

## Who must perform these services to qualify for payment

Physicians, including medical doctors (MD), osteopaths (DO), psychiatrists (MD/DO), chiropractors (DC), naturopaths (ND), physician assistants (PAs), Advanced Practice Registered Nurse (APRNs), and any other provider who has evaluation and management (E/M) services in their scope of practice.

**Link**: For more information on mental health **consultations** and evaluations, including those performed by psychologists, see Chapter 17: Mental Health and Behavioral Health Interventions (BHI).

## Prior authorization

Prior authorization is required when billing for:

- More than 20 office visits, *or*
- Visits that occur more than 60 days after the first date you treat the worker.

**Link**: For more information, see WAC 296-20-030 and WAC 296-20-03001.

## Requirements for billing

All **medical records** must contain documentation that justifies the level, type and extent of service billed. See the Documentation requirements section of this policy for more details.

### Determining type of visit: New patient, established patient or consultation evaluation and management service

If a patient presents with a work-related condition and meets the definition in a provider's practice as:

- A **new patient**, then a **new patient** E/M service must be billed, *or*
- An **established patient**, then an **established patient** E/M service must be billed, even if the provider is treating a new work related condition for the first time, *or*
- An inpatient or outpatient **consultation** that has been requested by the **attending provider**, the department, self-insurer or authorized department representative and all requirements for a **consultation** service has been met, then a **consultation** E/M service must be billed.

Per WAC 296-20-051 providers may **not** bill **consultation** codes for **established patients**.

Some E/M services don't apply to both **new** and **established patients**, such as hospital inpatient, observation care, and nursing facilities. These services are differentiated by initial and subsequent service. Emergency department services also don't apply as they are differentiated by level of medical decision making. In these cases, the insurer uses the CPT® definition to determine the appropriate **type of service** that must be billed.

**Links**: For the definitions of **new** and **established patients**, **consultations**, and initial and subsequent services, see Appendix A: Definitions and the CPT® book.

### Consultations

**Consultations** are only payable in certain circumstances and to only certain **attending provider** types. For more information, see the **Consultations** policy in Chapter 3: Attending Providers.

### Case management services

Case management services, such a telephone calls, team conferences, and online communications, have separate restrictions and requirements from those outlined in this policy. For more information, see Chapter 5: Care Coordination.

### E/M services via telehealth and audio-only

**Telehealth** is covered for most services that don't require a hands-on component. E/M provided via **telehealth** must be billed using in-person CPT® codes and modifier **–GT**. **New** and **established** outpatient **telehealth** CPT® codes **98000**-**98007** aren't payable.

The insurer doesn't cover any E/M services via audio-only, including the use of audio-only **new** and **established** outpatient CPT® codes **98008**-**98015**, brief virtual check-in CPT® code **98016**, or the use of modifier **–95** with in-person E/M CPT® codes.

For more information on **telehealth**, **remote**, and mobile service delivery, see Chapter 24: Telehealth, remote, and mobile clinic services.

## Documentation requirements

The American Medical Association (AMA) made substantial changes to the **New** and **established patient** E/M services effective January 1, 2021, and expanded those guidelines to all other E/M services (including **consultations**) effective January 1, 2023. The insurer has chosen to adopt these updated changes with slight modification as of July 1, 2023. Modifications include policies on separately billable services and admissions within the course of an encounter at another site. Additionally, the insurer doesn't allow shared visits in which multiple providers contribute to an E/M service.

### SOAP-ER note requirements

As outlined in Chapter 2: Information for All Providers, the insurer requires the addition of ER (Employment and Restrictions) to the SOAP format. Chart notes must document the worker's status at the time of each visit.

**Links**: For additional coding guidelines and requirements, see 2021 and 2023 American Medical Association (AMA) E/M Code and Guideline Changes or a CPT® book.

## Selecting the level of service

Select the appropriate level of E/M service based on coding guidelines in the CPT® book. This information can also be found in the 2021 AMA E/M new and established outpatient visit guideline updates or the 2023 AMA E/M guideline updates for all other E/M services.

Only time spent in covered activities by the provider on the calendar day of the visit (midnight to 11:59 p.m.) can be counted toward the E/M visit time. Check-in and check-out time can't be used when determining the length of a visit as this may include ancillary staff time, **wait time**, etc.

**When billing based on time, documentation must describe the covered activities performed. Generalized statements, such as "provided care coordination" aren't acceptable.**

Examples of services that can't be included in the time used to determine the level of E/M service, include but aren't limited to:

- The performance of other services that can be reported separately. See Separately Billable Services in this policy,
- Travel,
- Teaching that is general and not limited to a discussion that is required for the management of a specific worker,
- Discussions of the L&I claims process with the worker/family/caregiver.

**Note**: All questions, discussions, and/or concerns regarding the administrative process of L&I claims should be directed to the insurer.

## Separately billable services

Any procedure represented by its own CPT®, HCPCS, or local code must be billed separately, and the time spent on these services can't be included in the time used to determine the level of E/M service. This includes but isn't limited to services, such as:

- Care coordination (such as telephone calls or online communications), *or*
- Completing forms (such as a Report of Accident (ROA) or Activity Prescription Form (APF)), *or*
- Independently interpreting results (when represented by its own CPT® code), *or*
- Procedures (such as injections or Osteopathic Manipulative Treatment), *or*
- Any treatment-based service.

When these services are performed in conjunction with an E/M service, you must append modifier **–25.** Modifier **–25** isn't required when an E/M is billed with reports or forms.

**Note**: Evaluation and reporting is **bundled** into the payment of many services.

### Pre- and post-operative visits

Pre-operative visits are included in the global surgical package for major surgery when they occur after the decision to operate is made. E/M services that include the initial decision to perform surgery beginning on the day before major surgery aren't included in the global payment. In these instances, the E/M is payable separately when appending modifier **–57** (decision for surgery).

The decision to perform minor procedures is considered routine pre-service work and is included in the payment for the minor procedure. An office visit is only appropriate if it is significantly separately identifiable from the pre, intra, and post service work associated with the minor procedure and is billed with modifier **–25** (significantly, separately identifiable service).

Post-operative visits aren't separately payable within the established global period for the service billed.

**Link**: For more information on what is included in the global surgery package, see Chapter 23: Surgery.

## Using CPT® billing code modifier –25

Modifier **–25** must be appended to an E/M code when reported with another procedure or service on the same day. This applies to all E/M services.

The E/M visit and the procedure must be documented separately.

For the E/M to be payable, modifier **–25** must be reported in the following circumstances:

- Same worker, same day encounter, *and*
- Same or separate visit, *and*
- Same provider, *and*
- Worker's condition required a **significant separately identifiable E/M service above and beyond the usual pre and post care** related to the procedure or service.

**Scheduling back-to-back appointments, including to address injuries covered under separate claims, isn't appropriate and doesn't meet the criteria for using modifier –25**. In these cases, one visit addressing all injuries must be performed and the bill split equally between the claims. For more information on split billing procedures and requirements, see Chapter 2: Information for All Providers.

Failure to meet modifier **–25** requirements may result in denial or recoupment of the E/M service.

## Examples of billing with modifier –25

### Example 1: Minor procedure and time-based E/M service

A worker goes to the provider's office for a follow-up of their work related elbow and shoulder injury. The provider evaluates and documents findings of the shoulder injury and suggests a steroid injection based on their findings. The provider also evaluates and documents findings related to the elbow injury and determines that physical therapy may provide benefit and provides a referral.

The provider performs the pre-service work (such as cursory history, palpatory examination, discusses side effects). The provider then performs the steroid injection, discusses self-care and follow up with the worker, and completes the other necessary post-service work.

The provider documents the steroid injection (including pre-, intra- and post service work), totaling 25 minutes and an additional separately identifiable E/M service including record review, history, exam, counseling provided and charting time, totaling 30 minutes.

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### How to bill for this scenario

For this office visit, the provider would bill the appropriate:

- CPT® code for the steroid injection, and
- CPT® code **99214**, with modifier **–25**.

The provider can't include the time or activities spent performing the steroid injection (including the associated pre, intra and post service work) in selecting the appropriate E/M level. The provider must clearly document each service, including time spent on each service.

**Link**: For more information on billing minor office procedures, see Chapter 23: Surgery.

### Example 2: Case management service and time-based E/M service

A worker goes to the provider's office for a follow-up of their work related head injury. After reviewing the notes from the worker's neurologist the provider finds that they have questions regarding the current treatment plan. The provider documents a 10-minute telephone conversation with the neurologist on the day of the visit including all required documentation elements of that CPT® code. The provider evaluates the worker and documents findings of the head injury as well as the treatment plan.

The provider documents 10 minutes for the telephone call as noted above, and the separately identifiable E/M service including record review, history and exam, and charting, totaling 40 minutes.

### How to bill for this scenario

For this office visit, the provider would bill the appropriate:

- Local code **9919M** for the telephone call, and
- CPT® code **99215**, with modifier **–25**.

The provider can't include the time or activities spent performing or documenting the telephone call in selecting the appropriate E/M level, as this service is required to be billed separately. The provider must clearly document each service, including time spent on each service.

**Link**: For more information on billing telephone calls, see Chapter 5: Case Management Services.

### Example 3: OMT and E/M service

A worker goes to an osteopathic provider's office to be treated for back pain. The provider performs an E/M visit, including a multi-system examination, reviewing the worker's prior records, and counseling the worker on the importance of appropriate lifting techniques for when they return to work. Based on their findings the provider then advises the worker that osteopathic manipulative treatment (OMT) is a therapeutic option for treatment of the condition.

The provider obtains verbal consent, determines the appropriate technique for the worker and performs other pre-service work (such as cursory history, palpatory examination, discusses side effects). The provider then performs the manipulation, discusses self-care, provides follow up instructions for the worker, and completes the other necessary post-service work.

The provider documents the OMT, including the pre, intra and post service work, in their chart note along with the separately identifiable E/M service (such as the multi-system examination above and beyond the palpatory exam completed for the OMT service, reviewing records and counseling the worker on return to work).

### How to bill for this scenario

For this office visit, the provider would bill the appropriate:

- CPT® code for the OMT service, and
- **New** or **established patient** E/M code, with modifier –**25**.

The provider can't include the activities or time spent performing OMT services (including the associated pre, intra and post service work) in selecting the appropriate E/M level. The provider must clearly document each service.

**Link**: The same scenario and method would apply for chiropractors performing chiropractic care (**2050A-2052A**) with an E/M service. For more information on billing OMT and chiropractic care services, see Chapter 20: Physical Medicine.

### Example 4: Multiple E/M visits performed on the same day

A worker arrives at a provider's office in the morning for a scheduled follow up visit for a work related injury.

That afternoon, the worker's condition worsens and the worker seeks immediate medical attention and returns to the office without an appointment. The triage nurse agrees that the worker needs to be seen again. The provider sees the worker for a second office visit.

### How to bill for this scenario

Since the 2 visits were completely separate, both E/M services may be billed:

- The scheduled visit would be billed, with the appropriate level of **established patient** E/M code for that visit alone, with no modifier appended, *and*
- The unscheduled visit would be billed, with the appropriate level of **established patient** E/M code for that visit alone, with modifier **–25**.

The activities or time spent performing each separate E/M service can't overlap between the 2 visits, including charting or any other time spent in covered activities conducted on the same calendar day of the encounters (such as review of records, referrals). You can only count these activities under the applicable visit.

## Payment limits

A provider would only be paid for more than 1 evaluation and management visit if there were 2 separate and distinct visits on the same day. See Using CPT® billing code modifier –25 and Example 4 in the Separately Billable Services section of this policy for a scenario in which this may be appropriate.

An **established patient** E/M office visit code isn't payable on same day as a **new patient** or **consultation** E/M.

### Split billing

When evaluating and/or treating 2 or more separate conditions that aren't related to the same claim at the same visit, the split billing policy applies.

**Link**: For more information on split billing procedures and requirements, see the Split billing – treating multiple separate conditions payment policy in Chapter 2: Information for All Providers.

# Additional information

## Hospital admissions in the course of an encounter at another site

If a provider sees a worker at a location (initial site) and then sends them to the hospital to be admitted and performs the admission on the same date of service, only the initial hospital inpatient or observation care CPT® code can be billed (**99221**-**99223**). Any E/M performed at the initial site is considered **bundled** into the initial hospital inpatient visit and isn't payable separately. L&I follows CMS (Centers for Medicare and Medicaid Services) in regards to hospital admissions in the course of encounter at another site for E/M services.

## Behavioral Health Interventions (BHI)

When an E/M is performed on the same day as behavioral health interventions (BHI), BHI is included within the E/M service. BHI performed by an **attending provider** without an E/M service, may be billed using BHI local codes. For more information on requirements related to BHI, see Chapter 17: Mental Health and Behavioral Health Interventions (BHI).

## Office-based ultrasounds

Office-based ultrasounds used for evaluation and diagnosis are considered **bundled** into the evaluation and management (E/M) service and can't be billed separately. No separate payment will be made for these services.

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# Payment policy: Care plan oversight

## Who must perform these services to qualify for payment

The **attending provider** must personally perform these services.

## Services that can be billed

The insurer allows separate payment for care plan oversight services (CPT® codes **99375**, **99378**, and **99380**).

## Requirements for billing

Payment for care plan oversight to a provider providing post-surgical care during the postoperative period will be made only:

- If the care plan oversight is documented as unrelated to the surgery, and
- Modifier **–24** is used.

The medical record must document the **medical necessity** as well as the level of service performed.

## Payment limits

Payment is limited to once per **attending provider**, per worker, in a 30-day period.

Care plan services (CPT® codes **99374**, **99377**, and **99379**) of less than 30 minutes within a 30 day period are considered part of E/M services and aren't separately payable.

# Payment policy: End stage renal disease (ESRD)

## General information

L&I follows CMS's policy regarding the use of E/M services along with dialysis services.

## Services that can be billed

Separate billing and payment will be allowed when billed on the same date as an inpatient dialysis service for:

- An initial hospital inpatient or observation visit (CPT® codes **99221**-**99223**),
- An inpatient or observation **consultation** (CPT® codes **99252**-**99255**), *or*
- A hospital inpatient or observation discharge service (CPT® code **99238** or **99239**).

## Payment limits

E/M services (CPT® codes **99231**-**99233** and **99307**-**99310**) aren't payable on the same date as hospital inpatient dialysis (CPT® codes **90935**, **90937**, **90945**, and **90947**). These E/M services are **bundled** in the dialysis service.

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# Payment policy: Home and nursing facility E/M

## General information

L&I allows **attending providers** to charge for E/M services in:

- Nursing facilities, *and*
- Home or residence.

## Who must perform these services to qualify for payment

The **attending provider** must personally perform these services.

## Documentation requirements

In addition to the documentation requirements for E/M services, the medical record must document the location where the service was performed.

# Payment policy: Prolonged E/M

## Who must perform these services to qualify for payment

Providers who can bill E/M may bill prolonged E/M codes, when appropriate.

## Requirements for billing

Refer to the table below for prolonged E/M services billing requirements. Refer to CPT® for further details, including documentation requirements.

| If you are billing this **CPT® code**… | Then you **must also bill this (or these) other CPT® code(s)** on the **same date of service**: |
|---|---|
| **99417** | **99205**, **99215, 99245, 99345, 99350** or **99483** |
| **99418** | **99223, 99233, 99236, 99255, 99306** or **99310** |

### Prolonged Services Example – Established patient visit

For an 84-minute **established patient** E/M service bill **99215** and **99417** x 2.

To calculate this, the first 40 minutes are applied to the **99215**, which leaves a remaining 44 minutes of prolonged service. This equates to 2 units of **99417**. Don't report **99417** for any additional time increment of less than 15 minutes.

Separately billable services and the time spent on those services can't be included in the calculation for the E/M service, including prolonged services.

**Links**: For more information on prolonged E/M services, see the 2021 and 2023 American Medical Association (AMA) E/M Code and Guideline Changes and the CPT® book.

## Payment limits

E/M office visits are limited to a maximum of 3 hours per day. Payment of prolonged services is allowed within the maximum.

Prolonged E/M service codes are payable only when another time-based E/M service is billed on the same day.

The following prolonged services aren't payable:

- When the prolonged service is less than 15 minutes beyond the time for the associated E/M service, *or*

- When prolonged services are on a date of service other than the face-to-face evaluation and management service without direct patient contact, (CPT® **99358**, **99359**), *or*
- When a prolonged service is performed by clinical staff services (CPT® **99415**, **99416**).

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# Payment policy: Standby services

## Requirements for billing

A report is required when billing for standby services.

The insurer pays for standby services when all the following criteria are met:

- Another provider requested the standby service, *and*
- The standby service involves prolonged provider attendance without direct face-to-face worker contact, *and*
- The standby provider isn't concurrently providing care or service to other workers during this period, *and*
- The standby service doesn't result in the standby provider's performance of a procedure subject to a "surgical package," *and*
- Standby services of 30 minutes or more are provided.

## Payment limits

Subsequent periods of standby beyond the first 30 minutes may be reported and are payable only when a full 30 minutes of standby was provided for each unit of service reported.

Round all fractions of a 30-minute period downward.

# Related links for Chapter 9: Evaluation and Management (E/M)

The following links are related to topics and policies that appear in this chapter. This list is for your convenience only. Always refer to the specific policy for detailed information.

## RCWs and WACs

| If you're looking for more information about… | Then see… |
|---|---|
| Chiropractic **consultations** | WAC 296-23-195 |
| **Consultation** requirements | WAC 296-20-045 |
| **Consultations** | WAC 296-20-051 |
| Medical aid rules | WAC 296-20-01002 |
| Treatment not requiring authorization | WAC 296-20-030 |
| Treatment requiring authorization | WAC 296-20-03001 |

## Websites

| If you're looking for more information about… | Then see… |
|---|---|
| 2021 American Medical Association (AMA) E/M Codes and Guidelines | 2021 CPT® Evaluation and Management (E/M) Office or Other Outpatient and Prolonged Services Code and Guideline Changes |
| 2023 American Medical Association (AMA) E/M Codes and Guidelines | 2023 CPT® Evaluation and Management (E/M) Code and Guideline Changes |
| Becoming an L&I provider | Become A Provider |
| Fee schedules and payment policies for all services | Fee Schedules and Payment Policies (MARFS) |

## Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8:15 a.m. and 12 p.m. PT Monday through Friday.

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