Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 22: Other Services

Effective July 1, 2022

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

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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.

Sign language interpretation: Sign language interpretation includes American Sign Language (ASL), tactile interpretation, and sign languages from countries other than the United States.

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

The following CPT®, HCPCS, and/or local code modifiers apply to this chapter:

-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.

-8S (Health services coordination)

Used to indicate health services coordinators bill completed a second billable case note on the same day for the same claimant on the same claim. Payment for the second case note is made at 50% 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: Activity coaching (PGAP®)

Definition of activity coaching

The Progressive Goal Attainment Program (PGAP®) is the standardized form of activity coaching supported by L&I. It consists of an assessment followed by up to 10 weekly individual sessions. Only L&I-approved activity coaches will be paid. A list of activity coaches can be found using the Vendor Services Lookup Tool.

Services that can be billed

Billing code	Description	Unit limit	Unit Price
1400W	Activity Coaching Initial Assessment	6 units (1 unit = 15 min)	**$44.81**
1401W	Activity Coaching Reassessment	5 units per day 10 units maximum (1 unit = 15 min)	**$43.42**
1402W	Activity Coaching Intervention	4 units per day 40 units maximum (1 unit = 15 min)	**$41.32**
1160M	PGAP® Workbook/EBook/Video	1 maximum	**$109.25**

Payment policy: Activity coaching (PGAP®) telehealth

General information

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

Services can be offered in person, telephonically, or via **telehealth**. There is reimbursement parity regardless of the mode of service.

Telehealth services must occur either from a medical or vocational **origination site** or 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. Only vocational rehabilitation counselors are exempt from this requirement.

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.

Q3014 billing examples

Example 1: A worker, whose originating site is their attending provider's office, attends an in-person Evaluation and Management (E/M) appointment. The originating site provider documents all necessary information as part of this visit. Then, the worker requests the use of the provider's space to participate in a telehealth consultation with a distant site provider who is located in another office. The originating site provider or their assistant arranges a secure and private space for the worker to participate in the consultation. The provider at the originating site location with the worker bills the insurer **Q3014** for allowing this worker the use of their space for a visit with a distant site provider, but no other code is payable for this event to the originating site provider. The originating provider is required to separately document the activity as part of their bill for **Q3014**, and they submit separate documentation and a bill for the E/M visit that occurred earlier, noting the two distinct events in each documentation. The distant site consulting provider bills a consultation code, but they can't bill **Q3014**.

Originating site is…	Attending provider's office		
Originating site provider bills…	E/M visit code *and* **Q3014**	Originating site provider documents…	E/M visit *and* originating site visit **Q3014** (separate documentation)
Distant site provider bills…	Consultation code	Distant site provider documents…	Consultation

Example 2: A worker, whose originating site is their physician's office, attends an appointment for a telehealth consultation with a distant site provider. The originating site provider or their assistant arranges a secure and private space for the worker to participate in the consultation. The originating site provider bills the insurer **Q3014** for allowing this worker the use of their space for a visit with a distant site provider. The originating site provider is required to separately document the activity as part of their bill for **Q3014**. This provider can only bill **Q3014**, and the distant site consultant bills for their services provided. This distant site provider can't bill **Q3014**.

Originating site is…	Attending provider's office		
Originating site provider **bills**…	**Q3014**	Originating site provider **documents**…	Originating site visit **Q3014**
Distant site provider **bills**…	Consultation code	Distant site provider **documents**…	Consultation

Services that aren't covered

G2010 isn't a covered service.

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.

Q3014 billing examples

Example 1: A worker, whose originating site is their home, attends a telehealth appointment with their provider. **Q3014** isn't payable to the provider in this example. No reimbursement is payable to the worker for using their home or their equipment for this visit.

Originating site is…	Worker's home		
Originating site provider **bills**…	n/a	Originating site provider **documents**…	n/a
Distant site provider **bills**…	No billable services	Distant site provider **documents**…	n/a

Example 2: A worker, whose originating site is their attending provider's office, attends a telehealth consultation. The distant site consulting provider cannot bill **Q3014** because the worker is in a different location than the distant site provider. However, the originating site provider whose space the worker is utilizing may bill **Q3014**, so long as they provide appropriate documentation of the service provided. No other service is payable to the originating site provider.

Originating site is…	Attending provider's office		
Originating site provider **bills**…	**Q3014**	Originating site provider **documents**…	Originating site visit **Q3014**
Distant site provider **bills**…	Consultation code	Distant site provider **documents**…	Consultation

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.

Chart notes must contain documentation that justifies the level, type and extent of service billed. See Activity Coaching (PGAP®) 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 limits noted in Activity Coaching (PGAP®) apply regardless of how the service is rendered to the worker.

Payment policy: Activity coaching telephone calls to worker legal representatives

Who must perform these services to qualify for payment

Telephone calls are payable to approved PGAP® Activity Coaches only when they personally participate in the call.

Services that can be billed

These services are payable when providing outreach, education, and facilitating services with the worker's legal representative identified in the claim file.

The insurer will pay for telephone calls if the coach leaves a detailed message for the recipient and meets all of the documentation requirements. Telephone calls are payable regardless of when the previous or next office visit occurs.

Services that aren’t covered

Telephone calls aren’t payable if they are for:

- Administrative communications,
- Authorization,
- Resolution of billing issues, *or*
- Routine requests for appointments.

Requirements for billing

Use the correct local billing codes and provide documentation as described below.

If the duration of the telephone call is…	And you are a PGAP activity coach, then bill local code…
1-10 minutes	**1725M**
11-20 minutes	**1726M**
21-30 minutes	**1727M**

Documentation requirements

Each provider must submit documentation for the telephone call that includes:

- The date, *and*
- The participants and their titles, *and*
- The length of the call, *and*
- The nature of the call, *and*
- All medical, vocational or return to work decisions made.

This may be documented in a report and/or a session note.

Note: See Chapter 10: Evaluation and Management Services for telephonic communication with persons other than legal representatives.

Payment policy: After-hours services

Services that can be billed

CPT® codes **99050**-**99060** will be considered for separate payment in the following circumstances:

- When the provider's office isn't regularly open during the time the service is provided, *or*
- When emergency services are provided out of the office, and these services interrupt both normal office operations and other scheduled office visits.

Documentation requirements

Medical necessity and urgency of the service must be documented in the medical records and be made available to the insurer upon request.

Payment limits

Only one code for after-hours services will be paid per worker per day. A second day can't be billed for a single episode of care that carries over from one calendar day to the next.

CPT® codes **99050**-**99060** aren't payable when billed by:

- Emergency room physicians,
- Anesthesiologists/anesthetics,
- Radiologists, *or*
- Laboratory clinical staff.

Payment policy: Behavioral health interventions (BHI)

Definition of behavioral health intervention

Behavioral health interventions (BHIs) are 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.

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.

Behavioral health interventions are appropriate if the provider has reason to believe that psychosocial factors may be affecting the worker's medical treatment or medical management of an injury.

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

Who must perform these services to qualify for payment

Attending providers, psychologists, and Masters Level Therapists (MLTs) may provide these services. Coverage and billing requirements differ—see the table in Requirements for billing later in this section.

Services that can be billed

Prior authorization isn't required for behavioral health interventions.

MLTs may bill up to a maximum of 16 during the life of a claim. See the Behavioral Health Services policy 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.

Requirements for billing

BHIs are billed using the physical diagnosis or diagnoses on the claim.

If you are…	Then bill…
A psychologist	CPT® **96156**, **96158**, and/or **96159**, as appropriate
An attending provider	BHI as part of your Evaluation & Management service, per CPT® manual
A Masters Level Therapist (MLT) such as an LMFT, LICSW, or LMHC participating in L&I's pilot project	Using the billing procedures and guidelines in L&I's MLT Pilot Behavioral Health Services policy

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

Payment policy: Behavioral health interventions (BHI) audio only

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 Behavioral Health Interventions 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.

Payment policy: Health Services Coordination (HSC)

General information

Health services coordinators assist the providers, workers, and employers by:

- Assisting the worker in setting and accomplishing reactivation goals,
- Coordinating and tracking clinical referrals,
- Identifying barriers by conducting the Functional Recovery Questionnaire (FRQ),
- Tracking outcomes by capturing Pain and Function Scales,
- Referring workers to community services,
- Communicating medication issues to providers,
- Supporting return-to-work when medically possible,
- Facilitating the transition between providers, *and*
- Providing ongoing monitoring of the claim and worker's progress.

Who must perform these services to qualify for payment

Approved health services coordinators collaborate with providers, employers, workers, and vocational counselors within L&I's provider Best Practice programs to improve communication and reduce disability.

Coordinators are identified in one of the three Best Practice programs and have their own L&I provider number for each program they participate in.

The Department approves new health services coordinators, who must meet a set of minimum qualifications. A provider or others meeting the minimum qualifications may become health services coordinators when their HSC application and attestations are approved by L&I.

L&I Claim Managers maintain adjudicative authority. L&I will have the sole responsibility for approving health services coordinator's provider number applications, establishing minimum qualifications, and setting and reporting performance measures.

Links: Health services coordinators should visit our Health Services Coordination homepage for additional details.

L&I's ProviderOne website has details on how to obtain a provider ID.

Information about occupational health and surgical best practices incentive programs is available online.

Prior authorization

The attending provider must be enrolled in an L&I provider Best Practice program in order for the health services coordinator to bill for these services.

Services that can be billed

The following activities are billable per 6-minute unit:

- Care coordination planning,
- Communicating with any parties to the claim or treatment plan, including, but not limited to, workers, providers, and employers,
- Community and clinical resource identification,
- Pain/function scales completion,
- Transfer of care documentation,
- Case conferences planning, participation, and documentation, *and*
- FRQ completion.

The following activities are bundled into the payment for health services coordination:

- Any claim file review, *and*
- Preparing documentation (ex: case notes).

Health services coordination fee schedule

Code	Description	Program	Fee
1083M	**Surgical health services coordination (initial surgical intake)** Can be billed as a stand-alone service. Max 1 per claim every 3 years.	Surgical Quality Care Program (SQCP)	**$157.28**
1085M	**Provider Recognition Program complex care coordination** Can be billed as a stand-alone service. Max 1 per claim. *Note: Enrollment for this program begins July 1. Payment begins September 1, 2022.	Provider Recognition Program (PRP)	**$250**

Code	Description	Program	Fee
1087M	**COHE health services coordination** Can be billed as a stand-alone service. Can be billed with the **-8S** modifier. Max 16 hours per claim per incentive program, using six-minute increments.	COHE	**$9.68**
1088M	**Surgical Quality Care Program health services coordination** Can be billed as a stand-alone service. Can be billed with the **-8S** modifier. Max 16 hours per claim per incentive program, using six-minute increments.	Surgical Quality Care Program (SQCP)	**$9.68**
1089M	**Provider Recognition Program health services coordination** Can be billed as a stand-alone service. Can be billed with the **-8S** modifier. Max 16 hours per claim per incentive program, using six-minute increments.	Provider Recognition Program (PRP)	**$9.68**

Services that aren't covered

Time spent documenting the case note and reviewing of the claim file isn't covered.

In addition, the following activities aren't payable:

- Traveling to/from a work site,
- Conducting provider orientation/education,
- General administrative meeting time,
- Responding to provider questions about best practice reporting, *and*
- Discussing best practice reporting with the Medical or Program Directors.

Requirements for billing

When completing a second billable case note on the same day for the same claimant, bill using the **-8S** modifier.

Perform L&I health services coordinator standard work as defined on the care coordination webpage.

Documentation and recordkeeping requirements

Document sharing agreement must be on file with the insurer.

Approved application/attestations are required by each incentive program.

Health services coordinator must utilize MAVEN's standard case note and submit required fields, including care coordination plan. Provider Recognition Program pilot health services coordinators are exempt from utilizing MAVEN for the duration of the pilot.

Note: Failure to comply with these requirements will result in recoupment of payment by the insurer.

Payment limits

Each incentive program is limited to 16 hours of HSC billing per claim.

Payment policy: Locum tenens

Who must perform these services to qualify for payment

A locum tenens physician must provide these services.

Link: For information about requirements for who may treat, see WAC 296-20-015.

Services that aren't covered

Modifier **–Q6** isn't covered, and the insurer won't pay for services billed under another provider's account number.

Requirements for billing

The department requires all providers to obtain a provider account number to be eligible to treat workers and crime victims and receive payment for services rendered.

Payment policy: Provider mileage

Prior authorization

Prior authorization is required for a provider to bill for mileage.

The round trip mileage must exceed 14 miles.

Note: Reimbursement for provider mileage is limited to extremely rare circumstances.

Requirements for billing

To bill for preauthorized mileage:

- Round trip mileage must exceed 14 miles, *and*
- Use local billing code **1046M** (Mileage, per mile, allowed when round trip exceeds 14 miles), which has a maximum fee of **$5.70** per mile.

Payment policy: Sign language interpretation

General information

Sign language interpreters must follow all required standards for certification and interpreter behavior outlined in *Payment policy: All interpreter services* in Chapter 14: Language Access Services.

Prior authorization

Sign language interpretation doesn't require prior authorization on open claims.

Requirements for billing

Sign language interpreters must have an active L&I Provider ID.

Each submitted bill must be supported by an Interpretive Services Appointment Record (ISAR). Bills submitted without an ISAR may be denied. Please submit a completed ISAR (F245-056-000) with each bill. In addition to the ISAR, please attach an invoice with the following details:

- The interpreter's usual and customary fee amount, *and*
- Calculations used to determine the interpreter's usual and customary fee, including whether the fee includes an appearance fee and/or blocks of time (such as a 2-hour minimum).

Services that can be billed

Code	Description	L&I limit and authorization information	1 unit of service equals…	Maximum fee
9976M	In-person **sign language interpretation** provided to facilitate communication between a worker or crime victim and a healthcare or vocational provider. Interpretation time, wait time, and form completion time should be documented and shown as part of the calculation of the interpreter's usual and customary fee.	Doesn't require prior authorization.	1 visit. Each separate appointment for an individual worker/crime victim is considered one visit.	**By Report**

Services that aren't covered

Spoken language interpretation is covered under separate policies and is not billable using code **9976M**.

Sign language interpreters may not bill for mileage or travel time. However, if a **sign language** interpreter's usual and customary fee includes a block of time (such as a 2-hour minimum), that block can include time spent traveling to or from an appointment.

All other rules outlined in *Services that aren't covered* in *Payment policy: All interpreter services* in Chapter 14: Language Access Services also apply to **sign language** interpreters.

Additional information

Team interpretation

If a visit is scheduled for more than two hours, L&I recommends that two or more **sign language** interpreters be present in order to reduce fatigue and facilitate clear communication. All interpreters will be paid **By Report** for the visit when billing **9976M**. Group billing is not allowed; all interpreters must have valid L&I Provider IDs and should submit their own bills.

Note: For additional information on credentials, services that are covered, and other details regarding interpretation service, see Chapter 14: Language Access Services.

Links to related topics

If you're looking for more information about…	Then see…
Activity Coaching	Activity coaching guidelines on L&I's website
Administrative rules for "Who may treat"	Washington Administrative Code (WAC) 296-20-015
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Health Services Coordination	General information Minimum requirements Best practice incentive programs Standard work
Fee schedules for all healthcare facility services	Fee schedules on L&I's website
Masters Level Therapist Behavioral Health Services policy	Masters Level Therapist policy on L&I's website
Vendor services lookup tool	Vendor services lookup tool on L&I's website

Need more help?

Call L&I's Provider Hotline at **1-800-848-0811** or email **PHL@lni.wa.gov**

