Washington State Department of
Labor & Industries

Chapter 17: Mental Health and Behavioral Health Interventions (BHI)

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

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: Activity coaching (PGAP®)

General information

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)	**$46.86**
1401W	Activity Coaching Reassessment	5 units per day 10 units maximum (1 unit = 15 min)	**$45.40**
1402W	Activity Coaching Intervention	4 units per day 40 units maximum (1 unit = 15 min)	**$43.21**
1160M	PGAP® Workbook/EBook/Video	1 maximum	**$114.24**

Telephone calls with worker attorneys

One-on-one telephone calls with a worker's attorney are payable to approved PGAP® Activity Coaches only when:

- The Activity Coach personally participates in the call,
- The participant is the worker's legal representative identified in the claim file,
- The nature of the call includes providing outreach, education, and facilitating services,

- Administrative discussions regarding authorization, resolution of billing issues, and routine requests for appointments aren't covered.

Telephone calls with a worker's attorney by an Activity Coach are payable regardless of when the previous or next office visit occurs.

Required documentation

The required documentation includes:

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

This information can be included in a session note or documented separately.

Code & Description	Limits
1725M PGAP® Attorney Telephone Call	1 unit per provider, per worker, per day, regardless of length of call

Note: For more information on telephonic communication with persons other than the worker's attorney, see the Case management telephone call policy in Chapter 5: Care Coordination. Don't use **1725M** for calls other than one-on-one with the worker's attorney.

PGAP® services via telehealth and audio-only

Activity coaching (PGAP®), including **1400W-1402W** and **1160M**, may be performed in person, via audio-only, or **telehealth**. For more information on coverage and additional requirements for services provided via **telehealth** or audio-only, see Chapter 24: Telehealth, Remote, and Mobile Services.

Services that aren't covered

Voicemails aren't covered, even if a detailed message is left for the recipient.

Payment policy: All mental health services

General information

This policy is applicable to all mental health services. (This doesn't include Behavioral Health Interventions (BHI) or activity coaching (PGAP®)).

When mental health services are performed concurrently with one or more providers, the **attending provider** must coordinate care.

Prior authorization

All outpatient mental health services require prior authorization, unless it is the **initial visit** to open a mental health only claim.

Who the policies in this chapter apply to

The mental health services payment policies in this chapter apply to workers covered by the State Fund and self-insured employers.

The policies related to mental health services in this chapter don't apply to crime victims.

Links: For more information on mental health services for State Fund and self-insured claims, see WAC 296-21-270 and WAC 296-14-300.

For information about mental health services policies for the Crime Victims' Compensation Program, see WAC 296-31.

Who must perform these services to qualify for payment

Authorized mental health services must be performed by a:

- Psychiatrist (MD or DO),
- Psychiatric Advanced Registered Nurse Practitioner (ARNP); an ARNP who is certified and credentialed as a Psychiatric Mental Health Nurse Practitioner (PMHNP),
- Licensed clinical psychologist (PhD or PsyD), *or*
- Master's Level Therapists (MLTs), limited to Licensed Independent Clinical Social Workers (LICSW), Licensed Marriage and Family Therapists (LMFT), or Licensed Mental Health Counselors (LMHC).

Attending providers are required to join the Medical Provider Network (MPN) and have a provider account number prior to treating a worker, except for initial office or emergency visits per WAC 296-20-015. Effective July 1, 2025, Psychologists are required to join the MPN in order to become an **AP** on a claim or continue treating past the **initial visit**.

Link: For more information regarding provider accounts, see Chapter 2: Information for All Providers, Become a Provider, and Psychologists as Attending Providers, on our website.

Service	Psychiatrist (MD/DO)	Psychiatric ARNP	Psychologists (PsyD/ PhD)	MLTs
Attending Provider	Yes	Yes	Yes, for mental health only claims	**No**
Mental health evaluation	Yes	Yes	Yes	**No**
Psychotherapy	Yes	Yes	Yes	Yes
Prescribing psychotropic medications	Yes	Yes	**No**	**No**
Consultations for mental health conditions, including in lieu of an **IME**	Yes	Yes	Yes	**No**
Neuropsychological testing & evaluation	**No**	**No**	Yes	**No**
Psychological testing & evaluation	Yes	**No**	Yes	**No**
Narcosynthesis/ Electroconsulsive therapy	Yes	**No**	**No**	**No**
Transcranial Magnetic Stimulation (TMS)	Yes	Yes	**No**	**No**
Eligible IME Examiner	Yes	**No**	**No**	**No**
Impairment Rating/ Permanent Partial Disability	Yes	**No**	**No**	**No**

Mental health providers as attending providers (APs)

A mental health provider may only be an **attending provider** on a claim when the insurer has an accepted psychiatric condition and it is the only condition being treated, commonly referred to as mental health only claims. Mental health only claims don't include those that have previously had a physical condition, which has since been resolved or claims with a concurrent physical condition.

Attending providers can complete the Report of Accident (ROA), time loss certification and other reports and forms applicable to **APs**. For more information on who can be an **AP** and what forms are applicable, see WAC 296-20-01002, Chapter 21: Reports and Forms, and Chapter 3: Attending Providers.

Master's Level Therapists (MLTs)

Mental health evaluation (CPT® **90791** or **90792**) isn't covered when provided by Licensed Independent Clinical Social Workers (LICSW), Licensed Marriage and Family Therapists (LMFT), and Licensed Mental Health Counselors (LMHC), even when delivered under the direct supervision of a clinical psychologist or a psychiatrist. These providers may provide treatment only, after the worker has seen a a psychiatrist (MD/DO), psychiartric ARNP, or psychologist (PhD, PsyD) for evaluation.

Psychological and Neuropsychological testing & evaluation

Qualified technicians (such as a psychometrist) may administer psychological or neuropsychological testing and scoring under the supervision of a provider qualified to administer the evaluation. The psychiatrist or licensed clinical psychologist must:

- Interpret the results, *and*
- Prepare the reports, *and*
- Bill for the psychological or neuropsychological test administration and scoring performed by their qualified technicians.

Links: For more information and requirements for mental health testing, see the Psychological and Neuropsychological testing and evaluation policies in this chapter.

Services that can be billed

Interactive complexity

The add-on code for interactive complexity (CPT® **90785**) is only payable according to the limits found in CPT®. It isn't payable solely for the use of a language access provider. Documentation must include an explanation of the increased complexity and why it is required for proper treatment. Must be billed with CPT® code **90791**, **90792**, **90832**, **90833**, **90834**, **90836**, **90837**, **90838**, or **90853**.

Mental health services via telehealth and audio-only

Audio-only treatment is limited to mental health evaluation (CPT® **90791**) and psychotherapy services only. Mental health services may be performed via **telehealth** in most circumstances. For more information on coverage and additional requirements for

services provided via **telehealth** or audio-only, see Chapter 24: Telehealth, Remote, and Mobile Services.

Case management services

Psychiatrists, psychiatric ARNPs, licensed clinical psychologists, and MLTs are eligible to bill for case management services (telephone calls, team conferences, and online communications), but only when mental health services are authorized. For more information on restrictions and requirements, see Chapter 5: Care Coordination.

Rehabilitation facilities and programs

For more information on mental health rehabilitation facilities and programs, see Chapter 27: Rehabilitation Facilities and Programs.

Links: Brief emotional/behavioral screens and risk assessments (CPT® **96127**) aren't covered with other mental health CPT® codes, such as psychotherapy and mental health evaluations. For more information, see Chapter 21: Reports and Forms.

Services that aren't covered

Tests and measures, such as the Mini Mental State Examination (MMSE) and Minnesota Multiphasic Personality Inventory (MMPI) performed in isolation without additional testing aren't separately billable from an evaluation.

Psychologists can't bill E/M CPT® codes for mental health evaluations or **consultations**. They must use mental health evaluation CPT® code **90791**.

MLTs can't perform or bill for mental health evaluations or **consultations**.

App-based and texting therapy, such as Better Help, Talkiatry, Talkspace, and other similar services aren't covered.

Requirements for billing

Mental health providers must follow the reporting requirements in CPT® for the service billed.

Documentation requirements

Mental health providers are required to submit documentation to the insurer and the **attending provider**.

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. In addition, documenation must also include the requirements in the following locations:

- Mental Health Services: Authorization & Reporting webpage
- Chapter 2: Information for All Providers
- Specific service documentation requirements in the appropriate payment policy.

Mental health providers must submit documentation on the following schedule:

Frequency	Documentation	Additional Information
Every visit	Chart notes	Must contain all required information, as noted above, in order for the insurer to make appropriate decisions regarding coverage and payment.
Every 30 days	Report	A separate report is required and payable only upon request from the insurer when treating an unrelated mental health condition that is impacting recovery for an accepted condition (see WAC 296-20-055). **This report isn't required if this information is clear and submitted within visit chart notes.** Refer to Mental Health Authorization and Reporting for report requirements.
Every 60 days	Report	A separate report is required and payable only upon request from the insurer when treating an accepted mental health condition when chart notes don't contain enough information to provide a clear picture of progress. **This report isn't required if this information is clear and submitted within visit chart notes.** Refer to Mental Health Authorization and Reporting for report requirements and WAC 296-20-06101.

Payment limits

These following CPT® codes and their services are **bundled** and aren't payable separately:

- **90885**,
- **90887**,
- **90889**.

99080 is payable only when requested by the insurer. Interval reports (30 and 60 days) shouldn't be requested if the information is clear and included in chart notes submitted for treatment.

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.

Payment policy: Behavioral health interventions (BHI)

General information

Behavioral health interventions (BHI), also known as Health Behavior Assessment and Interventions, 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.

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 cannot 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 evidence-based methods.

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. For details, see the mental health policies in this chapter and the Treating Mental Health Conditions webpage.

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

Who this policy applies to

This policy on BHI applies to workers covered by the State Fund and self-insured employers.

The policies related to mental health services and BHI in this chapter don't apply to crime victims.

Links: For more information on mental health services for State Fund and self-insured claims, see WAC 296-21-270 and WAC 296-14-300.

For information about mental health services policies for the Crime Victims' Compensation Program, see WAC 296-31.

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 and may only hold one role on a claim. 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.

Prior authorization

Prior authorization is not required for BHI for the first 16 visits. Prior authorization is required for additional individual BHI visits.

Services that can be billed

BHI may be performed in-person or via **telehealth**. For more information on coverage and additional requirements for services provided via **telehealth**, see Chapter 24: Telehealth, Remote, and Mobile Services.

CPT® Code(s)	Description and notes
96156 **96158, +96159**	**Assessment, Re-assessment, and Individual Behavioral Health Interventions (BHI)** No prior authorization required. Combined maximum of 16 visits per worker for assessments and individual BHI. 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 must be billed with **96158**.
96127	**Brief emotional/behavioral screening and risk assessment** Not billable in addition to behavioral health intervention (BHI) services. Completion of these types of assessments (such as 2-item GCPS, PHQ-2, and PHQ-4) are considered to be already included within BHI services. 3 assessments per day, per provider, with a maximum of 6 assessments per provider, 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.

CPT® Code(s)	Description and notes
Bundled	**Pain Management and Brain Injury Rehabilitation** BHI is a **bundled** service when performed as part of a Brain Injury Rehabilitation Program (BIRP) or a Structured, Intensive, Multidisciplinary Program (**SIMP**). In these cases, BHI isn't separately payable. See Chapter 27: Rehabilitation Facilities and Programs 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. **Evaluation and Management (E/M) Service** BHI is a **bundled** service when performed as part of an evaluation and management (E/M) service. See Chapter 9: Evaluation and Management (E/M) for details.

For online communications and other case management services, see Chapter 5: Care Coordination.

Services that aren't covered

Services beyond 16 visits per worker aren't covered, unless prior authorization is obtained for 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 the All mental health services policy in this chapter for details on treating mental health conditions. If a mental health condition has been accepted or denied on a claim, BHI isn't appropriate and can't be billed. Don't perform or bill for BHI on claims with accepted or denied mental health conditions.

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

- **90885**,
- **96130**-**96131**,
- **96136**-**96137**,
- **96160**,
- **96161**,
- **96170**-**96171**, *and*
- **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 Master's Level Therapist (MLT) such as a LMFT, LICSW, or LMHC	CPT® **96156** for assessment or re-assessment. CPT® **96158** and **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 screening and risk assessments not performed on the same day as BHI.
An **attending provider** (except psychologists) or a **consultant**	The appropriate evaluation and management service (E/M) CPT® code(s), within their scope of practice. Stand-alone BHI follows the same limits as MLTs and psychologists above.

Link: For more information on E/M services, see Chapter 9: Evaluation and Management (E/M).

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 9: Evaluation and Management (E/M) 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: Mental health consultations and evaluations

General information

See the All mental health services policy in this chapter for more information on requirements and limits applicable to all mental health services.

Who must perform these services to qualify for payment

Authorized mental health **consultations** and evaluations must be performed by a:

- Psychiatrist (MD or DO), *or*
- Psychiatric Advanced Registered Nurse Practitioner (ARNP),
- Licensed clinical psychologist (PhD or PsyD).

Prior authorization

Prior authorization is required for all mental health services, unless it is the **initial visit** to open or reopen a mental health only claim. This requirement includes referrals for mental health **consultations** and evaluations.

Services that can be billed

When an authorized mental health referral is made to an appropriate provider, they may bill:

CPT® Code	Description	Psychiatrist (MD/DO)	Psychiatric ARNP	Psychologist (PhD/PsyD)	MLT
90791	Psychiatric diagnostic evaluation	Yes	Yes	Yes	**No**
90792	Psychiatric diagnostic evaluation, with medical services	Yes	Yes	**No**	**No**
Appropriate E/M code	Evaluation and Management (E/M) service	Yes	Yes	**No**	**No**

Mental health providers with E/M in their scope of practice (psychiatrists, psychiatric ARNPs) may choose to bill either psychiatric diagnostic evaluation CPT® codes or the appropriate level evaluation and management (E/M) service, based on what is most reflective of the service provided. Psychologists must bill CPT® **90791**.

Telehealth and audio-only

Some **telehealth** mental health services are covered. Audio-only mental health services are covered in limited circumstances. For more information, see Chapter 24: Telehealth, Remote, and Mobile Services.

Mental health evaluation codes (CPT® **90791**) may be used for initial and periodic evaluations, mental health **consultations**, evaluations to satisfy the 6-month in-person requirement, or as a precursor to more comprehensive psychological testing and evaluation.

Services that aren't covered

Master's level therapists (MLTs) can't evaluate or consult on a mental health evaluation. MLTs must refer to a psychiatrist, psychiatric ARNP, or a psychologist for these services.

MLTs aren't authorized to provide mental health evaluations. CPT® **90791**, **90792**, and E/M services aren't covered for MLTs.

Requirements for billing

All mental health **consultations**, regardless of CPT® code billed, must follow the requirements outlined in the **Consultations** policy in Chapter 3: Attending Providers.

Mental health providers using E/M CPT® codes to bill for their services must also follow the requirements outlined in Chapter 9: Evaluation and Management (E/M).

Telehealth 6 month in-person requirement

Once every 6 months, workers receiving **telehealth**-based mental health care must receive an in-person mental health evaluation to continue **telehealth**-based mental health care.

Note: MLTs must refer to a psychologist, psychiatric ARNP, or psychiatrist for an in-person evaluation to satisfy the 6-month in-person visit requirement.

Documentation requirements

Chart notes and reports must contain documentation that justifies the level, type and extent of services billed. For details, see the Mental Health Services: Authorization & Reporting webpage.

Services must be documented using the SOAPER format as described in Chapter 2: Information for All Providers.

Payment limits

Psychiatric diagnostic evaluation CPT® codes **90791** and **90792** are limited to 1 occurrence every 6 months, per worker, per provider.

Evaluation and Management (E/M) services are limited to 1 per worker, per provider, per day.

When a psychiatric diagnostic evaluation (CPT® **90791**, **90792**) is performed as a stand-alone service, in the absence of a corresponding psychological testing & evaluation episode, it includes test administration, scoring, interpretation, and report. In these instances, test administration codes (CPT® **96136**-**96139**, **96146**) can't be billed.

CPT® codes **90791** and **90792** can't be billed with neuropsychological testing & evaluation episodes (CPT® **96132**-**96133**).

Payment policy: Narcosynthesis and electroconvulsive therapy

Prior authorization

Prior authorization applies for all mental health services. Narcosynthesis and electroconvulsive therapy require additional prior authorization.

Who must perform these services to qualify for payment

Authorized services are payable only to psychiatrists.

Services that can be billed

Use CPT® codes **90865** (narcosynthesis) and **90870** (electroconvulsive therapy).

Link: For more information, see L&I's coverage decision for electroconvulsive therapy.

See the All mental health services policy in this chapter for more information on requirements and limits applicable to all mental health services.

Payment policy: Neuropsychological testing and evaluation

General information

Neuropsychological testing and evaluation consists primarily of individually administered tests that comprehensively sample domains that are known to be sensitive to the functional integrity of the brain.

Neuropsychological testing involves administration of standardized tests, for intellectual function, attention, executive function, language and communication, memory, visual-spatial function, sensoriomotor function, emotional and personality features, and/or adaptive behavior to evaluate the worker's neurocognitive function. The assumption is that these processes have been altered due to a change in the worker's neurological condition as a result of their injury.

The specific tests required to complete the evaluation is at the discretion of the provider, but requires a minimum of 2 tests.

These codes aren't appropriate when simply administering and/or scoring screening questionnaires, such as a PHQ-9, GAD-7, or PCL-5. See the Brief Emotional/Behavioral Screens & Risk Assessments policy in Chapter 21: Reports and Forms.

Note: Additional resources for service requirements may be available from the American Medical Association, Centers for Medicare and Medicaid Services (CMS), or professional psychological associations.

See the Psychological testing and evaluation policy in this chapter for details on psychological testing.

See the All mental health services policy in this chapter for more information on requirements and limits applicable to all mental health services.

Who must perform these services to qualify for payment

Only a neuropsychologist (PhD or PsyD) may provide neuropsychological testing and evaluation.

Qualified technicians (such as a psychometrist) supervised by a neuropsychologist may administer neuropsychological testing and scoring. The neuropsychologist must:

- Interpret the results, *and*
- Prepare the reports, *and*

- Bill for the neuropsychological test administration and scoring performed by their technicians.

Prior authorization

Prior authorization applies for all mental health services. Additional prior authorization is required to perform neuropsychological testing and evaluation services. When requesting authorization, providers must provide an explanation to support the need for more comprehensive testing than can be provided as part of a neurobehavioral status exam.

Only 1 type of testing (neuropsychological or psychological) will be authorized at a time. There is a limit of 1 episode of each type of testing per worker, per claim.

Requirements for billing

Neuropsychological testing and evaluation will be considered for authorization when it is medically necessary based on one or more of the following indications:

- Cognitive or behavioral deficits related to known or suspected central nervous system impairment, trauma, or neuropsychiatric disorders (such as traumatic brain injury, brain hypoxia, or due to toxic or chemical exposures),
- A treatment plan is required to measure functional abilities or impairments in individuals with known or suspected central nervous system impairment,
- Substance impact on cognitive impairment,
- Pre-surgery or treatment-related measurements of cognitive function to determine if it's appropriate to proceed with a medical or surgical procedure (such as deep brain stimulation, epilepsy surgery, stem cell or organ transplant) that may affect brain function,
- Determine through measurement of cognitive abilities if a worker's medical condition impairs their ability to comprehend and participate in treatment regimens, or to function independently after treatment,
- Testing the outcomes of cognitive rehabilitative procedures, *or*
- Evaluate primary symptoms of impaired attention and concentration that can occur due to neurological or psychiatric conditions.

Neuropsychological evaluations and neurobehavioral status examinations may be completed via **telehealth**, however, test administration and scoring must be performed in person. Direct supervision of technicians via **telehealth** isn't covered (modifier **–FR**). For more information, see Chapter 24: Telehealth, Remote, and Mobile Services.

Note: Occupational therapists (OT) or Speech Language Pathologists (SLP) may provide standardized cognitive performance testing (CPT® **96125**) to assist in identifying the worker's baseline function and treatment strategies. Formal neuropsychological testing may be referred to licensed clinical neuropsychologist (PhD or PsyD).

Services that can be billed

A single neuropsychological testing and evaluation episode of care includes separate services: a precursor evaluation (CPT® 96116, 96121), if necessary, the evaluation (CPT® 96132-96133), and test administration and scoring (CPT® 96136-96139, 96146). Each part of the episode is described below in more detail.

Neurobehavioral status examination (precursor evaluation)

A neurobehavioral status examination may be performed in-person or via **telehealth** prior to neuropsychological testing and evaluation as part of the episode of care, if necessary, to perform a clinical interview and/or to help determine what type of tests are needed and develop a plan for administration. This type of evaluation may also be performed as a stand-alone service in the absence of a corresponding neuropsychological testing & evaluation episode.

CPT® code(s) and Description	Additional information	Limit
Neurobehavioral Status Examination **96116** (1st hour) **+96121** (each additional hour)	May be completed independent of or **prior to neuropsychological testing** in-person or via **telehealth**. As a stand-alone service, this examination includes test administration, scoring, interpretation, and report, though it is insufficient to diagnose mild cognitive impairment. Mini mental state examinations (MMSE), MoCA cognition or other similar tests, when done without additional neurobehavioral testing, don't meet the definition of CPT® **96116** or **96121**.	**Up to a 4-hour maximum**; 1 unit of **96116**, 3 units of **96121.** Separate from limits for neuropsychological evaluation & testing. Can't be billed with psychological evaluation & testing.

Neuropsychological evaluation

Neuropsychological evaluation may be completed in-person or via **telehealth** and includes:

- Record review, *and*
- Test selection, at the provider's discretion based on the individual worker's need, goals of the evaluation, and clinical decision making during the evaluation, *and*
- Clinical decision making, *and*
- Interpretation and integration of test results with other sources of clinical data (including relevant history and collateral information from other sources), *and*
- Creation of a clinical report, *and*
- Treatment planning, *and*
- Interactive feedback to worker, and if appropriate the family member(s) or caregiver(s).

Note: Neuropsychological evaluation codes don't include test administration and scoring.

CPT® code(s) and Description	Additional information	Limit
Neuropsychological Evaluation **96132** (1st hour) **+96133** (each additional hour)	The assumption is that the processes being examined have been altered due to a change in a neurological condition as a result of the worker's injury.	**Up to an 8-hour maximum**; 1 unit of **96132**, 7 units of **96133.** Separate from limits for precursor evaluation & testing.

Test administration & scoring

Test administration and scoring are separately billable from the evaluation and include the administration and scoring of 2 or more tests performed on same or different days. This set of codes are applicable to neuropsychological and psychological testing services.

Tests must be administered in compliance with the rules and manuals provided by the test manufacturer and must be performed in-person.

Bill only 1 type of test administration and scoring codes (by provider, by qualified technician, or electronic platform) per episode. When testing is provided by a combination of these types, only the lowest level of testing can be billed. For example, if some testing & scoring was performed by a provider and the rest by a qualified technician, they must bill for the total test administration and scoring time under the technician CPT®

codes. Test administration and scoring must be billed by the neuropsychologist, regardless of who administered the tests.

Note: Test administration and scoring doesn't include interpretation of results. The interpretation must be performed by a qualified provider and is included in the neuropsychological evaluation (CPT® **96132**, **96133**).

CPT® code(s) and Description	Additional information	Limit
Test administration & scoring by a qualified provider **96136** (1st 30 minutes) **+96137** (each additional 30 minutes)	Neuropsychologist personally performs the test administration and scoring.	**Up to an 8-hour maximum**; 1 unit of **96136**, 15 units of **96137.** Separate from limits for precursor evaluation & neuropsychological evaluation. Can't be billed with technician or automated testing.
Test administration & scoring by a qualified technician **96138** (1st 30 minutes) **+96139** (each additional 30 minutes)	The neuropsychologist must bill and is responsible for supervision and evaluation of the tests (test selection, data oversight, clinical interview, feedback session, interpretation and analysis, reporting and **consultation**).	**Up to an 8-hour maximum**; 1 unit of **96138**, 15 units of **96139.** Separate from limits for precursor evaluation & neuropsychological evaluation. Can't be billed with provider or automated testing.

CPT® code(s) and Description	Additional information	Limit
Test administration & scoring by electronic platform (automated) **96146**	Automated testing via an electronic platform, such as a computer, which includes automatic generation of results.	**1 unit, per worker, per episode of care**. Separate from limits for precursor evaluation & neuropsychological evaluation. Can't be billed with provider or technician testing.

How to bill for neuropsychological evaluation & testing

All services performed as part of neuropsychological evaluation and testing are billed as a single episode of care (package). In order to ensure appropriate reimbursement, providers must bill according to the following guidelines:

- All services provided during the episode of care must be submitted on the **same bill**,
- All services on the bill must have the **same date of service**, which is the last day any work was completed for that episode of care. Don't bill using a range or different dates of service for each code, even if the episode of care was spread out over multiple days,
- Service **time and units are cumulative over the episode of care**, even if the episode is spread out over multiple visits. In order to bill 1 unit of service, total time must exceed the half way point for the codes time descriptor.
- **Time is calculated for each service (CPT® code) separately and can't be included in the time spent performing other billable services.** For example, test administration (CPT® **96136-96139**) time can't be included in the face-to-face time the provider spent evaluating and communicating the test results under neuropsychological testing evaluation (CPT® **96132-96133**).

Example

A worker presents to a neuropsychologist's office for neuropsychological testing and evaluation. The evaluation and testing was completed over several days, including a neurobehavioral status examination related to the episode of care. This example is intended to assist in understanding proper billing of these services. Each episode of care will vary depending on the individual worker's condition. The following shows this scenario broken down by task and how it would be billed.

Date of Service	Service(s) Provided (CPT®)	Description	Time
07/01/2025	Neuropsychological evaluation (**96132**/**96133**)	Record review and preliminary test selection.	**30 minutes**
07/01/2025	Neurobehavioral status exam (**96116**/**96121**)	Clinical interview via **telehealth**.	**75 minutes**
07/01/2025	Neuropsychological evaluation (**96132**/**96133**)	Modification of test selection based on neurobehavioral status exam via **telehealth**.	**10 minutes**
07/02/2025	Test administration & scoring by the provider (**96136**/**96137**)	In-person administration of series of tests. Recording of behavioral observations during testing. Scoring and transcribing of scores into data summary.	**195 minutes**
07/03/2025	Neuropsychological evaluation (**96132**/**96133**)	Integration of relevant clinical data and interpretation of testing results. Report generation.	**120 minutes**
07/05/2025	Neuropsychological evaluation (**96132**/**96133**)	Interactive feedback with the worker via **telehealth**.	**65 minutes**

Total time for the episode of care was **8 hours and 75 minutes**; neurobehavioral status exam 75 minutes (**1 hour and 15 minutes**), neuropsychological evaluation 225 minutes (**3 hours and 45 minutes**), and test administration and scoring 195 minutes (**3 hours and 15 minutes**).

The provider finalized the report on July 5, 2024, which is the last day work was completed on this episode of care. Correct billing for the services documented is:

- 07/05/2025 – **96116** (Neurobehavioral status exam) **–GT** x 1 unit,
- 07/05/2025 – **96132** (Neuropsychological evaluation) **–GT** x 1 unit,
- 07/05/2025 – **96133** (Neuropsychological evaluation, add-on) **–GT** x 3 units,
- 07/05/2025 – **96136** (Test administration & scoring by provider) x 1 unit, *and*
- 07/05/2025 – **96137** (Test administration & scoring by provider, add-on) x 5 units.

Note: Neurobehavioral status exams (CPT® **96116, 96121**) have separate limits from the evaluation and testing codes. For limits, see the Neurobehavioral status examination section above.

Services that aren't covered

Psychiatric diagnostic evaluations (CPT® **90791**) can't be billed with neuropsychological evaluation and testing.

Documentation requirements

The following documentation and test data must be sent to L&I or self-insured employer by the provider who performs the service:

- **The duration of each service provided (such as neurobehavioral status examination, neuropsychological evaluation, and test administration and scoring),**
- Relevant medical and psychosocial history,
- Sources of information (such as worker interview, record review, behavioral observations),
- Tests administered,
- Clinical decision making,
- Interpretation of test data and other clinical information, including:
    - The worker's test results with scores, scales, and profiles,
    - Raw test data that is sufficient to allow reassessment by a panel or **independent medical exam**iner (**IME**),
    - Records,
    - Written/computer-generated reports,
    - Global scores or individual's scale scores,
    - Worker responses to test questions or stimuli,
    - Providers' notes concerning worker statements and behavior during an examination, *and*
    - Test materials such as:
        - Test protocols,
        - Manuals,
        - Test items,

    - Scoring keys or algorithms, *and*
    - Any other materials considered secure by the test developer or publisher.
- Integration of sources of information (such as summary and impressions),
- Diagnosis, *and*
- Treatment recommendations and planning.

Note: The provider is responsible for releasing test data to the insurer per WAC 296-21-270.

Payment policy: Pharmacological evaluation and management

Prior authorization

All mental health services require prior authorization.

Who must perform these services to qualify for payment

Pharmacological evaluation is payable only to psychiatrists and psychiatric ARNPs.

Services that aren't covered

Pharmacologic management with psychotherapy using CPT® **90863**.

Requirements for billing

Services conducted on the same day

When a pharmacological evaluation is conducted on the same day as psychotherapy, the psychiatrist or psychiatric ARNP can bill:

- One of the add on psychotherapy codes (CPT® **90833**, **90836**, or **90838**) *and*
- Appropriate level evaluation and management (E/M) service.

Services not conducted on the same day

When a pharmacological evaluation is the only service conducted on a given day, the provider must bill the appropriate E/M code.

Links: See the All mental health services policy in this chapter for more information on requirements and limits applicable to all mental health services.

Payment policy: Psychological testing and evaluation

General information

Psychological testing is intended to test general psychological processes which are assumed to have an emotional, behavioral, environmental, and/or health etiology but are not directly mediated by the central nervous system as result of the worker's injury.

Psychological testing involves administration of several types of psychometrically standardized tests for measuring emotional and interpersonal functioning, intellectual functioning, thought processes, personality and psychopathology. A mini mental state examination (MMSE) or MoCA cognition or similar tests may be appropriate but can't be the only tests performed.

The specific tests a worker requires to complete the evaluation is at the discretion of the provider, but requires a minimum of 2 tests.

These codes aren't appropriate when simply administering and/or scoring screening questionnaires, such as a PHQ-9, GAD-7, or PCL-5. See the Brief Emotional/Behavioral Screens & Risk Assessments policy in Chapter 21: Reports and Forms.

Note: Additional resources for service requirements may be available from the American Medical Association, Centers for Medicare and Medicaid Services (CMS), or professional psychological associations.

See the Neuropsychological testing and evaluation policy for details on neuropsychological testing.

See the All mental health services policy in this chapter for more information on requirements and limits applicable to all mental health services.

Who must perform these services to qualify for payment

Only psychiatrists (MD or DO) or licensed clinical psychologists (PhD or PsyD) may provide psychological testing.

Qualified technicians (such as a psychometrist) supervised by a psychiatrist or licensed clinical psychologist may administer psychological testing and scoring. The psychiatrist or licensed clinical psychologist must:

- Interpret the results, *and*
- Prepare the reports, *and*
- Bill for the psychological test administration and scoring performed by their technicians.

Prior authorization

Prior authorization applies for all mental health services. Additional prior authorization is required to perform psychological testing services. When requesting authorization, providers must provide an explanation to support the need for more comprehensive testing than can be provided as part of a psychiatric diagnostic evaluation.

Only 1 type of testing (neuropsychological or psychological) will be authorized at a time. There is a limit of 1 episode of each type of testing per worker, per claim.

Requirements for billing

Psychological testing and evaluation will be considered for authorization when it is medically necessary based on one or more of the following indications:

- To aid in determining psychological disorder and its severity and functional impairments; to determine a psychiatric diagnosis when a mental health condition is suspected; or to achieve a differential diagnosis from a range of medical or psychological disorders that present with similar symptoms,
- Measure behavioral factors that impact disease management, including but not limited to: pre-surgical evaluation, assessment of emotional or personality factors impacting physical disease management, assessment of psychological factors in chronic pain workers, or adherence to treatment regimens,
- Measure functional capacity to delineate specific cognitive, emotional or behavioral bases of functional complaints or disability,
- Measure psychological barriers and strengths to aid in treatment planning,
- Measure risk factors to determine a workers' risk of harm to self and/or others,
- Perform symptom measurement to objectively measure treatment effectiveness, and/or determine the need for referral for pharmacological treatment,
- Measure and confirm or refute clinical impressions obtained from interactions with the worker, *or*
- Evaluate primary symptoms of impaired attention and concentration that can occur in many neurological and psychiatric conditions.

Psychological evaluations and psychiatric diagnostic evaluations may be completed via **telehealth**, however, test administration and scoring must be performed in person. Direct supervision of technicians via **telehealth** isn't covered (modifier **–FR**). For more information see Chapter 24: Telehealth, Remote, and Mobile Services.

Note: Any one of these could be encompassed into a standard mental health evaluation (CPT® **90791**, **90792** psychiatric diagnostic evaluation). Psychological testing & evaluations

include more comprehensive tests and typically a larger question than what can be answered in a psychiatric diagnostic evaluation.

Services that can be billed

A single psychological testing and evaluation episode of care includes separate services; a precursor evaluation (CPT® 90791), if necessary, the evaluation (CPT® 96130-96131), and test administration and scoring (CPT® 96136-96139, 96146). Each part of the episode is described below in more detail.

Psychiatric diagnostic evaluation (precursor evaluation)

A psychiatric diagnostic evaluation may be performed in-person or via **telehealth** prior to psychological testing and evaluation as part of the episode of care, if necessary, to perform a clinical interview and/or to help determine what type of tests are needed and develop a plan for administration. This type of evaluation may also be performed as a stand-alone clinical interview in the absence of a corresponding psychological testing & evaluation episode.

CPT® code(s) and Description	Additional information	Limit
Psychiatric Diagnostic Evaluation **90791**	May be completed independent of or **prior to psychological testing** evaluation. As a precursor to a psychological testing & evaluation episode, this might include the clinical interview and various screening measures.	**1 occurrence every 6 months, per worker, per provider.** Separate from limits for evaluation & testing. Can't be billed with neuropsychological evaluations.

Psychological evaluation

Psychological evaluation may be completed in-person or via **telehealth** and includes:

- Record review, *and*
- Test selection, at the provider's discretion based on the individual worker's need, goals of the evaluation, and clinical decision making during the evaluation, *and*
- Clinical decision making, *and*
- Interpretation and integration of test results with other sources of clinical data (including relevant history and collateral information from other sources), *and*
- Creation of a clinical report, *and*

- Treatment planning, *and*
- Interactive feedback to worker, and if appropriate the family member(s) or caregiver(s).

Note: Psychological evaluation codes don't include test administration and scoring.

CPT® code(s) and Description	Additional information	Limit
Psychological Evaluation **96130** (1st hour) **+96131** (each additional hour)	The assumption is that the processes being examined have an emotional, behavioral, environmental and/or health etiology related to the worker's injury but are not directly mediated by the central nervous system.	**Up to an 8-hour maximum**; 1 unit of **96130**, 7 units of **96131.** Separate from limits for precursor evaluation & testing.

Test administration & scoring

Test administration and scoring are separately billable from the evaluation and include the administration and scoring of **2 or more tests** performed on same or different days. This set of codes are applicable to neuropsychological and psychological testing services.

Tests must be administered in compliance with the rules and manuals provided by the test manufacturer and must be performed in-person.

Bill only 1 type of test administration and scoring codes (by provider, by qualified technician, or electronic platform) per episode. When testing is provided by a combination of these types, only the lowest level of testing can be billed. For example, if some testing & scoring was performed by a provider and the rest by a qualified technician, they must bill for the total test administration and scoring time under the technician CPT® codes. Test administration and scoring is billed under the psychiatrist or psychologists, regardless of who administered the tests.

Note: Test administration and scoring doesn't include interpretation of results. The interpretation must be performed by a qualified provider and is included in the psychological evaluation (CPT® **96130**, **96131**).

CPT® code(s) and Description	Additional information	Limit
Test administration & scoring by a qualified provider **96136** (1st 30 minutes) **+96137** (each additional 30 minutes)	Neuropsychologist, psychologist, or psychiatrist personally performs the test administration and scoring.	**Up to an 8-hour maximum**; 1 unit of **96136**, 15 units of **96137.** Separate from limits for precursor evaluation & neuropsychological evaluation. Can't be billed with technician or automated testing.
Test administration & scoring by a qualified technician **96138** (1st 30 minutes) **+96139** (each additional 30 minutes)	The qualified provider must bill and is responsible for supervision and evaluation of the tests (test selection, data oversight, clinical interview, feedback session, interpretation and analysis, reporting and **consultation**).	**Up to an 8-hour maximum**; 1 unit of **96138**, 15 units of **96139.** Separate from limits for precursor evaluation & neuropsychological evaluation. Can't be billed with provider or automated testing.
Test administration & scoring by electronic platform (automated) **96146**	Automated testing via an electronic platform, such as a computer, which includes automatic generation of results.	**1 unit, per worker, per episode of care**. Separate from limits for precursor evaluation & neuropsychological evaluation. Can't be billed with provider or technician testing.

How to bill for psychological evaluation & testing

All services performed as part of neuropsychological evaluation and testing are billed as a single episode of care (package). In order to ensure appropriate reimbursement, providers must bill according to the following guidelines:

- All services provided during the episode of care must be submitted on the **same bill**,
- All services on the bill must have the **same date of service**, which is the last day any work was completed for that episode of care. Don't bill using a range or different dates of service for each code, even if the episode of care was spread out over multiple days,
- Service **time and units are cumulative over the episode of care**, even if the episode is spread out over multiple visits. In order to bill 1 unit of service, total time must exceed the half way point for the codes time descriptor,
- **Time is calculated for each service (CPT® code) separately and can't be included in the time spent performing other billable services.** For example, test administration (CPT® **96136**-**96139**) time can't be included in the face-to-face time the provider spent evaluating and communicating the test results under psychological testing evaluation (CPT® **96130**-**96131**).

Example

A worker presents to a psychiatrist's or psychologist's office for psychological testing and evaluation. The evaluation and testing was completed over several days, including a psychiatric diagnostic evaluation related to the episode of care. The majority of test administration and scoring was performed by a pyschometrist with the provider performing a smaller portion. This example is intended to assist in understanding proper billing of these services. Each episode of care will vary depending on the individual worker's condition. The following shows this scenario broken down by task and how it would be billed.

Date of Service	Service(s) Provided (CPT®)	Description	Time
07/01/2025	Psychological evaluation (**96130**/**96131**)	Record review and preliminary test selection.	**30 minutes**
07/01/2025	Psychological diagnostic evaluation (**90791**)	Clinical interview via **telehealth**.	**75 minutes**
07/01/2025	Psychological evaluation (**96130**/**96131**)	Modification of test selection based on psychological diagnostic evaluation via **telehealth**.	**10 minutes**

Date of Service	Service(s) Provided (CPT®)	Description	Time
07/02/2025	Test administration & scoring by the provider (**96136**/**96137**)	Administration of series of tests. Recording of behavioral observations during testing. Scoring and transcribing of scores into data summary.	**30 minutes**
07/02/2025	Test administration & scoring by qualified technician (**96138**/**96139**)	Provider directs and supervises the continued administration and scoring of tests by the technician.	**180 minutes**
07/03/2025	Psychological evaluation (**96130**/**96131**)	Integration of relevant clinical data and interpretation of testing results. Report generation.	**120 minutes**
07/05/2025	Psychological evaluation (**96130**/**96131**)	Interactive feedback with the worker.	**65 minutes**

Total time for the episode of care was **8 hours and 30 minutes**; psychological diagnostic evaluation 75 minutes (**1 hour and 15 minutes**), psychological evaluation 225 minutes (**3 hours and 45 minutes**), and test administration and scoring 210 minutes (**3 hours and 30 minutes**).

The provider finalized the report on July 5, 2024, which is the last day work was completed on this episode of care. Correct billing for the services documented is:

- 07/05/2025 – **90791** (Psychological diagnostic evaluation) **–GT** x 1 unit,
- 07/05/2025 – **96130** (Psychological evaluation) **–GT** x 1 unit,
- 07/05/2025 – **96131** (Psychological evaluation, add-on) **–GT** x 3 units,
- 07/05/2025 – **96138** (Test administration & scoring by technician) x 1 unit, *and*
- 07/05/2025 – **96139** (Test administration & scoring by technician, add-on) x 6 units.

Note: Psychological diagnostic evaluation (CPT® **90791**) is not a timed code and is limited to 1 unit regardless of total time spent performing the service.

Because both the provider and a technician performed the test administration and scoring, the total time for this service must be billed under the appropriate technician codes.

Services that aren't covered

Neurobehaviroal status examinations (CPT® **96116**, **96121**) can't be billed with psychological evaluation and testing.

Documentation requirements

The following documentation and test data must be sent to L&I or self-insured employer by the provider who performs the service:

- **The duration of each service provided (such as psychiatric diagnostic evaluation, psychological evaluation, and test administration and scoring),**
- Relevant medical and psychosocial history,
- Sources of information (such as worker interview, record review, behavioral observations),
- Tests administered,
- Clinical decision making,
- Interpretation of test data and other clinical information, including:
    - The worker's test results with scores, scales, and profiles,
    - Raw test data that is sufficient to allow reassessment by a panel or **independent medical exam**iner (**IME**),
    - Records,
    - Written/computer-generated reports,
    - Global scores or individual's scale scores, *and*
    - Worker responses to test questions or stimuli,
    - Providers' notes concerning worker statements and behavior during an examination, *and*
    - Test materials such as:
        - Test protocols,
        - Manuals,
        - Test items,
        - Scoring keys or algorithms, *and*
        - Any other materials considered secure by the test developer or publisher.
- Integration of sources of information (such as summary and impressions),

- Diagnosis,
- Treatment planning.

Note: The provider is responsible for releasing test data to the insurer per WAC 296-21-270.

Payment policy: Psychotherapy

General information

See the All mental health services policy in this chapter for more information on requirements and limits applicable to all mental health services.

Who must perform these services to qualify for payment

Psychiatrists and psychiatric ARNPs

Psychotherapy performed with an E/M service may be billed by psychiatrists and psychiatric ARNPs when other services are conducted along with psychotherapy such as:

- Medical diagnostic evaluation, *or*
- Drug management, *or*
- Writing physician orders, *or*
- Interpreting laboratory or other medical tests.

Psychotherapy services without an E/M component may also be billed.

Clinical psychologists

Clinical psychologists may only provide psychotherapy without an E/M component. They can't bill psychotherapy codes with an E/M component CPT® **90833**, **90836**, or **90838** because medical diagnostic evaluation, drug management, writing physician orders, and/or interpreting laboratory or other medical tests are outside the scope of a clinical psychologist's license in Washington State.

Master's Level Therapists (MLT)

Master's Level Therapists (MLTs) may only provide psychotherapy without an E/M component. MLTs can't diagnose a mental health condition.

Prior authorization

Prior authorization applies for all mental health services.

Group psychotherapy

Group psychotherapy treatment is only authorized in conjunction with other mental health or individual psychotherapy treatment.

If authorized, the worker may participate in group therapy as part of the individual treatment plan.

Services that can be billed

CPT® Code	Description
90832	Individual psychotherapy, 16-37 minutes
90834	Individual psychotherapy, 38-52 minutes
90837	Individual psychotherapy, 53+ minutes
+90833	Individual psychotherapy, with an E/M service, 16-37 minutes (add-on to E/M)
+90836	Individual psychotherapy, with an E/M service, 38-52 minutes (add-on to E/M)
+90838	Individual psychotherapy, with an E/M service, 53+ minutes (add-on to E/M)
90839	Crisis psychotherapy, first 60 minutes
+90840	Crisis psychotherapy, each additional 30 minutes (add-on)
90847	Family psychotherapy, worker present, 50+ minutes
90853	Group psychotherapy (other than a multi-family group)

Services that aren't covered

The following CPT® codes and their services aren't covered:

- Psychoanalysis (CPT® **90845**),
- Family psychotherapy, without the worker present (CPT® **90846**),
- Multiple-family group psychotherapy (**90849**),
- Pharmacologic management with psychotherapy (CPT® **90863**). Use E/M CPT® codes, if appropriate.

Prolonged Services

Prolonged services (CPT® **99417**, **99418**) can't be billed with psychotherapy and are no longer allowed per CPT®.

Requirements for billing

Psychiatrists and psychiatric ARNPs may only bill an E/M service (CPT® **99202**-**99255**, **99304**-**99316**, **99341**-**99350**) for visits on the same day psychotherapy is provided.

The time spent performing psychotherapy can't be included in selecting the E/M level of service. The provider must clearly document each service (E/M and psychotherapy), including time spent on each service.

Documentation requirements

In addition to the other CPT® requirements, chart notes must document time spent performing psychotherapy.

Payment limits

Individual psychotherapy (CPT® **90832**-**90834**, **90836**-**90838**) is limited to 1 unit per day, per worker, per claim.

Group psychotherapy services

If group psychotherapy is authorized and performed on the same day as individual goal-oriented psychotherapy (with or without an E/M component), both services may be billed, as long as they meet the CPT® definitions and documentation requirements for each service.

The insurer doesn't pay a group rate to providers who conduct psychotherapy exclusively for groups of workers. Individual psychotherapy must occur in conjunction with group therapy.

Payment policy: Transcranial Magnetic Stimulation (TMS) for treatment-resistant depression

General information

The insurer covers transcranial magnetic stimulation (TMS) on a limited basis. Authorization for this treatment is dependent upon the conditions of coverage noted in the coverage decision for TMS therapy.

Links: See the All mental health services policy in this chapter for more information on requirements and limits applicable to all mental health services.

Prior authorization

Prior authorization applies for all mental health services. Additional prior authorization is required before initiating TMS treatment. Each course of treatment requires separate prior authorization.

Who must perform these services to qualify for payment

TMS must be performed by a:

- Psychiatrist (MD or DO), *or*
- Psychiatric Advanced Registered Nurse Practitioner (ARNP), *or*
- Certified technician under the supervision of one of the provider types above.

Requirements for billing

Billing of TMS codes must be in accordance with CPT® code definitions and requirements.

Evaluation and Management (E/M) service activities related to cortical mapping, motor threshold determination, and/or delivery and management of TMS aren't separately payable.

Services that can be billed

Transcranial magnetic stimulation (TMS) is covered for workers with treatment resistant major depressive disorder when the conditions of coverage are met as outlined in L&I's coverage decision.

Bill TMS using CPT® codes **90867**, **90868**, or **90869**.

If a significant separately-identifiable E/M service (which may include medication management or a psychotherapy service) is performed, then an E/M or psychotherapy code may be billed in addition to CPT® codes **90867**-**90869**. Use modifier **–25** for a separately identifiable E/M service. Use modifier **–59** for a separately identifiable psychotherapy service.

Services that aren't covered

TMS protocol that isn't FDA-approved isn't covered.

Bills for services performed without prior authorization will be denied.

Documentation requirements

Documentation must include the specific protocol used. The insurer must receive documentation including a copy of the treatment plan.

Chart notes must contain documentation that justifies the level, type, and extent of services billed.

When billing a significant separately-identifiable service using either modifier **–25** or **–59**, the services must be documented separately.

Payment limits

The total number of combined sessions allowed for CPT® codes **90867**, **90868** and **90869** is 30 per course of treatment. Each course of treatment requires separate prior authorization. Additional treatment courses must meet the guidelines described in L&I's coverage decision.

CPT® **90869** may be billed up to a max of 2 units per treatment course.

Treatment related to multiple claims for the same worker is subject to split billing. See Chapter 2: Information for All Providers for more information.

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 attending providers	Washington Administrative Code (WAC) 296-20-01002
Administrative rules for consultations and consultation requirements	WAC 296-20-045 WAC 296-20-051
Administrative rules for mental health services	WAC 296-21-270 WAC 296-14-300
Authorization and Reporting Requirements for Mental Health Specialists	Authorization and reporting rules on L&I's website
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare facility services (including ASCs)	Fee schedules on L&I's website
Mental health services payment policies for **crime victims**	Crime Victims program on L&I's website WAC 296-31
Mental health services website	Mental health services on L&I's website
Payment policies for **case management services**	Chapter 9: Evaluation and Management (E/M)

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 am and 12 pm PT Monday through Friday.

